The role of doctors in investigation, prevention and treatment of torture

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Summary

Doctors may assess and treat torture survivors; some may document crucial evidence of torture in medico-legal reports. However, there is a lack of education on torture and related ethical and legal issues at undergraduate and postgraduate level and many doctors are not aware of opportunities to work with organisations for the prevention of torture. This paper defines Torture, describes methods used, and sets out the human rights instruments and codes of ethical practice that mandate efforts to prevent torture. Medical complicity in torture is discussed and the need for national and international medical associations to prevent torture by both supporting doctors and recognising and tackling medial complicity. The paper offers guidance for assessing and documenting torture, and for providing health care for survivors of torture.

Introduction

Torture continues to be a subject of media headlines; this year was the 10th anniversary of the first prisoners arriving at Guantanamo, and torture in countries such as Libya continues to be widely condemned. Amnesty International reported that at least 81 world governments practiced torture in 2008.[1] The International Rehabilitation Council for Torture Victims (IRCT) indicated that torture is practiced in more than half of all countries in the world.[2] However, many cases of torture do not hit the headlines, for example, torture stories from asylum seekers in the UK often go unheard. Even the UK Border Agency's detention of victims of torture and trafficking was criticized earlier this year in the Vine report.[3]

In the UK, doctors may assess and treat torture survivors; some may document crucial evidence of torture in medicolegal reports (MLR). However, there is a lack of education on torture and related ethical and legal issues at undergraduate and postgraduate level and many doctors are not aware of opportunities to work with organizations for the prevention of torture.[4] This paper defines torture, describes methods used, and sets out the human rights instruments and codes of ethical practice that mandate efforts to prevent torture. Medical complicity in torture is discussed, as is the need for national and international medical associations to prevent torture by both supporting doctors and recognizing and tackling medial complicity. The paper offers guidance for assessing and documenting torture, and for providing healthcare for survivors of torture. It does not address controversies around the status of post-traumatic stress disorder (PTSD) as a legitimate diagnosis and what evidence supports

and human rights (HM, KB).

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specific treatment for torture survivors, as these issues have been the subject of previous reviews.[5,6]

Methods

The purpose of this clinical review is to inform doctors of the international guidelines and legislation on how to deal with torture victims and issues related to torture more generally. The article is therefore based on the best known international guidelines that were used by HM whilst working with victims of torture, taking account the experiences of KB and EJ on wider issues of torture, culture and war studies. We identified by Google the website of the key organisations that aim to prevent and protect against torture: United Nations, International Committee of the Red Cross, Amnesty International, World Medical Assocation, International Rehabilitation Council for Victims of Torture, Freedom from Torture, Physicians for Human Rights, Medical Justice, MEDACT and REDRESS. We also searched Pubmed and Google Scholar for guidelines related to torture. We included information, reports and articles that provide direct guidance on what doctors should do to assess and to protect vulnerable populations.

Box 1
Definitions of torture

'Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity' (UNCAT).

'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' (WMA).

UNCAT- United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

WMA - World Medical Association

Definitions, methods and functions of torture

It is important to establish a definition of torture so that estimates about prevalence, preventive actions and the treatment of the consequences of torture inform a coherent response (Box 1). Torture can be used to destroy dignity, gain information, draw a confession, create fear and punish. Knowledge of common torture methods is useful for doctors (Box 2), although methods are often region specific (see www.amnesty.org.uk for reports). Torture is commonly justified on the basis of security and safety; to gain information to prevent terrorist attacks and so prevent casualties. However, there is little evidence that torture actually leads to the disclosure of accurate information that can be used to protect the safety or security of populations, or prevent threats against the state. An American governmental report concluded 'there had been almost no empirical research into interrogation methods in the past 40 years' and said 'several studies have shown that coercive interrogation or torture also increases the risk of false confessions, since people will often say anything just to make it stop'.[7,8]

