Manual for Medical Groups

by

Danish Medical Group
Amnesty International

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DOCTORS AND TORTURE

by Povl Riis

This paper deals with the possibilities that doctors have of taking part in the fight against torture within the framework of Amnesty International. Let it be pointed out at once that, through other channels too, doctors take initiatives having the same idealistic aims. It may be mentioned, by way of example, that recently the Society of Swedish Surgeons sent the government of Pakistan a note severely condemning the Pakistani practice of using amputation of the hand as a special punishment of thieves.

The efforts that can be made by doctors will be described within the ranges:

1. Research
2. Information and further professional recruitment
3. Collegiate discipline
4. Contact with national and international media
5. Professional support to the general work done by Amnesty International

Research

The possibilities that doctors with scientific training have of disclosing and fighting torture cover a wide range. This range includes nosographic description of injuries inflicted by torture, the special forms in which they occur, elaboration of methods of detecting hidden torture, disclosure of torture and forced treatment masked as clinical therapy, pathoanatomical and pathophysiological studies of torture sequelae, physical, mental, and social consequences of torture, apart from the possibility offered by medical scientific tradition of laying down a research policy for the disclosure and prevention of torture.

Clinical description of torture sequelae, i.e., the nosographic method applied to this particular field, is still of great importance, especially after the appearance of the first medical reports from Amnesty International. Apparently, there are marked differences from country to country between the forms of torture used. Therefore, prevention cannot be based exclusively upon the nosographic de-

scriptions of, e.g., Greek or Chilean victims.

A particularly important aspect of the clinical description of torture is the increasing accuracy with which the occurrence of certain symptoms and signs can be related to torture as the cause, viz. presenting a likelihood bordering on proof, for which there is a long tradition in other spheres of clinical medicine as well. This *concrete exemplification* of the occurrence of torture, in the form of case reports or descriptions of small groups of persons, must be considered the cornerstone in the medical work of Amnesty International against torture, also after the more refined scientific methods to be mentioned below have come into increasing use.

Another important aspect of the research work is *elaboration of the technique for tracing hidden torture*, which may have been inflicted by chemical agents, thermal influence, electrical methods, etc. So far, chemical analyses seem to be most advanced for direct application.

Disclosing torture and forced treatment masked as medical therapy requires not only elucidation of the methods of action and violence used, but also professional knowledge of the relation that such methods bear to the alleged diagnoses plus a basic knowledge of what is considered at present the most expedient treatment of the alleged conditions. Within this sphere, one must be prepared to utilize professional insight to disclose both the postulated diagnoses and the alleged therapeutic indication.

Pathoanatomical and pathophysiological studies of the sequelae to torture must be considered necessary for a further refinement of the detection technique as mentioned above. Animal experiments may be performed, if the investigation of torture victims does not afford a possibility of lowering the detection threshold by using biopsies, electrophysiological and/or endocrinological methods, etc. As has been pointed out already, the person-centered studies are apt to come up against the difficulty that the triad of victim, equipment, and examiner cannot always be established, at least not while the effect of the torture is at its physiological height. This field of research makes great demands on the theoretical disciplines of medical science.

Medico-legal studies have an important place and great prophylactic potential, although for the individual victim they often cannot be instituted until a time at which the damage is irreversible, if not fatal. The empirical basis of forensic medicine in disclosing even minor injuries caused by violence, in distinguishing intravital from postmortal lesions, etc., has its natural place in medical efforts

in fighting torture.

Efforts by other health professionals do not belong directly to a discussion of the possibilities of doctors in fighting torture, but they should be mentioned at this time. Dentists, nurses, and others can render help within fields which in principle correspond to those applying to doctors.

An important item is investigation of *physical, mental, and social sequelae to torture*. Unlike the above-mentioned clinical evidence of the occurrence of torture, this applies to late sequelae, i.e., damage persisting for months or years after the torture has been inflicted. This research, which combines, e.g., neurological, psychiatric, psychological, and social variables with previous torture, makes great scientific demands, because several of the changes concerned occur also in groups of persons who have never been subjected to torture. Demonstration of mild but disabling changes of the central nervous system is a good example of the demands which have to be made on this important research.

If a kind of *research policy* is to be set up for the medical work done by Amnesty International against torture, it is not enough merely to compile a list of goals for the research which has to be included in this work. The policy must be based upon the realization of which fields of research can be applied at an early stage and which fields make such demands upon their practitioners that it would be more realistic to delay them until a later stage. Nosographic descriptions ought to be extensible to the international level. This fairly simple description of diseases and injuries of a clinical nature can be mastered by doctors who are given some primary instruction in the work, taught to systematize their observations, analyse them by simple statistical methods, etc.

Refinement of detection techniques ought to be a fairly early measure, as in this respect it is presumably possible to utilize an essential part of the highly developed technical insight already present within the medical disciplines. An example close at hand is clinical chemistry and its possibilities of using micromethods.

Another measure that should be used at a fairly early stage of the medical efforts is testing and correlating postulated diagnoses and forced treatments, in this way possibly disclosing them as torture.

Pathoanatomical and pathophysiological studies should be in the hands of doctors possessing the necessary insight into these fields. In general, scientific schooling should also be demanded before such methods can be used to

advantage within the framework of Amnesty International medical work. Medico-legal work should enjoy high priority. This is to say that the diagnostic methods of forensic medicine can be applied directly. In some cases, they can even be based upon photographs of the victims.

The most exacting work, as already mentioned, is systematic investigation of the sequelae to torture. The problem of setting up control groups and thereby disclosing a likelihood that the changes have a bearing upon a torture situation makes great demands on the scientific methodology and should therefore be introduced into the work at a relatively late stage.

Information and Further Professional Recruitment

An important aspect of the medical work against torture is using the comprehensive net of contact that doctors have, enabling them to give their colleagues information about the work and its importance and thereby make propaganda for further professional recruitment. This recruitment of doctors for continued efforts should take place at several levels, from financial support and membership or taking part on a local or national level in discussions of human rights, to active participation in letter groups, research groups, and the like.

Collegiate Discipline

An important initiative is the application by doctors to colleagues suspected of having taken part in torture, clinical control of persons tortured, forced treatment masked as clinical therapy, etc. This supplements the work of the letter groups by applying directly to those who violate fundamental human rights or are at least highly suspected of doing so. There is little doubt that the numerous global contact organs, organizations, etc., that have been established within medical science afford great possibilities of following up such applications and making them result in various forms of sanctions.

