TORTURE AS A CHALLENGE TO THE HEALTH PROFESSIONS AND THE WHO

PROFESSOR ERIK HOLST MD

I am grateful for this opportunity to bring the issue of torture, which has been my main concern for the last 20 years, before a WHO audience.

But I warn you that my presentation will be somewhat biased towards events that I have experienced and people I have known

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And I have also used a lot of sources that I shall not be able to give credit in this presentation.
I only hope that authors of the information, images and texts used in this presentation will feel that I made good use of their material

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DEFINITIONS OF TORTURE

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In the World Medical Association's Tokyo Declaration of October 1975 torture was defined as :

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The deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

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In the UN Declaration on torture in December 1975 torture was defined as

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person....

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....for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons....

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....It does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners.

2. Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment (CIDT)

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PHYSICAL TORTURE

Some of the most common methods of physical torture include beating, electric shocks, stretching, suspension, submersion, suffocation, burns, rape and sexual assault

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FALANGA IS PRACTISED ALL OVER

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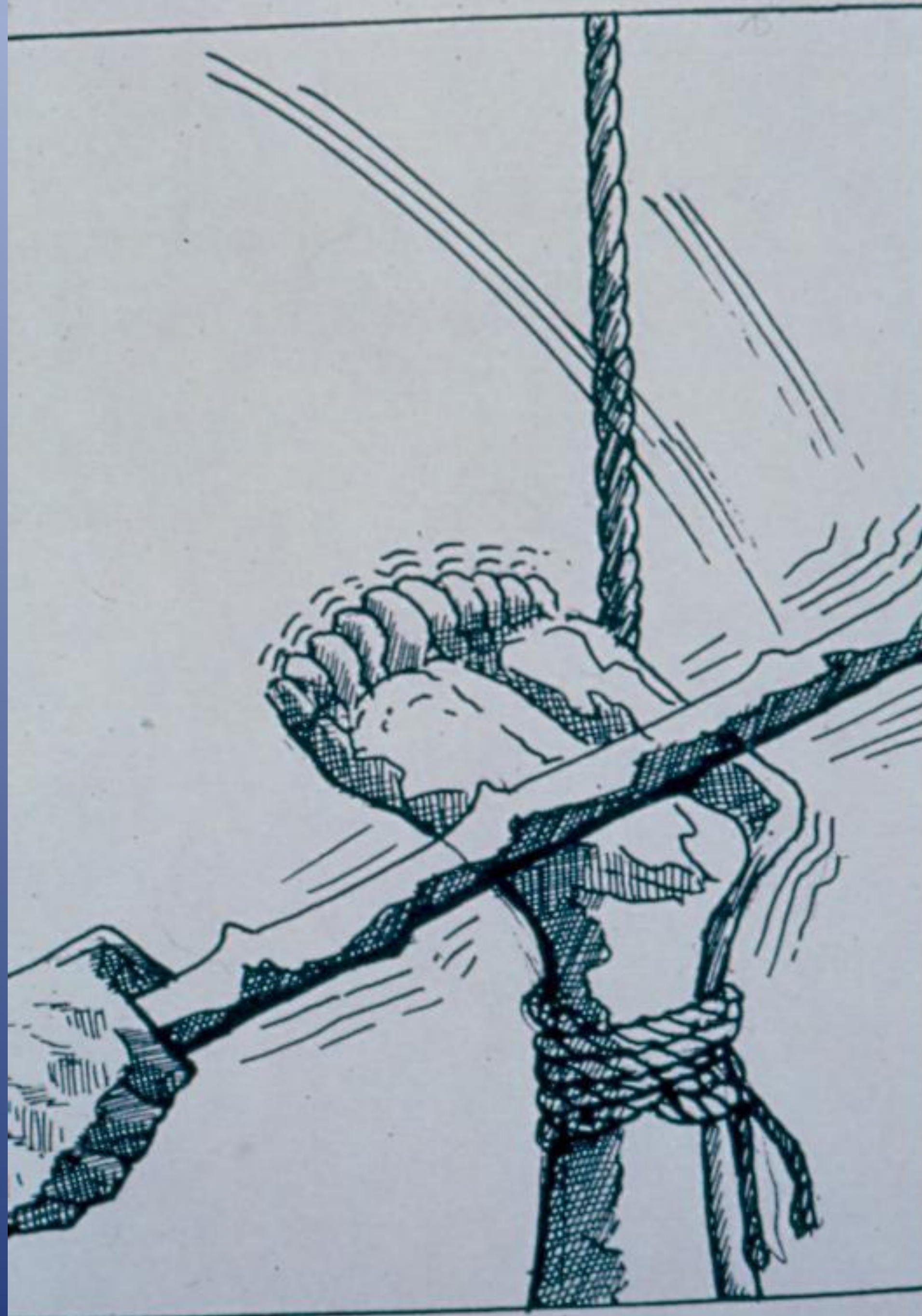

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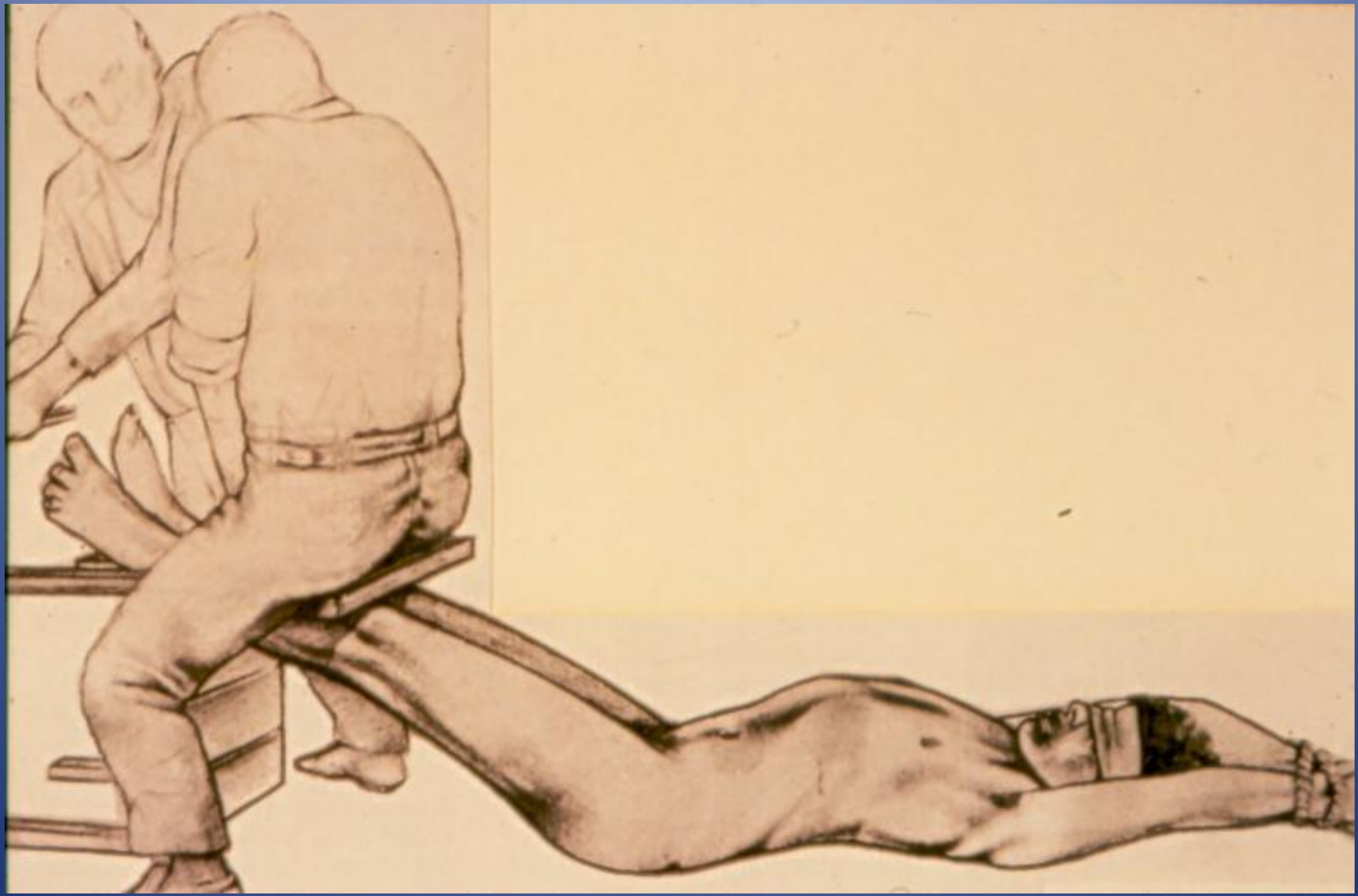