Torture is a global public health issue

In many circumstances torture is used against groups of persons or an entire population for destructive purposes. The consequences of torture can be long-term physical and mental injuries, with profound effects social and physical functioning. Imprisonment and related ill-health can contribute to loss of education and occupation over the life-course. Some survivors of torture become internally or externally displaced persons, for example, asylum seekers. A recent meta-analysis showed torture and other potentially traumatic events are endemic in countries affected by ongoing conflict and that torture is associated with mental disorder. The results supported the moderating effects of the environment; internally or externally displaced populations had higher rates of PTSD than those permanently resettled.[9] In another meta-analysis of refugee mental health, it was also found that contextual

Box 2
Torture methods and sequelae

Blunt trauma: beating, kicking, 'falanga' (beating of the soles of the feet repeatedly) dragging along the ground, whipping and nail removal

Positional torture: suspension, forced positions and twisting of limbs

Electric shocks and burns: use of acids, electrical instruments and cigarettes

Asphyxiation: use of chemicals, water boarding (immobilization, inhalation of water, forced suffocation leads the person to experience a situation similar to drowning) and hangings

Penetrating and crush injuries: stab and gunshot wounds, breaking digits

Sexual: rape, humiliation and direct trauma to genitalia

Amputation of digit or limbs

Pharmacological torture: use of sedatives and paralytics

Conditions of detention: deprivation of sensory stimulation e.g. blindfolding, solitary confinement, cramped condition in cells, poor diet leading to nutritional deficiencies, chaining and exposure to adverse weather

Psychological techniques and behavioural coercion: religious and cultural humiliation, forced betrayal or harm to others, threats of death, harm to family, mock executions and witnessing the torture of others

Sequelae: the distinction between physical and psychological methods of torture is artificial. Previously reported common physical symptoms and findings are headaches, impaired hearing, joint pain, gastrointestinal problems, fractures and scars.[34] Common mental symptoms include insomnia, nightmares, flash backs, memory problems, lack of concentration, anxiety and low mood. Increased rates of substance abuse, psychosis and suicidal thoughts have also been reported. A recent systematic review of mental sequelae shows large variation in the data.[35] Rape and other sexual violence may cause scars, fissures, testis atrophy, sexual dysfunction, pregnancies, sexually transmitted infections and mental health sequelae. Torture survivors may experience somatic symptoms[30] such as generalized weakness or chronic pain. This may have a psychological component but care must be taken to investigate a physical component, for example caused by repeated trauma or nutritional deficiencies.

factors after refugee displacement are moderators of mental health; economic opportunities and stable accommodation gave superior outcomes.[10]

International ethics and human rights

Torture is prohibited under a number of international and regional human rights instruments, international law and most domestic laws. Instruments include the *Universal Declaration of Human Rights*, the *Geneva Conventions* and the *United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (UNCAT). UNCAT defines the obligations of governments to prevent torture and to prosecute those responsible for the crime, to provide training and education for professionals, and to ensure generous redress and rehabilitation for victims of torture. As of March 2012 the convention had 150 parties.[11]

The *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, or* OPCAT, builds on the UNCAT. OPCAT obliges nations to set up independent preventive mechanisms. These examine the treatment of people in detention and make recommendations to government authorities to strengthen protection against torture while commenting on existing or proposed legislation. As of March 2012, 62 countries are party to the protocol, including the UK.[12]

OPCAT countries agree to international inspections of places of detention by the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT). The SPT is composed of 10 independent members of different professional backgrounds including lawyers, doctors and inspection experts; all have experience of human rights work. The SPT visits any places of detention including police stations, prisons (military and civilian), detention centres (pretrial detention, immigration detention and juvenile justice establishments), mental health and social care institutions and examines the treatment of detainees, recommending actions to be taken to improve the treatment of detainees. It does not provide legal or financial aid.

