Report from the *International Symposium on Torture and the Medical Profession* XIX Tromsø Seminar in Medicine

“The Ethical and Legal Responsibility of the Medical Profession in Relation to Torture and the Implications of Any Form of Participation by Doctors in Torture.”

by Ole Vedel Rasmussen, M.D.*, Knud Smidt-Nielsen, M.D.*, Gregorio Martirena, M.D., and June Lopez, M.D. #

Doctors and jurists from twenty-four countries assembled June 5-7, 1990, in Tromsø, Norway, to discuss the ethical and legal responsibility of the medical profession in relation to torture and the implications of any form of participation by doctors in torture. The meeting was organized as a continuation of the 1986 conference “Doctors, Ethics, and Torture” held in Copenhagen, arranged by the Danish Medical Association (DMA), and the Rehabilitation and Research Center for Torture Victims (RCT) (1), as well as the 1987 session convened in Montevideo, Uruguay, under the auspices of the Uruguayan Medical Association, DMA, and RCT (2). The Tromsø meeting was organized by Jørgen Cohn, University of Tromsø, Leo Eitinger, University of Oslo, and RCT; of particular interest was that for the first time doctors from several East European countries participated.

At the opening of the meeting, Inge Genefke (Denmark) mentioned the importance of the fact that the conclusions of the 1986 Copenhagen meeting (1) had now been adopted unanimously by the Standing Committee of Doctors of the EC (Comité Permanent) under the title of the "Statement of Madrid" (3).

The main topic of the Tromsø symposium was the role of the doctor who participates in torture. The Symposium’s aim was twofold:

1) to identify appropriate measures to hinder particularly exposed groups of doctors, the so-called “doctors at risk” (military doctors, prison doctors, forensic doctors) from participating in torture, and

2) to identify suitable possibilities for sanctions against those doctors who have acted as torturers.

The meeting also included presentation of the results of treatment and rehabilitation of torture survivors. Interventions were presented from the Netherlands, South Africa, West Germany, France, Pakistan, the Philippines, and Chile.

Leo Eitinger (Norway) stressed that it was important for doctors to participate not only in the diagnosis and treatment of torture victims, but also, most important, in preventive work. He said, “We must learn that torture is not a problem to be handled by the therapists only. It is a problem of society and to a certain extent of the medical societies all over the world. One of the best ways to help

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Human Rights are on the march – that is, repression and dictatorships are, generally speaking, on the retreat worldwide. Not only in Eastern Europe but also in various countries in the so-called Third World we see the tyrants fall and/or democratic elections carried through: Somalia, Ethiopia, Mali, Benin...

Very few countries, however, are not mentioned in the recently published 1990 review of Amnesty International. To be exact, 144 of the countries of the world, about 160, were listed as Human Rights violators, including (for the first time) all the Nordic countries. The organization is apparently growing stricter, or is northern Europe becoming worse?

What is even worse: Torture is still widely used. 70 of the countries on the abovementioned »black list« use torture against their prisoners. The International Rehabilitation Council for Torture Victims (IRCT) is concerned, however, that a great many former prisoners are not treated for the torture they were subjected to, perhaps many years before.

Within the last ten years, knowledge of the catastrophic effects of torture has grown tremendously in the world. We know that the aim of torture is to destroy active and healthy people, annihilating the identity of human beings with strong and dedicated personalities.

The treatment and rehabilitation of a number of the released prisoners, often exiles, is an off-spring of the humanity and mercy that are more easily found in the western World than in many other parts of the earth. But the most important fight is against the torturers.

Dictatorship and torture are closely connected, but not all dictators feel the need to torture the opponents of their regimes. It is difficult, however, to think of a fight against torture as means of suppression without contemplating a campaign for democracy.

The old tradition of democracy in Europe gives the European governments a special responsibility to help young and weak democracies. Politicians and experts in the western World have given much thought lately to linking the respect for Human Rights with the amount of development aid given to a specific country.

Rather than extracting money from the violators, the rich countries should think of giving money for the treatment of torture victims in poor and destabilized developing countries, simultaneously urging them to respect their fellow beings, i.e. Human Rights.

In the long run, even dictators may realize that suppression does not further economic order. They will hardly be influenced by the humanitarian arguments of do-gooders from the West, let alone Amnesty International or the UN Human Rights Commission. But misery may persuade them to change course.

Hundreds of thousands of ex political prisoners, now living in freedom still suffer the long term effects of torture. Just think of eastern Europe or the ex-dictatorships of Latin America. The victims certainly deserve to be treated by trained doctors connected to or at one of the some 30 centres for the rehabilitation of torture survivors which exist in the world today. They represent the often forgotten legacy of tyranny.
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victims is to confront these societies with the truth and with their duties.”

John Dawson (U.K.) reported that the British Medical Association had decided to set up a committee to investigate the problem of doctors who participate in torture and to publish a report which can supplement the previously published one (4).

Dawson emphasized the significance of separation between doctors and state: “The distance between the doctors and the state is crucial. For instance, important issues are involved in securing the provision of independent autopsies of people who die in custody as well as in the questions of whether doctors undertake intimate body examinations for the police or ‘virginity’ tests for immigration authorities.

