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COMPENSATION FOR TORTURE

At the fourth session in January 1992, the United Nations Compensation Commission Governing Council decided on a determination of ceilings rather than fixed amounts for compensation for mental pain and anguish (see next page).

This Compensation Commission was established by the Security Council for the processing and payment of claims against Iraq for direct losses and damage resulting from its invasion and occupation of Kuwait.

Approximately 430,000 claims of individual losses up to USD 100,000 were expected, and the Commission therefore issued criteria for the claims. The Commission further agreed to analyse the issue of compensation for claims on the grounds of mental pain and anguish, claims on which consensus could not be reached.

For that reason a panel of experts was invited to assist and advise the Commission. This panel was represented by 6 experts: two psychiatrists, the medical director of RCT, two experts in disaster psychiatry and medicine, and a lawyer, expert in war pensions.

This panel agreed that the work thus far deserved high praise, but felt that the work on the assessment of mental pain and anguish should be carried out considering several basic principles which should underlie the compensation procedures. Further, the panel stated that the Compensation Programme could be provided to the victims at a relatively early date. However, this could not take into account the delayed reactions of torture and other maltreatment.

Situations of extreme trauma inflict a deep feeling of injury on the victims' integrity and dignity, leaving them thoroughly humiliated, with long-lasting health problems. Many will have their work capacity reduced or completely destroyed. The panel found it regrettable that the possibility of compensation for late health damage resulting in losses of working capacity, quality of life and income, was not considered in the decision.

The panel also recommended that compensation should include redress, i.e. moral assistance to victims, financial compensation, and physical and psychological rehabilitation. These recommendations have been put forward with an awareness that the Compensation Programme for mental pain and anguish may well be used in other similar programmes that the UN and other bodies might undertake in the future.

Before the final text of the report of the panel, input by IRCT Council members was given as a basis for a further worldwide discussion of the whole problem of compensation.

A follow-up of this UN initiative – but with reference to a national Compensation Programme – is also expressed in a paper by B. Sharma, CVICT, Nepal (see page 77).

The final report of recommendations of modifying factors for the categories of the 1992 compensation decision is a work of consensus among different opinions. Thus a ceiling per incident of USD 5,000 for aggravated assault or torture is shamefully low. This is a compromise owing to the fact that two countries, China and India, were against giving as much as one penny for mental pain and anguish.

The points of view of IRCT are expressed in a paper: Considerations concerning criteria for financial compensation to victims of torture presented to the Commission in Geneva in March 1994.

This paper deals with three M's of compensation: moral, money, and medical, in situations where government sanctioned torture is practised. Economic rehabilitation for sufferings which took place in the past concerns compensation for physical and psychological sequelae. This should correspond to existing compensation rules established by the courts, but with an addition of at least 50% because torture is a specific trauma which leaves the victims with extremely serious personal injury.

Further compensation should take into account imprisonment (number of days), lost working capacity, lost seniority, lost property, and lost values in general – following rules for compensation for others.

And, lastly, a lump sum should be paid to the victims by the country responsible for the torture in consideration of the special nature of the trauma.

H.M.
Determination of Ceilings for Compensation for Mental Pain and Anguish

Decision taken by the Governing Council of the United Nations Compensation Commission during its Fourth Session, at the 22nd meeting held on 24 January 1992

Excerpts from 7 categories in total:

A: A spouse, child or parent of the individual suffered death.
   USD 15,000 ceiling per claimant;
   USD 30,000 ceiling per family unit.

B: The individual suffered serious personal injury involving dismemberment, permanent or temporary significant disfigurement or permanent or temporary significant loss of use or limitation of use of a body organ, member, function or system.
   USD 15,000 ceiling for dismemberment, permanent significant disfigurement, or permanent loss of use or permanent limitation of use of a body organ, member, function or system;
   USD 5000 ceiling for temporary significant disfigurement or temporary significant loss of use or limitation of use of a body organ, member, function or system.

C: The individual suffered sexual assault or aggravated assault or torture.
   USD 5000 ceiling per incident.

D: The individual witnessed the intentional infliction of events described in Categories A, B or C on his or her spouse, child or parent.
   USD 2500 ceiling per claimant;
   USD 5000 ceiling per family unit.

(...)

G: The individual was deprived of all economic resources, such as to threaten seriously his or her survival and that of his or her spouse, children or parents, in cases where assistance from his or her Government or other sources has not been provided.
   USD 2500 ceiling per claimant;
   USD 5000 ceiling per family unit.

The following overall ceilings will apply to total cumulative amounts available to claimants for payments for mental pain and anguish:
   USD 30,000 ceiling per claimant;
   USD 60,000 ceiling per family unit.

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Collaborators in the Occupied Territories: human rights abuses and violations / Be'er, Yizhar ; Abdel-Jawad, Saleh ; B'Tselem : The Israeli Information Center for Human Rights in the Occupied Territories. - Jerusalem : B'Tselem, 19940100. - 239 p. ; ill. - ISSN: 0792-8114.

Presentation of ambassador Jose Ayala Lasso, UN High Commissioner for Human Rights on the occasion of his visit to RCT/IRCT; Tuesday 28 June, 1994 / Geneve, Inge. - Copenhagen : IRCT, 19940628. - 2 p.

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UN High Commissioner for Human Rights launched appeal against torture during his two-day official visit to Denmark / United Nations Information Centre for the Nordic Countries. - Copenhagen : United Nations Information Centre for the Nordic Countries, 19940628. - 2 p.


Psychological effects of torture : a comparison of tortured with nontortured political activists in Turkey / Basoglu, Metin; Paker, Murat ; Paker, Ozgun ; Ozmen, Erdogan ; Marks, Isaac : Incesu, Cem ; Sahin, Dogan ; Sarimurat, Nusin. - In: American journal of psychiatry ; vol. 151, no. 1, 1994010000. - p. 76-81.


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Torture compensation issues in Nepal

By Bhogendra Sharma*

Introduction

A Himalayan kingdom sandwiched between giant neighbours, China and India, is known as Shangri-La by most international visitors. An autocratic government, under the rule of an absolute monarchy, was able to mask its face for some decades. A people’s movement in 1990 resulted in significant changes, in which the king was forced to hand over his power to the people. An interim government, composed of multiple political parties, was formed and ruled for one year. During this period, a constitution was drafted, which was later discussed and accepted by the democratically elected parliament. Several articles on the rights of the people were incorporated in the constitution, including an article against torture. Article number 14 (sub-article 4) states: “No person detained during investigation or for trial or for inquiry or other reasons shall be subjected to physical or mental torture nor shall s/he be given any cruel, inhuman or degrading treatment. Any person suffering from such kinds of maltreatment is entitled to compensation as specified by laws.” The 1990 constitution of the Kingdom of Nepal provides several articles that protect human rights. It also empowers the supreme court to issue various orders and writs, including habeas corpus, for the enforcement of constitutionally guaranteed fundamental rights.

The significant work done during the interim period was the ratification of international declarations and conventions, including those against torture. It is important to note that the elected government has not acceded to any of the international instruments, and that it has not yet properly followed up the reporting system on these treaties, to which the interim government acceded.

Several commissions were formed during the period of interim government to uplift the human rights situation and to correct the human wrongs. One of the commissions, the Mallik Commission, was formed to investigate human rights violations during the pro-democratic movement. The commission’s report was turned down by the elected government. The torturers and other human rights violators were not taken to court for trial. Not only was there amnesty for the human rights violators; many of the known torturers were promoted to higher posts. The state of impunity has led to further torture, and a law has not been put forward to bring the torturers to court. There is no law to provide compensation for the survivors of torture.

Torture and the law

There is no legal provision to file a case against torturers. Torture is routine in Nepalese police stations. There is much documentary evidence for deaths in police stations; none has been officially investigated by the government, and the police have not had to face trial in court. Very rarely, a torturer is dismissed from his job; this may occur when the case has been much publicized by the media, or when there is strong international pressure, especially by Amnesty International. The dismissal is done under the name of “departmental action”. Some known torturers who have suffered “departmental action” are supported by their colleagues and are enjoying what is virtually a better life after their dismissal. The reason for this should be investigated. Another form of “departmental action” is to transfer from place to place, just to fool people. This does not discourage the torturers from continuing their work.

Proposed Torture Compensation Act 2050

The issue of enforcement of constitutional guarantees against torture was discussed in the third session of the parliament in September 1992. Commitment to introduce a Compensation Act was expressed by the government at that time. The Compensation Act was introduced in the fifth session of the parliament during the summer of 1993. The Act was very controversial and was not passed. It was again presented in the sixth session of the parliament in the winter of 1994. This attempt was also a failure.

In the draft bill, the law would enable victims to obtain up to 50,000 rupees (US $1000) in compensation for acts of torture, provided that the victim makes a complaint to the district court (where he or she was detained) within 15 days of the date on which the torture was inflicted. The amount of money itself is a shameful indication of the commitment against torture. Since many of the victims are held incomunicado, and in several cases for well over 15 days, such a provision is seriously flawed. It is impossible for most torture victims to contact a lawyer and/or talk freely about torture as long as they are held in police custody. The definition of torture is too narrow, since it excludes psychological methods; psychological sequelae of torture are not included. The definition also excludes torture that is not inflicted for the purpose of extracting information or admissions. It does not mention anything about medical and psychosocial rehabilitation of torture victims.

Conclusion

Nepal’s 1990 constitution provides increased human rights protection than the previous ones. Its accession to the Torture Convention in 1991 has signified the government’s agreement with these basic principles. Government ministers and officials have expressed their opposition to torture in front of delegates from Amnesty International and at the World Conference on Human Rights in Vienna. However, the head of the government has failed to condemn torture publicly in our own country. National and international communities have expressed concern that the legislation required to enable compensation to be paid to torture victims had yet to strengthen the safeguards against torture to fulfil its obligation under the UN Torture Convention.

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India’s torture and abuse of Sikhs

Ten years’ confrontation in Punjab has brought no progress in finding a solution to the conflict

Civil wars in Europe’s Bosnia and Africa’s Somalia, Liberia, Rwanda, and Angola have placed the Indian-Sikh confrontation more or less in oblivion. However, the decade-long insurgency in the north Indian State of Punjab, which is still going on, has cost more than 10,000 lives, mostly summary executions by the police. As in Sri Lanka, the insurgents and the authorities are both utterly brutal, using torture, extrajudicial executions, and disappearances at will.

But there is no indication that the Indian government has made any effort to investigate the abuses committed by its own officers, let alone to prosecute the perpetrators. The police know fairly well that torture is prohibited by Indian law, but some policemen have (anonymously) admitted to journalists that “third degree” interrogation is generally not considered as torture.

_Human Rights Watch/Asia and Physicians for Human Rights_, in a recent publication*, quoted a police officer from Punjab as saying that he knew of between 4000 and 5000 examples of torture at his police station alone. In late 1993, India established a national _Human Rights Commission_ empowered to investigate reports of abuses. The report urges the Commission to conduct a thorough investigation into cases documented by Human Rights Watch, and not to spare the Director-General of the Punjab police, K.P.S. Gill.

The confrontation began in the early 1980s after some Sikh leaders – among them Sant Bhindranwale (who was killed during the attack by the Indian army on the Golden (Sikh) Temple of Amritsar in 1984) - demanded greater autonomy for the Sikhs, and some even talked of an independent state, _Khalistan_. Control over local river waters was the most important demand from part of the Sikh political party, the Akali Dal.

Some interrogation centres, such as the Mal Mandi in Taran Taran, have become notorious for torture. The methods used include electric shock, prolonged beatings with canes and leather straps, tying the victim’s hands and suspending him or her from the ceiling, pulling the victim’s legs far apart so as to cause great pain, and rolling a heavy wooden or metal roller over the thighs. Psychological forms of torture often include death threats, disrobing, isolation, and forcing family members to watch as a relative is tortured.

One police officer noted that _any person detained at a police station is tortured_. The torture is intended to obtain information regarding the names of militants, the whereabouts of weapons caches or future plans of militants. Those who were suspected of being militants, but gave no information during torture, were tortured to death. Detainees are frequently held _incommunicado_, which also increases the risk of torture. As far as Asian Watch is concerned, no member of the security personnel has ever been held responsible for his actions. (Sections 330 and 331 of the Indian Penal Code prescribe prison terms and fines for officers found guilty of torture).

The report makes several recommendations to the Indian government and to the military organizations operating in Punjab: to investigate the extrajudicial executions, the cases of torture, and to prosecute the personnel responsible for the abuses in civilian courts; to give the physicians of Punjab permission to carry out _post mortems_ in all cases of unnatural death, to train them, and give necessary community education to answer religious and cultural concerns about the process; to give detainees prompt medical examinations by civilian medical staff.

The Indian government should furthermore strengthen and enforce safeguards existing in Indian law that protect detainees from torture, including requirements that all arrests be made pursuant to warrants, that all detainees be brought before a magistrate or other judicial authority empowered to review the legality of the arrest within 24 hours. Among other recommendations, the militant organizations operating in the Punjab are urged to abide by the provisions of _International humanitarian law_ (the Geneva Conventions of 1949 plus protocols of 1977) which prohibit killings or other attacks on persons taking no part in the hostilities. Like many other civil wars in the world, this is a conflict imbued with hatred, in which moral appeals have little weight. It is to be hoped that some political compromise can be found one day, thereby reducing the inhumanity of both sides.

_H. D.

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Selected list of publications

received in the IRTC International Documentation Centre


Torture survivors in Lithuania

Interview with the Founding Members

By Maeve McMahon*

Drs. Vita Danileviciute and Kazys Remeliks are founding members of the Lithuanian Centre for Torture and Repression Survivors. The Centre was legally established in November 1993, and is still in its preparatory stages. In this interview extract, we discuss the major groups of torture survivors in Lithuania.

MMM: Who do you expect to come to the Centre for Torture Survivors?

