SILENT HEALERS

A Study of Medical Complicity in Torture

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Abstract

In current international law there are no good mechanisms to punish passive participation in torture. Much of the reason for this can be blamed on the nature of passive participation, since it is very hard to find physical evidence for its existence. There is currently a changing attitude in international law, where more and more victims are believed based solely on their testimony, and less weight is put on physical evidence.

Topic of the Text

This paper has been prepared in response to the rising number of statements from torture victims who claim that during their incarceration medical personnel cooperated with the interrogators by sharing medical documents, giving false statements, and providing other indirect assistance to the interrogator. Acts of torture and other cruel, inhuman, or degrading treatment and punishment can fall along a broad spectrum. This paper will focus on a large but neglected part of torture that can be termed *passive participation in torture*.

Part 1: Passive Participation and Dual Loyalty

The first section will shed some light on several questions: How does passive participation work? What are the mechanisms behind this behavior? And, who performs it?

Discernment of passive participation in torture, in cruel, inhuman or degrading treatment, or in punishment

Condemnation of extreme cases of health care personnel involved in torture, cruel, inhuman or degrading treatment, or punishment

When we commonly think about the involvement of doctors or other health care personnel in torture, cruel, inhuman or degrading treatment, or punishment, we usually think about the atrocities performed during the Second World War by health personnel in the name of medicine. It is for this reason that characters such as Joseph Mengele[1] are famous. Dr. Mengele became well-renowned as a result of his work as a doctor in Birkenau concentration camp in Auschwitz. Here he and other health personnel like him conducted medical experiments on Jews. Among other things Mengele introduced grass into detainees' bodies, with the intention of understanding how an infection worked. Unfortunately Mengele managed to escape to Latin America before it was possible to prosecute him. Even though this murderer escaped, his fellow colleagues were charged and condemned in the Nuremberg trials[2]. Modern international law regarding health professionals is based on the human rights issues that were addressed during the Nuremberg trial. Justice and society agree today to condemn health personnel who are involved in atrocities. At times it is suggested to condemn them to an even larger sentencing, due to their medical responsibility.

Gerard Ntakirutimana[3] is an example of a doctor who was eventually imprisoned for 25 years as a result of his actions in support of torture. Prior to April 1994, this Hutu man led a normal life based on his calling as a physician, and had several Tutsi persons involved in his life both personally and professionally. Nevertheless, this doctor changed his position and became one of the murderers in the conflict that divided Hutus and Tutsis in Rwanda in the mid-nineties. This conflict lasted about a hundred days, during which time no less than 500 000 Tutsis were killed[4]. Not long after the conflict ended, Doctor Gerard Ntakirutimana was found guilty of genocide and crimes against humanity by the International Criminal Tribunal for Rwanda (ICTR-96-10-1). In handing down his sentence, the Court emphasized the following aggrieving circumstances: *"As a doctor, he was one of the few individuals in his area of origin to have achieved a higher education and one of the rare schooled in Western universities. It is particularly egregious that, as a medical doctor, he took lives instead of saving them. He was accordingly found to have abused the trust placed in him in committing the crimes of which he was found guilty.*" (Paragraph 910).

Cases of less-evident complicity: passive participation

The examples described above remain extreme cases of doctors' implication in torture. It is easy to say that someone who injected virus or performed forced sex change operations is guilty of cruel and inhuman treatment. It may be less easy to condemn, with the same conviction, someone who did not oppose torture performed by others. Nevertheless, in many cases, health care personnel who participate passively in these actions can join the same category as their

[1] *Josef Mengele*, Jewish virtual library
[2] *The Nuremberg Trials: The Doctors Trial*, UMKC
[3] International Criminal Tribunal for Rwanda
[4] *Génocide au Rwanda*, Human Rights Watch,

torturing colleagues. For example, a circumstance might arise in which a state agent requests a doctor to make a diagnosis of a detainee. Although it is not made clear to the doctor conducting the diagnosis, the purpose of this exam is to target the detainee's weak points, and subsequently use this diagnosis against the detainee during an interrogation. If the doctor had refused to conduct such an examination and then share his or her findings for the purpose of harming the detainee, the agent would not have discerned the patient's weaknesses. As a result the agent would not have been able to use the findings for information extraction. When the doctor agrees to work for a third party, and not the patient, it is in violation of international law as well as general medical ethics. Another typical example of passive participation in torture on a doctor's part could be the creation or revision of a detainee's report at the request of a third party, omitting any written documentation of torture or maltreatment. Also in this case the health care personnel are working in the interest of a state agent by supporting degrading treatment or punishment and neglecting the detainee's health.