The effectivity of the different conventions and the magnitude of the problem were also discussed. A common characteristic is that the number of medical torturers is considerably larger than previously believed. From being a qualitative problem, this has now become a quantitative one. In his doctoral thesis (5), Ole Vedel Rasmussen (Denmark) found that doctors had participated in approximately twenty per cent of torture cases, and Peter Vest (Denmark) presented a study from RCT which showed a proportion of more than sixty per cent.

Gregorio Martirena (Uruguay) spoke about military doctors who had been excluded from the medical association because they had been found guilty of participation in torture during military dictatorship. The investigations of the medical association were far from being concluded. There are about eighty doctors on the list of suspects. The investigation committee was functioning only with great difficulty, as its work was being sabotaged by the authorities.

Diana Kordon (Argentina) spoke of the many doctors who had participated in torture during the military junta in her country. The medical association had been very passive. In Argentina, however, it had been possible to estab-
lish the first tribunal in which doctors judged guilty of participation in torture were named. Kordon asked for international support for the continued work of bringing doctors who had been guilty of participation in torture to trial.

The situation in Chile was almost identical. The medical association had previously investigated and excluded members who had been found guilty of torture, but this work has now almost come to a stop.

Ole Espersen, Former Minister of Justice of Denmark, proposed the establishment of a permanent tribunal system to pass judgement on doctors accused of participation in torture.

Doctors from Poland, Czechoslovakia, and the USSR spoke about the misuse of doctors for political purposes. The lack of knowledge about what was happening internationally was a significant factor. With the lessening of the isolation, optimism was expressed for the future and hope for international cooperation to raise the level of medical ethical standards.

As a member of both the UN’s and the Council of Europe’s committees against torture, Bent Sørensen (Denmark) reported on the important work of these committees. This work was still at an early stage, but “even the longest voyage starts with the first step”.

The problems were distributed in four workshops with the following tasks:

1) Monitoring and investigation of violations by physicians of codes of medical ethics and human rights;
2) Establishment of tribunals to investigate and try cases where physicians violate human rights;
3) Assistance and protection of physicians who come under threat because of their human rights activities;
4) Drawing up a universal code of medical ethics, and implementation of existing codes.

The main conclusions from the conference as a whole were to recommend:

A. The adoption of the Statement of Madrid by all national medical associations.
B. National medical assistance to demand the inclusion of medical ethics in medical school curricula (including the Tokyo and UN declarations).
C. International registration of established cases of medical involvement in torture, with the Montevideo group responsible for registration and dissemination. (Established at the meeting in Uruguay in 1987, the Montevideo group consists of representatives from the Uruguayan Medical Association, the DMA, and the RCT (2)).
D. An international reporting system for alleged cases of doctors’ involvement in torture, with the Montevideo group responsible for national and international investigations.
E. Creation by the Montevideo group of an international tribunal which, when relevant, could pass judgement on doctors accused of involvement in torture.
F. Development of methods to inform the vast number of practising doctors who today are ignorant of the torture problem so that, if faced with it, they will be prepared to react.
G. The establishment of a clearing house for interchange of information at a global level.
H. Establishment of an assisting team of doctors who will voluntarily take it upon themselves to travel out to help colleagues who come into acute situations of conflict with the authorities because of their active contribution to human rights.

The meeting can only be described as successful and the results as a new advance in the combat of torture.

References
Are we Advocates or Therapists?
The Psychiatric Perspective

by Caroline Gorst-Unsworth, M.D.*

In my work as a psychiatrist at the Medical Foundation, the question of advocacy versus therapy is one which encroaches on my work again and again.

I should start by explaining my role within the organisation and my way of seeing the problems presented to me by people who are seeking political asylum. I am asked to make a psychiatric assessment and prepare a report which will be used by their legal representative. This report, sent to the Home Office, should influence decisions about granting asylum in particular cases.

In addition to this report work, I am also asked to help the clients with their psychological distress—this may range from reassurance and support to long-term counselling or psychotherapy.

When I try to understand a particular client's problems, I find it appropriate to think at many levels. When a person describes a symptom that is troubling him, this may be understood at a cellular level (e.g. pain due to damage to soft tissues after falaka, or palpitations due to a high level of arousal), but I find it essential also to understand the higher levels of causation. Why was this person tortured?—because of the political climate in his country. And why is that country in such a situation now?—we need to look at world politics to understand this question. Therapy can be aimed at any level:

I could prescribe medication which would act at a cellular level to decrease the symptom. I could work with the client in psychotherapy to understand and come to terms with his difficulties in relation to the causative events. I could intervene at a national level by, for instance, lobbying the Home Office to change its policy on asylum seekers, or I could become involved in pressure groups that aim at changes in international policy.

So the causes and the remedies can be viewed at all levels. It is essential to put the client's symptoms into this wider framework to understand my role fully.

To return to my relationship with the client. Am I an advocate or therapist? Is it possible to be both?

In order to secure my client's refugee status in Britain, so that he can then receive therapy (on whatever level), I need to prepare a report.

A typical case:
A man who has a history that includes torture applies for political asylum. I am asked by his solicitor to prepare a psychiatric report and also to provide advice on future help for his psychological problems.

If I were to try and explain how I viewed this man's problems in a global way, I might say; "He was born into an ethnic minority in his country, has suffered all his life from repression, discrimination, and harassment. He has devoted his life to trying to change the political climate and was a much loved, respected, and powerful man within his community. After imprisonment and torture, he was forced to leave his homeland, his family, friends, and comrades to seek political asylum in a country that has not only played a part in the history of repression of his own people, but is now denying him a safe place. Every day he deals with bureaucracy, ignorance, and overt racism in a country where he has no purpose, no status, and an insecure future. Is it a wonder that he suffers frustration, despair, anxiety, and rage?"