VD: I think the main group will be soldiers of the former Soviet army – especially those soldiers who were forced to take part in the war in Afghanistan. Lithuanian men were forced to serve in the Soviet army and consequently to go to Afghanistan too. So, as I understand it, they experienced psychological torture. There is no doubt about that. And many of them experienced physical torture as well. I think they were abused not only by Russians, but also by young men from other Soviet Republics. Perhaps it is necessary to point out that young men from the Baltic States were called fascists in the Soviet army! The young men from Russia, Byelorussia, and Ukraine who served in the Soviet army did not like men from the Baltic Republics serving in the army. And it also seems that there were many disagreements between soldiers from Muslim countries – for example from Turkmenistan, Uzbekistan, and Kazakhstan – and those from the Baltic Republics.

MMM: Why were men from the Baltics sometimes called fascists?

KR: This comes from the Second World War.

VD: As you know the Baltic States were occupied later than other Republics. Maybe that is one of the reasons that people from other Republics did not like the Baltic States.

MMM: How many Lithuanian men were forcibly drafted into the Soviet army?

VD: Perhaps 80% of our young men were forced to serve throughout the period of occupation (1940-89). Only some special reason, e.g. medical, could exempt them from military service. Those who refused to serve in the Soviet army were put in prison for three to five years.

MMM: Do you know how many Lithuanian men went to Afghanistan?

VD: I don’t know the exact number, but there are now more than 4000 in Lithuania who were forced to take part in Afghanistan. And I think they are really a group of torture survivors. And we also know – although there are only preliminary data gathered by the Lithuanian Soldiers’ Mothers Union – that altogether more than 1000 people died in uncertain circumstances in the Soviet army, and more than 1000 young men were severely mutilated. But, as said, these are only preliminary data, because for many years people were afraid to speak about this problem. That is why we do not have exact data.

MMM: Who else do you think will come to the Centre?

KR: At this time we have identified four groups of torture survivors; men forced to serve in the Soviet army, people deported to Siberia, victims of the Nazi occupation, and people resisting the Soviet government.

MMM: Can you provide more details?

VD: About 350,000 Lithuanian people were deported, mostly to Siberia. Those people really experienced torture in the gulags. Their relatives experienced psychological torture in Lithuania. They were persecuted. If someone had a relative who was deported, it had negative consequences for the relatives after the Second World War. Ten years ago, even seven, it could be dangerous to have had a close relative who had been deported to Siberia. For example, if you wanted to go abroad, you had to answer many, many questions. The crazy questionnaires dealt with the deported relatives and with relatives who were living abroad – especially in Western countries.

MMM: So approximately 350,000 people were deported to Siberia and elsewhere. How many came back?

VD: I do not know the exact number, but perhaps more than half of them died – from cold, hunger, disease. And there were many restrictions for the people who did come back. Many of them were not allowed to live in Lithuania. They were forced to live in neighbouring countries – in Latvia, Kaliningrad, Byelorussia. There were many restrictions concerning jobs, difficulties in obtaining passports, and so on. The psychological torture therefore extended long beyond the deportation. This has changed only in the last six or seven years.

KR: I have a personal experience in my family. All my grandparents were deported to Siberia. Also my aunt, my father’s sister. When she came back, she entered Lithuania secretly and then married a man who was in the resistance movement. Neither could stay here. They could not obtain the legal papers they needed in order to work. And it was not safe for them. So they had to live in Kaliningrad. It was only in 1990 that they were able to return to live in Lithuania.

VD: I think that the majority of people seeking help are those who were deported during childhood. Some of them might have been born in Siberia. These people are now middle-aged. Another group of torture survivors comprises victims of the Nazi occupation, especially the people who were taken to Germany to concentration camps or forced labour. Again, some who were taken in their childhood are now middle-aged. This group, however, is probably not large. Still another group is the resistance fighters. After the Second World War, the resistance movement began as a fight, which lasted until 1955 or 1956. The resistance movement then continued as a non-violent one. Some people experienced torture because they were in this movement or because they were active resistance fighters.

During recent decades, the peaceful resistance movement concentrated on the
Lithuanian people's wish to have their own identity, their culture, books in their own language, to celebrate national and religious holidays, etc. Sometimes the authorities, in order to isolate people, put them in psychiatric hospitals, at other times in prison. During this peaceful period of resistance, torture was more psychological than physical.

Suggested reading

The Association of Israeli-Palestinian Physicians for Human Rights (PHR)* sees the following proposal (for an addendum to the Israeli Medical Association (IMA) code of ethics) as an important means for realizing the special role which PHR ascribes to physicians in preventing breaches of human rights in jails and preventing the torture of persons in custody or under interrogation.

Prevention of torture
Safeguards for doctors. Proposal by Israeli-Palestinian PHR

Introduction
The physician’s first duty is to his or her patient. When a conflict arises between the interest of safeguarding the physical and mental health of a person in custody and the interests of the custodian authorities, it is the duty of the physician to act for the good of the patient without applying other considerations of any kind.

Part 1
Preventing Medical Negligence or Defective Medical Treatment for Persons in Custody

1. A physician called upon to treat a prisoner or detainee (referred to below as: Prisoner), whether inside or outside a prison facility, will obtain the express consent of the Prisoner before administering any test or treatment. When the Prisoner’s express consent cannot be obtained (when he/she is unconscious, for example), the physician will act upon considerations identical to those which would guide him/her for a patient outside a prison facility.
2. A physician called upon to treat a Prisoner (whether inside or outside a prison facility) will provide the Prisoner with medical treatment identical to the treatment customarily given to any free patient in similar medical condition. The physician will not restrict the treatment or order its postponement until after the Prisoner’s release.
3. Where the medical staff of a prison facility are unable to provide the Prisoner with full treatment or expert consultation, the physician in charge will refer the Prisoner outside the facility and provide the outside expert with all the medical information necessary for the Prisoner’s diagnosis and treatment.
4. Where a Prisoner is examined and/or treated at his/her own request or that of his/her family, by a physician who is not employed by the Security Forces or the Prison Services, the prison facility physician in charge will cooperate fully with the examining/treating physician and present him/her with all the medical documents concerning the Prisoner.
5. Where a Prisoner needs constant medical supervision, surgical procedure or professional assistance in fulfilling basic needs, the physician in charge will transfer him/her without delay to the prison clinic or to a medical center outside the prison, as required by the severity of the Prisoner’s condition.
6. The physician in charge of the Prisoner’s health will respond in detail and within a reasonable time to requests for medical information referred to him by the Prisoner’s immediate family or its legal representative, subject to the written consent or refusal of the patient.
7. A physician with reason to believe that a certain Prisoner is not being provided with medical treatment as aforesaid, will report the matter to the IMA at the earliest opportunity and within no more than 15 days. Furthermore, a physician coming across evidence of breaches of the above or present paragraphs on the part of a colleague, will report the matter to the IMA at the earliest opportunity and within no more than 15 days.

Part 2
Prohibiting Participation in Torture and Imposing a Duty to Report Torture

1. Torture contradicts the basic principles of medical ethics. As stipulated in the Tokyo Declaration of the World Medical Association 1975, adopted in its entirety by the IMA, physicians are forbidden to ‘convenience, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim’s beliefs or mo-
2. A physician encountering evidence of acts of physical or mental cruelty or degradation towards a person in custody will take practical steps to prevent or end them. This duty applies to every physician encountering such evidence, for example during treatment of a Prisoner in a hospital or clinic outside the prison, or during military reserve service in a military detention center. In addition, the physician will report to IMA on the evidence which he/she has encountered, at the earliest opportunity or within 5 days at most. Physicians’ reports will be submitted to a special department (hotline) of the IMA Ethics Bureau, whose function will be their receiving, consulting the reporting physicians on their consequent ethical conduct, and taking urgent action on the incoming reports (as detailed in Part 4).

3. A physician with reason to believe that the conduct of a colleague is in breach of one or more of the above paragraphs will report the matter to the IMA at the earliest opportunity or within 5 days at most.

Part 3
Retaining Medical Independence and Preventing Participation in Torture

In order to retain his/her medical independence and refrain from involvement in actions contradicting medical ethics, every physician will take care to observe the following rules:

1. The physician will demand direct and confidential contact with any Prisoner he/she treats. The physician will insist that no medical examination or treatment be performed in the presence of a third party who might restrict free contact or affect the presence of a third party who might restrict free contact or affect the presence of a third party for his/her protection or for similar purposes, and makes that request in writing. A physician forced to provide urgent medical treatment despite non-fulfillment of this demand will report the matter to the IMA at the earliest opportunity or within 5 days at most.

2. A physician (male) asked to examine or treat a female Prisoner will demand the presence of an additional woman during the examination and/or treatment. A physician forced to administer urgent treatment despite non-fulfillment of this demand will report the matter to the IMA at the earliest opportunity or within 5 days at most.

3. Prior to examination or treatment of a Prisoner, the physician will ascertain that these will be provided in conditions allowing for the free and independent arrival at, and implementation of, his/her clinical decisions concerning the patient, guided only by considerations of the patient’s best interests. A physician forced to perform an examination or treatment despite his/her uncertainty of the existence of such conditions, will report the matter to the IMA at the earliest opportunity or within 5 days at most.

4. The physician will make detailed and precise records of the findings of each medical examination and a detailed and precise report on any medical treatment he/she administers to a Prisoner, in proper and orderly form including his/her own full identification as administering physician, in clear and legible handwriting. The physician will ensure that each medical document is kept in the Prisoner’s medical file. A physician prevented from accurately documenting and keeping his/her findings will report the matter to the IMA at the earliest opportunity or within 5 days at most.

5. Prior to any examination or treatment of a Prisoner, the administering physician will identify him/her to the Prisoner, giving his/her full name and position. The physician may not in any circumstances refuse to provide the Prisoner with his/her identifying details. A physician requested by any authority not to identify him/her to a Prisoner, or a physician forced to administer urgent medical treatment despite having been forbidden to identify him/her, will report the matter to the IMA at the earliest opportunity or within 5 days at most.

6. The physician will demand his/her administration of examinations, treatment or medical services, with the patient-Prisoner not blindfolded or otherwise prevented from seeing him/her (unless eye covering is required for medical reasons). A physician asked to do so or forced to administer urgent treatment to a Prisoner prevented from seeing him/her, will report the matter to the IMA at the earliest opportunity or within 5 days at most.

7. A physician shall not perform procedures of any kind which are not required for a Prisoner’s medical needs, and in particular shall not fill out forms or provide information facilitating interrogation or assessing the Prisoner’s physical or mental ability to withstand torture. A physician forced, for fear of his/her own well-being, to perform such procedures or provide such information, will report the matter to the IMA at the earliest opportunity or within 5 days at most. The aforesaid shall not prevent a physician from determining a certain Prisoner unfit for interrogation.

8. A physician deferring the provision of medical services so as to refrain from complicity in a breach of the patient’s rights, will report the deferral and the reasons for it to the IMA within 5 days at most from the date of his/her refusal. At the time of the deferral, the physician will explain the reason for his/her decision to the Prisoner. In no case will the physician defer urgent and vital medical treatment.

9. The physician will not be partner to a refusal to answer a need for medical treatment or nursing, or assistance in other vital needs of a Prisoner, where that need is expressed explicitly or concluded in another way.

Part 4
The Duties of the IMA in Preventing Medical Complicity in Torture

1. The IMA will found and staff a special department (hotline) of the Ethics Bureau, whose function will be to receive reports from physicians on the breach of one or more of the above paragraphs, to consult the reporting physicians on their consequent ethical conduct, and take urgent action on the incoming reports. Where a physician’s report under one of the above paragraphs raises a reasonable suspicion that a criminal offence has been committed by an official authority, the department, on behalf of the IMA, will apply to the relevant state authorities in demand for an inquiry into the complaint and receipt of an adequate
reply within a reasonable time. Where the report raises a suspicion of immediate and/or grave risk to the life or health of a Prisoner, this application will be made with maximal urgency or within three days at most of receipt of the report. The IMA will brief the reporting physician on its handling of the issue.

2. Where a physician employed at a prison facility is required to breach his/her medical independence or the principles of medical ethics, the IMA will refer directly to the warden of the facility demanding an investigation and an end to the breach.

3. Where the job of a physician employed in a prison facility is terminated or impaired in such circumstances, or where a threat to this effect arises, the IMA will provide that physician with legal assistance as necessary.

4. In exceptional cases, the IMA will consider authorizing that the identity of a physician reporting under one of the above paragraphs be kept confidential.

5. The IMA will take the disciplinary measures available to it against a physician found to have breached one of the above paragraphs.

**PHR Requests of the IMA for Action to End Torture**

1. The IMA will adopt an ethical code for physicians treating prisoners and detainees.

2. The IMA will see to the distribution of the ethical code and the principles upon which it rests, among its membership, the medical community in general and the general public. In particular, the IMA will see to the distribution of the code of ethics and its principles among those physicians serving in prison facilities.

3. The IMA will act to teach in medical schools all the details of the medical ethics that guide the treatment of prisoners and detainees, and will conduct periodic courses on this subject for physicians serving in prison facilities.

4. The IMA will found and staff a hotline for receiving reports of evidence of the torture or medical neglect of prisoners, as detailed in part 4 of the addendum: The Duties of the IMA in Preventing Medical Involvement in Torture.

5. The IMA will set up and operate a working group for investigating the involvement of physicians in interrogations in Israel. The group will publish its findings within a stipulated time.

6. The IMA will propose and promote a regulation instructing the direct subordination of physicians working in prison facilities, to the Ministry of Health or the Ministry of Welfare, rather than the prison authorities.

7. The IMA will act to promote legislation imposing on physicians a duty to report to state authorities any evidence of torture that may come to their knowledge, analogous to their duty to report evidence of child abuse.

