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MEDICINE AT RISK:
THE DOCTOR AS HUMAN RIGHTS ABUSER AND VICTIM

A background paper prepared by
the Medical Office,
International Secretariat of Amnesty International,
for the meeting:

"MÉDECINE À RISQUES:
RISQUES DE SERVIR LA RÉPRESSION OU D'EN ÊTRE VICTIME",

Paris, 19-21 January 1989.

MEDICINE AT RISK:
THE DOCTOR AS HUMAN RIGHTS ABUSER AND VICTIM

Introduction

In 1978, Amnesty International convened an international meeting in Athens which brought together some 100 health professionals from 13 countries to discuss "medical detection and effects of torture, the need for treatment, rehabilitation and compensation of torture victims, and other work of the medical profession against violations of human rights".

Among the many conclusions and recommendations made by the participants, three themes were identified for continuing study and campaigning. Two of these particularly relevant to the subject of "medicine at risk" were strategies for the prevention of torture, and the elaboration of medical ethics codes against torture [1].

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

The second encouraging development has been the active public opposition of some medical and other associations to torture and their commitment to disciplining those health professionals who participate in it (see below). However, in the face of continuing human rights violations and despite committed work by human rights groups and professional bodies [2], a wider degree of engagement by

[1] The third was the rehabilitation of torture victims. See Violations of Human Rights: Torture and the Medical Profession. Report of an Amnesty International Medical Seminar, Athens 10-11 March 1978. AI Index:CAT 02/03/78 [2] One of the associations which reversed a previous quiescent stand on human rights was the Colegio Médico de Chile which, after being permitted by the government to elect its own officers for the first time since 1972, embarked on a program of medical ethical awareness, including the novel initiative of publishing, in November 1983, the WMA's Declaration of Tokyo as a paid advertisement in a major Santiago daily newspaper. This reflected the Colegio's belief in the importance of a public and professional understanding of ethical standards particularly with regard to torture. See, Stover E. The Open Secret: Torture and the Medical Profession in Chile. Washington: AAAS, 1987.

health professionals in supporting colleagues at risk would make a significant contribution to the fight for human rights.

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

abuses.

Human rights standards specifically applicable to health professionals

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

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

The World Medical Association, at its assembly in Tokyo in 1975 adopted a declaration which stated that it was prohibited for a doctor to "countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty..." [3]

The World Psychiatric Association, in its Declaration of Hawaii (1977) stated, inter alia, that "no procedure shall be performed nor treatment given against or independent of a patient's own will..." and "the psychiatrist must never use his professional possibilities to violate the dignity or human rights of any individual or group...".

Nurses' and psychologists' associations have also set

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

out the responsibilities of these particular professions with regard to the care of those in detention.

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

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

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

- Examination of prisoners before interrogation to ensure that the prisoner can survive torture or to find sensitive foci for exploitation during torture.

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

- To "patch up" the victim after torture, possibly to

undergo further sessions or to make the prisoner presentable for appearance in court or after release.

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

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

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

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

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

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

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

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

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

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

[5] In Sudan in 1983, a surgeon was included in a delegation sent to Saudi Arabia to learn amputation techniques; he later participated in the carrying out of the first amputations in Sudan. In Iran, a new amputation device was apparently designed in 1985 with the advice of medical personnel in Teheran. [6] Occasionally some talk to the press; see a series of press articles about a Brazilian doctor who, in 1988, was disciplined by the Regional Medical Council of Rio de Janeiro for assisting torture in the 1970s: Istoé, 1, 8, and 15 April 1987. Bloche MG. Uruguay's Military Physicians: Cogs in a System of State Terror. Washington: AAAS, 1987. [7] Jadresic A. Doctors and torture: an experience as a prisoner. Journal of Medical Ethics, 1980, 6:124-7. [8]

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

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

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

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

Evidence of the participation of health professionals in violations of human rights

Evidence of the participation of health professionals in abuses of human rights is, unfortunately, readily found but perhaps not widely discussed or acknowledged. The report by the British Medical Association on doctors and torture,