However, the Home Office personnel (like the legal profession traditionally) like to work within a "Medical Model". They only want to know from me whether a person has a "disorder" that in some way proves his torture or persecution. They do not want a wider analysis of the problem. I have to define the problem in terms of a recognised diagnostic term such as "Depressive Disorder" or "Post Traumatic Stress Disorder". I ask about specific symptoms so that I can say that in my opinion, as a psychiatrist, this man's symptoms fulfill the criteria for a particular diagnosis, and this can then be used as evidence of a severe trauma. Even though I do not regard this person as being "disordered" in the sense of abnormality—in fact, he is suffering a very "normal" reaction to a very abnormal situation—I am required to put a medical label on his condition.

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Since I usually show my report to the client, he will regard his condition as officially defined, by a professional, as an illness/abnormality. This gives him the message that the solution is a medical one – he requires an expert, a psychiatrist, to help him. But I know that the solution to his problem is ultimately not medical, but political.

Where does this leave me in terms of effective therapy? On the one hand, “medicalising” the client’s problem may hinder an intervention at the appropriate level, other than at a cellular one.

One could say that by offering a medical solution, one is encouraging the person to be passive, to look to professionals for answers and to ignore the real causes for his situation to lose his political fight.

Also, traditional psychodynamic thought would argue that to be so obviously partisan prevents any kind of objective viewpoint; the therapist is put into the saviour role, with the patient as the helpless victim/child.

However, I would argue that there are some important differences in our clients that make it possible, and perhaps even essential, to be both advocate and therapist. First, most of our clients do not have the luxury of refugee status, so it is essential to secure a safe place before embarking on any kind of rehabilitation process. Second, after such a traumatic history, personal trust must be carefully nurtured, and making an obvious statement to the client that I am his advocate is the first step in gaining his trust. This statement of solidarity can be the most important aspect of the “holding” of such a traumatised patient. Third, these people often have a history of endless encounters with different officials who may ask searching personal questions and then never see the person again, so to pass a person on to another therapist may represent problems that add to their sense of dehumanisation.

Conclusion
In my work as a psychiatrist in such a specialised field, there is a need to be both advocate and therapist. These two roles have not traditionally fitted comfortably together.

The work in which we are involved is unique in representing such a challenge. It is not sufficient to turn our back on the advocacy work in order to carry out “pure” therapy. Personally, my conscience and interest in human rights led me into work with survivors of torture. If I wanted to deliver “pure” therapy, I would be working in private practice.

Rather than seeing the advocacy versus therapy question as an obstacle, I prefer to see it as creating an environment in which orthodoxy can be challenged and in which new and creative ways of working can be learnt.

I would value other opinions on the subject.

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**Children in Crisis**

From the Proceedings of *The first International seminar-Workshop on «Children in Crisis»*, November 27-December 10, the Philippines 1989, we reprint the country reports from the following countries: Argentina, Pakistan, the Philippines and South Africa.

The proceedings are published by Children’s Rehabilitation Center, 5B Escaler St., Loyola Heights, Quezon City, Philippines.

**ARGENTINA**

The discussions on the Argentina country report focused on five points: a) degree of repression; b) psychiatric management of torturers; c) long-term effects of torture on victims; d) ideological reasons for separating children from their families; and e) relating with Plaza de Mayo mothers.

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**Degree of Repression**

It was pointed out that what differentiates the situation in Argentina, Chile and Uruguay from other Third World Countries similarly suffering authoritarian repression is the absence of a state of war. The main problem is state terrorism as exemplified in widespread arrests, detention and censorship. On the other hand, countries such as the Philippines, Afghanistan, Cambodia and El Salvador are in state of war.

- In the Philippines, however, it was emphasized that there is state terrorism as well. Unarmed protest groups like peasant and labor groups suffer from state violence. The opposition movements come in the form of open, parliamentary and extra-legal movements on one hand, and in the form of underground, armed resistance, on the other.

- In cases where there are armed conflicts, there is the possibility of children getting caught in the crossfire.

**Psychiatric Management of Torturers**

Instances of torturers seeking psychiatric help in hospitals were also shared. Due to the passage of the Impunity law, the therapists were afraid of the possible consequences if they refused to treat torturers or if they made a stand on the issue. One such Argentinian therapist who made a stand fled to Spain as a consequence.

- A significant view which surfaced in the course of the discussion is that ethics and the therapists’ profession dictate that they could not help torturers with their problems unless justice is first given, that is, the torturer would be willing to admit to his crime or is remorseful. However, special considerations could be given particularly to the specific situations obtaining in the country. A specific exception which was given pertained to cases wherein torture
victims were transformed into torturers. The participants felt that cases like these must be further investigated.

**Long-Term Effects of Torture on Victims**

In relation to the kind of clientele, the Equipo de Asistencia Psicologica de Madres de Plaza de Mayo assists torture victims as well as families with member(s) who have disappeared. A lot of consultations on the case of children who were tortured or separated from their original families are received once the children reach adolescence. This shows the long-term effects of their traumatic experiences.

Symptoms also appear once these children reach the point when they want to marry. Daughters of disappeared persons tend to suffer maternity problems because of fear of having abnormal children.