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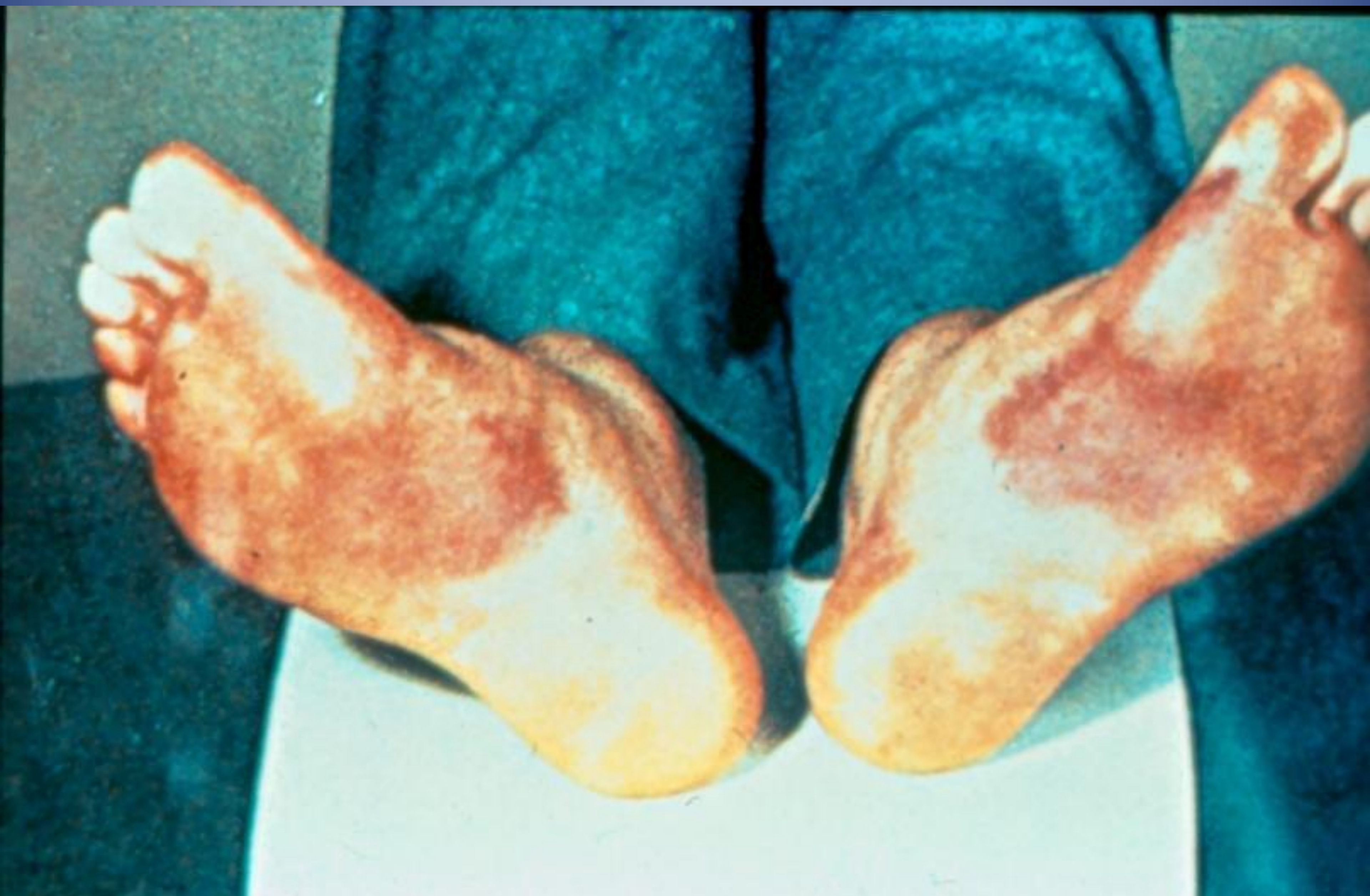

SUBMERSION ALSO WIDELY USED

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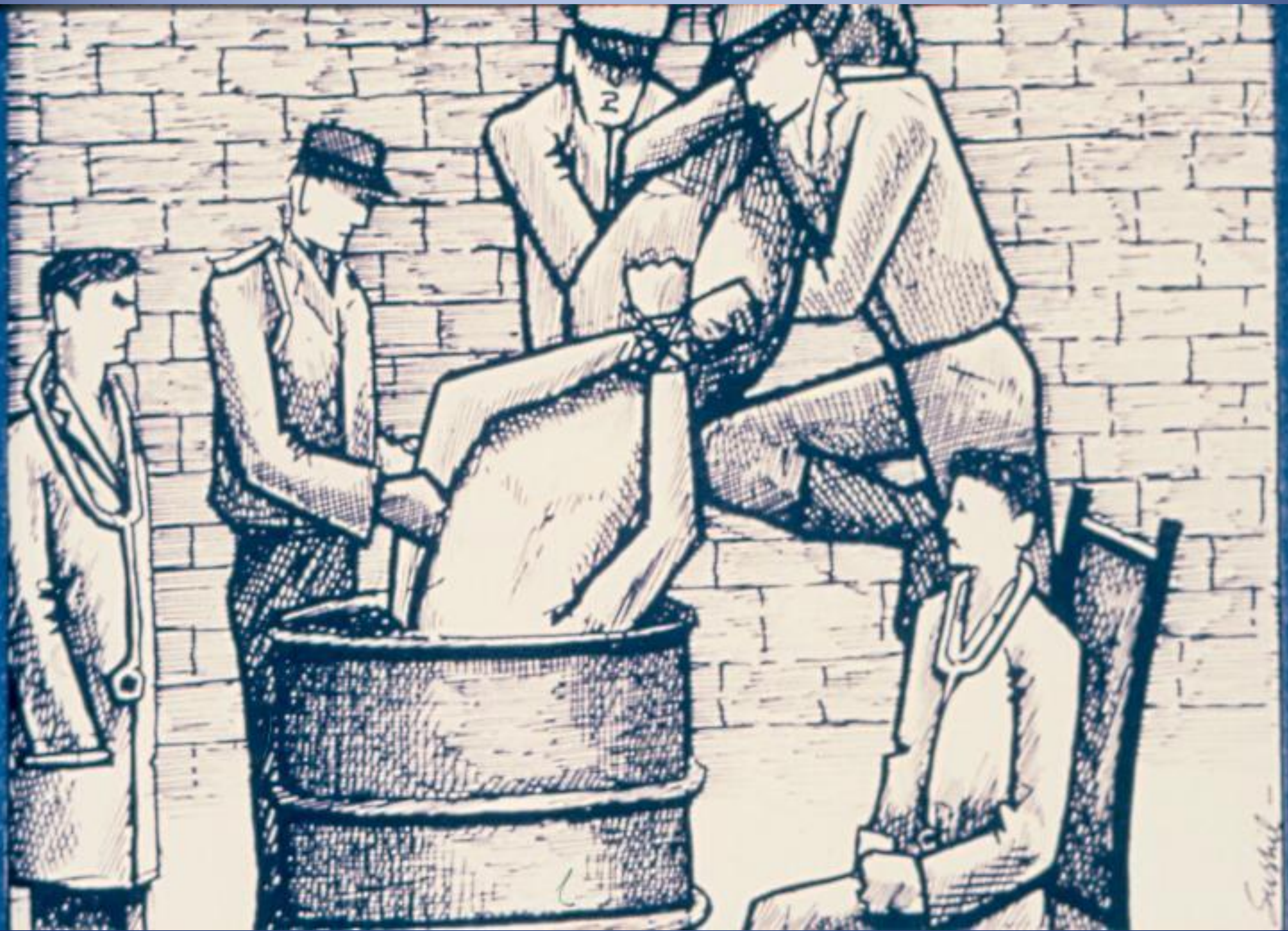