Contact with National and International Media

It is of great importance to the work of Amnesty International that it reach a size which may be designated as popular backing. This also applies to that part of the work which is done by doctors within the organization. In keeping up contact with the population, the public media – daily papers, weekly papers,

radio, and television – are important links. There may be a question of primary contact with the professional media, i.e., the medical journals. This is often followed by secondary reactions within the general media. Here we have a parallel with medical information in general, which is usually mediated through this channel, i.e., primarily a professional report with a secondary public reaction through the media. In special cases, it may be advisable to have primary contact with the general media, in the form of press conferences or campaigns.

Professional Support of General AI Work

Doctors and other members of the health sector have special presuppositions for supporting the general work done by Amnesty International. Frequently, questions of threatened health, medical terms, etc., will crop up in data dealing with prisoners' fates, and in such cases it is important to enlist the support of the health professions in assessing and weighing such data.

Teaching of Medical Students and Others within the Health Sector

At longer sight, an attempt should be made to integrate a number of the views and results based on the above-mentioned work in the education of future doctors, dentists, nurses, etc. This can be done by making the necessary information available on a national level, e.g., by papers in the medical press and possibly via monographs on these subjects, which could be sent on request to university teachers and others. Another possibility is to publish medical aspects of violations of the Universal Declaration of Human Rights in the form of teaching symposia.

A special sphere is the teaching of army doctors, who must be considered to need orientation about the clinical and forensic aspects of torture injuries and sequelae.

THE FORMATION OF THE DANISH MEDICAL GROUP

In 1973 Amnesty International (AI) held a conference in Paris devoted to the fight against torture. One of the subjects discussed at this conference was the individual or collective responsibility of doctors in connection with torture. It was recommended to set up a worldwide group of experts willing to travel for Amnesty International, and to examine prisoners who claimed to have been subjected to torture.

A group of doctors was established to work out an examination program and to examine prisoners who had been subjected to torture.

Initially the group consisted of nine doctors, who among them had a broad spectrum of experience within general practice, neurology, anatomy, psychiatry, surgery and internal medicine, and in particular endocrinology. The *object* of the work was to (1) collect information about torture with a view to disclosing whether statutes of the Commission on Human Rights had been violated; (2) investigate torture with a view to tracing sequelae (immediate or delayed) in the endeavor to institute prophylactic treatment and to reduce torture sequelae.

Preliminary Work

During the first months, the group worked out examination forms, sought out instruments and other equipment needed on travels to examine tortured prisoners. Bags to hold the equipment were procured and are held in readiness at all times.

Since knowledge – from a medical point of view – concerning the torture going on today is extremely limited, it was felt necessary to collect preliminary information on which to base the continued work. It was decided, therefore, to carry out a pilot project examining previously tortured prisoners from Chile now domiciled in Denmark, as well as previously tortured prisoners in Greece.

The object of the pilot project was:

a. To elucidate which forms of torture had been applied
b. To ascertain the immediate sequelae according to the victim's own description
c. To describe the possible objective sequelae at the time of examination
d. To demonstrate any objective sequelae at the time of examination

On the basis of these preliminary data, it was hoped to obtain information sufficient to indicate the direction of future and more comprehensive studies.

All the subjects were ex-prisoners who had been subjected to torture. All submitted voluntarily to the examination, and all wishes to remain anonymous have been respected. The selection was done by Chilean and Greek contacts.

Examination was performed from two weeks up to several years after release from prison.

Examination of each individual prisoner consisted in history taking and subsequent objective examination. It was carried out by two doctors with an interpreter present.

In taking the history, emphasis was laid on elucidating the following aspects:

Prisoner's background, social circumstances, family, and political activity

Previous diseases and state of health before the imprisonment (ordinary history, as for a medical record)

Arrest and charges, number of times interned

Prison conditions: total length of imprisonment, size of prison, number of prisoners, whether political and criminal prisoners were together, size of cell, number of prisoners in the cell, lighting, temperature, food, furnishings, sanitary conditions, access to medical aid, visits, warders, informers, international inspection

Questioning and torture: details of the nature, localization and duration of the immediately visible injuries

Symptoms: duration and intensity

State of health otherwise during the stay in prison

Trial, sentence, further course, judicial aid

Present symptoms

Knowledge of other torture methods

Family circumstances

The physical examination comprised an ordinary medical examination including a cursory neurological examination with special focus on the possible objective findings after the specific form of torture to which the individual prisoner had been subjected.

For this purpose, a systematic procedure of examination and a structured interview (same questionnaire) were used, and in each individual case a detailed report was written according to a fixed pattern. The data were later transferred to punch cards and analyzed manually. The results have been published in *Evidence of Torture*, to which the interested reader is referred.

Since that time, we have examined, in addition, approximately 30 tortured Chilean refugees now living in Denmark, 8 tortured refugees living in various European countries and sent by AI London to Denmark for medical examination. We have had missions to the Basque country in Spain, where 36 tortured persons were examined. In 1977 we were in Northern Ireland and in contact with 78 persons.

In the course of time and in step with our extended knowledge, our examination forms and the structure of our reports have been essentially altered and improved. Several subgroups have been formed, which will be presented in the following.

Within the past 6 months, medical groups have been established in other countries, and it is of great importance to coordinate the examination techniques and reports so that the results are rendered comparable.

RESEARCH GROUP ON FALANGA

The Danish Medical Group of Amnesty International has in 1975 and 1976 travelled to Greece in order to carry out examinations of 35 ex-prisoners who had been tortured.

It was found that falanga was a very common form of torture (29 out of 35). Falanga (similar to *bastanado*, similar to caning) is blows to the soles of the feet with a cane, stick, baton or other wooden or metallic tool. Two to 7 years after the falanga torture, 14 of the victims reported symptoms in the form of fatigue and/or pain of varying severity in the feet, legs and joints when walking.

The objective findings were few. We did not find a reduced or altered sensitivity. In 4 victims, the plantar reflex was absent. Six reported tenderness to pressure in places in the sole consistent with their difficulty in walking. Two of the victims could walk on their heels only. Four had diffused swelling and impaired function of one or both ankle regions.