The Istanbul Protocol

The United Nations manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (the 'Istanbul Protocol') was developed over three years with the involvement of more than 40 organizations, including the World Medical Association (WMA).[13] This followed the death of a Turkish university graduate and

Box 3
Baki Erdogan and the Istanbul protocol

Baki Erdogan, a 29-year-old university graduate, was detained in western Turkey in 1993. He was taken to hospital after 11 days of interrogation at the police headquarters and died the same day. The official autopsy stated that he died of acute pulmonary oedema as a result of a 10-day hunger strike. The Turkish Medical Association carried out an independent investigation and produced an alternative medical report which disclosed numerous flaws in the autopsy and found that the official forensic examination did not follow the standards of the Minnesota Protocol. They determined the cause of death to be adult respiratory distress syndrome as a result of the use of torture. This successfully challenged case inspired the Turkish Medical Association to host an international meeting and work began on a manual for the investigation and documentation of torture and other forms of ill treatment. The result was the production of the Istanbul Protocol. This is composed of six chapters and four annexes:

- Relevant international legal standards
- Relevant ethical codes
- Legal investigation of torture
- General considerations for interviews
- Physical evidence of torture
- Psychological evidence of torture
- Annex I: 'Istanbul principles'
- Annex II: Diagnostic tests
- Annex III: Anatomical drawings
- Annex IV: Guidelines for the medical evaluation

investigations by the Turkish Medical Association (see Box 3).

The Istanbul Protocol is now an internationally recognized guideline for medical and legal experts. It can be used as a tool to gather and document accurate and reliable evidence in connection with cases where torture is alleged and to help practitioners to assess the consistency between allegations and medical findings. Crucially it states that: 'Witness and survivor testimony are necessary components in the documentation of torture. To the extent that physical evidence of torture exists, it provides important confirmatory evidence that a person was tortured. However, the absence of such physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars (Paragraph 161)'.

The WMA promotes the dissemination of the Istanbul Protocol and training of physicians on the identification of different modes of torture, in recognizing physical and psychological symptoms following specific forms of torture and in using the documentation techniques foreseen in the Istanbul Protocol. The medical legal reports, using the guidelines, can be used to support asylum procedures, requested where a victim of torture is seeking reparation or in cases where the perpetrator is brought to trial and used collectively for monitoring and advocacy campaigns by human rights organizations. Clearly, such campaigns need firm actions by practitioners and their respective professional bodies to ensure the spirit and the letter of the various protocols are enacted.

Allegations of torture at detention facilities around the world are numerous. Very few of these allegations have been substantiated by concrete evidence. A project[14] led by Physicians for Human Rights (PHR) coordinated a team of specialists to examine 11 former detainees from the US controlled Guantánamo Bay, Abu Ghraib and Bagram Airbase detention facilities. These examinations, following the Istanbul Protocol principles, were made possible due to effective collaboration between the medical specialist team and lawyers representing the former detainees.

Medical complicity

Medical complicity in torture is active or passive participation by doctors in torture. Examples include use of medical knowledge to aid interrogation techniques, supervising use of chemicals to torture, providing false medical reports and failure to report torture. Passive participation, such as failure to report torture, is often less recognized and punished.[15] One factor that can cause medical complicity in torture is *dual loyalty*, whereby doctors put the perceived interests of their organization or state ahead of their absolute duty of care to their patient. The International Committee of the Red Cross (ICRC), PHR and others have questioned the role of health professionals in torture; doctors in interrogations 'provide a moral shield that confers the aura of respectability on practices that may involve torture'.[16]

All medical complicity in torture, whether active or passive, fundamentally violates medical ethics and human rights law. Medical ethical codes prohibit health professionals assisting in

torture. These have a basis in the hippocratic oath and the principle of 'do no harm', and in more recent years include the Nuremberg Code which emerged from the trials of Nazi doctors, and the WMA declarations of Geneva and Tokyo. In March 2009, a resolution was passed by the United Nationals Humans Rights Council on the role and responsibility of medical and other health professionals in 'torture and other cruel, inhuman or degrading treatment or punishment'.[17] A *BMJ* article stated the importance of the resolution targeting states, urging them to act to prevent health workers from becoming involved in torture and to protect those who stand out against it.[18] The UN special rapporteur on torture examines international practice relating to torture in any state and reports to the UN Commission on Human Rights. The 2009 resolution tasks the special rapporteur on torture to give special attention to medical complicity in torture.