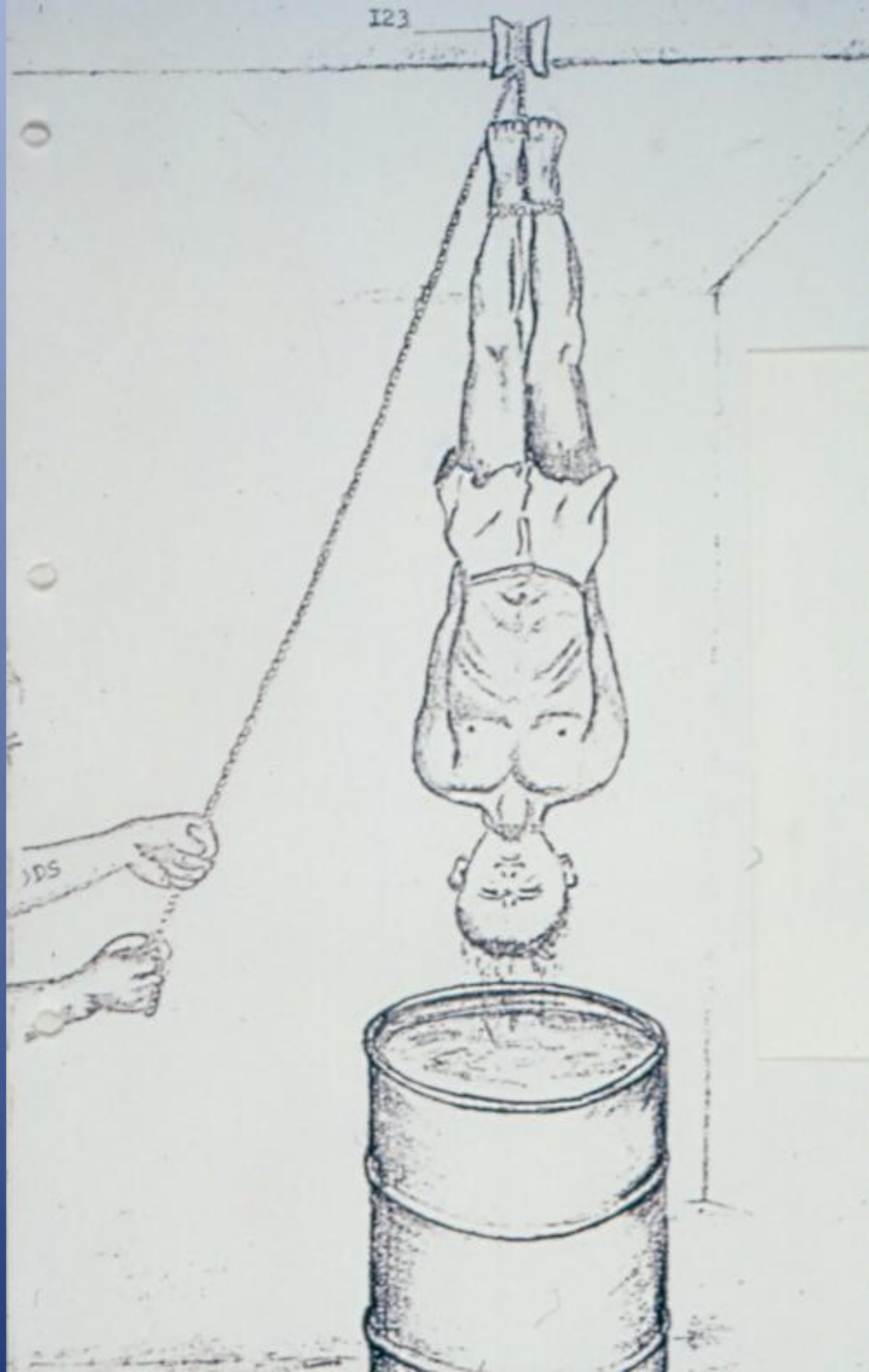

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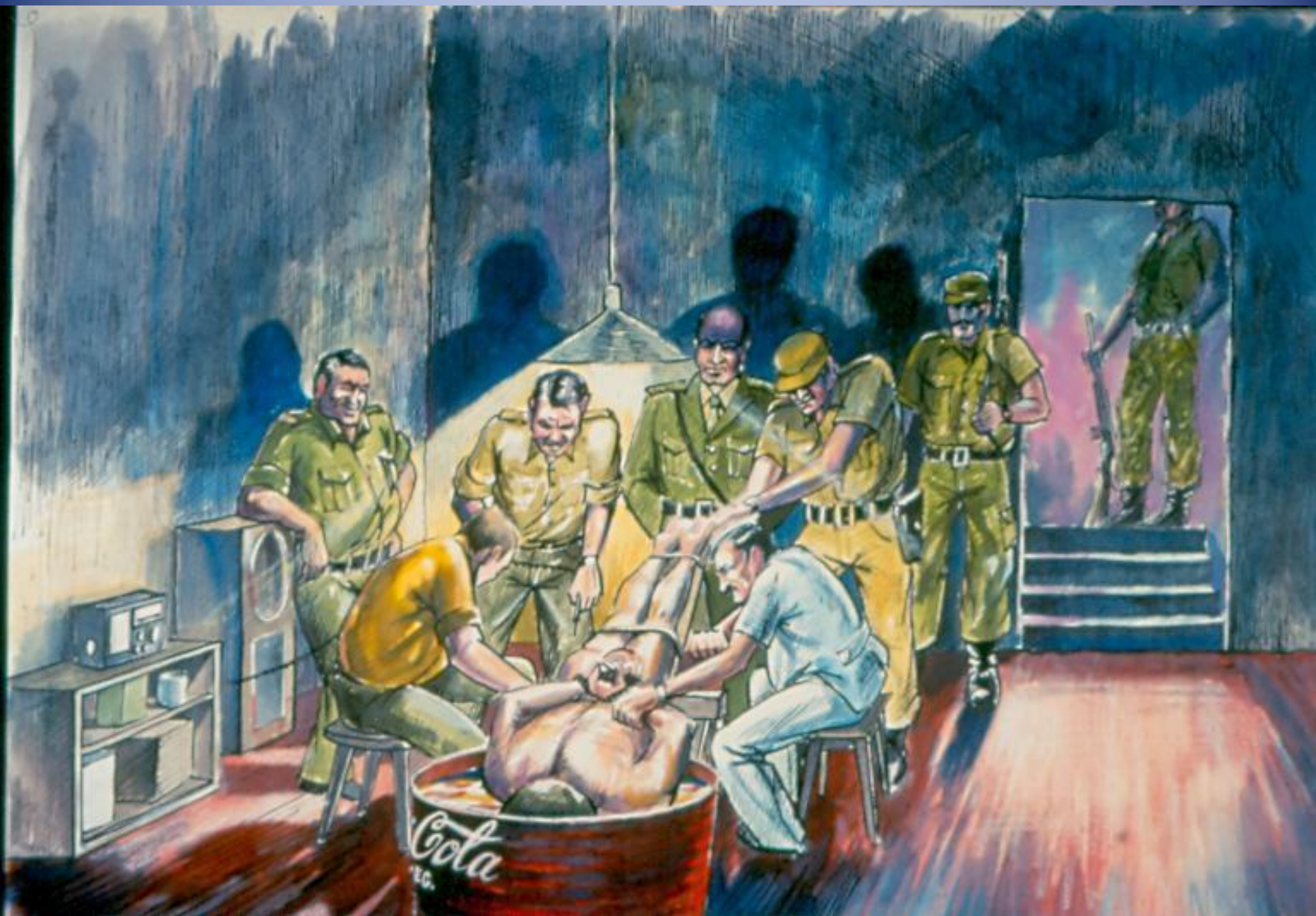
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AND MANY KINDS OF SUSPENSION