In order to get some insight into the pathogenesis of the acute falanga symptoms and the persistent difficulty in walking in the victims, the medical group made another trip to Greece in the summer of 1977. The leader of the mission was a specialist in anatomy from the medical group. We concentrated on examining those victims who had complained at previous examinations of chronic difficulty in walking. At the same time, we tried to glean information from Greek colleagues about other victims having similar symptoms.

We have obtained X-rays of the feet and in some cases of the ankle, knee and/or hip joints in 5 of the victims with walking difficulties. In only one case, the radiography revealed a small periosteal calcification on the second left metatarsal phalanx, which may be due to the falanga torture.

We thoroughly studied the anamnestic knowledge: falanga causes severe pain in and swelling of the sole. More or less rapidly, the swelling extends to the medial side of the foot and ankle region and to the distal part of the leg, making the foot and ankle region "pyramid-shaped." The swelling persists for about two weeks, often with more or less extensive suggilations and ecchymoses.

We had no facilities for examining joints and bones for possible microfractures, posttraumatic osteoarthritis, necrosis of bones and joints not demonstrable by X-rays and possible nerve injuries with formation of neuroma. All of the results were negative, possibly because none of the named phenomena were present or because processes of repair have rendered it impossible to disclose objective

injuries at the late date of the follow-up examinations.

We have considered many hypotheses in the explanation of the acute and chronic symptoms after falanga. One after the other had to be abandoned, and – partly by exclusion – our attention focused on the possibility of the falanga lesions being a "closed-compartment syndrome" of the foot.

In the leg, this syndrome is well-defined, both in the acute and chronic forms. As far as we know, it has, however, never been described in the foot.

The closed-compartment syndrome is defined as a painful, eschemic circulatory disturbance caused by increased pressure and volume in an anatomical muscle compartment with relatively nonelastic walls. The increased pressure results in a reduced venous return and consequently a reduced flow in the capillaries and smaller arteries. This again leads to a reduced supply of oxygen and accumulation of lactic acid, resulting in a further increase in volume. In other words, with insufficient circulation in the minor vessels, the muscle compartment becomes ischemic.

The area is extremely painful, red, hot and tender. Movements cause pain. The affected muscles may gradually develop functional deficits and sensitivity disturbances. The pulsation of the major arteries is usually normal. In the chronic closed-compartment syndrome in the leg, the patient complains of pain in the muscles on exertion.

There is a striking similarity between the above-mentioned features of the closed-compartment syndrome of the leg and the anamnestic and diagnostic data we obtained from the falanga victims.

Therefore, we carried out a series of studies on feet from fresh corpses left by will to the Institute of Anatomy to investigate whether conditions for the development of the closed-compartment syndrome existed in the foot.

We dissected the feet, injected them at various sites in the plantar, and injected the vessels.

Altogether, our findings suggest that the condition of the closed-compartment syndrome is present in the foot. A detailed report of our findings has been published in the *Journal of the Danish Medical Association.*

If, from our present knowledge, we should suggest a treatment of the falanga victims, our only suggestion is that they should be given intensive physical therapy, heat therapy, rehabilitation, etc.

In our opinion, there is not a definite indication for surgical treatment (fasciotomy) of the closed-compartment syndrome in falanga victims, in contrast to patients with the acute closed-compartment syndrome of the legs.

ENDOCRINOLOGICAL-SEXOLOGICAL RESEARCH GROUP

This working group comprises four doctors who are specialists in surgery, internal medicine (subspecialty: neuroendocrinology), psychiatry and medical physiology. The object of the work has been to investigate whether torture causes changes of the serum-FSH, serum-LH, serum testosterone and sexual function in previously tortured Greek men as parameters of hypothalamic pituital gonadal function.

Background

From our previous examinations of torture victims, we have discovered that the majority exhibited sequelae to the torture. The symptoms and signs were comparable to those described for the post-traumatic cerebral syndrome and to some extent to the concentration camp syndrome. Head injury seems to be a major factor in the development of the sequelae. It is well known that many stress situations affect the gonadal function. It has not been clarified how much importance is to be attributed to mental trauma, and how much to other factors. In young executed persons, pathological changes of the gonads have been reported, and this is interpreted as a direct psychogenic action upon the gonads. Hunger, malnutrition, trauma to the genitals may also play a role. Investigations of ex-prisoners from the concentration camps of World War II have frequently disclosed impotence and have also revealed a close relationship between cephalothopy and head injuries. The concentration camp syndrome could be correlated to the degree of weight loss, although it was not possible to state whether that was the cause. The possibility of a hypothalamic dysfunction has been suggested.

In animal experiments, it has been demonstrated that selective injury to specific areas of the hypothalamus totally abolishes any kind of sexual behavior. In man, areas in the hypothalamus and the limbic system may interfere with libido and potency. Numerous investigations have shown a definite connection between impotence and organic brain disease, but the exact localization has not been demonstrated. Furthermore, male impotence has been reported in various diseases of the temporal lobe (tumor, trauma, epilepsy). Impotence has also been reported in connection with minor, repeated cranial traumas.

The relationship between concentration of the sexual hormones and sexual

function is complex and so far unestablished. For instance, men with pituitary hypogonadism do not respond completely to sex hormone substitution therapy, while in many persons with sexual dysfunction the gonadal hormone levels are within the normal range. On the basis of our primary results in examining previously tortured persons, we imagine that head injury combined with a total psychophysical stress may cause organic brain injury, possibly of the hypothalamus. Of course, gonadal injury may be imagined also, on a traumatic as well as on a psychological basis.

We therefore decided to reexamine some of the Greek ex-prisoners whom we had already examined in 1975/76. To simplify the study, we examined exclusively men.

Procedure

The examinations were carried out in two stages in 1976 and 1977 in Greece. All equipment needed for the examination was brought from Denmark. We examined a total of 17 men. Blood samples of 40-50 ml were drawn between 8 and 10 a.m. After remaining at room temperature for a couple of hours, they were centrifuged, pipetted off, deep-frozen and taken to Denmark in the deep-frozen state. Serum testosterone, FSH and LH were determined by radioammunoassay technique. Sexual function was elucidated by a questionnaire in the Greek language, filled in by the ex-prisoners in private and followed by an interview.