The latter kind of participation is less obvious than experimentation or large-scale murder. The health care personnel remain, nevertheless, culpable participants in torture, cruel, inhuman or degrading treatment, or punishment. The main purpose of this paper is to bring to light this invisible complicity, namely *passive participation*. This type of behavior is in contrast to *active participation*. The distinguishing factor for the active participants lies in the extreme nature of how the health care personnel take part in the extraction of information. Fortunately the number of health care personnel worldwide who are active participants in torture are few. Unfortunately, there are too many blind eyes and much of the torture that does take place is invisible.

It is less problematic to find and prosecute the obvious participants than the subtle or less-engaged ones. According to Steven H. Miles, author of "Oath Betrayed," somewhere between 20 and 50 percent of torture survivors report "*...seeing physicians serving as active accomplices during the abuse*"[5]. These numbers, Miles explains, do not contain any figures regarding physicians who falsify medical records or detainees' death certificates, nor do the figures take into account torture techniques designed by professional health care personnel. There is more focus on human rights in general, and not particularly on torture[6]. Reports of passive participation in torture are therefore almost impossible to find.

Examples of passive participation

In a report from 2002, Physicians for Human Rights explains that there are six types of dual loyalty[7]. It can be said that dual loyalty is a major contributor to passive participation in torture or other mistreatment. According to Physicians for Human Rights, the six types of dual loyalty are as follows:
"*(A) Using medical skills or expertise on behalf of the state or other third party to inflict pain or physical or psychological harm on an individual that is not a legitimate part of medical treatment.*
(B) Subordinating independent judgment, whether in evaluative or treatment settings, to support conclusions favoring the state or other third party.

[5] *Oath Betrayed. Torture, Medical Complicity, and the War on Terror*, page 24
[6] *Appeal for increase of European contribution to fund for victims of torture*
[7] *Dual Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms*

(C) Limiting or denying medical treatment or information related to treatment of an individual in order to effectuate policy or practice of the state or other third party.
(D) Disclosing confidential patient information to state authorities or other third parties in circumstances that violate human rights.
(E) Performing evaluations for state or private purposes in a manner that facilitates violations of human rights.
(F) Remaining silent in the face of human rights abuses committed against individuals in the care of health professionals."

These are common situations that we can qualify as passive participation in torture, cruel, inhuman or degrading treatment, or punishment. Unlike other kinds of more active participation, these last cases are rarely revealed, nor punished. The passive participation of health care personnel in torture and other cruel treatment is far less recognized and punished compared to cases of active participation. This difference is embedded in the nature of torture, which forces the victim to remain in the shadow of society and requires him or her to remain silent about the abuse. The nature of passive participation itself also contributes to the difference between prosecution of its agents and those who participate more actively. Since the doctors who participate passively are actually guilty of their lack of report, their negligence or their decision to have turned a blind eye, it remains very difficult to document a passive act. It is also very difficult to find the guilty health care professionals, since the victims may not even get to see them. An example is Amin Shqirat, who was in detention on the 28th of December 2004. He explained that "*They brought me to a doctor who examined me and then returned me to the interrogation blindfolded and handcuffed*."[8] As a result, very few legal instruments can be used against passive participants, and in then end, a large portion is not brought to justice.

Reflection on the reasons why doctors would get involved in this type of participation

Several authors try to explain why responsible characters like physicians can be involved in passive participation of torture, cruel, inhuman or degrading treatment, or punishment. It is important to keep in mind or to understand why health care personnel would participate in these acts, because it seems only when their motivation will be understood that it will be possible to put an end to this practice.