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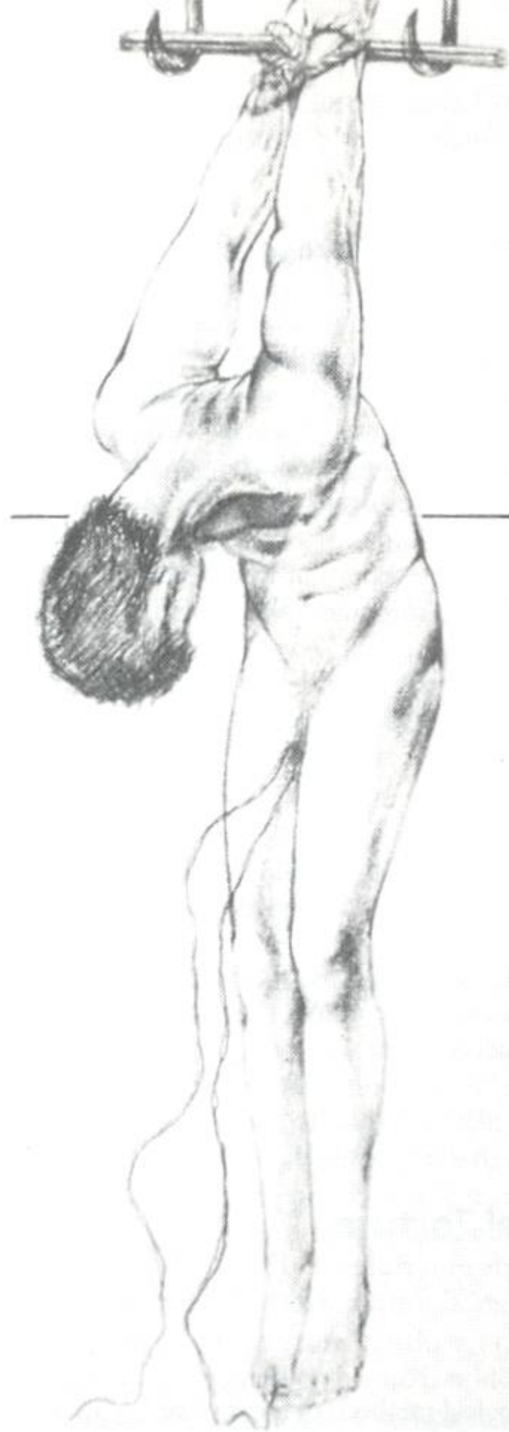

BEATING

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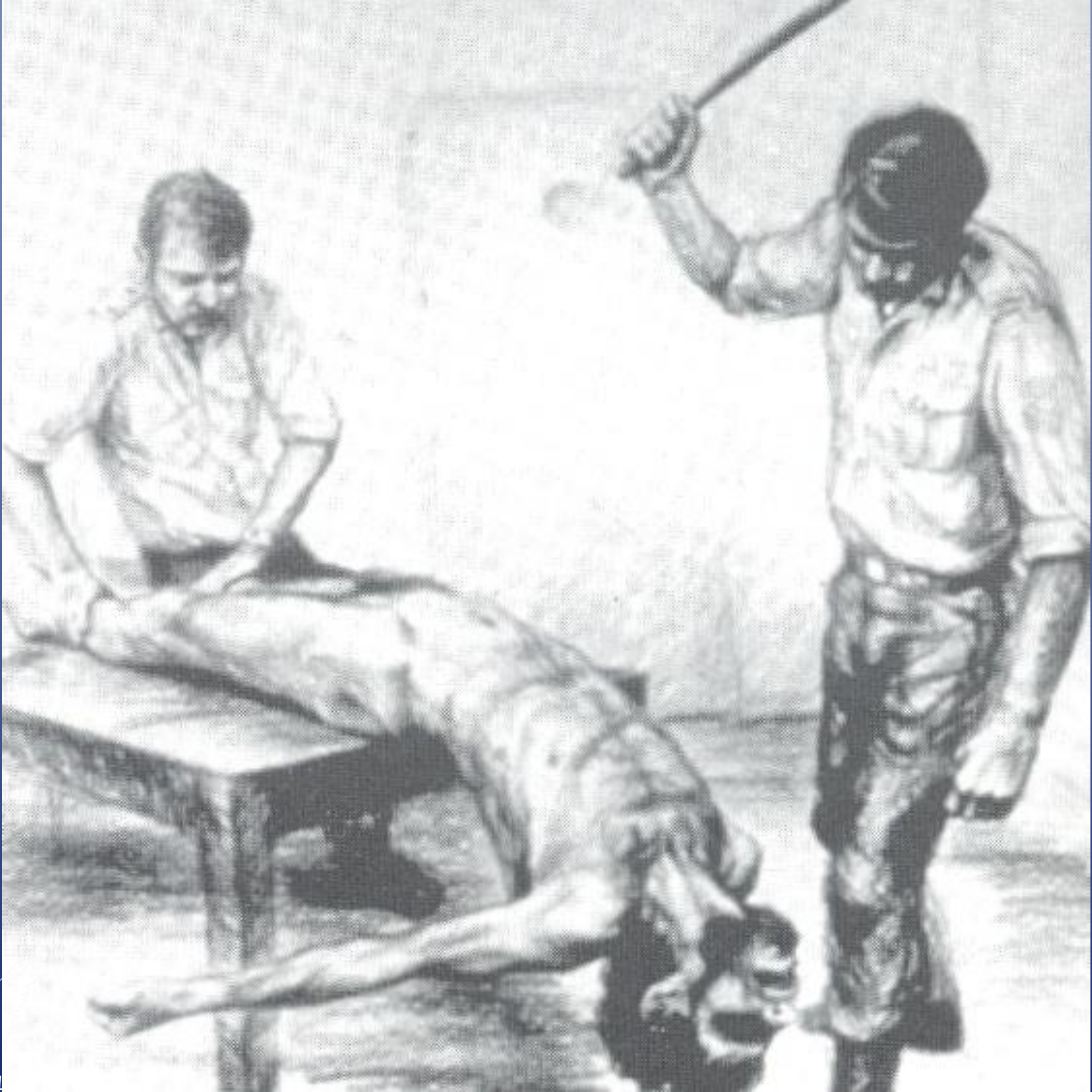