There were no difficulties in getting the probands to answer the questions.

We also investigated a control group of 11 healthy Greek men not subjected to torture with regard to the hormonal parameters.

For practical and financial reasons, only the above-mentioned analyses were carried out, but extra serum was deep-frozen with a view to possible further investigations. It may be added that we later performed studies for the serum concentration of prolactin.

The study as such has not been completed and was presented at a closed seminar in Athens in March 1978. The results have been published at the 3rd International Congress of Medical Sexology in Rome in October 1978. Beyond this, the results will be published as an article in an international medical-scientific magazine.

Amnesty International medical groups in other countries are urged to take up this problem, to perform further and more detailed investigations than what we have done so far. Of course, such investigations should also include women.

CEREBRAL ASTHENOPIA

Definition

Abnormally rapid fatigue of the structures involved in vision.

Background

Pötzl (1928) was the first to name the phenomenon. Among the remission phases which occurred after blindness caused by bullet wounds in the back of the head, Pötzl described one phase which he termed cerebral asthenopia. The characteristic finding in this phase is abnormal fatigue of the structures involved in vision. When the patient fixates on an object, it first appears sharp, but if he continues to stare at it for more than a few seconds, the object becomes unclear, and autokinetic phenomena, diplopia or blurring of vision may occur. These disturbances disappear if the patient fixates on another object, but return as soon as fixation is maintained.

Cerebral asthenopia has been found in connection with:

1. Lesions of the occipital lobes
2. Other localized brain lesions
3. Diffuse brain damage
4. Intercranial vascular diseases
5. (In animal experiments) lesions of the mesencephalon in the region of the oculomotorius and trochlearis nuclei (colliculus superior and inferior)

Cerebral asthenopia therefore being a sign of organic brain damage, we hypothesized that torture victims who have been subjected to head trauma might suffer from cerebral asthenopia as a sequela. We have therefore included an examination for cerebral asthenopia in our standard examination program of torture victims.

Procedure

1. Goldstein-Scheerer stick test
2. Weige-Goldstein-Scheerer color form blocks

Sources of Error

1. Astigmatism
2. Medication (e.g. parasympatolytica)

3. Previous serious cranial trauma followed by dementia
4. Previous or present cerebral vascular diseases

So far only a few torture victims have been investigated for cerebral asthenopia. Among them was a 35-year-old Asian man who had been subjected to severe torture and malnutrition in a prison in Tanzania. He had a strongly positive test for cerebral asthenopia. Two men from Northern Ireland who had been subjected to head trauma were also tested; both had a positive test for cerebral asthenopia.

We intend in the future to examine more torture victims for cerebral asthenopia in order to evaluate whether this is a useful diagnostic tool for the detection of torture sequelae. We would like to encourage other medical groups to perform similar investigations.

PSYCHIATRIC GROUP

The psychiatric group was established in the spring of 1975. It consists of five psychiatric specialists, all heads of psychiatric departments.

The main interest is centered on ethical problems relating to treatment of non-voluntary patients in psychiatric institutions. In the autumn of 1975, a seminar was held at Rungsted, Denmark, attended by psychiatrists from England, Norway, Sweden, and Holland, as well as a legal advisor. Four subgroups were formed to deal with the following subjects:

1. Enforced psychiatric treatment
2. Technical criteria for the diagnosis of psychosis
3. Legal safeguards for psychiatric patients
4. Psychiatric ethics

The group has worked out a set of ethical rules which have already been discussed in the Danish Psychiatric Society and are to be discussed in other psychiatric associations.

We have acted as a letter group in cases having psychiatric aspects, mainly in the USSR, but also in situation where suicides in prisons, etc., have been reported by the International Secretariat in London.

The group also acts in an advisory capacity for the other medical groups when psychiatric expertise is needed.

CHILDREN AND TORTURE

It has been known for many years that children, too, are subjected to torture, but direct physical torture of children has not been published until recently. Psychological torture of children, e.g., by taking them as hostages and maybe forcing them to be present while their parents are being tortured, has also been reported.

On the other hand, it has not been generally known that children whose parents have been imprisoned and/or subjected to torture quite often suffer from various mental and/or psychosomatic symptoms.

Recognizing this serious problem complex, especially at long range, the Danish Medical Group of Amnesty International in 1976 established a special group consisting of a nurse, a social worker, a child psychologist, a psychiatrist and a pediatrician.

The task of this group is to examine children who have themselves and/or whose parents have been subjected to psychological and/or physical torture. We use a special examination form containing spaces for information concerning the child's history, psychomotor development, previous diseases, description of separation from one or both parents, imprisonment, and forms of torture, as well as their consequences to the child, physical as well as psychological. In addition, the child is examined by a doctor, in some cases also by a child psychologist. A special part of the form is devoted to social conditions, including data on housing, financial status, education, and work, as well as any problems in adaptation to the new environment, with respect to work as well as to language.

In 1977, we started examining children from Chile now living in Denmark whose parents had previously been subjected to torture. It was a condition that the children be 15 years of age or younger at the time the child or its parents were imprisoned. The registration is mediated through the Danish Refugee Council, as a greater part of all Chileans in Denmark are refugees. As investigations comprise all children from Chile registered by the Refugee Council, it will also include children who have not themselves and whose parents have not been subjected to torture. This group of children will then act as a control group. The investigation will comprise a total of 300 - 400 children.

FORENSIC MEDICAL GROUP

The forensic medical group was formed two years after the initiation of medical work on torture – a work which obviously has many medico-legal aspects. The fact that two years were to pass before the group was formed reflects the teething troubles in getting the medical work organized.

The group is composed of four specialists in forensic medicine and one professor of law.

The first task which the group took up was, quite naturally, to evaluate death certificates and legal documents relating to persons who presumably had been tortured to death. These documents were sent to the group by the CAT Department (Campaign against Torture), London. The group has received photographs, death certificates, autopsy reports and other official documents. All incoming material is evaluated by at least two members of the group, and the conclusions drawn by the group are subsequently used by Amnesty International in London.