It is vital that national and international medical organizations recognize and prevent medical complicity in torture. Although many of these organizations endorse the ethical codes and human rights instruments that prevent medical complicity, only few of these organizations implement action against medical complicity. In Chile after the end of the Pinochet regime, during which hundreds of citizens were tortured, the Chilean Medical Association investigated and expelled a number of doctors who were involved in torture. In South Africa two doctors were punished after failing to treat or report the injuries of antiapartheid activist Steve Biko, who died in police custody from torture-related injuries. However, the doctors were only punished eight years later, during which time the South African Medical Association failed to respond as it should have done. One result of the pressure from the international campaign was the withdrawal of the South African Medical Association from the WMA, to pre-empt their expulsion.

Examples of medical complicity in torture and the failure of medical organizations to act on this are not only historical. The PHR report 'Aiding Torture' called for an independent investigation into the role of health professionals (doctors and psychologists) in known instances of torture in prisons holding terrorist suspects.[19] This report made use of a leaked document from the ICRC, which claimed Central Intelligence Agency-employed doctors were present in Guantanamo to monitor methods of torture including water boarding and shackling.[20] The report concluded that 'the alleged participation of health personnel in the interrogation process and, either directly or indirectly, in the infliction of ill-treatment constituted a gross breach of medical ethics and, in some cases, amounted to participation in torture and/or cruel inhuman or degrading treatment'.

In the UK, Medical Justice have documented the failure of 'Rule 35', the detention centre rule that should ensure vulnerable people, including torture victims, are not detained.[21] Medical Justice also reports on the inadequate documentation of torture by health professionals working in detention centres and subsequent lack of appropriate treatment. Medact's recent report 'Preventing Torture'[22] addresses the gap between the ethical codes and medical practice. The report gives recommendations to National Medical Associations and the WMA on how they can work more effectively towards eliminating torture, both through the support they give members and in their response to medical complicity. Recommendations include education in diagnostic skills and ethical duties, access to confidential advice for doctors and a clear referral system to the UN special rapporteur.

Although medical complicity in torture should be condemned and prevented, a *BMJ* editorial reported 'more doctors abet torture than treat the millions of victims'.[23] This view overlooks the larger number of health professionals, who are involved in the prevention of torture, the investigation of torture and the treatment of torture survivors.

Doctors Treating Torture Survivors in the UK: 'What to do and know'

Globally, doctors' voices can make a difference. By joining human rights organizations including Amnesty, Medact and PHR, doctors can advocate for the prevention of torture. The WMA encourages medical associations and other health professionals to participate in the OPCAT process in order to ensure: the ratification of the protocol by their country, and the participation of health professionals in the national preventative

mechanisms to address health issues related to torture and the impact of detention.

In the UK, doctors can volunteer for organizations working with torture survivors and receive training from them (e.g. Medical Justice [www.medicaljustice.org.uk], Freedom from Torture [www.toturecare.org.uk] and the Helen Bamber Foundation [www.helenbamber.org]). As well as the Istanbul Protocol, there are other guidelines on documentation of torture and working with torture survivors.[24–27] The Human Rights Foundation of Turkey published an illustrated 'Atlas of Torture', which is an excellent resource.[28]

Many torture survivors in the UK will be asylum seekers or refugees. They are entitled to register with a GP and access all National Health Service services. Asylum seekers who have had their case rejected and are at the end of the appeal process may also be entitled. Torture survivors can have complex needs and may require a package of treatment including medical care (for both physical and mental health needs); physiotherapy, counselling and psychotherapy. For many torture survivors' packages of treatment should also include legal services; practical help with basic needs (food, shelter and language lessons); further social care and integration, including living skills, building networks, education and employment training. It is essential not to underestimate the time taken to assess needs and implement a good package of treatment, and important to effectively coordinate with other professionals involved; including GPs, legal aides and refugee organizations. Redress, a human rights organization that helps torture survivors obtain justice, is a good source of legal information for both health professionals and torture survivors (www.redress.org).