8. The IMA will act to establish and apply the right of every prisoner to receive a medical opinion from an external physician, independent of the prison authorities.

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**Doctor involvement in torture. A historical perspective**

Doctor participation in torture and punishment from the Middle Ages until the present day: an old phenomenon, a new ethical issue

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Abstract

In spite of the Hippocratic Oath medical doctors have throughout the history of medicine participated in torture. However, it was not until the time of the Middle Ages that the skills of doctors had developed to a point where their application could be of direct use to torturers. During the Middle Ages the doctor was considered to be a representative of the authorities. At present the involvement of physicians is part of an illegal clandestine activity. Recent studies indicate large-scale employment of medical doctors in the torture chambers, but information has been relatively scarce and to a large extent unnoticed. An understanding of the doctor’s role in torture and punishment has given insight into the functions of medical ethics under extreme circumstances and has provided theoretical constructs.

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Introduction

“We have doctors here who can wake up the dead.”

These words were not meant to pay homage to modern medicine, but were
uttered in Europe in 1958 to a man about to faint under torture, this way escaping into unconsciousness\textsuperscript{1,2}. The quotation exemplifies the participation of medical doctors in torture, which is the subject of this review.

The medical profession has been guided by medical ethics for more than two millennia. The doctor has become the archetypal healer guided by the principle:

PRIMUM NON NOCERE
(\textit{Above all, do no harm})

At the Rehabilitation and Research Centre for Torture Victims in Copenhagen, however, it has been noted for several years that patients during psychotherapy often mentioned that medical doctors were involved in the implementation of torture. These doctors were acting on behalf of the authorities and to the detriment of the health of the victims. In a study about to be published by one of the authors (PV) it is demonstrated that medical doctors were involved in more than half of the periods of torture. Other studies also indicate extensive use of medical skills in the torture process\textsuperscript{3,4}.

The aim of this study was to review the participation of the medical profession in the implementation of torture and punishment in a historical perspective from the Middle Ages up to the present, in order to establish a more general outlook of the violations of contemporary medical ethics. No attempt has been made to explore the incentive of individual doctors. References are from medical journals, autobiographical material, and other literature. It is noteworthy that before the early seventies only a few references apart from some papers on Nazi atrocities can be found in medical journals. In this study, neither descriptions by former prisoners on a “crusade” against a specific political system\textsuperscript{5} or artistic representations have been included. Doctor torturers, however, are described abundantly in the works of Dostoevsky, Koestler's \textit{Darkness at Noon}, Orwell’s \textit{1984}, and are also shown in the film \textit{L’aveau} (1970) by Costa Gavras\textsuperscript{6,7}.

**Historical review**

Torture is as old as the human race but the participation of doctors in this process was first conceptualised in the 14th and 15th centuries\textsuperscript{8,9}. Only then were medical and surgical skills developed to a point where their applications could serve the aims of the torturers.

\textit{From the Middle Ages to the Period of the Enlightenment}

During this era torture was an instrument of the judiciary, provided for in both ecclesiastical law (the Inquisition) and criminal law. The physician as a representative of the church or the state became an essential participant in the process of torture. Torture itself had evolved into a complex system of rules and regulations, one of the more well-known being that an accused person was not to be tortured on a Sunday\textsuperscript{10}. The presence of a doctor was frequently requested during interrogation as well as punishment. Concerning the latter it was the doctor’s duty to evaluate whether the guilty person could withstand the penalty. If the victim became unconscious, a physician was to assess whether the condition was real or simulated, and in accordance with the result of this examination the torture was either suspended or resumed\textsuperscript{11}. For those prisoners condemned to the gallows by whipping was frequent, and after punishment the executioner would call on the ship’s surgeon’s skills\textsuperscript{11}. After punishment, the doctor was to provide a rudimentary form of treatment\textsuperscript{12}.

The criminal is stripped from the waist upward. He is extended with his face downward, his arms upon one bench and his legs upon the opposite, which are held by two slaves that stand opposite each other. The executioner, who is generally a Turkish slave, stands over him with a rope in his hand, with which he is to beat the criminal without the least mercy; for if he happens to be remiss, which is seldom the case, “the sous comitée” uses him as he should have used the criminal. Thus then every stroke is laid on with the executioner’s whole force, so that each blow raises a wheal as thick as one’s thumb. Few that are condemned to suffer this punishment can sustain above ten or twelve blows without fainting. This, however, does not prevent the executioner from proceeding. He continues to lay on the miserable and seemingly lifeless carcass, till the number of blows ordered by the major are completed. Twenty or thirty are generally inflicted for slight offences. I have seen 50, 80, even an 100 ordered; but then those who are punished seldom recover. When the allotted number of stripes are given, the surgeon barber of the galley rubs the criminals back with salt and vinegar; which, though it may prevent gangrene, yet renewes all the poignancy of his former anguish.

If a doctor was not present the executioner himself was often requested to treat the injury. Accordingly medical knowledge was one way of ensuring the enforcement of prescriptions, i.e. preventing more injury being inflicted than was called for in the punishment meted out. At the same time the doctor, as a representative of authority, became part of the legitimisation of punishment including torture.

Medieval judicial torture, including doctor participation herein, was an integral part of the legal process. Medical doctors apparently accepted their role in spite of the Hippocratic Oath. The protests of Dr. Fabricius Hildanus (1460-1534) against torture stand out as an exception\textsuperscript{13}.

Apart from more direct participation in the torture of that period anatomy was also abused by the executioners. In the human body organs like the liver, kidneys and large vessels may be pushed aside without major injury provided certain anatomical routes are followed. This insight was used in execution through impalement\textsuperscript{14}. As part of this punishment, used particularly in the central European area, a rod was forced through the body from the perineum (entry near the anus) to exit at the tip of the right scapula (shoulder), leaving the victim to a lingering death. Few factual accounts are available, and to capture the horrors involved one has to turn to literature. The Yugoslav Nobel laureate Ivo Andric describes in one of his works how a torturer impales a victim\textsuperscript{15}.

(The victim was flat on his stomach, and his arms and legs were secured by ropes tightened by assistants.) They (the lookouts) could only see the bound body shudder at the short and unexpected prick of the knife, then half rise as if it were going to stand up, only to fall back again at once, striking dully against the planks. As soon as he had finished (cutting), the gipsy leapt up, took the wooden mallet and with slow measured blows began to strike the lower blunt end of the stake. Between each two blows he would stop for a moment and look first at the body in which the stake was penetrating and then at the two gipsies, reminding them to pull slowly and evenly. The body of the peasant, spreadeagled, with which he is to beat the criminal without the least mercy; for if he happens to be remiss, which is seldom the case, “the sous comitée” uses him as he should have used the criminal. Thus then every stroke is laid on with the executioner’s whole force, so that each blow raises a wheal as thick as one’s thumb. Few that are condemned to suffer this punishment can sustain above ten or twelve blows without fainting. This, however, does not prevent the executioner from proceeding. He continues to lay on the miserable and seemingly lifeless carcass, till the number of blows ordered by the major are completed. Twenty or thirty are generally inflicted for slight offences. I have seen 50, 80, even an 100 ordered; but then those who are punished seldom recover. When the allotted number of stripes are given, the surgeon barber of the galley rubs the criminals back with salt and vinegar; which, though it may prevent gangrene, yet renewes all the poignancy of his former anguish.

For a moment the hammering ceased. Merdan (the executioner) now saw that close to the right shoulder muscles the skin was stretched and swollen. He went forward quickly and cut the swollen place with two crossed cuts. Pale blood flowed out, at first
slowly then faster and faster. Two or three more blows, light and careful, and the iron-shod point of the stake began to break through at the place where he had cut. He struck a few more times until the point of the stake reached level with the right ear. The man was impaled on the stake as a lamb on the spit, only that the tip did not come through the mouth but in the back and had not seriously damaged the intestines, the heart or the lungs.

In 18th century France, the doctor’s intervention to stop a particularly cruel form of punishment could instead lead to direct execution of the victim:\(^{12}\)

For over two solid hours was Damiens tortured with the boot, but in the face of agony so frightful that it drew forth shrieks of anguish, and time and time again brought him to the point of fainting, he refused to speak. At length, when his limbs were crushed and broken, the surgeon said he could stand no more. On the scaffold the end came.

In the British army doctors were involved in the medical evaluation of the victim after punishment by whipping, and if the physician suspended the whipping because he feared for the victim’s life, the rest of the sentence would be resumed once the victim had sufficiently recovered:\(^{12}\)

A soldier of the First Regiment of Grenadier Guards, of which regiment the Duke of Wellington is Colonel, having been convicted of insubordination, intoxicated on duty, and of refusal to deliver up his arms when ordered by his officer, was sentenced to receive 500 lashes. After receiving 200 lashes, the surgeon of the regiment interfered, and put a stop to the brutal punishment, in consequence of the life of the soldier being in danger. The soldier was then removed to the military hospital in a hackney coach, his back being dreadfully lac erated. As a sort of refinement in cruelty and to increase the severity of a punishment which could not be inflicted to the full extent without depriving the unfortunate culprit his life, a fresh hand was procured at every 20 lashes.

During the era of slavery (South American slavery being no less heinous than North American), severe punishment was inflicted for minor offences. Doctors were occasionally called on to prevent excessive damage to the “property”:\(^{16,17}\)

During the 18th and 19th century slavery was gradually abolished, and at the same time the use of judicial torture declined. One of the main reasons was that it was no longer required to obtain a confession in order to establish guilt:\(^{10}\). In the Encyclopaedia Britannica of 1832, torture is described as practically extinct in Europe. The practice lay dormant, however, only to reappear on an unprecedented scale during the Second World War.

The Second World War
Large-scale torture occurred in Europe and in the Far East during the war, and the medical profession was well represented in the torture chambers. In the Western world not only German National Socialist doctors disregarded all notions of ethics, but also some medical doctors in countries under occupation participated in unethical procedures. From Denmark, at least one physician left for Buchenwald concentration camp to attempt to “normalise” homosexuals through hormonal and operative means:\(^{18-21}\).

Several major works have been written about the atrocities committed in the Far Eastern region and in Europe, and the abuse of medical knowledge with the purpose of pseudo-scientific experimentation and the destruction of human beings:\(^{22-36}\).

The prewar euthanasia programs, according to which medical doctors brought about the death of the infirm, were turned into medicalised killings by “white coats in SS boots”. Doctors stood at the ramps awaiting the millions of victimised human beings arriving from all over Europe. Physicians were responsible for the choice of who was to be killed immediately, who was to live for a short while as a slave labourer, and who was to be used as a human guinea pig for medical experimentation. The results of such experimentation were reported at meetings and in scientific communications of that time:\(^{27-28}\).

In September 1942 Dr. S. Rascher approached Himmler in a letter describing a series of experiments concerning hypothermia. Details of the experiments are given, including tables on how long human beings can be submerged in cold water before dying:\(^{34}\).

The subjects were placed in the water wearing full flight uniform, winter or summer combination as well as flight helmet. A life jacket made of rubber or kapok prevented submersion. The experiments were carried out at (water) temperatures between 2.5 and 12 degrees (Celsius). In one part of the experiment the occiput as well as the brainstem was out of the water, while in another part of the trials the occiput (brainstem) and cerebellum was submerged in the water. (…) Deaths occurred only when the brainstem as well as the cerebellum were cooled down.

In the murderously absurd reality of the Second World War, an order of Heinrich Himmler (June 1942) authorised third degree interrogations but stipulated that physicians were to be consulted after more than twenty strokes:\(^{36}\).

At the Nuremberg Medical Trial there were 23 defendants. Fifteen were found guilty and 7 were hung. Four of the seven were medical doctors:\(^{38}\).

Fewer details are known about experimentation on human beings carried out by Japanese doctors during the war. The lack of a major medical atrocity trial covering the Far Eastern Area allegedly stems from the fact that the results of the experiments were handed over to the US in return for freedom for prosecution:\(^{39}\).

In the Allied countries virtually nothing is known about medical doctors involved in the interrogation of prisoners or abuse of detainees in the war years. The literature in general, however, points to no systematic excesses by the medical corps of the allied armies.

The Beginning of the Cold War
During the fifties and sixties the involvement of medical doctors in the torture process received scant attention. The assumption, that all physicians benevolently offered treatment seems to have been accepted at face value. A physician’s participation in torture was usually only described in more indirect terms, as exemplified in the well-known paper by L.E. Hinkle and H.G. Wolff on forcible indoctrination in Eastern Europe during the fifties:\(^{30}\).

Sometimes the physician intervenes to call a halt if he feels a prisoner is in danger. The unintended death of a prisoner during the interrogation procedure is regarded as a serious error on the part of the prison officials.

This same aspect of medicine was also illustrated in the Memoirs of Josef Cardinal Mindszenty. During his interrogation and subsequent show-trial in 1949 in Hungary, the involvement of medical doctors was pivotal:\(^{31}\).

Page 98 reads:

My first meal (after being arrested) consisted of soup, meat, and vegetables. I took very little, since after my treatment the previous night I was convinced that I was being prepared for the interrogations and the subsequent show trial. My suspicion became a certainty when, unannounced and unexpected, three doctors appeared. After lunch they entered my room and without introducing themselves and without asking me or the guards any questions they began to examine me. They felt my thyroid gland, for which I
had previously had surgery, examined my eyes, listened to my heart and lungs, took my pulse and blood pressure. A rather earnest man of between fifty-five and sixty directed the examination; the two younger men, around thirty-five, respectfully and attentively followed his instructions. The doctors left medicines, and at the following meals the guards gave me the prescribed doses.