**Ideological Reasons for Separating Children from their Families**

A sticky issue cropped up on the case of children who were separated from their parents to prevent them from believing what their parents believed or because the parents had disappeared. Many of these children have been brought up by people from the ruling group or by families which support the dictatorship. The question was posed: What happens when the children discover they were simply adopted?

The Argentinian panel believed in the need for restitution of the children to their original families. If the children remained in the family which adopted them, it would be tantamount to condoning the repression which happened under the dictatorship. They said that the children must be given the opportunity to enjoy the love of their original families.

- The panel added that the children have a right to their own personal identity. Identity problems might become worse if they are not returned to their original families. They cited a documentary movie where a family adopted a child whom they did not know belonged to a family whose members have been tortured. Investigations were made to ascertain the real parents of the child.

- The role of media in perpetuating unlawful separation of children from their families was also pointed out. The panel lamented the fact that a media campaign has been launched, as part of the Impunity Law, that adopted children not be returned to their real families.

- A question was raised on whether it is possible for children who have been separated from their real families to develop love for their new families. If so, what have been done in relation to this?

The Argentinian panel said that the issue is complicated. Two possible situations for consideration were presented:

1. If the family who adopted the child were the same people who killed the parents of the child, then a perverse situation is created. In this case, the child must be returned to his legitimate family.
2. However, in cases where the families which adopted the child had no participation in killing the parents or in the process of repression, they believe that the real or natural families should be given legal rights to the children. At the same time, a good relation should be maintained between the real family and the family which adopted the child.

It was stressed that these cases could cause real problems if one treats the psychological from the bigger social problem and context. There could be no short-term solutions to these complex problems. One could only be reminded that these are the consequences of state terrorism.

It was added that some researches show that in some cultures, children below 12 years old could not make a sufficiently informed or wise decision on which parent to join when they separate (e.g. in divorces). In others, the age required is nine years. What is important to keep in mind is how the dignity and rights of the child are protected and respected.

**Relating with Plaza de Mayo Mothers**

The panel also related their experience with the mothers of the Plaza de Mayo. These mothers formulated ways by which they could handle their traumatic experiences. They noted that some people have become ill because of the repressive conditions. There were efforts to provide therapy to these people either individually, in groups, or as families. The panel pointed out that these people were not really sick but only need to adjust to the new conditions of their lives.

To face their problems, orientation of the mothers on their situation was given. They were also provided with information on what could have happened to their children. These activities have become important during and after the dictatorship. The groups as well as the therapists went to the areas where the traumatic experiences happened, such as the houses of the mothers. In many cases, they went to places where mothers usually congregated.

**PAKISTAN**

The paper covered various aspects of the socio-political and economic situation in Pakistan. It presented the plight of the children in that country and the cultural factors affecting the quality of life of its people.

The discussion which ensued after the presentation of the country report encompassed six areas of the situation in Pakistan. These six areas are: a) functional literacy; b) pre-arranged marriages; c) children in labor force; d) handling victims of torture; e) the state of oppression in Pakistan; f) influx of refugees.

**Functional Literacy**

Clarifications on the statistics on literacy in Pakistan were made. The presenter explained that the percentages were culled from the Pakistan economic survey. Statistics on the state of literacy in Bangladesh and the Philippines were then shared. Drop out rate is highest between Grades 1 and 2 in Bangladesh, and between Grades 4 and 5 in the Philippines. In addition, studies in Bangladesh show that people there do not exhibit functional literacy.

**Pre-arranged Marriages**

The custom of pre-arranged marriage is seldom observed in Pakistan, unlike in Bangladesh which is commonly made with children from 10 to 14 years of age. In the Philippines, early pre-arranged marriages are confined to the tribal communities in the north.

**Children in the Labor Force**

The exploitation of children in the labor force was given due attention during the discussion. As a situationer, it is
often the case for parents of children in the labor force to receive lump sum for the services of their children. The children are thus forced to stay and work with their employer until they have repaid their so-called »loan«.

An organization was recently founded to protest [sic] child laborers and workers. There is much to be desired of other organizations in the area toward this direction since most of them are confined to social work.

Handling Victims of Torture
The presenter described the approach being used in handling torture victims as »eclectic«, with focus on »interpersonal transaction« of the individual with other persons, and with himself. The victim’s interactions with people are assessed before the program of therapy is worked out. Therapy sessions provided are most difficult because of the reluctance of victims to narrate their experiences.

The report also highlighted risk in pursuing work with victims of torture because of the socio-political condition in Pakistan. It cited the organization »Voice Against Torture« as having made a great impact in making people aware of the situation.

The State of Oppression in Pakistan
The nature of oppression in Pakistan, its cause and the factors affecting the situation were qualified in the course of the discussion.
- Recurring ethnic problems due to the heterogeneity and complexity of Pakistan’s culture and the criticism since Urdu was made national language of Pakistan. Each of Pakistan’s many states has its own ethnic character. Differences among the ethnic groups fuel ethnic strife. Rising unemployment and worsening poverty aggravate the situation. All of these divert people’s attention from the real problems confronting Pakistan as a nation.
- Discrimination of minority group. This is reflected by their inability to participate in general elections unless they field their own candidates. Minority religious groups are likewise stripped of their rights to establish places of worship.
- Discrimination of women. Pakistani women are regarded as second class citizens. Because of this discrimination, it was pointed out that this could be another area of protest because what affects women of a given society affects the plight of their children. It was added that there is need for women to be aware of their reproductive rights and their rights over their bodies.
- Massive military repression as indicated by the continuous deployment of soldiers in rural communities to confront the unarmed population. Killings, arrests, and detention of political prisoners are a common occurrence. While political prisoners of the past regime were already set free, some are still languishing in jail because they were tried and convicted by the military tribunal and therefore are denied of their right of appeal.
- Perceived weakness in leadership. Benazir Bhutto has remained popular among the people. Yet, she has not been able to impose the needed reforms either because she has to compromise with other political groups to remain in power or because discriminatory laws in Pakistan are related to religion and therefore cannot be repealed.