[9] ("Yo solo cumplo con mi trabajo".) Testimonies on detention procedures, torture and prison conditions in Uruguay. AI Index: AMR 52/18/79, 25 June 1979.
[10] Lifton RJ. The Nazi Doctors. London: Papermac, 1987.
[11] Bloche, op. cit.
[12] Ruthven M. Torture: the Grand Conspiracy. London: Weidenfeld and Nicolson, 1978; Peters E. Torture. Oxford: Blackwell, 1985.

published in 1986, concluded that "the evidence given to the [BMA] leaves no room for doubt that doctors are involved in many parts of the world in the physical and psychological torture of prisoners." [13]

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

Abuses of psychiatry for political reasons have been documented in the USSR, Czechoslovakia, Romania and Yugoslavia, though the role of psychiatrists in these abuses probably varies from those who knowingly falsify a psychiatric diagnosis with the express purpose of colluding in the imprisonment of a political or social non-conformist to those whose role is more passive and who fail to protest at the failure of the legal system and their own colleagues and superiors to protect individuals from such abuses. The motivations of psychiatrists involved in these practices probably include genuine belief in the diagnoses such as "sluggish schizophrenia" [14] as well as conformist, bureaucratic and ideological reasons [15].

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

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

[13] BMA, op. cit. p.22. Reich W. The World of Soviet Psychiatry. In [14] Stover and Nightingale (eds), op. cit. [15] See Bloch S, Reddaway P. Russia's Political Hospitals London: Gollancz, 1977 [16] Curran WJ, Casscells W. The ethics of medical participation in capital punishment by intravenous drug injection. New England Journal of Medicine, 1980, 302:226-30. [17] Kevorkian J. Medicine, ethics and execution by lethal injection. Medicine and Law, 1985, 4:307-13. [18] Cited in AI. The death penalty in the [USA]: an issue for health professionals. AI Index: AMR 51/40/86, 1986.

of such behaviour has yet to be ruled upon by the APA.

The involvement of health professionals in certain other human rights violations - flogging, amputations, prolonged solitary confinement - is more contentious since these abuses are provided for by law in some countries and doctors' presence at their infliction may be specified in law. However, some individual doctors and some medical associations have nevertheless protested at such punishments being carried out in their country. For example, the Mauritanian Association of Doctors, Pharmacists and Dentists expressed "deep concern" at the involvement of physicians in the punitive amputation carried out on three convicted thieves in

September 1980. Another amputation took place in June 1981 and again a doctor was involved though it was reported that two amputations carried out in 1982 were executed by a medical auxiliary following refusal by doctors to assist. In Pakistan, both the Karachi branch of the Pakistan Medical Association and the Pakistan Junior Doctors Association voiced their concern about floggings of political prisoners.

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

> The experiences of those who gave information to the [BMA] demonstrates that a refusal to compromise is effective in the early stages, firstly because the doctor himself is less likely to be compromised and secondly because the apparatus of the state is likely to be vulnerable to concerted public opposition. Once these early stages have been allowed to pass unchallenged, it may be too late to avoid serious abuse. [18]

Human rights violations directed against health professionals

Reasons for repressive measures being taken against health professionals include:

- their real or perceived peaceful or violent political activities against the government.
- their activities in human rights groups
- their professional activities or criticisms of government health policy.
- their giving treatment to injured armed opposition figures.

[18] BMA report, op. cit., p.22.

- the perceived deterrence value of making an example of the health professional.
- accidental reasons (for example, being in the wrong place at the wrong time).

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

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

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

In the USSR, those involved in the work of the unofficial Moscow Working Commission to Investigate the Use of Psychiatry for Political Purposes were detained in connection with their work in documenting the practice of internment of prisoners of conscience on spurious psychiatric grounds. Dr Leonard Ternovsky (b.1933), a radiologist, was arrested on 10 April 1980 in Moscow and was charged under Article 190-1 of the RSFSR Criminal Code with "anti-Soviet slander". He was subsequently convicted and sentenced to three years' imprisonment. Other members of the Working Commission were also imprisoned in the period 1980 to 1981, culminating in the sentence of 12 years' imprisonment and internal exile for Dr Anatoly Koryagin, the psychiatric consultant to the Working Commission, following the publication in the British journal The Lancet [19] of a paper describing his experiences of the misuse of psychiatry for political purposes.