Major reason for passive participation: Dual Loyalty

The main reason usually given as an explanation for the passive participation of physicians in torture or other cruel treatment is the situation of *dual loyalty*. A working group between Physicians for Human Rights (PHR) and the University of Cape Town (UCT) in South Africa defines this situation as "*a clinical role conflict between professional duties to a patient and perceived or real obligations to the interest of a third party, and focuses on instances where the human rights are in jeopardy*"[9]. This definition stems from the report "*Dual loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms*", and can be applied to many situations, such as when medical staff is loyal to a

[8] *"Ticking Bombs". Testimonies of Torture Victims in Israel*
[9] *Health Professionals and Torture: Resources & Background Reports*

hospital's insurance policy and not the interest of their individual patients. In this paper the third party mentioned in the definition of dual loyalty is the authority in charge of torture and other cruel, inhuman or degrading treatment, or punishment.

Situations that can provoke dual loyalty

The program director of the previously mentioned working-group between PHR and UCT, Leonard Rubenstein, stated four circumstances in which health professionals can find themselves in a situation of dual loyalty, and where the human rights of the client accordingly can get violated[10].

A situation of dual loyalty can, first of all, be explained by a *lower quality of care*. This might be due to a variety of reasons such as the culture at the institution, local pressure, or national laws demanding sub-treatment of certain ethnicities. Confronted with dual loyalty, doctors employed in a prison might *remain silent*. They sometime do not report to authorities, or other institutions or organizations that might help to improve the human rights of the patient. The health personnel might also have to *impose medical procedures to serve state interests*. One example can be the use of chemicals in a torture related situation, as well as the supervision and injection during an execution. Finally, there are cases of *compromising one's medical judgment*, as when the health professional might be pressured to leave out any evidence of torture from the medical statement.

Other reasons for health professionals to be implicated in torture

Amnesty, in their report called "*Doctors and Torture*"[11], lists five reasons for why medical personnel might be involved in torture:

1) *Bureaucratic necessity*, which is, indeed, equivalent to a situation of dual loyalty since it refers to health personnel who find it difficult to go against the wishes of their employer.

2) *Persuasion*. This might be done using ideology, for instance using the importance of the security of the state, and the significance of the health professional's help.

3) *Pressure and threats*. Health personnel can, for instance, be physically threatened not to tell anyone what is going on, they can loose their job, or receive threats to their family.

4) *Workplace pressures*. This point is similar to the last one, and is also a part of the dual loyalty problem. Pressure is put on the medical personnel, by the use of expectations or threats, to stay loyal to the institution that they work for.

5) *Lack of awareness of medical ethics*. Some medical personnel think that if they do no participate in the actual torturing, they are not in breach with medical ethics. This is of course incorrect.

With some of the personal reasons for health personnel to participate in torture, cruel, inhuman or degrading treatment, or punishment explained, it is easier to build solutions in the form of preventive systems. This will be discussed in greater detail in the conclusion of this paper. Still, as a start, all leading organizations should punish members that participate in torture, cruel, inhuman or degrading treatment, or punishment. Unfortunately, at present time, many organizations do not condemn this action, and some even tolerate it.

[10] *Healthcare Professionals and Dual Loyalty: Technical Proficiency Is Not Enough*
[11] *DOCTORS AND TORTURE, CHAPTER 2: WHY DOCTORS GET INVOLVED*, Amnesty International

Part 2: High-level Support of Torture

This section will look more closely at the reasons why organisations and institutions would want to support torture.

How and why do certain medical organisations support torture?

An example of why an organisation would want to support torture can be the American Psychological Association (APA). On the surface APA seem to be following the *UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (UNCAT). The statement on their WebPages declares that the "*APA has made absolutely clear that it is always unethical for a psychologist to participate in torture or cruel, inhuman or degrading treatment in any setting for any purpose*"[12]. This declaration is written in its full length under the APA resolutions, and is an adoption of the UNCAT.

However, when the APA, in the reaffirmation on the 19th of August 2007, defines torture or cruel, inhuman, or degrading treatment, or punishment, it is not in the lines of the UNCAT definition. The policy is instead founded on the *McCain Amendment*[13] that rests on the 5, 8 and 14 amendments of the Constitution of the United States of America[14]. The problem with using these amendments is that they are not clear about the exact definition of torture and cruel, inhuman, or degrading treatment, or punishment. The amendments demand that the detainee has been charged for a criminal act, and they do not apply for non-US citizens located outside the US. [15]. Adopting this logic, health professionals like John Leso, a behavioral psychologist, can be a member of the APA and still design interrogative techniques to be used in the detention facilities at Guantanamo Bay[16].