Influx of Refugees
The rise of refugees from neighboring countries demands attention. Refugees need help to adopt [sic] to their new lives and cope with the trauma of migration and war. In spite of this, the government of Pakistan has failed to provide the much needed support.

PHILIPPINES

The Philippine report covered the status of insurgency in the country, the human rights situation, the Children's Rehabilitation Center (CRC) Program, and nongovernment organizations (NGOs) working directly or indirectly for the cause of children in crisis.

Status of Insurgency
There are two existing insurgency groups in the Philippines. The Moro National Liberation Front (MNLF) and its military arm, the Bangsa Moro Army (BMA) operate in the Muslim populated areas of Mindanao. The National Democratic Front (NDF) and its military arm, the New People’s Army (NPA), on the other hand, can be found in almost all provinces of the Philippines except for the small islands north of the country.
- The size of the guerrilla units of the NPA ranges from a squad to the size of a battalion in some areas.
- The NPA is now operating in the urban areas where they liquidate those they consider as »enemies of the people« after trying them in people’s courts in the communities.

Human Rights Situation
There was long debate on whether to classify actions of the NPA such as executions and torture done during the purging of informers as human rights violations. But the human rights groups adhered to the international definition that human rights violations are acts perpetrated by the state against its people. Since the rebels operate outside the law, the state could very well file criminal charges against the rebels.

Based on the tally made by the Medical Action Group (MAG), even if the actions of the rebels were to be considered human rights violations, the number of those committed by the military still far exceeds those committed by the rebels.

It was noted that the pattern of human rights violation during the time of Marcos was prolonged detention and torture in the various detention centers and safehouses. Under the Aquino regime, torture also occurs outside the detention centers, that is, in the community setting due to the widespread formation of paramilitary groups. The number of summary executions and disappearances have likewise increased.

Workers from various health programs set-up by nongovernmental groups experience harassment from the state since they expose the inadequacy of health services of the Philippine government.

As a result of the low intensity conflict or the total war policy at the grassroots level, economic and medical blockades have been set up in the communities. Persistent harassment of the people accused of supporting or being members of the NPA have likewise proliferated.
Children's Rehabilitation Center (CRC) Program

The sharing of the CRC activities revolved around these discussion points:

- For orphan children, it is helpful that they go through the whole grief-work process. This would facilitate their transfer to volunteer foster families.
- There is also a need to focus therapy work on the parents as adults since they also find themselves in difficult situations.
- Funding of CRC comes from local and international support groups. It does not get any form of support from the government. In fact, the staff suffer harassment in the course of doing their work.
- Psychologists, social workers, child educators and social scientists make up the work force of CRC. Almost anyone who is interested to work with CRC is welcome. The staff and the volunteers all undergo the necessary training.
- There is difficulty in finding personnel due to the high risks involved, the specific skills needed for the work, and the element of the commitment which the jobs call for.
- It was emphasized that the therapists themselves are in need of therapy due to the great demands of the work. Thus, the «Therapy for Therapists» program was envisaged.

Non-Government Organizations in the Philippines

There is a very good network of different organizations in the Philippines where referrals are done depending on the organizations’ field of specialization. Some of these organizations are:

- Free Legal Assistance Group (FLAG)
- Medical Action Group (MAG)
- Task Force Detainees Philippines (TFDP)
- Families of the Involuntarily Disappeared (FIND)

These groups, along with other people’s organizations, sectoral and grassroots organizations, have come together to provide an alternative support system in the work with children in crisis.

SOUTH AFRICA

Four issues evolved during the discussion of the South Africa country report they are: a) children under detention; b) actions taken by professional organizations; c) nature of psychological intervention; and d) politics and ethics of scientific search and therapy.

Children under Detention

Clarification was sought on the accuracy of statistics used in the paper specifically on the 170,000 children detained. The South African delegation responded that there was in fact an indiscriminate arrest of children in large numbers. Such move was meant to intimidate the Black population.

Actions Taken by Professional Organizations

A follow-up question pertained to actions of protest taken from a medical point of view by the International Pediatric Association in relation to tortured children and children in prison. It was stated that while it is the role of professional groups to expose the effects of repression and apartheid, it has become difficult to do so because of strict media censorship. It was also added that not all medical professionals are sympathetic to the cause of anti-apartheid groups. It is only the Psychological Association that has openly made a statement against apartheid.

Corollary to this, it was noted that the existence of favorable foreign policies in some countries in relation to South Africa prevents the spread of anti-apartheid international organizations in other parts of the world.

Nature of Psychological Intervention

The nature of psychological intervention considering the dangers of political persecution and practical difficulties was also discussed. It was mentioned that intervention is usually completed within a single contact.