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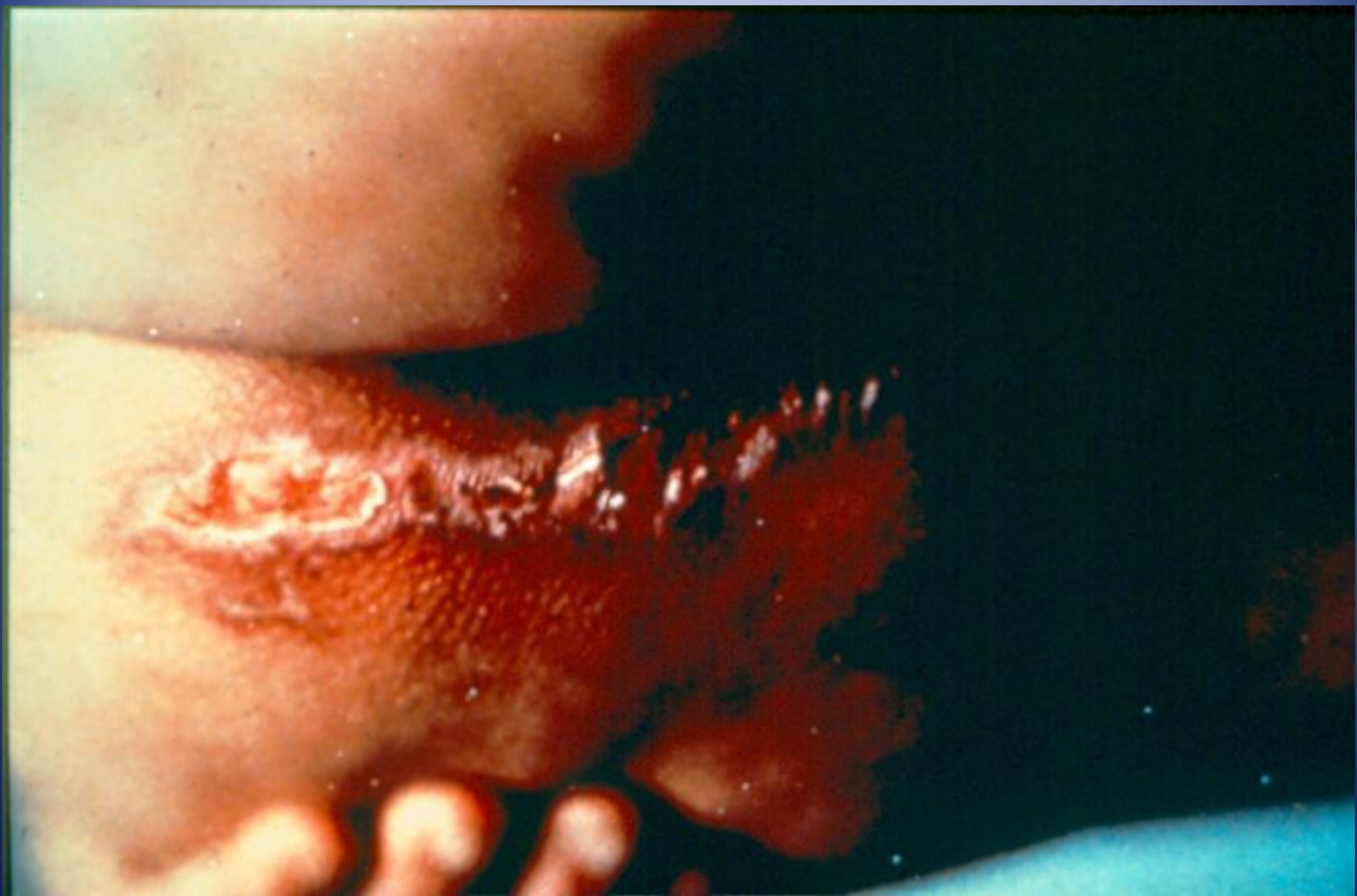
BURNING WITH CIGARETTES BUT ALSO SOMETIMES WITH HOT IRON RODS



PSYCHOLOGICAL TORTURE

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Psychological forms of torture commonly include: isolation, sensory deprivation, sleep deprivation, pharmacological torture, threats, humiliation, mock executions, mock amputations, and witnessing the torture of others especially the victim's loved ones

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You are alone against a system that wants to destroy or humiliate you or make you confess, and has the power to do so.

And you end up feeling shame and guilt because you were unable to resist or survived while others died.

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It seems to be particularly frightening if health professionals instead of helping you are involved in the process

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DIAGNOSING TORTURE SEQUELAE

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With this multitude of torture methods there are of course a corresponding wide range of physical and psychological sequelae.

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The most important physical consequence of torture is chronic, long-lasting, pain experienced in multiple sites. Studies have shown that after ten years pain is still highly prevalent.

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The mental health consequences of torture are usually more persistent and protracted than the physical aftereffects

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The psychological problems most often reported are anxiety, depression, irritability, aggressiveness, emotional liability, self isolation, withdrawal; confusion/disorientation, memory and concentration impairments; lack of energy, insomnia, nightmares, sexual dysfunction.

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While the physical sequelae may be healed the psychological impact of both physical and psychological torture often leaves life-long scars that victims have to learn to live with and to cope with

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And this traumatic experience also have an impact on family and friends – often called secondary victims

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A number of classification systems for forms of torture and diagnostic tests for physical and mental torture sequelae have been developed

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These were eventually merged into the

Istanbul protocol

or the *Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*

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This was developed by 75 experts in this field under the auspices of Physicians for Human Rights USA and Human Rights Foundation Turkey and became an official UN Document in December 2000

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TORTURE IN THE TWENTIETH CENTURY

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The post-WW II disclosure of the extensive use of torture (and human experimentation) by totalitarian regimes in Germany and Japan immediately prior to and during WW II caused the issue to be placed high on the international human rights agenda after the war.

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But in spite of the unanimous and absolute prohibition of the use of torture in post-WW II international human rights law and humanitarian law, (which Sir Nigel will deal with) there was in the early 1970s a growing international concern with allegations of widespread use of torture

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And there was special concern for alleged direct or indirect involvement of physicians and other health professionals in torture

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Already in the late 1950s there had been allegations of human rights abuses in connection with the repression of uprisings against French colonial rule especially in Algeria

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French military doctors, whose task it was to monitor torture, were left in an ethical dilemma. A doctor attached to a French torture unit is quoted as observing: “Our problem was, should we heal this man who will again be tortured or let him die?”

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The World Medical Association did not answer that question until 1975 in its Tokyo declaration

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In the late 1960s there were also allegations of the use of torture in connection with the repression of IRA activities in Northern Ireland - again involving military doctors.

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It is reasonable to assume that events in Northern Ireland was part of the background for Amnesty International's first campaign for the abolition of torture launched in 1972, with Ireland's Sean McBride chairing AI's executive board.

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And in the middle of this growing awareness of the problem came the overthrow of the constitutional government of Chile by the Chilean armed forces on 11 September 1973 with its much publicised gross human rights violations, which also involved military doctors

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The result of all this was that the issue of torture was brought up during the 1973 UN General Assembly : The Danish Foreign Minister Mr. K. B. Andersen (1914 – 84) was alarmed by the many reports of torture and was followed by his Swedish and Dutch Colleagues who voiced similar concerns

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So, in a 1974 UN General Assembly Resolution, WHO was invited to *“draft an outline of the principles of medical ethics, which may be relevant to the protection of persons subjected to any form of detention or imprisonment against torture and other cruel, inhuman or degrading treatment or punishment “*

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In response a WHO document

“Health aspects of avoidable maltreatment of prisoners and detainees”

was prepared in consultation among others with WMA

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This document in para 14 states that in principle *WHO is concerned with "health ethics" in the sense of the right of all peoples, including prisoners and detainees, to be spared avoidable hazards to physical or mental health.....*

....rather than with medical ethics in the sense of medical deontology.

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The latter, WHO felt, should be left to the health professions themselves

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The document further states in para 16.

For the terms "torture", "cruel", "inhuman", and "degrading" no medical or scientific definitions exist. And general definitions consist of the exchange of one form of words for another.

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This leads the authors of this document to the following conclusion in para 19:

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In view of the impossibility of arriving at a workable definition of the points at which neglect becomes ill-treatment, ill-treatment becomes cruelty, and cruelty becomes torture, the general term "avoidable maltreatment" has been used in the title of this paper.

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We shall see how this assessment also decided the terminology chosen by WHO, when it was later confronted with the issue of the special medical needs of victims of torture

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The problems in Northern Ireland not only mobilised Amnesty International but also brought torture onto the agenda of the WMA during its GA in Stockholm 1974

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The President of the Irish Medical Association complained about British military doctors' involvement in force feeding of IRA detainees on hunger strike in Northern Ireland

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Dr . Anthony Farrelly, President of the Irish Medical Association, who put torture on WMA’s agenda in 1974

The Secretary of British Medical Association raised to the challenge, and together with colleagues from the Irish Medical Association produced a draft for the Tokyo Declaration

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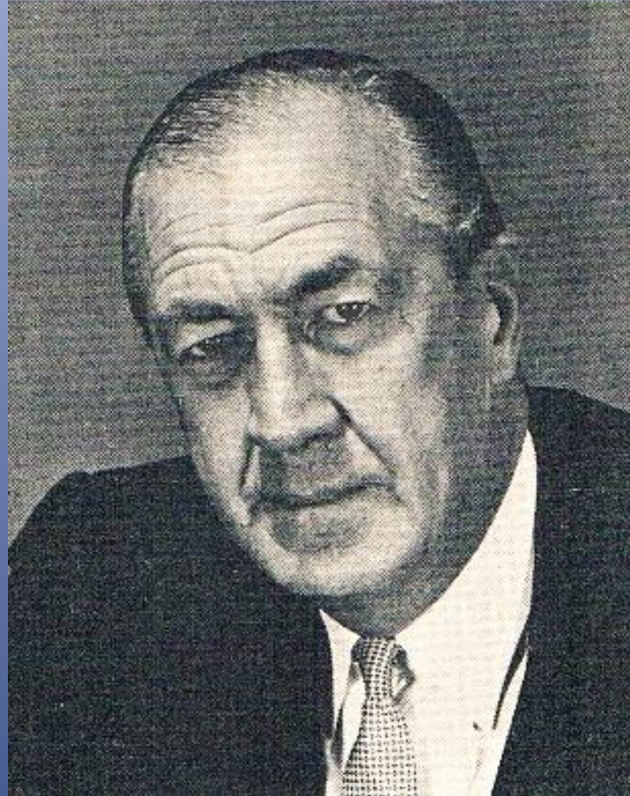

Dr. Derek Stevenson (1911 - 2001),
Secretary of British Medical Association

So, at a WMA Council meeting in Paris March 1975 we reviewed and accepted a draft declaration for presentation at the forthcoming WMA assembly in Tokyo. The draft was also brought to the attention of the WHO and the 5th UN Congress on the Prevention of Crime and the Treatment of Offenders.