After a while, of course, hunger forced me to eat something, and so they finally succeeded in mixing the drugs into the food I was given. I concluded that because the doctors, always the team of three, came to see me every day either at mealtimes or immediately after. There were, however, some days on which I was examined again between meals. They did not speak to me at all, asked me no questions, and gave me no information. But from their conduct and their presence I concluded that in addition to the effects of the drugs, they were supposed to determine whether I could endure the beatings, how far they could go with their physical torture, whether my heart would give out. They had to balance the dosage of the drugs and the physical and psychological torture in such a way that they could bring me to the show trial and expose me without its making a bad impression. The goiter operation, which had impaired my heart must have particularly concerned them.

And on page 117:

Probably, too, no more drugs were given to me. Nevertheless the doctors appeared as usual to examine me. It seemed to me that they were more concerned that they had been and that they stayed longer. Probably they were under orders to prevent my collapsing completely.

Professionals are also incriminated in Solzhenitsyn's description of the prison physician:

The prison doctor was the interrogator's and executioner's right-hand man. The beaten prisoner would come to on the floor only to hear the doctors' voice: "You can continue, the pulse is normal". After a prisoner's five days and nights in a punishment cell the doctor inspects the frozen, naked body and says: "You can continue." If a prisoner is beaten to death, he signs the death certificate: "Cirrhosis of the liver" or "Coronary occlusion". He gets an urgent call to a dying prisoner in the cell and takes his time. And whoever behaves differently is not kept on in the prison.

Present day involvement

Torture today can be divided into existing judicial torture, and torture as part of clandestine illegal activity. The latter is called New Torture.

Existing Participation in Judicial Punishment Including Torture

Since the Middle Ages medical practitioners had been called upon to participate in the punishment including torture meted out by the courts. He was required for three main purposes:

a) to be present during interrogation and to monitor the torture process
b) to evaluate whether the convict could withstand the punishment, and to be present during the execution hereof
c) to treat the injury inflicted during punishment and torture.

It is possible even today to observe these three functions being enforced. Doctors are forced to lend their skills to a process which is to the detriment of human beings rather than to the promotion of health.

The position of the British authorities in the struggle against the IRA in Northern Ireland is a typical illustration of the first purpose.

During the early seventies the British authorities were accused of using torture as means of extracting information. A commission of inquiry led by Sir Edmund Compton was formed; its findings in 1971 led to the formation of a three-man committee on interrogation chaired by Lord Parker. A majority report by the latter stated that the applied psychological interrogation methods were justifiable provided medical doctors were present to minimise the risk of life-threatening situations. These psychological interrogation methods were later defined as torture by the European Committee of Human Rights, and as "inhuman and degrading treatment" by the European Court of Human Rights.

The second purpose may be exemplified by the official duty of medical officers to evaluate the medical status of convicts facing solitary confinement or restriction of diet. This duty is specifically outlined in the Standard Minimum Rules for the Treatment of Prisoners and Related Recommendations, paragraph 32:1 and 3 (UN, 1955, 1977).

Paragraph 32:1 reads:

Punishment by close confinement or reduction of diet shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.

and paragraph 32:3 reads:

The medical officer shall visit daily prisoners undergoing such punishment and shall advise the director, if he considers the termination or alteration of the punishment necessary on grounds of physical and mental health.

In addition the re-emergence in several countries of Islamic law (Sharia) has received much attention. In the Islamic texts of law and ordinances the doctor's duties to the state are described in de-
A doctor is to be present, and ... before being whipped the prisoner is to be examined by an army doctor so as to ensure that the execution of the punishment will not cause the death of the convict.  

In Pakistan a law was introduced which ensured that amputations were to be performed by a qualified surgeon under local anaesthesia (1977). The latter provision was designed to be for the proper benefit of victim and doctor. 

In the Occidental world, doctors may be called upon to prepare a criminal for the death penalty in the innovative form of execution by lethal injection. Doctors may be requested to perform a venous cutdown, this way preparing the criminal for death. Whereas most professionals condemn such actions others have endorsed them even to the point of advocating experiments on the condemned that cannot be performed under other circumstances with informed consent. 

The third purpose, direct intervention of the medical doctor either simultaneously with torture or shortly thereafter may be illustrated by medical doctors' collaboration in judicially ordered amputations. As stated doctors may be requested to perform amputations according to Islamic law, but even if the doctor himself does not perform the amputation he is still expected to stop the subsequent exsanguination. Thus the doctor's skills ensure that the punishment does not lead to the uncalled for death of the victim. 

New Torture 

Torture is prohibited by national legislation in the vast majority of countries as well as by numerous declarations and conventions, among which are several speaking directly to the medical profession e.g. the Tokyo Declaration and Principles of Medical Ethics. Any violations of the medical profession in torture are a violation of the ethical codes. The Chilean Medical Association plainly and flatly declares: 

The Department of Ethics states that the work of a physician and that of a torturer or an accomplice are incompatible. The Department believes this so strongly that proof of the mere presence of a physician in a place of torture is sufficient grounds for his expulsion from the association. 

Doctors are obviously still involved in torture on several continents, as exemplified by reports from Chile, Argentina, Turkey, South Africa, Iran, and Tanzania. 

The actions of individual doctors in the torture process have been described elsewhere. Apart from this more or less direct participation, the direct use of medical knowledge in the training of soldiers to resist torture (and to teach torture methods?), which was previously accepted, has now been questioned on ethical grounds in Denmark as well as in several other countries. These topics are also discussed in the Handbook of Medical Ethics published by the British Medical Association. 

There are several published examples of personal experience of present-day involvement of the medical profession in torture. 

The trials after the Greek Junta gave insight into this topic. Outstanding is Dr. Dimitrios Kofas, nicknamed the "orange doctor", because he prescribed oranges even in the face of overt major trauma. Prisoners were forced to stand for days and ... at intervals, a prisoner might receive a visit from the former army doctor at ESA, Dr. Dimitrios Kofas, also a defendant at the trial. He would advise when their condition made it dangerous for the ordeal to continue. He was said to have acted as the "traffic controller" for torture, although he disputed the degree of control that he was alleged to have had. But Michail Vardanis gave an example in evidence of such "traffic control": "... a man arrived who was introduced to me as Dr. Kofas. He took my pulse and asked Petrou how many days I had been there. When Petrou told him it was the fourth day, he said: 'All right!' He then left and I continued having to stand upright". 

Other accounts deal with the torture that occurred in General Military Hospital No. 401 in Athens. 

The victim awoke 

... in a consulting room ... the leather couch, the straps, all those people in white coats, the machine (for electric shock)... I couldn't understand what the whole business was about ... I thought they were making experiments. This senseless torture, this scientific orderliness, the clean hands with the fingernails cut short, the absolute whiteness of their coats. 

He (the victim) heard one of the white-coated torturers addressed as Surgeon Colonel: "I hold on to that - I wanted to find out his name. In ten days I learned it: he was Surgeon Colonel Karagounakis, General Director of General Military Hospital No. 401." 

In Argentina Jacobo Timerman has reported on doctor participation in his torture: 

Two days have gone by without torture. The doctor came to see me and removed the blindfold from my eyes. I asked him if he wasn't worried about my seeing his face. He acted surprised. "I'm your friend. The one who takes care of you when they apply the machine. Have you had something to eat?" "I have trouble eating, I'm drinking water. They gave me an apple." "You're doing the right thing. Eat lightly. After all, Ghandi survived on much less. If you need something, call me". "My gums hurt. They applied the machine to my mouth." 

He examines my gums and advises me not to worry, I'm in perfect health. He tells me he's proud of the way I withstood it all. Some people die on their torturers, without a decision having been made to kill them; this is regarded as a professional failure. He indicates that I was once a friend of his father's, also a police doctor. His features do seem familiar, I mention his father's name; this is indeed the son. He assures me that I'm not going to be killed. I tell him that I haven't been tortured for two days, and he's pleased. 

and from Chile Dr. Alfredo Jadresic described the same phenomenon: 

The military doctors who came to the tent hospital on duty did one day's work every fortnight. I presented my complaints to them for the brutal way the prisoners were being treated and for the torture and asked them to convey my concern to the medical and military authorities. Most of the doctors were young and some had been my students in the past. Several of them showed their sympathy for the tortured prisoners, and promised that they would do something. Others, perhaps the majority, pretended to ignore what they saw and appeared very much afraid of talking about it. A few of them justified what was happening on political grounds. Once, a young doctor replied to me in a rather aggressive manner: "What do you expect? We are at war!" taking for granted, obviously, that the practice of torture should be acceptable in case of war. 

In Spain Eva Forest described her reactions to a medical doctor in the torture chamber: 

Then the doctor accomplice arrives, he smiles cynically, he is a key figure in this play-acting. "What has happened? That is terrible! Did you fall? Did you jump? Play? You have been dancing perhaps?" With a theatrical gesture he takes your hand, and flaps you with his stethoscope over your body: "Nothing is wrong, a rattle, a nightmare, anxiety, tension, hysteria, fear, do continue, carry on, work away, finish your job, I'll be back later..." 

It should be mentioned that doctors must also have taken part in the development of methods of "delayed killing", for example the Thallium poison-
ing of prisoners released from jail in Iraq. Thallium brings about the victim's painful death weeks or even months later. There are also allegations of injections of cytostatics in Chile, as later. There are also allegations of injecting of prisoners released from jail in painful death weeks or even months because of its potential for direct and torture described in the literature.

Psychiatry as medical torture

Because of its potential for direct and deep attack on an individual's mental functions including personality, psychiatry may become a powerful instrument in the hands of repressive governments. Psychological methods and psychopharmacological drugs may be incorporated into torture in a number of ways. The doctors involved may participate directly or indirectly, and practices range from false certification of psychiatric disease to outright medical torture.

During the Second World War psychiatric experiments were performed in the concentration camps of Europe. In Dachau concentration camp prisoners were given psychotropics, including mescaline, in the search for a truth serum.

During the era of the cold war, psychiatry has allegedly been misused in the former USSR and Eastern Bloc countries. It appears, however, that some cases may represent the treatment of patients in a psychiatric system which is out of line with mainstream modern community-based psychiatry. Nevertheless many human beings, be they mental patients or political dissenter, have been under "care" that cannot be accepted as psychiatric treatment as such. They have been kept under strict regimes in special psychiatric hospitals for insane criminals. Large doses of neuroleptics have been injected without drugs to alleviate the side effects, and individuals have been subjected to insulin shock. Hyperthermia and severe pain may be deliberately caused by the injection of sulfazine (a 1% solution of sulphur in oil). One of several descriptions by ex-prisoners is given in the book Punitive Medicine by Alexander Podrabinek.

These injections are indeed more intensive (than amnion pills, A.P.); in addition, they cause incredible pain. As a rule these injections are made in the buttocks; according to my own observations, people could not sit for months. They had to stand while eating and lie on their stomachs at night. They could not sleep; they suffocated and complained of burning in the mouth. All they could do was lie holding to bed boards in order not to suffocate. The pain was so unbearable that they could not sit or lie like normal people.

Doctor involvement in medical torture during the beginning of the cold war may not have been limited to countries behind "the Iron Curtain" of the time. In the US activities took place which may be labelled medical torture, as shown in documents released because of the Freedom of Information Act. The CIA allegedly conducted experiments on non-consenting individuals, of whom at least one committed suicide, long-term sensory deprivation against the subject's will, as well as other refined techniques of "brainwashing". The research programs ended in 1963 and ongoing court cases by private citizens against the US government are still to settle the extent to which American courts will define these acts as medical torture.

Abuse of psychiatry was also witnessed during the wars of liberation in the colonies as evidenced in the case of Mrs. Djamilia Boupacha. Her situation was complicated by doctors failing to take appropriate action. When her case eventually came to court she was certified incompetent by a psychiatrist with the apparent aim of silencing her testimony of torture by counter-insurgency troops.

Similarly, hard interrogation techniques in Northern Ireland were, in the words of the report by Sir Edmund Compton, officially acceptable as long as "a medical doctor with some psychiatric training was present" as a safeguard against unnecessary death.

In the prisons of Uruguay in the early seventies, psychiatry was used to the detriment of the prisoners, at least two psychiatrists and a psychologist being employed in the prison service. Part of their duties was allegedly to detect unbalanced individuals and to place them in solitary confinement to hasten mental break-down.

Finally capital punishment needs to be mentioned. At the date of writing, 1990, it is openly used in more than 100 countries. Many individuals and organisations interpret the death sentence as a psychological form of torture. Particularly in the US the participation of medical doctors in general and psychiatrists in particular has been openly discussed. Treatment of mental disease or certification of its absence may render an individual "fit for execution".

Main findings and concepts

Up until the Second World War doctor involvement in torture was never really questioned, in spite of an accepted structure of medical ethics.

However, the activities committed during the Second World War were clearly unlawful, and at the Nuremberg trials doctors were punished according to international law. The ethical aspects, although mentioned at the time, did not lead to any major reaction from the medical associations of the allied countries. Thus the belief continued that such actions were committed by solitary sadistic perverted criminals.

The German Medical Association had actively been engaged in endorsing the policy of repression before and during the war; after the war, the association called German doctors who denounced the crimes traitors. The Dane Dr. Thygesen, detained in a concentration camp, asked the German Medical Profession directly:

"Where were you?"

The colonial experience shows a similar pattern: when exposed, the practice of torture was denied, attributed to the excesses of individuals, or defended as a necessary evil to protect and uphold the values of the colonial powers in the struggle against terrorists. Again, doctors participated as members of the armed forces, and no medical associations took action against doctor involvement in torture during these years.

This was the situation until the seventies. Two events in particular drew attention to the issue of doctor involvement in torture: the interrogation procedures in Northern Ireland employed by the British against the IRA, which has already been mentioned, and the Steve Biko affair.

Concerning the official British reaction to events in Northern Ireland only a minority report by Lord Gardiner (1972) seems to understand the meaning of the Hippocratic Oath. The British Medical Journal, in an editorial, responded favourably to the findings of Lord Gardiner, and his minority views were eventually followed by the Government in debarring the "Depth Interrogation", one of the many euphemisms for torture.