The participants recognized that speaking of a post-traumatic syndrome is difficult since children suffer from constant stress. Intervention, it was agreed, could vary from breaking the silence to helping the children construct some meaning from their experiences or simply putting people in touch with others through seminars wherein community leaders are trained to be therapists.

The panel also cited their attempts to combine western and traditional methods in the intervention process.

Politics and Ethics of Scientific Research and Therapy

A participant remarked that the purpose of the Conference was to come up with a scientific research regarding children in crisis and not one on politics. He was specifically reacting to a statement in the country report regarding scientific research as being political. In response, another delegate argued that one cannot divorce himself from the context of what is being studied because even the questions being asked by the researcher and his interpretation of data are colored by his own perceptions and attitude. He added that to take a political stand does not imply distortion of data. He can still employ academic and professional approaches to therapy.

The concept of active medical neutrality in relation to the question of ethics was also introduced. From the Philippine experience, establishing political solidarity with the clients has proved helpful as a first step to psychological therapy. Once this is achieved, there can be no ethical questions raised.

Otherwise, there should at least be sympathy with the cause.

The concept of active medical neutrality, it was explained to the group, emphasizes that if physicians are to treat everybody, they do not just sit in their clinics and wait. They should seek them from among the most marginalized population.

While mention was also made of the importance of remaining apolitical in getting international support it was stressed that the presence of the participants in the workshop signifies their commitment to human rights. In the final analysis, it was realized that there is no such thing as being a political for eventually, each one has to make a decision where to stand vis-a-vis with certain realities. In the end, what is paramount is the goal of everyone to bring humanity to others.
Turkey

Amnesty International’s annual report reveals that torture is still being used widely in Turkey, and in certain cases leads to the death of the victim. Ten provinces in the South-eastern part of the country have been under military martial law in an effort to suppress the Kurdish guerillas. There have also been several examples of forced closing down of newspapers and journals. According to Amnesty it is still very difficult for lawyers to get in contact with political prisoners who have been arrested by the police, and in 1990 hundreds of political prisoners were sentenced to jail or death – a total of 315 Turks have been sentenced to death, but the authorities do not yet dare to carry out these sentences.

News in Brief

Still widespread torture in El Salvador and Guatemala

Despite frequent murder threats, it has been possible for a year now to keep a torture treatment centre open in San Salvador. However, the word torture is practically never heard in the country.

However, the neighbouring country, Guatemala, with a considerably larger degree of political persecution, does not have such a centre.

- The centre functions well, but it lives a dangerous life, according to Professor Bent Sørensen, Denmark, member of UN’s Anti Torture Committee, who has just visited the two Central American countries together with Dr. Ole Vedel Rasmussen, Denmark. Both doctors have for a number of years participated in national and international work for torture survivors. The two doctors preferred to travel together for security reasons. Conditions are insecure and dangerous for foreigners, Professor Sørensen points out.

In 1987, El Salvador had its first torture treatment centre, under the auspices of the Salvadoran Human Rights Commission. However, it was forced to close down during a guerilla offensive in 1989 – the staff of the clinic had to flee abroad.

The name of the present centre is »Children’s Integration Union». There is no open talk about torture or torture victims, only of conflict victims. From starting treating children's nervous symptoms etc., the centre is now treating grown-up victims of 11 years’ of civil war.

Treatment is given partly for psychological sequels of torture (e.g. humiliating sexual treatment or mock executions), partly for psychological torture as such in the form of terror acts (bombardments), captures and the disappearance of family members.

Private relief organizations cooperate with the Human Rights Commission and refer the victims for treatment. The medical section of the treatment centre see about 300 patients for consultation or treatment per month.

The private Human Rights Organization has established a large documentation centre. The statistics for May, for example, showed that there had been 26 new political prisoners, of whom 10 had disappeared, and 16 had died.

Even though the dictatorship in Guatemala was overthrown five years ago, the right-oriented death squads are extremely active, about 1000 killed or reported missing in 1990. Since 1966, 45,000 persons have disappeared the same way.

Guatemala and El Salvador both have a large union, the Widows’ Organization. The organization in Guatemala had more than 10,000 members. In that country, where 60% of the population are poor Indians (El Salvador has only 5% Indians), thousands of widows live in misery, without any knowledge of the law.

One widow told her story: Her grandparents were murdered. She had been married twice: her first husband was taken away in 1981, the second husband in 1990 – and she has not heard anything about any of them. Several brothers of her second husband had also disappeared. As for herself, she is often forced to flee because of death threats.

The whole world is now awaiting Guatemala’s forthcoming report to the UN’s Anti Torture Committee in Geneva with great expectations, because this country – unlike El Salvador – has ratified UN’s special Convention Against Torture.
Professor Ole Aalund, Denmark

– a distinguished advocate of human rights and fight against torture.

One of the people who was working most intensely in the fight against torture, Ole Aalund, died recently while on his way to Latvia. He was sent there by "Physicians for Human Rights, Denmark" to help the suppressed.

Ole Aalund had used his professional expertise and spare time for many years to describe the sequelae of torture and the mechanisms of deliberate violence. His field of work included a wide variety of research on torture that has taken place both internationally and in Denmark. He was also an unflagging guide and supervisor for four MD theses on torture that were presented at the University of Copenhagen. They are the first in the world to deal with the examination of torture victims and methods of demonstrating the sequelae of torture. They are thus important tools in the fight against torture.