Testimonies can be used for MLR, to direct preventive efforts and can have a therapeutic effect. Doctors may receive a request from a legal representative to provide an MLR on an asylum seeker who has a history of torture, and use of the Istanbul Protocol can guide this report (Box 4). Torture survivors sometimes find that the giving of testimony and the pursuit of justice is as important to them as physical and mental rehabilitation and can have a healing effect.[29] Quiroga and Jaranson's review found that 'although retelling the trauma story for reframing and reworking has been a central tenet in treatment, recovering memories of the torture must be done in a safe setting, with the appropriate timing and with acknowledgment of cultural variations in the expression and interpretation of these memories. If done within a therapeutic setting, this can lead to anxiety reduction and cognitive change … in some therapies the torture story is transformed into a testimony, to transform the survivor's story of shame and humiliation into a public story about dignity and courage, returning meaning to life'.[30] Records of testimonies can also provide valuable evidence of the types and context of torture, which can direct preventive efforts.[31]

If an MLR on a torture survivor is requested, it is important to provide the torture survivor with a clear explanation of the doctor's role, responsibilities and the examination procedures. It is also necessary to gain informed consent and explain to the torture survivor the extent of the confidentiality and who can have access to his/her case file. Working with professional interpreters, meeting

Box 4
Points for medical reports

- Clinicians qualifications
- Statement regarding veracity of testimony
- Documents reviewed, e.g. Statement of Evidence Form
- History, including details of alleged torture
- Physical and psychological examination
- Appropriate investigations, results, photos of injuries
- Diagnosis
- Interpretation of the relationship between the physical and psychological findings and reported torture (Paragraph 187 Istanbul Protocol)
  - (a) Not consistent: the lesion could not have been caused by the trauma described
  - (b) Consistent with: the lesion could have been caused by the trauma described but it is non-specific and there are many other possible causes
  - (c) Highly consistent: the lesion could have been caused by the trauma described and there are few other possible causes
  - (d) Typical of: this is an appearance that is usually found with this type of trauma but there are other possible causes
  - (e) Diagnostic of: this appearance could not have been caused in any way other than that described
- Conclusion and recommendations

(For further information see Annex IV Istanbul Protocol)

needs (e.g. female patients often prefer female interpreters) is crucial, as is avoiding interpretation by family or friends, for confidentiality, quality of interpretation and explanation of relevant socio-cultural facts.

When documenting, one should not assume that memory inconsistencies mean the history is falsified. Research on memory shows that discrepant accounts can be reconstructed from autobiographical memories in the general population and in the case of torture survivors, the normal variation in memory may be exacerbated.[32,33] It may be difficult for the survivor to discuss their history of torture in the first interview; time since the torture may give rise to confusion over dates; they may not wish to disclose details that they view as politically sensitive or that may endanger them or others further; and the memory impairment could be due to a mental disorder, such as depression, or a physical disorder, such as post-head injury. In one study of Kosovan and Bosnian asylum seekers autobiographical memories, those with high levels of post-traumatic stress were more likely to give inconsistent accounts if they had to wait a long time between interviews, and more likely to be inconsistent with details they rated as peripheral to their experience.[33] The use of a safe environment, sufficient time and scheduling repeat appointments enables trust to be built. The history can be checked with other available documents and any discrepancies discussed with the torture survivor to seek their explanation.

Clinicians need up-to-date knowledge of the various protocols, skills to ensure their assessments and reports are of the highest standard, and the courage to not turn a blind eye and be complicit, however far removed, from acts of torture by state or non-state organizations.

Conclusion

Torture remains a common practice globally. National and international medical organizations, in partnership with others, need to aid implementation of the codes and instruments prohibiting torture and address medical complicity. Medical bodies can also support more doctors to get involved in international advocacy and prevention campaigns, the investigation of alleged torture and the treatment of survivors of torture. In the UK, doctors see torture survivors, many of whom are asylum seekers, and not only provide direct treatment of their medical and psychological health needs, but may coordinate complex packages of care and be requested to write MLR. Medical schools, postgraduate deaneries and medical royal colleges need to do more to ensure promotion of existing guidelines on both the documentation of torture and work with torture survivors, and to support further training. Joint training with legal professionals, asylum caseworkers and human rights organizations could ensure more effective practice that prevents torture and provides a rapid and effective treatment where needed.

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