[19] Koryagin A. Unwilling patients. Lancet, 1981, i:821-4.

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

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

On 31 March 1980 a one day strike was called by lawyers in Damascus and this was supported by other branches of the Bar Association and by other professional associations including members of the Syrian Medical Association.

Shortly after the strike, the national congresses and regional assemblies of the Medical, Engineers' and Bar Associations were dissolved by the Syrian Ministerial Cabinet. In the days that followed the dissolution, numerous lawyers, doctors and engineers were arrested and held without charge or trial. At least two doctors were later executed and some 100 doctors remain imprisoned still without charge or trial more than eight years after their arrest.

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

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

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

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

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

Since 1980, Amnesty International has issued medical appeals on behalf of health professionals in the following 30 countries:

Afghanistan
Algeria
Benin
Chile,
Colombia
Cuba
Czechoslovakia
El Salvador
German Democratic Republic
Guatamala
Iran
Laos
Nepal
Paraguay
Republic of Korea
Romania
Singapore
Somalia
South Africa
Sri Lanka
Sudan
Turkey
Uganda
USSR
Uruguay
Vietnam
Yugoslavia,
Zaire.

The role of professional and other associations in combatting violations and protecting health professionals

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

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

Unfortunately, in many cases the associations themselves are under severe threat or acute repression. As noted above the Syrian Medical Association was dissolved after calling for human rights reforms in 1980; members of the Turkish Medical Association were prosecuted in 1986 for calling for an end to the death penalty in Turkey; the Chilean Medical Association was raided by security agents in 1985 at the time it was organising a meeting with international participation on the theme of the role of medical associations in the protection of human rights.

However, it is striking that medical associations and other professional bodies in countries where abuses occur systematically have frequently not spoken out against them nor taken any apparent action against health professionals collaborating in torture, covering up deaths following ill-treatment or carrying out other unethical acts. Individuals doctors seeking support from their association or an obvious body to whom to complain, may interpret the silence of the professional association (sometimes correctly) as a disinterest in the issue or an unwillingness to speak out. If the professional leadership will not speak out, the pressure on individuals to remain silent is all that greater [20].

Recently, the Uruguayan Medical Association has been active in promoting the idea of an international medical forum for the hearing of evidence of medical abuses against human rights. This idea was recently supported at a meeting in Geneva in October 1988 of the International Council of Health Professionals.

Some specialist groups of professionals have looked at ways of using their own expertise to counter human rights violations. For example, forensic scientists have contributed to the drafting of a protocol for the [20] Individual doctors can nevertheless speak out. The

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

investigation of deaths in detention or in other circumstances where a proper investigation of the cause of death should be instituted [21], and have participated in a number of investigations which have had the objective of clarifying the fate of persons whose deaths have been the subject of deliberate cover-ups.

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

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

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1 Easton Street
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To: All sections
Medical groups

From: Medical Office, Campaign and Membership Department

Date: 27 February 1989

Paper prepared for an international seminar organized by the French Section

Title of seminar: "Medicine at Risk: The Doctor as Human Rights Abuser and Victim"

Summary

Attached is a paper prepared at the International Secretariat as a background document for the above-mentioned seminar, organized in January this year by the French Section and its medical group. The seminar focused on the risk of health professionals assisting in human rights violations or of becoming the victim of repression for refusal to assist (the involvement of health professionals covers such areas as doctors' complicity in torture, the issuing of inadequate or spurious death certificates in cases of death in detention or suspected EJEs, doctors' participation in the death penalty, etc...)

The attached background paper explores the themes of the seminar and covers
. human rights standards specifically applicable to health professionals
. evidence of the participation of health professionals in violations of human rights
. human rights violations directed against health professionals
. the role of professional and other associations in combatting violations

It contains references for further reading and is available in English and French.

Distribution

As above.

../...

Recommended actions

A) Sections:

. Sections where there is an interest in starting a medical group may find it useful to make the paper available to members of the developing group. . The paper should be centrally filed for future reference. It is external and may be made available to press and others expressing an interest in the subject.

B) Medical Groups:

. Medical group coordinators may want to make the paper available to group members. It may be used in any way the group finds appropriate.