What are the possible reasons for the APA to retain the option of performing cruel, inhuman, or degrading treatment, or punishment?

In the drafting of an APA ethical report in 2006, no less than six of the ten board members had "close ties"[17] with the army of the United States. Four of the six had also served in Amercican detention centers in either Guantanamo, Abu Grahib or in Afghanistan.The relationship between psychologists and the Army of the United States has a long history[18] and is, for this reason, an example of dual loyalty on an organizational level. It is not surprising that the APA has not taken stronger measures to ban torture and other cruel, inhuman, degrading

[12] *FREQUENTLY ASKED QUESTIONS REGARDING APA'S POLICIES AND POSITIONS ON THE USE OF TORTURE OR CRUEL, INHUMAN OR DEGRADING TREATMENT DURING INTERROGATIONS*
[13] *Senate Supports Interrogation Limits*
[14] *Reaffirmation of the American Psychological Association Position Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and Its Application to Individuals Defined in the United States Code as "Enemy Combatants"*
[15] *Interrogation of Detainees: Overview of the McCain Amendment*
[16] *Open Letter to Sharon Brehm*, President of the American Psychological Association
[17] *Psychologists group still rocked by torture debate*
[18] *Collective Unconscionable*

treatment, and punishment. If the APA was to end their relationship with the United States Army, the financial repercussions would be grave.

Physicians for Human Rights-Israel (PHRI) states in their paper "*Physicians and Torture-The Case of Israel*"[19] that the Israeli Medical Association (IMA) was far too lenient in their definition of torture and other cruel, inhuman, degrading treatment, and punishment. Much like the APA the IMA had financial interests in maintaining a bond with the Israeli Security Agency (ISA, formerly known as GSS, General Security Service). Although the IMA board has on several occasions promised PHRI to change the policy which policy into more specific terms, these changes remain to be seen. PHRI believes that all physicians in Israel should take a stand against any form of torture and other cruel, inhuman, degrading treatment, and punishment since physicians in Israel, like in the US, "*do not face any threat to their lives.*" [18]

Death threats or not, it is unacceptable for any health professional to be involved in the custom of torture and other cruel, inhuman, degrading treatment, and punishment. There are many international guidelines that are very specific on what the position of health care personnel should be.

Part 3: Ethical Guidelines

Many large medical organizations have created several guidelines for health professionals to follow regarding torture. It is particularly important to demonstrate the existence of these guidelines after having seen the policies that are applied by the APA, an internationally-recognized organization, or the IMA, a national medical association.

International Protocols, Declarations, Recommendations and Resolutions

All organizations and institutions all over the world should prohibit any participation in torture and other cruel, inhuman, degrading treatment, and punishment. It is not uncommon to adopt guidelines from the World Medical Association (WMA), since they were among the earliest health care organisations to create protocols for health professionals in torture-related situations. The WMA is, however, far from the only group to have addressed the subject.

The Tokyo declaration from 1975[20]

This declaration is aimed specifically at medical personnel, and condemns all actions that could passively or actively harm a client. The World Medical Association adopted the Tokyo declaration during their 29th assembly in Tokyo in 1975. The declaration was revised pending the 170th and the 173rd WMA council session in France in 2005 and 2006.

[19] *PHYSICIANS AND TORTURE - THE CASE OF ISRAEL*
[20] Tokyo declaration

The Istanbul protocol[21]

The Istanbul Protocol is a manual created to assist in the research of accusations of torture. The steps mentioned in the protocol are intended to assist in the gathering of evidence, as well as showing how to report any findings. The Istanbul protocol became a UN official document in 1999.

The Istanbul Protocol was drafted by more than 75 experts in law, health, and human rights during three years of collective effort involving more than 40 different organisations, including The International Rehabilitation Council for Torture Victims. The extensive work involved in creating this document was initiated and coordinated by the Human Rights Foundation of Turkey (HRFT) and the Physicians for Human Rights USA (PHR USA).[22]

Nurses' Role in the Care of Detainees and Prisoners (Policy of ICN)[23]

The International Council of Nurses (ICN) is a federation with 124 local nurses' associations worldwide. They endorse the 1948 Universal Declaration of Human Rights, and the 1949 Geneva Convention. The ICN position is that the primary concern for a nurse is the patient who needs nursing.

Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment [46]

The High Commissioner for Human Rights points to six principles that physicians should follow at all time.

Recommendation Nº R (98) 7 concerning the Ethical and Organizational Aspects of Health Care in Prison[24]

The Council of Europe made a list of recommendations which overall addressed the responsibilities of health care professionals to act in accordance with international law.

World Medical Association Declaration Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment[25]

This policy details which rights and duties can be expected from a medical doctor in a torture related situation. It is also reaffirmed that there is never any excuse for violating human rights.

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[21] Istanbul protocol
[22] *Izmir Treatment and Rehabilitation Centre*
[23] *Nurses' Role in the Care of Detainees and Prisoners*
[46] http://www.unhchr.ch
[24] *Recommendation No R (98) 7 concerning the Ethical and Organisational Aspects of Health Care in Prison*
[25] *World Medical Association Declaration Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment*

World Medical Association Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment[45]

The WMA asks health professionals to report cases of torture as well as to report individual health care personnel involved or affiliated with torture. It also calls for health care professionals to avoid any affiliation with torture.

Part 4: Grassroots Fight Against Torture

The Medical College in Chile, and Its Struggle for Human Rights

The Chilean Medical College can serve as an example of a medical institution that fights, both historically and presently, for human rights. Unlike the APA and IMA, this does not depend on the severe threats that has been given to the people involved in the struggle. Chilean Interior Minister writes that from the 11th of September 1973 until the 10th of March 1990, no less than 28,459 persons were victims of political imprisonment or torture in Chile. Of these 1, 244 were younger than 18, and 176 were younger than 13[26]. The period from 1973 till 1990 was marked by the dictatorship of Pinochet, the commander of the Chilean army and leader of a rebellion that took control of the country[27]. The numbers of victims during this period was likely much higher than reported, since the police that helped gather this information also worked for Pinochet during his dictatorship The police's affiliation with the dictatorship may have scared many from sharing their experiences.

The Medical College of Chile (MCC) is, like the Turkish Medical Association (TMA), willing to use their influence to change the behavior of their members. The MCC did, and the TMA do, stress human rights and proper medical ethics in societies where opposing the authorities could hold grave outcomes on the lives of the protesters. The MCC has already expelled Dr Vittorio Orvieto Tiplitzky in September 2005, Dr Hernán Horacio Taricco Lavín in 1989, Dr Osvaldo Leyton Bahamondes in 1991, and currently Dr Pedro Valdivia Soto is under investigation. The four doctors have been expelled, or are under investigation, due to their complicity in the kidnapping and murder of Manuel Leyton.

The first of the four doctors involved in this particular case was expelled from MCC as early as 1989, and though it has taken some time, the effects of the MCC policy can now be seen to have an influence on the Chilean legal system. On the 24th of July 2007, Chilean Judge Alejandro Madrid started the process of prosecuting 13 health professionals, doctors and nurses, for their involvement in the murder of Manuel Leyton[28]. All of the above-mentioned doctors form

[45] *World Medica Association Resolution on the Responsibility of Physicians in the Ocumentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment*
[26] *COMISIÓN NACIONAL DE PRISIÓN POLÍTICA Y TORTURA*
[27] *Key Dates in Gen. Augusto Pinochet's Career*, THE ASSOCIATED PRESS
[28] *Prisioneros de guerra fach*, CRONOLOGÍA Nº 96

a part of the implicated 13, as well as the chief nurse of the Londres clinic Eliana Carlota Bolumburu Taboada, that has now been expelled from the Chilean College for Nurses[29].

In Chile and Turkey it was the medical associations that drove the legal system into taking action. In South Africa it was, to the contrary, a grass-root movement of health professionals, who, with the help of the court, in the end forced the national medical association to take action against two of their members. The two health professionals were Doctors Benjamin Tucker and Ivor Lang, both accomplices to the death of Stephen (Steve) Bantu Biko.