Through this work, the group developed a more systematic approach. It has now extended its activities to cover studies of the legal basis for making up death certificates and conducting autopsies in respect of prisoners having died in countries practicing torture. The questions examined in such cases are: Who filled in the death certificate, and was he/she attached to the institution concerned (prison or similar establishment)? Was a legal autopsy performed? Who was responsible for the performance of autopsy? To elicit information on these points, the group approaches WHO and forensic pathologist colleagues in countries where torture is exercised. The objective of this work is, of course, to have established international rules with respect to the filling in of death certificates. In the group's opinion, the ideal solution would be a rule to the effect that where death occurs in an institution, the death certificate shall be made out and autopsy performed by persons who are not in the employ of or otherwise attached to the institution concerned.

A third sphere of activity is letter actions. At the request of Amnesty International in London, the group writes to the appropriate forensic medical au-

thorities for information about the circumstances surrounding deaths which are presumed to have been caused by torture. It should be pointed out that the group does not rest content with a negative answer or no answer. Every case is followed up as far as at all possible, and relevant cases are published in medical journals.

The members of the group make their services available to Amnesty International when the organization desires the presence of medico-legal experts at the place where autopsy is to be performed.

The group has contacted colleagues abroad with a view to establishing an international group of interested medico-legal experts. Contacts to this end have so far been established with colleagues in the United States, the United Kingdom, Finland and Norway.

DENTAL GROUP

The work of the dental group was started about one year after the medical group had been established. The reason odontological expertise was needed so soon was that, according to the medical examinations, practically all victims had been subjected to torture involving the head and/or face.

For the dental examinations, a special questionnaire was made out, in analogy with the medical questionnaire. It has been revised several times, as our experience has increased. The history includes questions concerning the torture, early symptoms after torture, present symptoms, and dental care before, during, and after torture and imprisonment.

During the first year of our cooperation with the physicians, the victims were referred for dental examination if the physicians felt this was necessary. However, it was gradually discovered that some victims also had lesions of the oral cavity of which the physicians were unaware. For this reason, all victims are now examined by dentists as well as by physicians.

To extend our knowledge, a dentist took part in the medical examinations in Spain in December 1977, even though actual torture had not taken place. Several of the victims had been released a short time before our examinations, and this afforded a good basis for assessing the effect of the torture sequelae and the general effect of imprisonment upon the teeth.

So far, the dental group has examined 34 torture victims, and in 28 of these victims the findings were, in very brief summary:

a. 5 had one or more teeth loose because of blows
b. 2 had lost teeth in direct consequence of blows
c. 6 had lost teeth in secondary consequence of blows
d. 6 had sustained fracture of one or more teeth during torture
e. All the victims had varying degrees of peridontal diseases
f. All but a very few of the victims had lost teeth during the stay in prison
g. All but a very few of the ex-prisoners were tender to palpation of the temporo-mandibular joints and/or masticatory muscles

h. 5 ex-prisoners complained of symptoms from the temporo-mandibular joints
i. 5 ex-prisoners had been subjected to electrical torture to the teeth, lips, tongue and/or temporo-mandibular joints
j. Quite a large number of the ex-prisoners had had injuries to the soft tissues of the lips, chin, tongue, cheeks, etc., leaving scars in a few of them
k. All the ex-prisoners from Spain who had been subjected to the "bath" (immersion of the head and upper part of the body into dirty water filled with vomit, blood, urine, hairs, etc.) had suffered from stomatitis

Evaluation of the findings in relation to imprisonment and torture presupposes a good knowledge of the victims' background. Without such knowledge, it is often very difficult to assess the actual deterioration of the teeth. It is essential to know about each victim's dental status prior to torture and stay in prison, about the normal dental status in the community concerned, and about the victim's social status. Innumerable studies have shown that oral hygiene, degree of treatment, and dietary habits are closely associated with education and social status. Therefore, it is of the utmost importance to establish dental groups in as many countries as possible, as this will greatly facilitate the correct interpretation of our findings.

To disseminate knowledge about the work of the dental group, we presented a paper at the International Congress of the Medical Groups of Amnesty International in Athens in March 1978, and a paper of ours has been accepted for publication in the journal of the Danish Odontological Association. Furthermore, reports of the dental group are distributed via the medical groups, so that interested doctors and dentists in other countries can receive orientation and, we hope, inspiration for continued studies.

MEDICAL LETTER GROUP

One aspect of the medical profession's fight against torture is exemplified in the work of the medical letter groups initiated in Denmark in 1975.

The idea of doctors' being able, by means of their professional skill, to make a special contribution to the Amnesty International letter actions emerged among some medical doctors who, as conscientious objectors, were doing their national civil service in the AI office in Copenhagen. They organized a letter group involving doctors who were already AI members and enlisted additional members through advertisements in the medical press.

The letter group works together with other AI groups in fighting torture in general, as well as the death penalty, improper legal proceedings, and isolation from next-of-kin. We are, however, specially concerned with:

1. Prisoners suffering from illness, be it natural or a direct result of torture or other forms of ill-treatment, who are not receiving proper medical care.
2. Prisoners belonging to the medical profession in any capacity.

The Danish medical letter group has been functioning for four years. At present it consists of about 125 members divided into five subgroups of equal size and a committee of nine who meet every two months and provide contact with the AI office. The group employs one half-time secretary.

The committee gets its information from AI in London by telex or post. On average, we receive a case sheet once a week, describing in as much detail as possible the plight of the person or persons concerned.

Many of these are "Urgent Actions", which concern people who are under sentence of death or in immediate peril of dying from illness or maltreatment. Sad to say, we deal mostly with urgent cases, as these are pouring in at an alarmingly increasing rate.

Members of the committee take turns composing letters to the authorities involved (i.e., presidents, ministers of justice, or police chiefs, many of whom seem

to have a predilection for adding "General" to their titles). The letters, which must be kept polite and nonaggressive, however heated one may feel about the subject, ask for leniency. We state that "we know" and that "you are responsible", but we do it in a nice, restrained way.

It is considered important that we appear as a medical group, implying a shared professional indignation without any political overtones. Amnesty International can be referred to, unless there are specific instructions to the contrary. If AI London requests us to, we include a brief description of its aims and principles. The letter should be written in the appropriate language, and interpreters are available through the local AI office.

The secretary forwards three copies of each letter to the members, together with a copy of the case sheet. Only one of the five subgroups is contacted on each action, so that each group will be involved on an average of once every five weeks.