He was a cofounder of the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen, and soon became a member of its board. Furthermore, he was a cofounder and, till his death, chairman of the scientific society "Anti-Torture Research", which sponsors and initiates research on sequelae of torture. He also used a lot of energy as a member of the medical group of Amnesty International.

Ole Aalund was a warm and loving person who enlightened our daily work with his sense of humour. He was an invaluable support for our common goals, and his death is a great and painful loss for us all.

Our thoughts go to Ilse, Karen and Anders.


Lis Danielsen
Inge Genefke
Erik Holst

Ole Vedel Rasmussen
Bent Sørensen
Olav Minor Vedel

Dr. John Dawson, England

Dr. John Dawson, born 18th of August 1946, died 20th of December, 1990, 44 years old.

It was with great sorrow that we learned about the death of Dr. John Dawson, who better than any one else understood the obligation of the medical profession to work against torture.

John Dawson was a very noble representative for the British Medical Association.

He was instrumental in persuading a group of eminent laymen and clinicians to serve on the BMA AIDS working party, which in turn convinced the BMA council that the association needed to take a leading role in educating the public, politicians, and above all its own profession.

In the ethical field we will remember his involvement in the production of The Torture Report, The BMA Handbook of Medical Ethics and Doctors' Dilemmas.

At the international meeting on "Torture and the Medical Profession" in Tromsø, Norway, last summer, he showed a profound understanding of the doctor torturer problematieque and the immense responsibility of the medical profession to prevent torture by assisting fellow doctors who are at risk.

His great dedication in this new and important field of medical ethics will be deeply missed. But we sincerely hope and trust that all doctor colleagues will carry on his valuable work in his spirit.

Ole Vedel Rasmussen
Henrik Marcussen

Doctors' Dilemmas
MEDICAL ETHICS AND CONTEMPORARY SCIENCE
Melanie Phillips
John Dawson
Factfinding Missions Registered


Reviewed by Johanne Cummings*

This bibliography has developed from a study carried out earlier by SIM and published by Martinus Nijhoff Publishers: Human rights missions: a study of the fact-finding practice of Non-governmental Organizations, 1986.

By widening its scope to include Inter-Governmental Organization reports as well as Non-Governmental Organization reports of observer missions to trials and elections this bibliography contains about 550 entries, arranged by continent (five) and country, chronologically.

With this arrangement it is easy to learn that 163 pages out of a total of 378 are given to “America (North and South)” and to draw various conclusions from this fact. The preface, however, is careful in treating this problem, basically recommending “that NGOs achieve a balance within their own fact-finding activity as well as within the human rights community as a whole”. A warning against “intended overlap” caused by “a temporarily receptive public opinion”, but mostly a strong plea for strengthening the efforts to establish better circulation of human rights information “such as the network HURIDOCS…” so that “unintended overlap” in missions is avoided. The bibliography refers to reports published between 1970 and September 1986, the great majority written in English, some in French, and a few in Spanish, Dutch, and German.

The entry for each report is “reproduced according to fixed fields … in the HURIDOCS Standard Formats” which does not necessarily make for pleasant reading, but probably helps to keep the price down on an already quite expensive publication.

Apart from author, title, etc. this format contains an Index Field used for keywords, e.g.: legislation, torture, trade unions, detention, trials, political prisoners, etc. These keywords in turn make up one of the three indexes; the other two being a country index and a publishers’ index (i.e. the organization which published the report, not necessarily the same as the one that organized the mission).

The annotations, placed in the Free Text field, are in the form of 515 line abstracts, giving:
1. the purpose of the mission,
2. the structure of the report, and
3. information on any appendices, conclusions, declarations, etc.

In view of the difficulties one meets in trying to find reports of the kind here listed, this bibliography meets a great need in the world of “grey literature”. The research and compilation are both most admirable. I hope that the publishers will continue to update the publication, since its reference value is inestimable. It would also help organizations which send out missions to avoid the problem of overlap.

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Important New Textbook for Nurses


Reviewed by Knud Smidt-Nielsen, M.D.*

Torture has spread like a cancerous growth during the past half century, and it is now practised in five continents and in one third of all countries. At the same time the fight against torture has been intensified, and, as part of this process, a manual has appeared for the very first time, describing torture, its aims, methods, sequelae, and treatment. It has been written for nurses, but it describes several fundamental facts about torture in such a way that all health and social workers will benefit from reading it. Both authors are attached to the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen, one as head nurse, the other as psychiatrist, and both have long experience in the treatment of torture victims, or “torture survivors”, a more correct term which is used throughout the booklet.

The introduction stresses the importance of understanding the essence of torture: that its aim is to destroy the individual by breaking down his personality.

The chapter that follows describes the epidemiology and methods of torture, the understanding of which is important for the treatment. Somatic, psychological, and psychosomatic sequelae are described. It is stressed that torture survivors often isolate themselves because they have lost their self-confidence and ability to trust others. They often have feelings of anxiety, depression, disturbed sleep, and sexual problems, but it is also stressed that these reactions are normal in normal human beings who have been exposed to inhuman treatment.

Chapter 3 describes the background to the creation of the RCT, whose main tasks are rehabilitation of torture survivors and their families, research into the sequelae of torture, and training of national and international health personnel in the treatment of torture survivors. The treatment involves several specialities, and its aim is to build up the personalities of the torture survivors so that they can again become responsible for their own lives and achieve
an acceptable existence. This has proved possible in several cases, against all odds.