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The opening session of the World Medical assembly in Tokyo, October 1975

In October 1975 we adopted the

WMA DECLARATION OF TOKYO

Guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment

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The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

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The physician shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

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The physician shall not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened

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Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially

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A few months later in December 1975 the UN General Assembly adopted the *Declaration on the Protection of All Persons from Being Subjected to Torture or Other Cruel, Inhuman or Degrading Treatment or Punishment*

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The resolution contains the first expression of concern for victims' rights in Article 11:

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Where it is proved that an act of torture or other cruel, inhuman or degrading treatment or punishment has been committed by or at the instigation of a public official, the victim shall be afforded redress and compensation in accordance with national law.

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This UN GA also adopted a resolution, which invites WHO *“to give further attention to the study and elaboration of principles of medical ethics relevant to the protection of persons subjected to any form of detention”*

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This in fact sends the ball back to the WHO in spite of WHO's clearly indicated preference to leave medical ethics and deontology to the health professions

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So, from 1976 the WHO Executive Board and Director General were obliged by the GA to involve themselves in this issue – but did so in close collaboration with WMA and CIOMS (Council for International Organizations of Medical Sciences)

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The eventual outcome was an UN GA resolution of 18 December 1982 *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.*

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It protects the prisoners and detainees against unethical behaviour of health professionals but fails to protect the health professionals trying to uphold these principles against pressure from military, police or prison hierarchies.

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To help bridge this gap the WMA in 1997 adopted the

WMA DECLARATION OF HAMBURG

concerning

Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment

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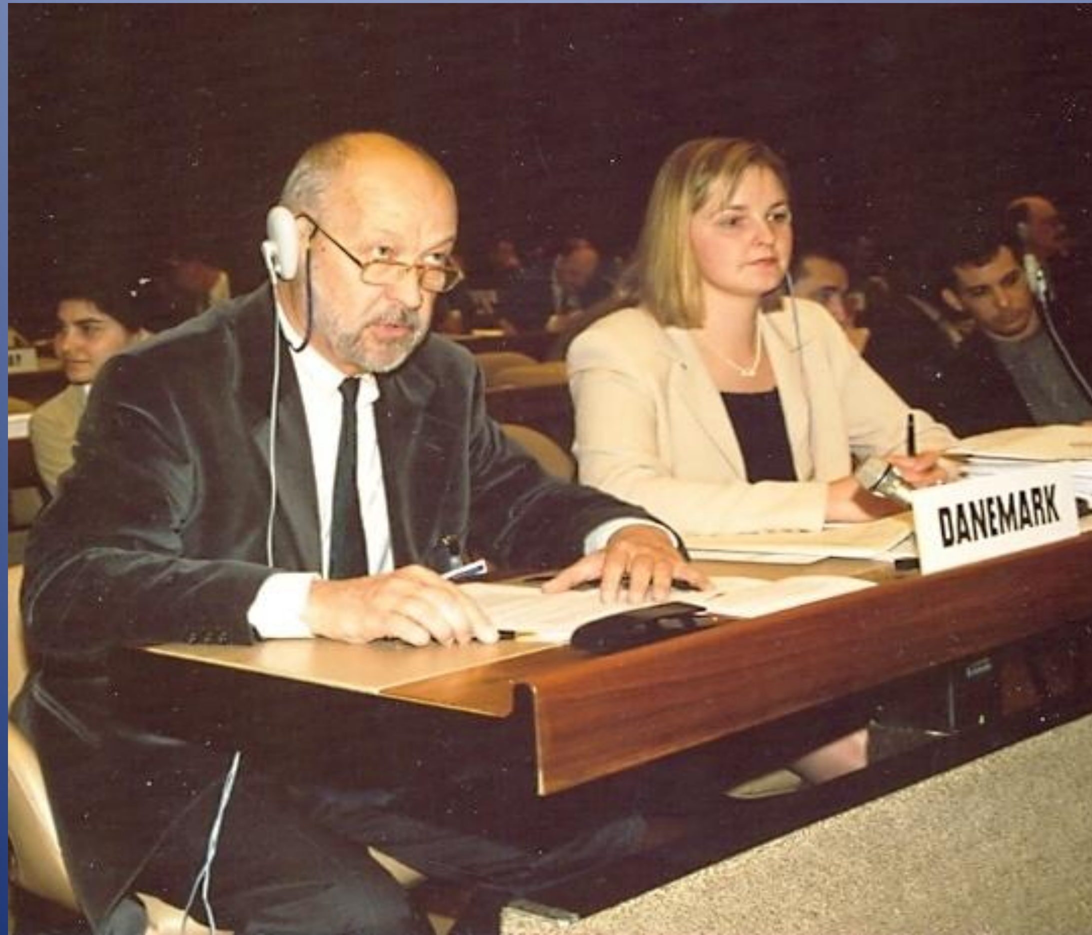
I also had opportunity to voice our concerns in this respect on behalf of the Danish delegation to the UN Commission on Human Rights in 1998



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Other health professions adopted declarations or statements on non-involvement of their professions in torture

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In 1986 American Psychological Association adopted a Resolution against Torture and Other Cruel, Inhuman, or Degrading Treatment

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In 1989 the International Council of Nurses adopted a: Statement on Nurses and Torture

And in 2007 the World Dental Association adopted: Guidelines for dentists against torture.

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Finally in 1984 came the cornerstone in the international human rights law regarding torture

The UN CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT

As of July 2011, the Convention had 149 state parties

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A so-called Treaty Body was established to monitor the proper implementation and respect for the provisions of the convention in the form of a
Committee against Torture (CAT).
consisting of 10 independent experts

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Professor Bent Sørensen a Danish surgeon was the only physician in the first Committee against Torture, which started its work in 1987
(Speaking at an IRCT Council meeting in Agra India in 1999)

2nd World Conference on Human Rights in Vienna 1993

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The need for member states to deal more effectively with torture and provide appropriate care and reparation to victims of torture received specific attention at the 2nd World Conference on Human Rights in Vienna 1993

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A separate chapter 5 on torture was introduced in the final document: The Vienna Declaration and Action Plan for Human Rights – a Danish diplomatic contribution for which I had the privilege of providing the language

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Point 59 reads *The World Conference on Human Rights stresses the importance of further concrete action within the framework of the United Nations with the view to providing assistance to victims of torture and ensure more effective remedies for their physical, psychological and social rehabilitation.*

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ABUSE OF PSYCHIATRY

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In 1971, Vladimir Bukovsky smuggled to the West a file of 150 pages, which in his opinion documented the political abuse of psychiatry in USSR, requesting Western psychiatrists to examine the six cases documented in the file.

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Psychiatrists from Sheffield University described Bukovsky's cases in the British Journal of Psychiatry in August 1971 concluding:

"It seems to us that the diagnoses on the six people were made purely in consequence of actions in which they were exercising fundamental freedoms"

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Also in 1971 Dr. Semyon Gluzman co-authored the document *An In Absentia Psychiatric Opinion on the Case of P.G. Grigorenko* (General Grigorenko had spoken out against human rights abuses in the Soviet Union).