Upon receipt, each doctor reads the case sheet from the London office, as well as the finished letter (in translation if the language is not English), and decides whether to participate or not. If he/she agrees with the aim of the letter, he/she signs one copy of it, adding "M.D." after the signature, stamps it with his/her official stamp, and sends it.

In order to make the actions simultaneous, there is a deadline of two weeks within which the letters must be sent. One of the extra copies is to be sent back to the local AI office; the other is for the member's own use.

The posting itself, by the way, is quite a tricky business. It is considered important that the envelope look as impressive and official as possible. Use of hospital stationery is advised, if available. The letters should be sent by air mail and registered if possible. Precautions against "philatelists" among the postal staff have to be taken by using "uninteresting", slightly defaced stamps.

Apart from these letters to individuals, we also appeal to professional organizations (legal or medical) and to the local embassy of the country in question. Additionally, a small group of eminent psychiatrists participates in letter actions which have strong psychiatric aspects – a very efficient way to get through to the doctors who abuse psychiatry by detaining and torturing political prisoners in mental wards.

A follow-up is undertaken in all actions, using either a standard letter or, in special cases, a letter composed by the committee member who composed the original letter.

A first reminder is sent five weeks after the original letter, urging an answer and

announcing that the national medical association of the country will be informed if there is no answer forthcoming.

If, after another five weeks, no answer has been received, the national medical association of the country is informed and a second reminder is simultaneously sent off to the authorities, announcing this time that the World Health Organization (WHO) and World Medical Association (WMA) will be informed about the case. If there is still no answer forthcoming within five weeks, copies of all our letters in the case are forwarded to WHO and WMA.

Fortunately, an increasing number of our actions do result in answers. Copies of these replies are forwarded to the International Secretariat in London and the committee member in charge of the action sends a mild reply immediately, requesting further information in order to try to launch a dialogue.

At intervals of approximately six months, the committee reports back to the members about the actions and their results.

We also work in close cooperation with the other medical groups and with the board of the Danish Medical Association.

Amnesty International's public relations group helps us by publishing some of our activities in the newspapers, and the Danish Medical Group as a whole has a column, "Amnesty-Memento," in the *Danish Medical Weekly*.

Does all this work?

The answer is yes. It is impossible to make anything vaguely reminiscent of reliable statistics concerning these matters, as so many other factors are involved, but in about half the cases the conditions of the prisoners have definitely improved. We have good reason to believe that our actions have played an important role in bringing this about.

The idea has spread, and medical letter groups are springing up around the world. Up until now, groups have been established in Sweden, France, Holland, Canada, Switzerland, the U.S.A., Greece, Australia, Norway, and India, and more are on the way. What we really need now is the cooperation of additional groups in the Third World, as we believe their help could have a great significance.

One last note: In light of the Medical Advisory Board's initiative via medical committees in Holland and Denmark to approach doctors proved to have participated in torture, the medical letter group has taken up the question of strongly suspected doctors.

GRANTS TO A MEDICAL GROUP

Travels abroad to examine torture victims, as well as comprehensive and highly specialized research projects, require considerable financial aid.

In the course of time, therefore, the Danish Medical Group has tried to obtain grants from public as well as from private funds.

In the first couple of years, 1974-76, no financial aid was forthcoming, in spite of numerous applications.

It was not until 1977 that the group received recognition for its work, partly in the form of grants from private foundations and private persons, but also through the Danish Medical Association, including grants for which no applications can be filed.

In the autumn of 1977, through the Danish Medical Association, we sent an appeal to all the association's members for financial support, and this gave a praiseworthy and appreciable response.

The Danish Medical Research Council has awarded several grants-in-aid to research groups and for the clinical examination of people subjected to torture, as well as for the experimental work done to disclose whether torture has taken place.

The Minister of Finance in 1978 granted considerable aid, and in the same year the medical group received financial support from the King Christian X Foundation, with the approval of Her Majesty Queen Margrethe II.

Finally, it should be noted that a physician honored in 1978 with a prize for his scientific achievement passed the money on to the medical group.

RESULTS FROM AN ACUTE MISSION TO NORTHERN IRELAND

In light of allegations which continued to reach Amnesty International, the International Executive Committee decided to send a research mission to Northern Ireland. Due to the fact that the majority of allegations reaching Amnesty International referred to persons in the custody of the Royal Ulster Constabulary, the terms of reference of the mission were restricted to investigating such allegations rather than more general charges of human rights violations. The mission, consisting of a Dutch lawyer, a Danish doctor, and a member of Amnesty International's International Secretariat, visited Northern Ireland on the 28 November - 6 December 1977. It was joined on the 30 November by a second Danish doctor. The team interviewed organizations and individuals in Belfast, Dungannon, and Londonderry. Most of those interviewed were complainants. In addition to speaking with the complainants and a number of organizations concerned with civil liberties, the mission met lawyers, doctors, politicians at the local and national levels, and, among the authorities, the Deputy Secretary of State, a representative of the attorney general's office, the chief constable and the deputy chief constable of the RUC, the head of the RUC complaints branch and members of his staff, members of the Police Federation of Northern Ireland, and the Director and Deputy Director of Public Prosecution. In addition, it met the chairman, secretary, and other members of the Northern Ireland Police Authority, doctors under contract to the Authority, members of the Police Surgeons' Association, and the head of the Police Complaints Board. During the mission, the Amnesty International delegates obtained direct testimony from 52 persons who alleged that they had been maltreated while in police custody. The delegates also examined medical reports relating to 13 of the 52 cases, and five of the 52 agreed at the request of the delegates to be further examined in greater detail by the medical members of the mission. In addition to obtaining testimony directly from the above-mentioned persons, the delegates also examined medical reports and other apparently corroborative data in relation to a further 26 cases of alleged maltreatment. Thus, overall, a total of 78 cases were examined in some detail by the mission. On the basis of the findings, the mission reached the following conclusions:

1. On the basis of the information available to it, Amnesty International

believes that maltreatment of suspected terrorists by the RUC has taken place with sufficient frequency to warrant the establishment of a public inquiry to investigate it.

2. The evidence presented to the mission does not suggest that uniformed members of the RUC are involved in the alleged maltreatment.
3. The evidence presented to the mission suggests that legal provisions which have eroded the rights of suspects held in connection with terrorist offences have helped create the circumstances in which maltreatment of suspects has taken place.
4. The evidence presented to the mission suggests that the machinery for investigating complaints against the police of assault during interview is not adequate.