Individual doctors at the time also began to react to the abuse of detainees. In a letter in the Lancet, April 1972, concerning the situation in Northern Ireland, Dr. J.P. Lane states:
Doctors should clarify their ideas on the extent to which passive participation and ill treatment is compatible with membership of the medical profession. I have sought without success to interest the General Medical Council in this question.78

The editorial in the British Medical Journal of March 25, 1972 illustrates the reluctance of the profession to acknowledge the extent of involvement:

"Enemy" and "friend" are not words in the doctor's vocabulary: only "patient". And apart from a few sad exceptions this merciful neutrality has guided doctors' footsteps through the years of barbarism and folly.79

Despite what the British Medical Journal has to say about "merciful neutrality" the concept is simply not valid in the torture situation as illustrated in the case of Steve Biko.

Due to the openness of the South African Society at the time of his death (1977) the affair received wide publication. Pertinent to the discussion of the dawning understanding in the medical world about doctor participation in the torture process is the statement of the defendant doctor:42

I did not know that in this particular situation one could override the decisions made by the responsible police officer.

The involvement of medical doctors in torture thus clearly involves lack of practical applications of medical ethics in the individual case.

Gradually the participation of medical doctors in torture became an independent ethical issue. A number of reports from victims of torture were published, and incidents of doctor involvement exposed. It became clear that the involvement described was not restricted to the acts of a few doctors. Rather, the:

mentioning of medical involvement is often incidental to the report of other aspects of the torture.43

It is evident from descriptions of present-day doctor involvement in torture that an alteration in the nature and purpose of torture has taken place. Rather than the extraction of information or confession or even punishment, the aim of torture today is to destroy an individual's ability to live an active fulfilling life and to disrupt his or her identity.67 That individual is then to be released back into society, to serve as a deterrent to others. To ensure the person's survival in the torture chamber, medical knowledge is called for. The old evaluation "Fitness for Flogging" has become the mere supervision of vital functions during the total onslaught of the individual.

Involvement of physicians in torture encompasses a range of actions from active participation in the torture chamber to the passive writing of false medical certificates. Doctors may also certify individuals as insane who are about to give testimony against authorities who have sanctioned or perpetrated torture. The ease with which participation or collusion of the medical profession is induced has been labelled "the slippery slope".77,79

It has also been realised that when doctors participate in the process, they are most often acting in their capacity as government employees. This led to the forming of the concept, "doctors at risk", i.e. physicians employed by the military, police or prison authorities and including forensic scientists and district surgeons.44 But not only is the medical profession at risk: so are other professions such as the legal profession and the police. Contrary to legal ethics, lawyers are requested to change existing laws, thereby denying whatever legal protection the citizens may have. The police often take direct part in repression. Accordingly a new term has come into existence: professions at risk.

In some areas consensus has not yet been reached and thus the reference to "grey areas in medical ethics". Included in this concept are such issues as punishment under Islamic Law, psychiatric evaluation of death-row prisoners in the USA, and alleged misuse of psychiatry in the USSR.

The formal hierarchical structure of repressive governments, surprisingly similar from country to country, appears to exert powerful coercive influence on individual doctors involved in the torture process.

Conclusion

There is no question whatsoever that medical doctors have participated in the implementation of punishment including torture throughout history, in spite of the principles of medical ethics. Information about these activities, and even disclosure of these topics, have been scant after the Second World War. Only recently has it been realised that participation is not represented by the acts of a few criminals, but is a systematic though clandestine activity throughout the world. The healing hand becomes the hurting hand, through active participation or by default. Only a few persons have reacted to this dimension of medicine or even acknowledged it to be a matter of actual concern. Most medical associations have not spoken out, with a view of abolishing these deontological transgressions. The issues have mainly been formulated through publications of autobiographic accounts from individuals who have suffered torture, examinations of torture victims by medical groups within Amnesty International and at centres for the rehabilitation of victims which now exist in several countries.

The Chilean Medical Association sums up the ethical developments in this whole area:

If a person is a certified physician he ceases to be one the moment he enters the torture process.

References

Evidence of organized violence among refugees from Indian-held Kashmir

By
Hans Draminsky Petersen*†
Johan Heugh Wandal†

Summary
Indian-held Kashmir is a region from which grave human rights violations have previously been reported. Findings among refugees from that region are described in this article. Seventeen persons said that they had been tortured by the Indian security forces. This conception is corroborated by the findings among children tortured by the same forces, and by other publications. Findings indicate lack of discipline among the Indian troops, or wanton violations of Indian laws and internationally recognized human rights. The Indian government should strengthen the control measures in the armed forces and allow international institutions to inspect the activities of the armed forces operating in Kashmir.

Introduction
There has been dispute between India and Pakistan over Kashmir since 1947, and for the past five years many local resistance groups have been in armed conflict with the Indian army and security forces.

Human rights violations by the Indian Security Forces have been published, including killing of civilians, torture, custodial death, rape, and arson. Physicians for Human Rights/Denmark (PHRDK), visited the Indian-held part of Kashmir in June 1993, and examined a number of civilians who had been exposed to torture and gunshot by the Indian Security Forces. The findings have recently been published, together with information about similar violations of human rights given by local lawyers and physicians.

From 5-11 June 1994, PHRDK, together with a consultant physician in infectious medicine, visited camps for refugees from Indian-held Kashmir, located near Muzafarrabad in the Pakistan-controlled part of Kashmir. The aim of the visit was to assess the health situation in the camps. It became clear very early in our visit that many of the inhabitants of the camps had been victims of torture or other kinds of organized violence. Many of the victims were below 15 years of age at the time of exposure to violence. Their cases have been described elsewhere. The adult cases are described here.

Methods
Selection for examination
The initial purpose of the visit was to assess the general health conditions in the camps. As it became clear that many persons had physical sequelae of organized violence sustained in their home region (Indian-held Kashmir), interviews and physical examinations of such people were undertaken. In particular, we asked the leaders and elders of the camps to encourage parents of the children who had been exposed to torture or ill-treatment to bring the children for examination. However, many adults wanted to describe their personal experiences and were consequently included in our study. Before visiting any camp, we adopted the following procedure:

1. The camp to be visited was selected the night before, and the camps were not notified of our visit.
2. This was agreed with a local interpreter who was familiar with the conditions in the camps.
3. On arrival at the camps, the elders were contacted to make contact with possible victims of organized violence.

Interview and examination
The persons who presented themselves were interviewed in the presence of the interpreter, the elders of the camp, and, in some circumstances, other persons who had come for an examination. The examinees were asked if they consented to the interview, to photographs being taken, and to publication of their cases. The interview was conducted to obtain a detailed history of the alleged torture/ill-treatment, the time and place of the incident, and information about who was responsible for the torture.

Due to the short time available and the lack of training of the interpreter, the interview was limited to factual information: psychological aspects or symptoms could not be thoroughly explored. The clinical physical examination that followed was to some extent limited by the presence of other people.

Any lesion alleged to have been caused by torture was described, measured, and photographed for documentation. Consistency between the history and physical findings was assessed in each case: the validity of the statements of exposure to violence was appraised using previously described methods.

Finally, an assessment was made as to whether the histories and clinical findings fitted together at a group level, and with information from other sources, to see if a general pattern of violence in Indian-held Kashmir was indicated.

In this report, the term torture is used when a person was physically ill-treated systematically, e.g. exposed to physical violence during an interrogation. Harsh treatment, e.g. random beatings during military search operations (“crackdowns”) in the villages, was not classified as torture but as ill-treatment.

Material
Six camps were visited on 8 occasions from 5-11 June 1994. A total of 55 persons were examined. At the time of the alleged violent incident, 32 were above 15 years of age. According to the definitions given above, torture was reported by 17, subjection to ill-treatment by 9. Three had been shot at by the Indian Security Forces and another three reported exposure to landmine explosions.
The camps visited were inhabited by 4770 registered refugees by 15 April 1994. All the visited camps were located near Muzaffarabad in Pakistan-held Kashmir. All the examinees originated from the Indian-held part of Kashmir; they stated that torture, ill-treatment and/or shooting had been committed by the Indian Security Forces, either the regular army or the Border Security Forces (BSF).

Results

Torture

Seventeen men stated that they had been subjected to torture by forces from the Indian army or the BSF 6 months to 4 years before our examinations. Their ages ranged from 16-51 years (mean 30) at the time of the alleged torture. Fifteen mentioned beatings and/or kicks as the predominant form of torture. Bayonet cuts were indicated by 4, and another 4 had chilli poured onto wounds or into the rectum. Suspension by arms or feet was described by 4 persons. Three told of burns with cigarettes or with a heated metal object. Five persons reported that they had been given electric shocks. Three reported crush trauma induced by a heavy weight on the limbs, or by having the fingers forcibly pressed together while the rod was inserted between the fingers. Table 1 summarizes the described torture in all the cases.

Physical findings allegedly caused by torture were present in 15 cases. Seven had small, non-specific scars after beatings and kicks. Two persons who said they had been burnt with cigarettes had small, round scars (cases 5 and 54); some of the scars, however, were of considerable size (1 1/2-2 1/2 cm), allegedly caused by secondary infections. Case 23, who reported that he had been burnt with a heated metal object, had small non-specific scars in accordance with his statement.

Of the 4 cases who alleged being cut with bayonets, 3 (nos. 17, 23, 25) had narrow or biconvex scars (fig. 1), the latter apparently originating from deep lesions which had not been sutured.

Case 29 had a multitude of large scars said to have been caused by bayonet-wounds. The tip of his nose and distal part of the nasal septum were missing. The remainder of the soft part of the nose was scarified, somewhat beak-like. On the upper lip, just below

<table>
<thead>
<tr>
<th>Case no.</th>
<th>Sex, age in years</th>
<th>Alleged origin of lesions</th>
<th>Clinical findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>M, 18</td>
<td>Kicks, beatings, suspension by the feet. Cigarette burns. Infected cigarette burns. Heavy weight on 3rd right finger.</td>
<td>2 NS scars on the head and the left hand. 10 rounded scars approx. 1/2 cm in size on feet and left hand. 2 1/2 cm and 1 1/2 cm round scars on right arm and chest. Convex deformity of 3rd right finger nail.</td>
</tr>
<tr>
<td>6</td>
<td>M, 51</td>
<td>Kicks, beatings, soldiers jumped on his limbs. (Electric shocks to fingers, toes, ears and penis. Chilli solution poured into rectum.)</td>
<td>Deviation of 2nd-5th right fingers and deformity of 5th metacarpal bone.</td>
</tr>
<tr>
<td>8</td>
<td>M, 27</td>
<td>Rod inserted between fingers which were forced against each other. (The roller, electric shocks against ears.)</td>
<td>Distal amputation of left 4th finger.</td>
</tr>
<tr>
<td>10</td>
<td>M, 41</td>
<td>Longlasting suspension by the right arm. Beatings with rifles and iron rod against legs.</td>
<td>Deformity of left elbow joint with 20° lateral deviation. Amputation of left leg 5 cm below the knee.</td>
</tr>
<tr>
<td>14</td>
<td>M, 29</td>
<td>Beatings with sticks.</td>
<td>15° impaired extension and 20° lateral deviation of right elbow. 6 x 1/4 cm; 6 x 1/4 and 2 x 3 cm scars on knee and back.</td>
</tr>
<tr>
<td>15</td>
<td>M, 21</td>
<td>Kicks, beatings.</td>
<td>Multiple NS scars.</td>
</tr>
<tr>
<td>17</td>
<td>M, 34</td>
<td>Cut with bayonet on left foot, chilli in wound.</td>
<td>7 cm x 2 mm scar on left foot.</td>
</tr>
<tr>
<td>22</td>
<td>M, 21</td>
<td>Beatings with sticks. (Electric shocks to hands.)</td>
<td>Convex deformity of left radius.</td>
</tr>
<tr>
<td>23</td>
<td>M, 26</td>
<td>Beatings with rifles and burn with heated iron. Cuts by bayonets.</td>
<td>3 NS scars 1-2 cm in size on the head and abdomen. On left calf 2 biconvex 5 x2 cm and 2 x1 cm scars. In right ankle region 2 4 cm x 1 mm scars.</td>
</tr>
<tr>
<td>25</td>
<td>M, 41</td>
<td>Beatings. Cuts by bayonets, chilli poured onto wounds.</td>
<td>2 mm x 3 cm NS scar on the head. 2 transverse biconvex scars on right forearm 4 1/2 x 1 cm, 5 1/2 x 3/4 cm and 5 cm x1 1 mm (fig. 1). 4 x 4 cm and 2 x 2 cm scars on the chest and the neck.</td>
</tr>
<tr>
<td>26</td>
<td>M, 16</td>
<td>(Beatings and suspension by the arms). Shot in the right foot during attempt to escape.</td>
<td>Deformity of lateral aspect and stiffness of right ankle.</td>
</tr>
<tr>
<td>29</td>
<td>M, 21</td>
<td>Cuts with bayonets, wounds infected.</td>
<td>See text, (fig. 2).</td>
</tr>
<tr>
<td>30</td>
<td>M, 32</td>
<td>Beatings with rifles, chilli poured onto wounds.</td>
<td>4 x 4 cm irregular scar on left calf.</td>
</tr>
<tr>
<td>40</td>
<td>M, 29</td>
<td>Beatings with sticks and rifles on the back. With the back in a forced flexed position.</td>
<td>Significant bend on the back at the level of the 10th thoracic vertebra which protrudes (fig. 3).</td>
</tr>
<tr>
<td>48</td>
<td>M, 31</td>
<td>(Beatings, electric shocks.)</td>
<td>Physical examination not done due to poor psychological state.</td>
</tr>
<tr>
<td>53</td>
<td>M, 40</td>
<td>Beatings, kicks. (Electric shocks and suspension.)</td>
<td>3 NS scars. Deformity of left foot and ankle joint, see text (fig. 4).</td>
</tr>
<tr>
<td>54</td>
<td>M, 39</td>
<td>Burns with cigarettes (kicks and beatings).</td>
<td>2 circular scars approx. 1 cm in size on left leg.</td>
</tr>
</tbody>
</table>
Arm, showing sharply demarcated biconvex and linear scars allegedly caused by cuts with bayonets.

the opening of the cavity of the nose, there was a transverse scar, 2 mm x 3 cm. In the left frontal lesion there was a 6 cm x 8 cm excavated scarified area with alopecia (fig. 2). Furthermore, there were irregular 8 cm x 2 1/2 cm, 10 cm x 6 cm, and 8 cm x 3 cm scars on the neck, a large irregular scar on the left calf, and a 10 cm x 2 cm irregular scar in the right groin.