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Gluzman and his co-authors came to the conclusion that Grigorenko was mentally sane and had been taken to mental hospitals for political reasons.[

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In January 1972, Bukovsky was sentenced to 12 years of camp and exile, mainly on the ground that he had, with anti-Soviet intention, circulated false reports that mentally healthy political dissenters were incarcerated in mental hospitals and were subjected to abuse there

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Vladimir Bukovsky (1942 -) currently Senior Fellow at the Cato Institute London

And Gluzman was sentenced to serve seven years in a Siberian labour camp followed by three years in Siberian exile for refusing to diagnose General Grigorenko as having a mental illness.

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Professor Semyon Gluzman (1946 -) - here offering an impressive Ukrainian pie during our visit to Kiev in 1993.

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The allegations were brought up at the World Psychiatric Association Congress in Mexico City in November 1971, but were successfully rejected as cold war propaganda by the USSR delegation headed by Dr. Snezhnevsky

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Bukovsky's revelations were also picked up through Radio Free Europe by Dr. Ion Avianu then working at the Psychiatric Clinic of the University of Bucharest.
He realised that this kind of political abuse of psychiatry was also taking place in Romania.

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Dr. Avianu managed to disclose this information through Radio Free Europe but was sacked from the University after a so-called “unmasking” session, where he was unanimously condemned by his colleagues but refused to withdraw his accusations. In 1977 he had to leave the country

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But the growing international concern for the abuse of psychiatry for political purposes eventually led the WPA to adopt the DECLARATION OF HAWAII during their meeting in Honolulu in 1977

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Para 7…..The psychiatrist must on no account utilize the tools of his profession, once the absence of psychiatric illness has been established. If a patient or some third party demands actions contrary to scientific knowledge or ethical principles the psychiatrist must refuse to cooperate.

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At a symposium on *Torture and The Medical Profession* at the University of Tromsö, Norway in June 1990 professor Gluzman asked me to read his presentation

Abuse of psychiatry: Analysis of the guilt of the medical personnel

as he was unsure of his English pronunciation

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So I found myself reading out what was in fact a terrible indictment of my profession

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And I could not help feeling that I might have failed by not having paid enough attention to this issue when I was from1977-79 what Halfdan Mahler jokingly called *The Godfather of the European Medical Mafia* or more precisely President of the Standing Committee of Doctors of the EEC (European Economic Community)

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But USSR was not part of the EEC and we had honestly – though apparently naively - believed that our psychiatric colleagues had taken care of that matter with the adoption of the Hawaii Declaration – which had also been accepted by the USSR delegates.

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But professor Gluzman's paper also contained this passage:

"Neither the director general of the WHO nor the director of the department for the protection of mental health of the WHO manifested professional or human interest in this problem...

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…So during several contacts with the Soviet side, in Moscow, neither Dr. Mahler nor Dr. Sartorius asked: How does the MOH of the USSR inform the medical personnel of special psychiatric hospitals of the MIA on the UN Principles of Medical Ethics ? Is the MOH fulfilling its international objectives ?”

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And you will remember that between 1975 and 1982 torture was on the agenda of the WHO especially concerning the ethical obligations of health professionals in relation to detained persons, which includes patients committed to closed psychiatric wards .

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So, we all stood corrected and for me personally it was an experience that contributed to my decision to get more directly involved in the work of IRCT, where I had been appointed vice-president a few months earlier

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Our Soviet colleagues were finally forced to leave the WPA in 1984 to escape a threatening exclusion but they were readmitted in 1989 in the general euphoria by the end of the cold war – after having reluctantly admitted their collaboration in political repression and promising to end this abuse .

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PROVIDING APPROPRIATE HEALTH CARE TO VICTIMS OF TORTURE

A NEW CATEGORY OF PATIENTS

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In spite of the many victims surviving Nazi torture in Germany and occupied countries they were not at the time seen as needing special medical attention. Among the few exceptions were severely traumatised resistance fighters and holocaust survivors in the Netherlands

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They received psychotherapeutic and psychiatric care from Centrum ‘45 in Noordwijkerhout and from Dr. J. Lansen and his staff at the Jewish Community Mental Health Services in the Sinai Centrum in Amersfoort

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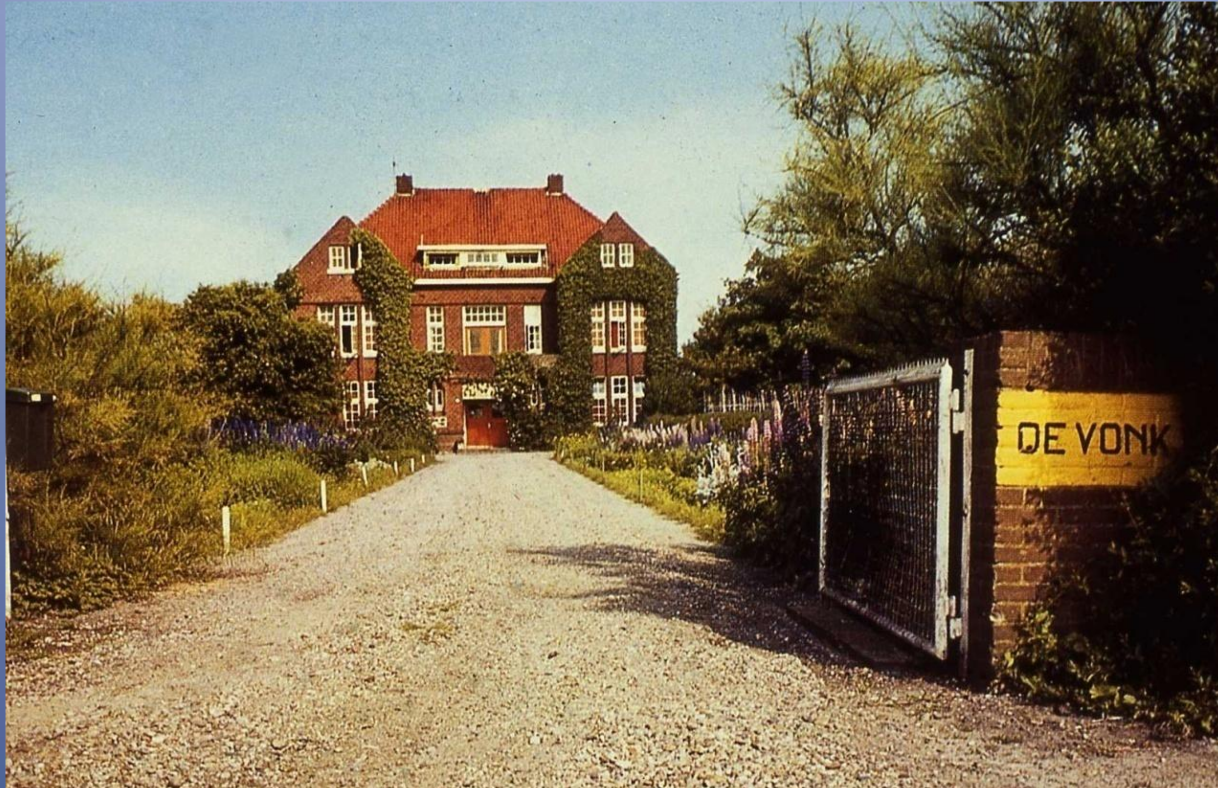

Centrum '45 in De Vonk hostel
Noordwijkerhout the Netherlands

But the exodus of refugees from the horrors of Cambodia and Chile in the 1970s created a new interest in diagnosing physical and mental torture sequelae and in the development of appropriate care for torture survivors.

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In 1974 four doctors in Denmark headed by Dr Inge Genefke formed an AI medical group in response to a call by Amnesty International to help diagnose torture victims and produce forensic evidence that could help hold torturers to account in a court of law.