Recommendations:

1. Amnesty International recommends that, for reasons relating to the protection of suspects and police officers alike, a public and impartial inquiry be established to investigate the allegations of maltreatment.
2. The terms of reference of this inquiry should include consideration of the rules relating to interrogation and detention, admissibility of statements, and the effectiveness of machinery for investigating complaints against the police of assault during interview.
3. The inquiry should have access to all relevant data on individual cases of alleged maltreatment.
4. Pending the establishment and reporting of such an inquiry, Amnesty International recommends that immediate steps should be taken to ensure that suspects being interviewed by the Royal Ulster Constabulary on suspicion of terrorism are protected against possible maltreatment. Measures to this end should include access to lawyers at an early stage of the detention.

Following the publication of this report from Amnesty International in June 1978, the Secretary of State for Northern Ireland announced that a committee of inquiry would be appointed, rather than a public inquiry. This committee would not be asked to look at individual cases of maltreatment.

This committee published the *Report of the Committee of Inquiry into Police Interrogation Procedures in Northern Ireland*, which was presented to Parliament by the Secretary of State for Northern Ireland by command of Her

Majesty the Queen in March 1979. It is a very detailed document, ending with a summary with 64 principal conclusions and recommendations. Some of these are:

(16) Medical officers in 1977 and early 1978 made representations about the treatment of prisoners, and in some of the cases investigated by Amnesty International there was *prima facie* evidence that ill-treatment had taken place. Our own examination of medical evidence reveals cases in which injuries, whatever their precise cause, were not self-inflicted and were sustained in police custody.

(24) Interviews should not last longer than the interval between normal meal-times or extend over meal breaks, or continue after midnight, except for urgent operational reasons. Not more than two officers at a time, or six in all, should interview one prisoner. Officers should identify themselves by name or number.

(25) A Code of Conduct should be drawn up for interviewing officers, to form a separate section of the RUC Code.

(30) The present situation calls for senior police officers to exercise their responsibility for the good conduct of interviews, rather than for the supervision of interrogation to be transferred to another body, and for changes in police procedures to allow any misconduct to be detected at once and dealt with without delay.

(32) Senior detective officers should allot part of each working day to supervision.

(33) The number of uniformed supervisory inspectors on duty throughout the day at Castlereagh Interrogation Center should be increased, and the supervisory strength at inspector level elsewhere should be reviewed.

(34) Responsibility of inspectors for the welfare of prisoners should plainly extend to periods in an interview room, and they should, if necessary, enter the room and stop the interview.

(35) Viewing lenses should immediately be installed in all remaining rooms where interviews take place.

(36) Closed-circuit television cameras should also be installed in all interview

rooms used for interrogation. The monitor screen should be used by the uniformed supervisory staff on duty, and further monitors should be provided for use by senior uniformed officers.

(39) Medical examination should not necessarily take place after each interview, but the uniformed police staff should ask each prisoner after each interview whether he has any complaints and whether he wishes a medical officer to see him.

(40) Medical officers should see all terrorist suspects and persons suspected of scheduled offences during each period of 24 hours and offer them an examination.

(42) The importance of medical examination should be impressed on prisoners both by medical officers and in printed notices.

(45) The consistent refusal to allow access to a solicitor throughout the whole period of detention is unjustifiable. Without prejudice to their existing rights, prisoners in Northern Ireland should be given an unconditional right of access to a solicitor after 48 hours, and every 48 hours thereafter. But solicitors should not be permitted to be present at interviews.

(56) Responsibility for considering the prosecution of police officers should remain with the Director of Public Prosecution, who should continue to receive all cases in which criminal conduct by a member of the RUC is alleged.

(57) The Director of Public Prosecution should specify to complainants the possible criminal offences for which prosecution has been considered, and indicate whether his decision has been reached on evidential or other grounds and any reason for delay.

(58) The director should inform the Chief Constable of cases which he considers especially suitable for the commencement of disciplinary proceedings.

(64) The Police Complaints Board should be informed of all disciplinary action arising from the investigation of complaints, and their requests for information should be met.

MEDICAL GROUPS IN OTHER COUNTRIES

In establishing medical groups in countries where this part of Amnesty International activities has not yet been tried, it is important to direct the activities of fields which, according to experience so far, have proved realistic and gainful. More ambitious initiatives should be put off, as far as possible, to a later stage, when the inner structure of the work, secretarial functions, etc., have been worked up. These items, as well as the possibilities of contact with the public, will be discussed below. Finally, the problems concerning the international structure of this work will be discussed.

Tasks

It is realistic, and at the same time important, to establish *letter groups* at an early stage. This refers not only to the prisoner-oriented letter campaigns, but also to participation by doctors in international collegiate discipline, operating by applications to doctors suspected of having taken part in the exercise or control of torture.

Another important aspect which should be included in the early work is *research*. To a newly established medical Amnesty organization, it is expedient to point out the *description of torture injuries and sequelae* and present a clinical likelihood or evidence of their occurrence. No doubt it is important for the medical groups of the country concerned to apply to countries or regions in which they have special linguistic, cultural, or political presuppositions for working. By this means, it is possible to avoid further duplication of medical Amnesty International work. It is a deplorable fact that the need for such work is considerable. To benefit the preventive efforts, it is important for medical Amnesty International initiatives to operate in several places on all continents.

An important item is *channels for reporting* where torture and forced treatment are being masked as medical therapy. Also in this respect, early efforts must be possible.

Medico-legal investigations should also be initiated as an early measure. On

the other hand, newly started organizations should be cautioned against instituting *pathophysiological and pathoanatomical studies* at an early juncture. The same applies to *investigations into the sequelae to torture*, at least where such investigations include psychiatric, psychological, and social variables.

It ought to be possible to make an early start of doctors' *participation in general Amnesty International work*. As already mentioned in another connection, doctors and other medical personnel have great opportunities to support Amnesty International adoption groups by their ability to assess the significance of data concerning health in the reports received. This medical support to other Amnesty International work will also counteract any tendency for the medical work to take place in a kind of enclave within other national Amnesty International work.