One leg of case 10 had been amputated, allegedly after exposure to extremely violent beating of his leg. He also reported that he had been suspended by his right arm for a long time; he had obvious sequelae of an injury of the right elbow. Four persons (nos. 14, 22, 40, 53) had clinical signs of fractures, allegedly caused by torture (figs. 3 and 4). Case 53 stated that he had been subjected to severe beating and kicking of his left calf and ankle. On examination, the left foot was laterally rotated 45°, and pronated 20°. The arch of the foot was accentuated – the foot was 3 cm shorter than its fellow. There was considerable muscular atrophy of the left leg, its largest circumference being 28 cm, compared with 36 cm on the right side.

Three persons who alleged crush trauma had deformity of a nail (case 5), sequelae of fractures of the hand (case
Table 2. Data concerning exposure and clinical findings in 9 persons allegedly subjected to ill-treatment.


<table>
<thead>
<tr>
<th>Case no.</th>
<th>Sex, age in years</th>
<th>Alleged origin of lesions</th>
<th>Clinical findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>M, 46</td>
<td>Beatings with sticks.</td>
<td>Amputation of 5th finger on right hand, 1 NS scar on leg, 6 cm × 1 mm scar on left calf.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cut with bayonet.</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>M, 71</td>
<td>Shot against head, wound sutured.</td>
<td>Transverse 4 cm × 1 mm scar on the head, slight prominence of bone.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stuck with bayonet against head.</td>
<td>5 mm deep, triangular 12 × 12 mm scar in parietal region (fig. 5).</td>
</tr>
<tr>
<td>33</td>
<td>F, 20</td>
<td>Beatings and kicks, thrown out from 1st floor.</td>
<td>Amputation of left leg below knee.</td>
</tr>
<tr>
<td>36</td>
<td>M, 21</td>
<td>Beaten with a stick against right eye.</td>
<td>Opaque right cornea.</td>
</tr>
<tr>
<td>39</td>
<td>F, 43</td>
<td>Beaten with sticks.</td>
<td>Deformity and impaired function of right wrist.</td>
</tr>
<tr>
<td>49</td>
<td>M, 52</td>
<td>Beaten with sticks and rifles.</td>
<td>3 NS scars on head and calves.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cut with a bayonet.</td>
<td>1 cm × 1 mm scar on left wrist.</td>
</tr>
<tr>
<td>50</td>
<td>M, 86</td>
<td>Beaten with rifles.</td>
<td>NS scar on left knee. Slight prominence of bone on left 5th rib.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cut with bayonet.</td>
<td>2½ cm × 1 mm and 4 cm × 2 mm scars on right hand and on the head.</td>
</tr>
<tr>
<td>51</td>
<td>M, 46</td>
<td>Beatings with rifles and sticks.</td>
<td>2 NS scars on right calf.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cut with knife on right hand.</td>
<td>4 cm × 1 mm scar on right hand.</td>
</tr>
<tr>
<td>55</td>
<td>M, 41</td>
<td>Beatings with sticks and rifles.</td>
<td>2 × 1½ cm irregular scar and excavation of bone in the parietal region.</td>
</tr>
</tbody>
</table>

6), and partial amputation of a finger (case 8).

Physical findings accorded with the history in 15 examinees. Case 26 did not have physical sequelae of the alleged torture, and case 48 could not be examined.

**Ill-treatment**

Nine persons, 7 men and 2 women, aged 20-86 years, stated that they had been ill-treated by the Indian Security Forces 2-4 years before our examinations (table 2). The ill-treatment had taken place in their homes, villages, or in a rural area; it was not carried out during interrogation or arrest. Eight said that they had been beaten, five that they had been cut or stuck by bayonets or knives. One reported being shot at, one that she had been thrown out of a window.

Four who reported being beaten had non-specific scars. One had a scarified cornea after a single beating.

Case 12 said that he was beaten violently with sticks a few times during the crackdown. He tried to protect himself with his right hand, but his little finger was hit and broke off at the proximal joint; it became completely loose and had to be amputated. Case 33, a woman whose left leg had been amputated at
Four who reported cuts with knives or bayonets had thin scars (cases 12, 49, 50, 51), while case 27 had a deep triangular scar allegedly caused by a bayonet thrust (fig. 5). This man stated furthermore that he had been shot in the head; in accordance with this, he had a scar on the head with associated prominence of the bone.

Other injuries
Another 2 persons stated that they had been shot by the Indian Security Forces 1-3 years before our examinations. A woman reported sustaining a fracture of a leg when she jumped out of a window in an attempt to escape from a crackdown.

Three persons reported injuries from land mines when they fled from the Indian part of Kashmir 1 month - 2 years before our examinations (figs. 6 and 7, table 3).

Discussion
Persons examined in our study were all self-selected. Consequently, the figures cannot be extrapolated to assess the prevalence of exposure to organized violence among inhabitants of the refugee camps. We are, however, impressed that in a few days we could identify a high number of persons who reported exposure to torture in particular, and to other kinds of violence.

Concerning torture, there was consistency in all 17 cases of visible sequelae to violence between the history of torture given by the examinee and our clinical findings. We stress that the persons examined were not informed in advance about the examinations, which reduces the risk of fabrications. Furthermore, the interviews (with the consent of the examinees) took place in the presence of others who must have been familiar with their histories through close contact in the camps and in the villages of origin. In our view, this design further reduces the risk of fabrications. Most of the torture victims had clinical findings that corroborated their statements about torture. In the majority of cases, the findings indicated exposure to very violent traumatization, and in several cases the findings were beyond what may be classified as non-specific scars.

Six persons exposed to torture had signs of fractures or had amputations. Two had scars that originated beyond any doubt from cigarette burns. The transverse, biconvex scars are highly suggestive of non-sutured, inflicted cuts. The location on the calf clearly points to an intentional injury. Case 29 had evidently been tortured with cuts, as indicated by the loss of the tip of his nose and by the small transverse scar just below the nose cavity. Judged by the appearance of the lesions, the nose must have been cut from below. Furthermore, he had multiple large scars, e.g. the area on the scalp with traumatic alopecia, which corresponded with the history of bayonet injury. The other large scars may represent the sequelae of infected bayonet lesions.

Table 3. Data concerning exposure and clinical findings in 6 persons who stated miscellaneous traumatization.

<table>
<thead>
<tr>
<th>Case no.</th>
<th>Sex, age in years</th>
<th>Alleged origin of lesions</th>
<th>Clinical findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>M, 18</td>
<td>Shot at during attempt to escape from “crack down”. Broke right foot.</td>
<td>$\frac{3}{4} \times \frac{1}{2}$ cm, $\frac{1}{2} \times \frac{3}{4}$ cm and $\frac{1}{3} \times 1$ cm scars on left thigh, right hand and left arm.</td>
</tr>
<tr>
<td>18</td>
<td>F, 18</td>
<td>Jumped out from first floor in an attempt to escape from a “crack-down”.</td>
<td>Clinical examination not done.</td>
</tr>
<tr>
<td>38</td>
<td>F, 49</td>
<td>Shot by security forces while travelling in a public bus. Treated in a surgical department.</td>
<td>3 scars, $2 \times 3$ cm on right thigh. Impaired flexion of the right knee (180°-90°).</td>
</tr>
<tr>
<td>24</td>
<td>M, 25</td>
<td>Hurt by a land-mine explosion while crossing the cease-fire line.</td>
<td>Splintered fracture of the right calf 10 cm above the ankle. 10 scars, $2 \times 3$ mm - $2 \times 30$ mm on right hand and arm and right side of the chest. 3-4 mm hard foreign body in subcutis of right upper arm. 20° impaired extension of the distal joint of right 4th finger.</td>
</tr>
<tr>
<td>34</td>
<td>M, 25</td>
<td>Hurt by a land-mine explosion while crossing the cease-fire line.</td>
<td>Amputation of right foot (fig. 6).</td>
</tr>
<tr>
<td>41</td>
<td>M, 18</td>
<td>Hurt by a land-mine explosion while crossing the cease-fire line.</td>
<td>$3 \times 5$ cm scar with loss of bone substance on the lateral aspect of the right heel (fig. 7).</td>
</tr>
</tbody>
</table>
The description of violent torture, in some cases mutilating, employing available non-specific instruments, including cigarettes and heated iron, electricity, and ropes for suspension, is in accordance with other reports from Indian-held Kashmir (1, 2).

The nine persons who "only" reported ill-treatment all had physical signs of traumatization in accordance with the history. Six had signs of bone and/or joint lesions, including 2 cases of amputations. In particular, 5 persons had scars marks evidently caused by sharp or pointed traumatization. The many histories of physically substantiated bayonet injuries fit into a pattern further corroborated by similar findings in 4 children.

In this series, the 3 histories of land mine injuries were corroborated by clinical findings. In 2 there were injuries of bony structures of the feet. The other case had a multitude of small scars on one side of the body, compatible with exposure to a shower of splinters from an exploding mine. Furthermore, there was a comminuted fracture of the calf on the same side. The surgeon who treated this case said that the victim was wearing heavy boots at the time of the incident, and this had protected the foot from lesions. Whether the fracture was caused by a land mine explosion is not quite clear, but the scars otherwise described are highly consistent with exposure to such an explosion. All three land mine victims stated that the traumatization took place when, as civilians, they tried to cross the cease-fire line.

The findings of this study, including the histories of shooting of civilians during "crackdowns" and in public places, are in agreement with the results of the previously published studies1,2, i.e. that the civilian population of Kashmir is very severely affected by the ongoing conflict, and that the Indian Security Forces are responsible for a high number of serious violations of human rights. Mutilating torture and randomly used ill-treatment occur. Such transgressions are not rare, since physical sequelae of torture and ill-treatment can easily be demonstrated. It seems that the Indian Security Forces do not care about taking measures to avoid leaving marks in their victims after torture and ill-treatment. This may indicate that the measures of discipline within the security forces are ill-functioning, or that torture and ill-treatment form part of a chosen policy, thereby violating the Indian constitution, which prohibits the use of torture. The necessary steps to reduce the number of Human Rights violations are described elsewhere1; they include the introduction of control bodies, including access to Indian-held Kashmir of international institutions such as the International Committee of the Red Cross.

References
3. Petersen HD, Wandall JH. Evidence of physical torture of children from Indian-held Kashmir. (Submitted for publication).

Professor Bent Sørensen’s Travel Grants

Professor Bent Sørensen’s Travel Grants in Support of Medical Doctors’ and other Health Professionals’ Participation in International Activities to Combat Torture and its Consequences were established under the RCT at the occasion of former president of RCT (1984-90) Bent Sørensen’s 70th birthday, March 8, 1994.

A number of travel grants will be available in 1995 to enable medical doctors and other health professionals from all parts of the world to participate in international activities aiming at combating the practice of torture and providing appropriate care and assistance to victims of torture.

These travel grants will be awarded to cover the cost of participation in scientific or professional meetings as well as in fact finding missions and study trips relating to torture and its consequences. Travel grants may also be awarded to allow participation in relevant education and training activities either as faculty or student.

The grants will be awarded by a review committee appointed by the board of the RCT and will be based on written applications received before February 1, 1995. The applications should contain all relevant information on

1. Purpose
2. Budget
3. C.V.

and should be sent to

Professor Bent Sørensen’s Travel Grants
Rehabilitation and Research Centre for Torture Victims
Borergade 13
DK-1300 Copenhagen K
Denmark.

Bent Sørensen, Professor, MD, DMSc, former President of RCT, member of CAT (UN’s “Committee Against Torture”) and 1st Vice President of CPT (Council of Europe’s “Committee for the Prevention of Torture”). Photo: Alberto Venzago.

TORTURE Volume 4, Number 3 1994
This communication attempts to account for certain aspects observed by us in our capacity as psychotherapists working at the Social Rehabilitation Service (SERSOC) in Uruguay with female political prisoners who were pregnant, gave birth, and raised their babies in prison.

We consciously chose cases for analysis when there was a stable, consolidated couple and pregnancy was desired.

It is important for all pregnant women to have a supportive environment that allows her to feel that she is available to be with the baby and to feel responsible for it. This may have consequences on her future role as a mother. According to Winnicott, this availability is "the 'normal illness' that enables her to adapt in a delicate and sensitive manner to the infant's needs from the very beginning."

The mother may temporarily abandon the rest of the world in order to devote herself in a practically exclusive manner to her new baby when there is somebody who makes this possible, who makes her feel supported and at the same time allows her to forget everything she will temporarily "abandon" while being cared for by others. We can think of this when, for example, there are other children.

The lack of a favourable environment hinders an adequate meeting between mother and baby. The foundations for the creation of the new being's personality are being set during this first period, so that any difficulty may signify an obstacle to the child's future emotional development.

How then should we think of the situation of a pregnant woman in prison? Minimal physical cares (gynaecological controls, good feeding, rest) were not provided. Insecurity was an everyday experience, coupled with constant threats, the absence of spouse and family. The optimal conditions that grant the serenity required by the future mother were lacking.