After a preliminary examination by psychotherapist, neurologist, rheumatologist, social advisor, dentist, and nurse, among others, the treatment is started, with psychotherapy, physiotherapy, and social advice as the main points. The booklet describes these three elements of treatment in detail, and it is mentioned that the treatment may last a long time and that the rest of the family should be involved. Friendly, not hospital-like, surroundings are emphasized throughout in order to build up confidence between the patients and those who are treating them; this is of great importance for the outcome of the treatment. No secret is made of how difficult this process of confidence-building is, since the torture survivor has usually lost all faith in his fellow human beings. Other factors can make the treatment difficult, e.g. culture differences, or excessive fear of simple routine visits to the dentist or the radiologist. Various psychological reactions are described in this connection, including aggressive tendencies because of insecurity and fear, and advice is given about how one should react. This extremely important section, about the close daily patient/nurse relationship, is particularly well written.

Chapters 5 and 6, respectively, deal with the problems that arise when survivors are admitted to hospital, and the important role of the interpreter during the treatment.

Chapter 7 covers the ethical rules for nurses in connection with torture, and relevant international rules are described, especially the 1984 UN convention against torture, which was ratified by Denmark in the same year. It is a depressing fact that health professionals, and doctors in particular, have to a large extent taken part in torture, and in doing so have seriously violated all the ethical rules in this connection. It is therefore very positive that the Nurses’ International Organization (ICN), as mentioned in the booklet, has proposed the following three rules:

1) nurses must not take part in or be present at torture,
2) nurses must not make available their professional skills at torture, and
3) nurses must not take part in actions that can decrease a person’s ability to resist torture.

The final chapter discusses how best to continue work against torture. It is accepted that information alone is not enough – training is also necessary. Great emphasis is put on following article 10 of the UN convention against torture, which describes the necessity of training and informing health personnel about the ban of torture. The authors regard it as a duty to ensure this by training, and by contact with hospitals and general practice. They are certainly right, since any nurse or doctor or social worker may be the first contact for a torture survivor. It is therefore of great importance that they are aware of the problems of torture beforehand. This booklet is written in a clear and straightforward way and contains all the experience obtained during the ten years of work with torture survivors. Although this manual is mainly meant for nurses, it can be recommended for all health staff and social workers – for doctors it is almost indispensable.

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Doctors and torture do not go well together. Doctors are trained to cure people, not to destroy their bodies and souls. However, this concept does not always seem to hold, as has been shown by Amnesty International’s Danish medical group, who have talked with and examined torture victims, and more particularly by RCT’s investigative work on torture survivors from dictatorships.

Particularly in dictatorships, where large groups of doctors work for the authorities, there are several examples of violations by military, prison, and forensic doctors of the generally accepted rules of medical ethics and the declarations of human rights.

This is typical for societies in which the rules of human rights are not followed, and where these “doctors at risk”, today’s name for these state employed doctors, are used and allow themselves to be misused for torture and other violations of human rights.

Sadly, the examples are numerous. They can be registered in several ways. As example, the doctor may be asked to indicate before the torture, where it is likely to be most effective, or it may be a question of helping the torturers by examining the condition of the victims with respect to continuing the torture, or of performing the torture themselves, or of filling in the necessary certificates, which are often not in agreement with the facts. This odious system is revealed by Nazareth in his film as he confronts three such representatives of doctor-torturers from Argentina, Uruguay, and Brazil.

## Selected List of Documents Received at the RCT-International Documentation Centre


Health services for the treatment of torture and trauma survivors: from symposia sponsored by the AAAS Committee on Scientific Freedom and Responsibility:


Forthcoming Conferences and Seminars

Pakistan, Islamabad, 1991, October 9-11
Regional Asian Conference on Rehabilitation of Torture Victims.
Organized by: Voice against Torture Pakistan, in cooperation with: Rehabilitation and Research Centre for Torture Victims, Denmark.
Last date for submission of articles, papers and country reports along with an abstract was 31 August 1991. The abstracts will be printed in the form of a booklet.

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Rubya Mehdi/Pervaiz Akhter
Overseas Coordinators of the Conference
Sjelor Boulevard 81, 4 T.V.
2500 Valby
Denmark
Tel: +45 31 16 74 52

USA, Washington, D.C., 1991, October 24-27
The Reality of Trauma in Everyday Life: Implications for Intervention and Policy.
7th Annual Meeting of the International Society for Traumatic Stress Studies.
For further information, please contact
The International Society for Traumatic Stress Studies
435 N. Michigan Avenue, Suite 1717
Chicago, IL 60611-4067
USA

Chile, Santiago, 1991, November 24-29
Health, Political Repression and Human Rights.
III International Conference of Centres, Institutions and Individuals Concerned with the Care for Victims of Organized Violence.
For further information, please contact:
Elisa Neumann
Manuel Rodriguez 33
Santiago, Chile
Tel: (562) 6957534 – 6955931
Fax: (562) 6988609

Budapest, Hungary, 1991, October 24-26
IVth International Symposium on Torture & the Medical Profession
This meeting is a continuation of the meeting in 1990 on “Torture and the Medical Profession”, the meeting in Montevideo in 1987 on “Doctors involved with Torture”, and the Copenhagen meeting in 1986 on “Doctors, Ethics and Torture”.
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