Establishing Contact with the Media

In other connections, it has been mentioned that contact with the public media is important in order to procure the necessary popular backing of Amnesty International's work. This is a decisive presupposition for the successful work of the organization, its financial possibilities, and its ability to adapt itself to new conditions. This requires contact with the public media. It may be contemplated whether such contact with daily papers, weeklies, radio, and television should be direct, in the form of press releases, press conferences, etc., or whether to use the ordinary medical channels of command: publishing the reports in the national professional press, whence the media transmit the information secondarily. The risk of primary contact with the media is that the reports may be hurried through at a time when they have not been finished professionally. At longer sight, this may prove a strain on the medical profession, and especially its scientific community. Reversely, there is a favorable experience of primary contact with the professional channels, with secondary quotation and follow-up within the public media.

International Contact between the Various National Groups

Setting up medical groups under Amnesty International auspices in various countries gives rise to the question of how these groups can collaborate and coordinate their efforts. It is a matter of discussion whether a truly international organization would be preferable or whether a looser contact would be equally expedient and more realistic.

The experience of international organizations is that they have a very high cost/benefit ratio. Moreover, much time is expended on procedure, if work in the national sections is to be directed and controlled centrally. It would appear that a looser structure of collaboration might be more expedient. Such collaboration could be set up by holding a meeting every year or every other year. For instance, countries having medical Amnesty International groups might alternate in acting as host country and secretariat (which will involve a good deal of work). Presumably, the nonhost member countries could be persuaded to contribute a certain sum towards the secretariat expenses. Such a joint conference ought to comprise one or more main topics and thereafter divide into sections in which the doctors of the individual countries could meet their colleagues working within the same field, i.e., letter groups, doctors working on the description of torture sequelae, etc., having separate sections.

It is worth considering whether the medical groups and other Amnesty International groups within the health sector ought to aim at official contact, via a loose but still formal international structure, with international organizations in the field – WHO, WMA, CIOMS, etc. – but of course within the framework of the main organization, Amnesty International.

It seems justified to conclude that the possibilities of preventing the use of torture and capital punishment through the work of the medical groups depend more upon the fieldwork carried out by the various active groups than upon the formal structure of international collaboration within this sphere.

ANTI-TORTURE RESEARCH: RESEARCH GROUP ON PROCEDURES TO REVEAL ELECTRICAL TORTURE

Electrical torture is, to an increasing extent, being executed in such a way that macroscopic lesions in the skin are absent. This challenge in 1974 prompted the formation of a Danish medical group with the specific aim of trying to establish diagnostic procedures that could reveal this type of torture. In the following, an account of the work performed by the group up to now is presented in chronological order.

As a first step, the group consulted specialists in the field of forensic medicine to define specific diagnostic approaches. It became clear that metal deposits on the skin from the electrodes should not be expected to be of diagnostic significance.

The group then procured access to an electrical prod comparable to those used for driving cattle. This prod had been used for electrical torture of prisoners. The electrical features of this instrument were characterized, leading the group to suggest two possible avenues for research on sequelae to electrical torture:

1. Dermatological and histological studies
2. Neurophysiological studies

Subsequently, neurophysiologists were consulted and advised the group to concentrate its efforts on exploration of alternative (1). A review of the literature indicated that reports on comparative studies of sequelae to heat and electrical exposure of the skin were not available. Such studies were considered to be highly relevant to the diagnostic objective, because most authors have suggested damage to the skin via electricity to be the result of concomitant heat influence. Only a few investigators consider it morphologically feasible to distinguish between lesions in the skin produced by heat and electricity respectively. The planning also included studies comparing sequelae from exposure to electricity with alterations occurring spontaneously in unexposed skin.

According to the literature, animal studies preferably should employ porcine skin, since this morphologically is close to human skin. Hence, a protocol was

drafted for experiments on pigs. The group at this stage comprised 4 physicians and 2 physicists and now was expanded to include a veterinarian.

Financial support for preliminary exploration of the subject was granted via application to the Danish Medical Research Council. The grant allowed the manufacture of simple instruments for depositing heat and electrical energy, respectively. Both instruments were equipped with energy-releasing metal knobs with dimensions identical to the electrodes of the torture prod and positioned similarly. It was considered essential to measure the energy so that comparable deposits could be made via heat and electricity.

The experiments were initiated in February 1976 and have been performed continuously since the start. All experiments have been performed on fully anesthetized pigs. Initially, amounts of energy were applied with uniformly produced well-defined alterations in the skin. The protocol included subsequent studies of lesions in response to exposure at the energy level released from the torture prod.

Resources in the vicinity of U.S. $16,500 have been made available to meet expenses for special equipment, experimental animals and technical assistance. Without the interdisciplinary composition of the group and access to equipment and facilities in several institutions, it would not have been possible to perform the experiments. These have led to the definition of criteria for reliable differentiation between cutaneous sequelae to exposure to heat and electricity, respectively.

Using the defined criteria in blind studies, the nosographic sensitivity was found to be 0.81 and 0.76 in regard to exposure to heat and electricity, respectively, while the nosographic specificity was 1.00 in both cases (Danielsen et al., 1978). The most outstanding histological features for heat-exposed skin were diffuse subepidermal clefts and granular eosinophilic cytoplasm in the epithelium. In contrast, homogeneous "white necrotic" segments were seen in the attached epidermis from electrically influenced skin. Using direct current, exposure to only 6 Joules produced characteristic alterations in epidermis, sweat glands and vessel walls. At the level of 8 Joules, alternating current induced alterations detectable via light microscopy without leaving macroscopic changes. This level of energy is comparable to that deposited via the torture prod.

The results of each trial are evaluated at monthly meetings and form the basis for the next experiment. At these meetings, the group is informed by its chairperson about the current status of other groups acting within Amnesty Inter-

national. Pertinent tasks are delegated to members, and special emphasis is placed on the preparation of scientific papers to be published in a variety of journals.

At the 11th International Council meeting in Cambridge, England, September 1978, the decision was taken that Amnesty International shall not sponsor medical experiments involving the use of either human beings or animals. In November 1978 the organization Anti-Torture Research (ATR) was founded. The objective of ATR is to promote research on the biomedical consequences of torture.

The interdisciplinary composition of this medical group has proved to be highly advantageous in regard to proper planning and execution of the experiments. Hence, the group recommends making the topic of research and activity the common denominator, matched by a relevant interdisciplinary numerator.

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