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The group was allowed to admit a number of torture survivors from Latin America to the University Hospital in Copenhagen for further medical examination and in the process they realised that these people were in serious need of health professional assistance

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Dr. Inge Genefke, who saw the need for a medical response to torture sequelae

This led in 1982 to the creation of a special Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen and in 1986 to the creation of its international arm: The International Rehabilitation Council for Torture Victims (IRCT)

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Current headquarters of RCT and IRCT in Copenhagen celebrating the end of occupation and GESTAPO torture in Denmark on the evening of May 4th 1945

A parallel initiative was spearheaded by Dr. Richard F. Mollica and his staff who in 1981 established the Indochinese Psychiatry Clinic at Harvard School of Public Health, which continued as the Harvard in Refugee Trauma Program and Clinic at Massachusetts General Hospital in Boston

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Dr. Richard F. Mollica cofounder of the Indochinese Psychiatry Clinic and the Harvard Refugee Trauma Program and Clinic in Boston

In the mid 1980’s, Harvard Refugee Trauma Clinic developed the first valid and reliable screening instruments for measuring trauma-related psychiatric disorders in refugee populations.

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In the following years many new rehabilitation centres and programmes for victims of torture among refugees were created in Western Europe, North America and Australia.

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They came to constitute
THE TREATMENT MOVEMENT
to distinguish it from the
awareness-raising Amnesty
International in London and the
urgent assistance oriented “SOS
Torture” or OMCT in Geneva

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AVRE centre in Paris

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Rehabilitation Centre for Torture and Trauma Damaged at Karolinska University Hospital, Stockholm

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The Center for Victims of Torture in Minneapolis

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BZFO Centre in Berlin

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But soon also centres providing assistance to torture victims in their own country were created in Latin America, Turkey, and later in Asia, Africa and Eastern Europe – often working under difficult conditions and sometimes subject to state harassment.

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CINTRAS Centre in Santiago Chile

Human Rights Foundation Turkey Centre in Adana

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When I was asked to take over the chair of the Board of RCT and the vice presidency of IRCT from 1990, I saw it as an opportunity to bring the organised medical profession behind not only the efforts to prevent medical involvement in torture but also behind the efforts to assist the victims of torture

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So, by the end of 1992 I left my chair of social medicine at the University of Copenhagen to spend the rest of my professional life trying to improve the situation for the victims of torture in this world

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In the following years we engaged in a major effort at IRCT to create awareness of and centres for victims of torture globally, wherever it became possible thanks to the disappearance of many repressive regimes in both East, West and South.

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Cowley House Centre in Cape Town

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ICAR Foundation’s centre in Bucharest
The medical director Dr Camelia Doru
receives the UN Rapporteur on Torture

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In this effort we were greatly assisted by the existence since 1984 of the UNVFVT and by a special budget line for victims of torture which we convinced the EU to create in 1994– not to forget the generous financial help from the Jette and Alan Parker's OAK Foundation

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And we received substantial financial and unfailing moral assistance from the Danish parliament, the Danish MFA and its diplomatic missions, which also afforded a certain protection for centre initiatives in difficult political environments

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Wherever we went to promote services or new centres for victims of torture we started off with awareness-raising national or sometimes international seminars involving both the national medical association and the local medical school or faculty of medicine as sponsors of the events

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PMA
MEDICAL
THE
• International Rehabilitation Council for
PMA

EL COME TO THE PARTICIPANTS & GUESTS
OF
ATIONAL SEMINAR ON TORTURE AND MEDICAL PROFESSIONALS
VENUE- HOTEL BLUE STAR KATHMANDU. 4-7 JUN 1995 NEPAL MEDICAL ASSOCIATION.

Dr. Wang Debing, president of Beijing Medical University opens a an IRCT seminar on *Medical Aspects of Torture* in Beijing 1993 together with his vice president

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IRCT
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VIII International Symposium on Torture -
A Challenge to the
Health, Legal and Other Professions
Inauguration by
Hon'ble Ch Justic Dr. A. S. A and

The National Human Rights
Commission of India

Archbishop Desmond Tutu in his opening speech to the IRCT Symposium in Cape Town November 1995. “The IRCT shows to all of us that something can be done for those who have suffered so terribly”.

ATTEMPTS TO INVOLVE THE WHO IN THE PROMOTION OF SPECIALISED CARE FOR VICTIMS OF TORTURE

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A WHO Working Group on the Psychosocial Consequences of Violence held a meeting in The Hague 1981 on

Helping victims of violence

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This meeting recommended that the topic of violence and its effects on health be the subject of continuous professional discussions on the national, regional, and global levels

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In response a working group on *The Health Hazards of Organized Violence* was established in1986 under the programme on Health Services Research at WHO/Europe

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This working group held its first meeting in April 1986 in Veldhoven, The Netherlands
Dr. Genefke took part together with a number of other pioneers from rehabilitation centres in Western Europe

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Organised violence was defined as *the interhuman infliction of significant avoidable pain and suffering ……. It includes "torture… cruel, inhuman or degrading treatment or punishment"….*

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The Advisory Group on Health Hazards of Organized Violence met again in 1988, 1993, and 1998 However, the problem of providing special professional health care to individual victims of torture and their families was somehow lost in the process

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Instead the process culminated in a WHO and UNHCR sponsored *International Consultation on Mental Health of Refugees and Displaced Populations in Conflict and Post-Conflict Situations* held at WHO HQ in Geneva October 2000.

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This consultation produced a Declaration of Cooperation which addresses the issue of appropriate interventions in the aftermath of man-made or natural mass catastrophes – not the issue of long term professional assistance to victims of torture

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The declaration states specifically:

.....Specialised clinical interventions responding to individual needs are limited. They must be balanced, because they respond to the needs of a few, may possibly become stigmatizing, tackle problems in isolation, are expensive and non-sustainable......

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Could one have expected WHO to promote instead the need for strengthening UNHCR's and immigration services' capacity to provide specialized professional care to Survivors of Extreme Violence as they are called in this document ?

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Or could WHO have promoted appropriate specialized health care for Survivors of Extreme Violence among refugees and asylum seekers as a normal part of a comprehensive health care systems as is now the case in Denmark, the Netherlands, and Norway?

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CAN TORTURE BE PREVENTED ?

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Most of the torture related international efforts since WW II have focussed on the prevention of torture.

The monitoring function of the CAT has been mentioned and was later supplemented by a UN Special Rapporteur on Torture

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The Council of Europe created a European Convention for the Prevention of Torture with a Committee for Prevention of Torture (CPT), which from the start had several members from the of health professions

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This was inspired by The Swiss Committee against Torture created by a Swiss banker Jean-Jacques Gauthier, who in the 1970s had the idea, that torture of prisoners and other detained persons could best be prevented by external control of prisons and other detention sites

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The Swiss Committee changed its name into the Association for Prevention of Torture (APT), which in recent years has successfully promoted the globalisation of this idea, leading to the OPCAT which aims at creating a global system of inspection of detention sites

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Also the Organization for Security and Cooperation in Europe (OSCE) in 1997 established an Advisory Panel for the Prevention of Torture to provide advice on how to develop programmes and activities to combat torture in OSCE States

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In this context it should finally be recognised that rehabilitation centres for victims of torture make very important contributions to prevention by providing medical documentation for the continued practice of torture

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Thus the publication in the Lancet in 1991 of an article documenting 200 cases of torture treated at a HRFT centres finally forced the Turkish government – which until then had rejected all AI reports as anti-Turkish slander – to admit that the phenomenon did in fact exist

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Governments are extremely sensitive to accusations of torture and will stand on their head to escape such accusations even when necessary - as we have seen in recent years - denying that torture is torture

CONCLUDING REMARKS

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Of course it would be ideal if states would just put end to the practice of torture – as the UN has tried to convince states to do since 1948

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And one could have hoped that the threat of punishment would have deterred law enforcement and military personnel from becoming torturers.

But in real life torture continues to be practiced and most torturers as well as their taskmasters enjoy *de facto* impunity

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According to Amnesty International's most recent annual report torture or cruel, inhuman or degrading treatment is practiced in 111 countries – in some countries sporadically and in others as an endemic phenomenon.

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So there will continue to be a need for a qualified multidisciplinary public health response to the special needs of torture survivors and it is my hope that the WHO will take up this challenge

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Thank you for your attention !