

The medical community's response to torture

One would have thought that decades after international treaties prohibited torture absolutely, the practice would no longer be debatable by serious people. But one of the perverse effects of the war on terrorism has been the revival of the idea that torture can be legitimate in so-called exceptional cases, such as a calibrated infliction of pain to interrogate suspected terrorists. And now, as in the past, it is impossible to discuss torture without addressing the role and obligations of physicians who might be asked to measure the imposition of pain, examine the health status of the victim, or who might learn of torture when examining detainees. The revived discussion raises anew whether the medical community's condemnation of torture, though worthy, has been an adequate response.

Almost 30 years ago, the revulsion in the medical community at revelations that physicians had participated in torture in dictatorial regimes was transformed into an eloquent statement of principle, the Declaration of Tokyo, by the World Medical Association (WMA). Looking back, the declaration is a remarkable document. Both terrorism, spectacularly displayed at the 1972 Munich Olympics, and guerrilla violence in the developing world were seen as threats as grave then as those from Al Qaeda and similar terrorist groups are today. But the WMA refused to equivocate, taking an absolutist stance: "doctors shall not countenance, condone or participate in torture . . . in all situations, including armed conflict and civil strife." It cited the principle that doctors must have complete clinical independence in pursuing the fundamental purpose of relieving an individual's distress and stated "no motive, whether personal, collective or political, shall prevail against this higher purpose".

The medical profession has reason to be proud of this pioneering statement, which significantly predates the 1991 UN Convention Against Torture, and remains as compelling as ever. Yet, torture has continued and doctors find themselves implicated, often involuntarily. Paradoxically, because of pressures authorities place on physicians, inadequate training in documentation of torture, and absence of support from peers even medical examinations of detainees—designed as a safeguard against torture—can become a vehicle

for gaining medical sanction for practices that include torture. At worst, evidence of torture is suppressed,¹ at best inadequately documented.²

The message we should take from this experience, though, is not that medical resistance is ineffective, but that three steps are essential to strengthen it. First, medical documentation of torture must be improved, and physicians protected

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from reprisals. The Istanbul Protocol for Documentation of Torture,³ which established standards and guidance for medical examinations of torture victims, can provide guidance for higher quality examinations of detainees and contribute to the protection of physicians. An ongoing Istanbul Protocol Implementation Project, sponsored by the International Rehabilitation Centers for Victims of Torture, WMA, Physicians for Human Rights, and the Human Rights Foundation of Turkey, should aid the process immensely.

Second, passive participation in torture needs to be squarely addressed. A decade ago, the British Medical Association (BMA) urged a duty by doctors to take action to stop torture when they become aware of it.⁴ More recently, an international working group on dual loyalty and human rights in the health professions—defined as simultaneous obligations, express or implied, to a patient and to a third party, often the state—has proposed practice guidelines that would prohibit passive participation or silence in the face of torture. The report states that “a health professional passively participates [in torture] by permitting his or her clinical findings or treatment to be used by authorities to aid the process of torture.”⁵ The proposed guidelines urge health professionals not to be present when torture takes place (usually for the purpose of medical monitoring of victims) and “to report violations of human rights that interfere with their ability to comply with their duty of loyalty to patients”. National and international medical associations should adopt standards such as these, which create the expect-

tation that physicians confronted with torture will act to stop it.

Finally, the medical community as a whole needs to speak out far more forcefully against torture. No longer can the obligation be understood as attaching mainly or exclusively to physicians working in detention facilities. Both the BMA and the working group on dual loyalty urge professional organisations to speak out against torture and provide support to physicians in situations in which compliance with ethical and human rights obligations is difficult. National and international medical organisations should not shrink from this duty, of which the courageous stand of the Turkish Medical Association is an exemplar. Nor should associations tolerate the idea that torture is acceptable in exceptional cases. The WMA properly resisted that argument in 1975, recognising that exceptional cases inevitably lead to regimes of torture. Indeed, silence in such circumstances amounts to tolerance.

The international medical community can take pride in its role in seeking to end torture throughout the world. Today, though, we face a crisis not only because torture continues, but also because it is being newly legitimised in some quarters. The considerable efforts by the medical and human rights community risk being undermined if a voice as clear as it was in Tokyo is not heard once again.

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- 1 Physicians for Human Rights. Torture in Turkey and its unwilling accomplices. Boston: Physicians for Human Rights, 1996.
- 2 Heisler M, Moreno A, DeMonner S, Keller A, Iacopino V. Assessment of torture and ill treatment of detainees in Mexico; attitudes and experiences of forensic physicians. *JAMA* 2003; **289**: 2135–43.
- 3 UN Office of the High Commissioner for Human Rights. Professional training series no 8: Istanbul protocol—manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. New York: United Nations, 2001.
- 4 British Medical Association. *Medicine betrayed*. London: Zed Books, 1992.
- 5 Physicians for Human Rights and University of Cape Town Health Sciences Faculty. Dual loyalty and human rights in health professional practice: proposed guidelines and institutional standards. Boston: Physicians for Human Rights, 2003. http://www.phrusa.org/healthrights/dual_loyalty.html (accessed April, 2003).