Perhaps the most dramatic aspect of imprisonment and torture was the explicit intention to transform everything that was known and familiar into something uncanny, terrifying. Far from favouring any vital process, the idea was to create disorder. It was not only what was absent, but rather the presence of horror. The "other" was there to cause pain and suffering. The aim was to create discontinuity and to destroy the individual's existence as such. To dehumanize what is human in mankind.

We may establish a certain parallel between the extreme experience of torture, that seems to produce a regressive situation in the victim, and the first moments of absolute dependence of the baby in relation to the mother under normal conditions. The impotence of the newborn implies the existence of the mother, who begins to give meaning to its needs. It is she who interprets and responds to them, granting the baby relief and satisfaction.

We might think that torture promotes a regression to very early stages of development. The baby is at the mercy of its mother, while the detained person, with hands tied, using a hood, is at the mercy of the torturer. The normal mother-child relationship is mainly about caresses and maternal cares for the baby. In the detained person, the conditions of imprisonment and torture cause displeasure and suffering, and aim at disintegration. The victim will thus be submerged in the most terrible insecurity.

On the other hand, normal pregnancy implies a regressive movement that will prepare the way for the mother's identification with her growing baby, allowing her to know its needs better. This regression results in a special need for protection and understanding, which, under favourable conditions, she will find in the surrounding environment.

In detained pregnant women, the experience of lack of protection was dramatically enhanced due to all the insecurities of everyday living. Perhaps she could find some support in her own ideals, and in the company of other prisoners who, although they could sometimes help her, were likewise helpless. We know that the different personal histories will impinge on the intensity of these experiences.

How can we think of the meeting between the mother and the baby? What are the characteristics of this link? What did this child represent for this mother who was alone and forsaken?

A patient, under psychotherapy, said: "We had planned to have this child, we had many expectations...many plans...even the girls...they were sleeping when they took me, I kissed them...I didn't know what to do" (she cried)..."I felt alive when I could feel him move. It was something that was mine and that would be protected while inside. I wondered how so much prison would affect him...I didn't want him to be born because I didn't know what would happen to him...if I would know him...meanwhile I had him in my womb, I took care of him as much as possible...Carlos [her husband] had also been taken, and the news I had from him was terrible...Pedro was born suddenly, very fast, and they immediately took him away, I practically did not see him...and they took him. Try as I may, I couldn't remember his face...fortunately he was fat and cried very hard...I was desperate because I didn't know where he was. I wanted to have him with me and they would not bring him...They gave him to me only on the following day...I was afraid I wouldn't see him again..."

The patient further stated that Pedro was a child who cried all the time. She recalled: "I couldn't even go to the toilet...sometimes I felt like covering his mouth because it was as if he was suffocating me, he didn't want to be with anybody else, everything had to be with me...and when they freed us, it was the same at home" (when Pedro was born).
was 2\(\frac{1}{2}\) years old) ... “I remembered my daughters who didn’t have me and were growing, and I was missing it ... the elder, Isabel, was beginning to write, and the searches ... we could not greet each other or touch ... Sofia [the younger] used to cry all the time ... they did not even let me kiss her. Pedro became my partner, my other daughters. He was everything for me ... I felt he depended on me, but it was I who was dependent. He filled my life, and I wasn’t alone any longer ... but he was also my tyrant, he used to cry night and day and I tried to remain calm ... not to feel angry.”

This history shows a situation of helplessness and absolute dependence. The mother, whom we will call Silvia, was everything for her child, and at the same time, this child was everything for her. This permanent presence, when mother and baby only had each other, seemed to force them to a total reciprocity. Each one needing the other to satisfy all their needs, with the illusion of feeling that they formed a unity, that each was part of the other.

It seems difficult to be rescued from this dual link. Although the mother was present in reality day and night, the crying demand from the baby is proof of all that was lacking in her presence. There was a demand that could not be decoded. Crying as such could not be calmed, and thus it denounced the failures in maternal support.

We are facing a paradox: the one who needed support was the one who had to support. Silvia sought support in her baby (Pedro was everything for her). Her child was the only thing she possessed, her only link with the world. He was the confirmation that there were other things apart from horror in prison. She continued alive and had been able to give life. But at the same time, Pedro was imprisoned with her. And she knew that the only way to continue having him close to her was to keep him in prison. In a certain manner, Pedro had the mission of redeeming everything Silvia lacked. He was experienced as an extension of herself. Differentiation would imply losing him. Let us not omit that she could have him with her only while she nursed him. When breastfeeding was interrupted, the child was to be set “free”.

But on the other hand Pedro did not let her “breathe”, he “suffocated” her; and she immediately added that she tried not to feel angry. The aggressive feelings apparently had no reason. The relationship always seemed coloured by a strong ambivalence, when the urgent need permanently to satisfy the child could be hiding a great hostility towards this child, by whom she felt devoured and imprisoned.

This modality of relating, where there seems to be only one person and not two, will have consequences in the separation-individuation process and in the child’s consolidation of his own identity.

Finally, we would like to mention certain aspects related to the link these patients establish with the institution where they are treated, and with the treating psychotherapist.

The institution becomes a reliable frame of reference that functions as a bridge with the world. It will be experienced as responsible for repairing the damage produced by society and must satisfy a demand that often has no limits.

In the transference, the patient repeats the experience of being forsaken and impotent. The therapist is sometimes experienced as omnipotent: she can do everything and will therefore be able to give her all she needs.

At other times, the patient will feel that her therapist does not give her anything, or that what she receives from the therapist is neither good nor sufficient. This demand reminds us about her baby’s constant crying in prison. What is it that she is now asking for?

We must be particularly careful not to let ourselves be trapped in the counter-transference and through our technical responses stay in the place where patients constantly try to put us. We should not offer ourselves now as Silvia offered herself to the baby, granting the illusion that we can give all she requires.

It is of fundamental importance that we should be able to offer psychotherapy in an institutional setting related to Human Rights, and thus allow the working through of prison experiences, which will make it possible to find a different manner of relating and which will help to cut this chain of repetitions. Only this will allow an escape from Etinger’s law, which states that “the consequences of the extreme situations lived in prison with punishment not only affect the victims, but also their relatives, up to the second and third generation”.

Servicio de Rehabilitación Social SERSOC
Casilla de Correos 10757 Sucursal 60
Montevideo Uruguay

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Selected list of publications

**received in the IRCT International Documentation Centre**

The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps / Malica, Richard F.; Donelan, Karen; Tor, Svang; Lavelle, James; Elias, Christopher; Frankel, Martin; Blendon, Robert J. - In: The journal of the American Medical Association; vol. 270, no. 5, - 19930804, - p. 581-586. - ISSN: 0048-7844.

Prospective pilot study of survivors of torture and organized violence: examining the existential dilemma / Gorst-Unsworth, Caroline; Velsen, Cleo van; Turner, Stuart. - In: The journal of nervous and mental disease; vol. 181, no. 4, - 19930400, - p. 263-264. - ISSN: 0022-3018.


The ethics of medical involvement in torture / Downie, R.S. - In: Journal of medical ethics; vol. 19, no. 3, - 19930900, - p. 135-137. - ISSN: 0306-6800.

The ethics of medical involvement in torture: commentary / Hare, R.M. - In: Journal of medical ethics; vol. 19, no. 3, - 19930900, - p. 138-141. - ISSN: 0306-6800.


Sudanese Victims of Torture Group (SVTG)

Presentation at launching ceremony, 29 June 1994

"Dear Ladies and Gentlemen,

Our Group is made up of Sudanese individuals who were subjected to torture on account of their suspected political opposition to the current military regime, which seized power on 30 June 1989. This is the first group of its kind in the history of post-modern Sudan. The closest group to it in its broad nature is the now banned Association of Judicial Amputees, i.e. those who lost their limbs as a result of the implementation of shari‘a between September 1983 and March 1985. We define torture in accordance with the 1975 Tokyo Declaration, which was prepared by the World Medical Association:

"[Torture] is 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."

There is evidence to suggest that under the present regime, torture has been in the main directed against professionals, doctors, engineers, university teachers, lawyers, teachers, journalists, and trade unionists and politicians. Since its coming to power, the regime has been living in mortal fear of the possibility of a collective action by these highly influential groups. Those committed to a multi-party democracy and to a separation of religion from politics and the state have been under particular attack and victimization. As time went by and as the shaky regime of 1989 began to entrench itself, it became unmistakably clear that the regime’s security apparatus assumed a central status within its power structure. By setting up an ever-widening network of extrajudicial detention centres, the security forces created its own parallel prison system and its own state within the state.

As the ruling National Islamic Front is an organization run by an educated elite, it was no surprise that one of their first steps was to install a university teacher at the top of the security apparatus, and this was a university teacher who fully knew the merit of specialization and who reportedly devoted a great deal of his time to preparing for his future vocation. Under his meticulous supervision, the institution of torture sprang up almost overnight, with its trained personnel and its requisite infrastructure.

The unusual viciousness of the regime and its security arm is, we believe, due to the nature of its totalitarian ideology. The regime projects itself as an embodiment of a “Divine Project”, as a vanguard regime that is showing the Muslims the world over the way ahead. Any real or imagined opposition to such a regime becomes thus a “satanic” act against which the utmost rigor of “jihad” has to be directed. Torturing active or potential opponents becomes thus a worthy way of “jihad”. In fact, the security head, the university teacher, has gone on record as saying that he hoped that God would be pleased with his performance.

This performance has so far meant and still means horrendous suffering for those detained in the regime’s secret detention centres, better known as “ghost houses”. The name signifies the world of constant darkness in which the detainees have to live wearing hoods. The detainees are constantly threatened that their eyes will be gouged out if they dare to remove their hoods. Though the authorities constantly deny the existence of “ghost houses”, the Sudanese, and in particular those threatened with arrest, know that these “ghost houses” constitute an integral second self of the regime.

In these “ghost houses”, the express task of the torturers is the breaking of the body and soul of their victims. This is done through systematic beating, electrical torture, burning, suspension, sexual torture, mutilations, and other innumerable methods of torture. Detainees are subjected to continuous psychological pressure and torture. Deprivation of sleep and physical exhaustion through repetitive exercises and through standing for long hours are common methods of psychological torture. Isolation in tiny cells and deprivation of social contact is known to have driven some victims crazy. A systematic attack on the detainee’s personality is mounted and sustained from the first day of arrest, the victims are forced to perform humiliating acts such as crawling on the ground and barking like dogs. The victims are often threatened with executions, disablement, and threats against their families.

Over the past five years, hundreds of Sudanese citizens have been subjected to the atrocities of torture and ill-treatment. With victims of torture, as you may be aware, problems do not end once they are released from detention. The victims of torture suffer from physical and psychological sequelae. In the case of Sudanese victims, we can report the following sequelae:

1. Severe pain from wounds
2. Loss of teeth, which have been knocked out
3. Fractures
4. Difficulty in walking
CENTRE PRESENTATION

5. Impaired hearing
6. Scars from electrical torture, and disfiguring scars from burning
7. Chronic joint pain.

The psychological sequelae can have devastating effects. Let me cite the distressingly tragic example of a certain Badr al-Din al-Taum, an engineer who used to work for the Department of Housing. Mr al-Taum was arrested in November 1989 and was subjected to severe physical and psychological torture. On his release, he was a changed person who was psychologically permanently damaged. A few days after his release, Mr al-Taum attacked and murdered his wife, his father-in-law, and his mother-in-law, and smashed his small daughter against a wall. Mr al-Taum was taken to a mental house and he died shortly afterwards, reportedly taking his own life.

We have decided to set up our Group in order to provide the victims of torture inside and outside Sudan with the support they desperately need. SVTG will strive to provide as much medical, material, and moral support as possible for the victims of torture.

SVTG will also be campaigning to publicise the plight of detainees in Sudan, particularly those in "ghost houses". We hope through these campaigns to put as much domestic and international pressure as possible on the Sudanese regime to stop the practice of torture and to release all the prisoners of conscience. SVTG will also seek redress for the victims of torture and for the bringing of torturers to trial.

SVTG calls for a committed respect for human rights as enshrined in the Universal Declaration of Human Rights, which was ratified by Sudan, and the Convention against Torture and other Cruel, Inhuman and Degrading Treatment and Punishment, which was signed but has not yet been ratified by Sudan. SVTG is opposed to any discrimination on the basis of one's political views, religious beliefs, gender, or cultural or ethnic background. SVTG's campaigns and cultural and educational work will strive to disseminate and promote these values.

PERSONAL COMMUNICATION

A partial testimony by Mr Abd al-Bagi El-Rayad, SVTG

It was in the early hours of 8 December 1989 that I was arrested. The front door of my house in the Burri district of Khartoum was smashed open and moments later I was confronted by two grim looking security officers who said that they had orders to arrest me. I was by myself at home, as my wife and little boy had gone to stay with relatives. I was given a few minutes to dress myself hurriedly and I was bundled into a car waiting outside.

The journey's destination was the Headquarters of the Security Forces and there I was to join dozens of other detainees. The detainees came from all walks of life, but what they all shared was their commitment to democracy and secularism. This was enough of a crime to end up in a detention centre. We knew that, and in a way we had expected it, some of us being "graduates" of General Ibrahim Abbud's and General Ja'far Nimeiri's prisons. But what none of us had guessed was that we were being pushed into a new kind of inferno in the very heart of Khartoum. An inferno that was soon to be known as "ghost houses" and where a detainee's very psychological fibre was meant to be broken or at least mutilated.

I joined a group of detainees on the roof of the five-storey Security building. It was quite cold and matters were made worse by a security man who sprayed us with cold water. We spent eight miserable days on that roof, given one poor meal a day and allowed to relieve ourselves only once a day. After two brief stops we were pushed into the inferno. On the way to the "ghost house", about 23 of us were blindfolded, herded like cattle inside a minibus and we were covered by a blanket. The journey of suffering into the dark underworld of torture had just started.

The car stopped and we were taken, still blindfolded, into a storeroom and squashed there, all 23 of us. We heard a scream from one of us and the cold and dull thud of a gun butt against the flesh. For six days we remained in that tiny room, living in perpetual darkness as we were blindfolded all the time. Food, which we were never supposed to see, was given once a day. And the once-a-day one-minute visit to the toilet was a horrible journey of suffering, because the guards lashed us on the way to and back from the lavatory.

I was the first person to fall sick. There was no fresh air in that tiny room and I fainted. Alarmed and desperate, two of my fellow detainees pushed my nose against the keyhole. They removed me to another room. Once I recovered from my exhaustion, the torture began. I was made to stand inside a barrel which was filled with ice for about three hours for three days in a row. I was still blindfolded.

On the tenth day I was transferred to another room where I found another four detainees. They were indescribably filthy because they had been kept in a toilet with an open waste-pipe and a flood of sewage. After 48 days I was released. I was made to sign an undertaking that I would not oppose the government, that I would not move from Khartoum, and that I would only leave my house out of necessity.

As a result of my torture, the nerves and blood vessels of my left leg were inflamed. Just before Christmas 1991, the doctors had to amputate my leg at St George's Hospital in London.

Mr Abdel Bagi El-Rayad is 38 years old. He was a lawyer and a member of The Sudan Bar Association and the Lawyers' Democratic Front. He lives at present in London with his wife and son. He is a founding member of the Sudanese Victims of Torture Group and is at present the Group's Secretary General.

Over the last year and in the course of setting up our Group, we have received a lot of help and encouragement from different quarters. We would like to thank, among others, the following organizations:

1. The Redress Trust
2. Prisoners of Conscience
3. International Pen
4. The Rehabilitation and Research Centre for Torture Victims in Copenhagen
5. Medical Foundation for the Care of Victims of Torture

We would like to announce that our branch in Egypt will now be launched. The setting up of a branch in the USA is under way. As far as our arrangements in Sudan are concerned, we do not like to speak about them now owing to the security of those involved."
“When it comes to killing you can do things with doctors that would have been much harder without”


A meeting on bioethics The Meaning of the Holocaust for Bioethics took place at the University of Minnesota from 17-19 May 1989. The papers from this meeting have been brought together in the book When Medicine went Mad. Bioethics and the Holocaust.

This text deals with the lethal experimentations on humans in the concentration camps, including the experiments on twins by Dr. Mengele; it also reviews the killing in the form of euthanasia, and later the large scale killing of everyone who was perceived as a threat to the Third Reich, or as subhuman.

The book includes statements from survivors of lethal human medical experimentations during the Shoah, as well as from leading bioethicists of the 1990s, primarily from the USA.

When medicine went mad deals with the medical experimentation and medicalised killing in Europe, partly because it was the aim of the organisers of the meeting, but also because of the scarcity of published material from the war in the Far East.

The chapters deal with extremely difficult ethical questions, including the moral and ethical defence employed by the perpetrators. Several of the authors even dare to venture into the area of forbidden questions, and ask bluntly:

“If the Holocaust could be defended on ethical grounds, then what use is bioethics?”

In summary, it is alleged that the German medical profession voluntarily studied and introduced a massive sterilisation programme, affecting primarily the mentally handicapped. This sterilisation programme developed into euthanasia in the killing of more than 70,000 psychiatric patients, and this task was completed before the beginning of the war.

Furthermore, the sterilisation and the “mercy-killing” had advocates all over the world at the time, even to the point at which it was discussed openly in the medical journals of the major Western powers.

The killing was rationalised primarily on a utilitarian, philosophical, and ethical basis.

The destruction of mental patients turned out to be the stage rehearsal for the killing of anyone deemed a threat to the Third Reich, or as inferior.

Once the killing of all unwanted humans in Nazi Germany and its occupied territories was begun, it was soon realised that the SS troops trained in mass killing could not continue their butchery indefinitely. Therefore techniques were sought “for a less disturbing way of getting the job done”, which became the medicalisation of the termination of millions of lives, as expressed in the title of this review. It is a statement by the bioethicist Robert N. Proctor on page 38 in the book When Medicine went Mad. Bioethics and the Holocaust.

At about the same time, experimentation began in the concentration camps, often with a lethal ending. The text reviews the hypothermia and high altitude experiments, as well as Dr. Mengele’s studies on twins.

A few doctors were prosecuted after the war, not for killing the insane but for the part they played later in mass murder and lethal human experimentation. The book examines their arguments and excuses, and several of the authors, in dismay, reach the conclusion that the criminals actually defended their act on moral and ethical grounds.

Some topics are dealt with at length in the book, e.g.:

1. Use of the term “science” in relation to the experiments on humans in the concentration camps; analysis of such issues as “Was the research necessary and/or justified?” Researchers disagree on these topics, as do survivors of the experiments.

2. Should the results from these experiments be used?

To the surprise of the investigators, it appears that the results have been repeatedly referred to in the medical literature, and as late as 1989 in a textbook of physiology.

Survivors also disagree on this issue. Some would like the information to be put in a glass case for the world to see but never use: “The information was robbed from the victims, therefore you cannot use it.” Others want it destroyed, and others again would like it to be used so that at least some good could come of the atrocities, this raising issues such as: “Is a wrong less wrong if you get something good out of it?” and in using the data it is also argued: “Acknowledgement is better than the uncomfortably averted gaze”.

It has for years been argued, from the comfortable position of currently accepted ethics, that the issues described above are clearly and unequivocally unethical prima facie, even to the point of the debate losing interest. In When Medicine went Mad. Bioethics and the Holocaust, we are forced once again to open our eyes and face the darker sides of our nature. It is an excellent book that I recommend to everyone interested in ethical thinking, or even in medicine in general, its research, and its potential for misuse.

Peter Vesti, MD, Psychiatrist
Consultant to RCT
Copenhagen, Denmark
Physiotherapy for torture

Danish physiotherapists have taken the initiative to include treatment of torture victims in the training of physiotherapists all over the world.

The initiative was triggered at an international meeting in Copenhagen, at which therapists were confronted with reports of the widespread use of torture and the role of the therapist in the treatment of torture victims.

The Board of the World Confederation for Physical Therapy (WCPT) ended its ordinary meeting in Copenhagen on 22 July 1994, and the Association of Danish physiotherapists (ADP) used the opportunity to start a special Danish effort for people who have survived torture. In particular, the physiotherapists wanted to introduce the Danish experiences in this field in the training curriculum for physiotherapists worldwide.

In the future, students should learn about the commonest forms of torture, and how to give appropriate treatment to the victims.

New address in Turkey

Human Rights Foundation of Turkey/Izmir Branch

has moved to a new address:

Cumhuriyet Bulvari No: 212 D:3
Alsancak 35220 Izmir
Turkey
Tel: 0.232.463 9147
Fax: 0.232.463 4646.
The Martin Ennals Award given to a Chinese dissident

The recipient, Harry Wu, spent 19 years in prison

The Martin Ennals Award, named after the late Secretary General of Amnesty International, was given earlier this year to a Chinese citizen, Harry Wu, aged 57. He spent 19 years in a Chinese labour camp after having criticized China’s Communist regime in his response to Mao Tse-tung’s appeal “Let One Hundred Flowers Bloom”.

The award, which was given for the first time this year, is granted to individuals (exceptionally to organizations) in respect for their Human Rights commitment, but with a special view to encouraging their future work in that field.

Mr Wu announced that the prize money, 25,000 US$, would be used to bring more information on the Laogai Camp, into which he was put for criticizing Chinese support for the Soviet invasion of Hungary in 1956, being labelled a “counterrevolutionary Rightist”. He was just a student, having attended a geology college in Beijing, and only did what Mao had requested: for people to speak out and criticize the government. It was a trap.

In his acceptance speech in Geneva on 3 March 1994 the Chinese dissident Harry Wu received The Martin Ennals Award at a ceremony in Geneva, Switzerland.

In March, Harry Wu remembered the fifty million Chinese and Tibetans who suffered or died in what he called “The Chinese GULAG” (the labour camps in China). In the Laogai Camp, the Communists used hunger as a weapon; prisoners who did not work long hours, or who did not confess false crimes, were starved to death.

“In Laogai I became a robot, I forgot my dignity, everything. I surrendered, I cooperated with wardens, I beat fellow prisoners, I stole food, I fell to my knees before a prison guard and begged for mercy during solitary confinement. This is how I survived. I was not a hero. Heros never survive the Laogai ...”

Six years after he was released, he obtained a visa for the US. He had been a lecturer at the Wuhan Geoscience University and now succeeded in becoming a visiting scholar at Berkeley and Stanford Universities. He has written several books on his bitter experiences in Laogai.

A film was shown at the award ceremony, “Laogai: Inside China’s GULAG”, produced by Yorkshire Television; it included footage which Harry Wu secretly filmed when he in disguise visited Laogai in 1991.

TORTURE WORLDWIDE

The case of Faisal Barakat

Between 8 and 10 October 1991, Faisal Barakat, a young Tunisian student and member of the illegal Islamic movement Hizb al-Nahda, was arrested in Nabeul, Tunisia.

On 17 October his family was notified of his death and an autopsy report was presented saying that he had died in a road traffic accident.

On 28 February 1992, however, Professor Derrick J. Pounder issued his report, which contradicts the previous report from the Tunisian doctors.

Professor Pounder, who is a well-established forensic expert, ends his report:

“... The entire pattern of injury is that of a systematic physical assault and very strongly corroborates the allegation of ill-treatment and torture that has been made. The injury pattern as a whole and the injuries to the anus, feet and buttocks in particular are incompatible with involvement in a road traffic accident and this explanation for the death has no credibility in the light of the autopsy findings.”

Mr Khaled Ben M’Barek, who is coordinator at the “Centre for information and documentation about torture” has mobilized both Amnesty and CAT in order to establish the correct cause of death.

Three years after this tragic event, Mr Khaled Ben M’Barek is still engaged in putting this matter right, an engagement that has not been without personal sacrifice.
CALL FOR PAPERS

VII International Symposium

CARING FOR SURVIVORS OF TORTURE
Challenges for the Medical and Health Professions

Cape Town, South Africa
15-17 November 1995

The conference is organised by the International Rehabilitation Council for Torture Victims (Copenhagen) and the Trauma Centre for Victims of Violence and Torture (Cape Town). The plenary sessions, workshops, panel discussions, and seminars will focus on the following topics:

1. Diagnosis and treatment of physical sequelae of torture.
2. Diagnosis and treatment of psychological sequelae of torture.
3. Family and community approaches to the provision of health services for torture survivors.
4. International action towards the rehabilitation of torture survivors.
5. Experiences of health workers with torture and rehabilitation in African countries.
6. Experiences of health workers with torture and rehabilitation in the rest of the world.
8. Torture, ethics, and the health professions.
10. The social psychology of state-sponsored violence: do we treat perpetrators?

Abstracts should be sent before 15 March 1995 to either:

International Rehabilitation Council for Torture Victims
(IRCT)
Borgergade 13
P.O. Box 2107
DK-1014 Copenhagen
Denmark
Tel: (45) 33-76-0600
Fax: (45) 33-76-0500

or

The Trauma Centre for Victims of Violence and Torture
Cowley House
126 Chapel Street
Cape Town 8001
South Africa
Tel: (27) 21 45 7373
Fax: (27) 21 462-3143

If you wish to submit an abstract in a language other than English, please enclose an English translation and indicate in which languages the paper could be delivered.

A limited number of fellowships are available for conference participants presenting papers. Priority will be given to speakers from African countries.
FORTHCOMING CONFERENCES AND SEMINARS

Haywards Heath, West Sussex, United Kingdom
November 18-20, 1994
First Annual European Trauma Conference
Trauma Treatment in the 90's: Towards the 21st Century.
The United Kingdom and Finland Members of the International Association of Trauma Counselors.

Further information:
Lori Beth Bisbey.
9 Portland Road
East Grinstead
W. Sussex RH19 4EB
United Kingdom
Tel: 44-342-323107
Fax: 44-342-324316

Baltimore, Maryland, USA
April 19-23, 1995
3rd World Congress on Stress, Trauma and Coping in the Emergency Services Professions.

Further information:
International Critical Incident Stress Foundation, Inc.
ICISF
5018 Dorsey Hall Dr.
Suite 104
Ellicott City, MD 21042
USA
Tel: (410) 730-4311
Fax: (410) 730-4313

Paris, France
May 7-11, 1995
The Fourth European Conference on Traumatic Stress of the European Society for Traumatic Stress Studies.

Further information:
Medicongres - IV° Ecots
18, rue d'Armenonville
92200 Neuilly-Sur-Seine
France
Tel: +33 1 47.22.90.79
Fax: +33 1 47.45.15.45

Amsterdam, The Netherlands
July 16-20, 1995
Amsterdam '95: The Fourth International Conference on Health Law and Ethics in a Global Community.

Further information:
American Society of Law, Medicine & Ethics
765 Commonwealth Avenue,
Suite 1634
Boston, MA 02215
USA
Tel: (1) 617-262-4990
Fax: (1) 617-437-7596

The Rehabilitation and Research Centre for Torture Victims (RCT) is an independent, humanitarian, non-political organization established in 1982 to help victims of torture and to contribute to the prevention of torture. Its main objectives are to rehabilitate persons who have been subjected to torture, to rehabilitate their families, to instruct Danish health professionals in the examination and treatment of persons who have been subjected to torture, and to carry on research into the nature, the extent and the consequences of torture.

The International Rehabilitation Council for Torture Victims (IRCT) is a private non-profit foundation, created in 1986 by the RCT. The objectives of the foundation are, on an international basis, to support research into all aspects of torture, to support education and training of health professionals and of other relevant personnel in the medical, social, legal and ethical aspects of torture, and to serve as an international clearing house for information about torture activities.