The South African Medical Association and the case of Steve Biko

Trial two of doctors

October 1985, during the Steve Biko trial:
"*Kentridge: The fact that Mr. Biko was in chains was not mentioned until your fourth affidavit. Didn't you think it necessary to mention that in your original report?*"
"*Lang*: *No. I didn't mention it. Biko was still lying on the mat chained by his one foot. I cannot remember whether Biko was handcuffed, I was not told that Biko had been violent again.*"[30]

Steve Biko was a human rights activist working against the South African apartheid, and he died while being in detention in 1977. Dr. Tucker and Dr. Lang both stated that the physical condition of Steve Biko was good enough to allow a transport from Port Elizabeth to Pretoria, some 800 miles away[31]. The doctors were accused of not having performed a proper medical examination, as well as falsifying medical documents.

On the 17th of October 1985, the South African Medical and Dental Council stripped Dr. Tucker of his medical license for three months, and gave Dr. Lang a reprimand. Dr. Tucker was treated harder, as he was the district surgeon, and had been Dr. Langs' supervisor.
The road to the ruling in 1985 was long, and had been pushed forward by both individual health professionals, as well as the South African Supreme Court (SASC). The South Africa's Medical and Dental Council (SAMDC) had first ruled, in 1980, that the two doctors had done nothing wrong, where they henceforth had been excused on all points. This led to a protest to the Medical Association of South Africa (MASA), who retained the verdict by the SAMDC in 1980. The ruling first changed after protests from individual doctors pleading the SASC, who subsequently concurred with the protests, and told the SAMDC to make a new inquiry[32].
In this latter judgment, the ruling changed[33] "*One of the most infamous cases involving inappropriate and negligent care of a detainee by district surgeons was the death of Stephen Bantu Biko*."[34]. The Truth and Reconciliation Commission supported their view by saying that the most common failure of the district surgeons was, in general, a failure to carry out their duties like stated by international guidelines. The reason for this failure to obey the guidelines is

[29] *DECLARACIÓN PÚBLICA: COLEGIO RECHAZA ACTOS ENFERMERA INVOLUCRADA EN CASO LEYTON*
[30] *No. 46- Steve Biko*, Hilda Bernstein
[31] *PRETORIA DOCTOR LOSES HIS LICENSE*, Sheila Rule
[32] *Human Rights and Health; the Legacy of Apartheid*, Science and Human Rights Program
[33] *Institutional Hearing: The Health Sector*,Truth and Reconciliation Commission
[34] *Institutional Hearing: The Health Sector*,Truth and Reconciliation Commission

partially explained by the lack of medical ethics in the general curricula of health professionals, according to the commission.
In the case of Steve Biko, TRC found six points to highlight the failures made by the doctors Tucker and Lang:
"*1) maintain patient-doctor confidentiality norms; 2) treat their patient with dignity and respect; 3) examine the patient thoroughly; 4) record and report injuries accurately; 5) diagnose illnesses and prescribe appropriate medication; 6) register complaints (particularly pertaining to assault and torture*"[35].

A Case Example of Dual Loyalty

In South Africa the district surgeons were expected to assist the police, as well as the prison authorities, on grounds of national security. This, according to the committee of peace and reconciliation in South Africa, is as well what the majority of the district surgeons did[36].

Before the anti-apartheid policy came into force in South Africa, the reality was very different from now, as can be seen from the example of the criminal procedure act number 51 of 1977, in article 294 (whipping of juvenile males), under point 5, where it said that:

"(5) If a district surgeon or assistant district surgeon certifies that the person concerned is not in a fit state to receive the whipping or any part thereof, the person appointed by the court to execute the sentence shall forthwith submit a certificate to the court which passed the sentence or to a court having like jurisdiction, and such court may thereupon, if satisfied that the person concerned is not in a fit state to receive the whipping or any part thereof, amend the sentence as it deems fit."[37].
In other words, in 1977 the South African district surgeon, or the assistant district surgeon, would have to decide if the male juvenile would be able to take a whipping or not. The idea behind this act is of course to insure the survival of the male juvenile, with the help of a health care professional. It does, however, indirectly, promote whipping of juveniles. It is within the context of this sort of reality that many health care professionals find themselves, and it is within this reality that they are expected to take a stand for human rights. This act regarding juvenile whipping may no longer be in use in South Africa, but there are other examples, like the indirect acceptance of torture in the IMA and APA guidelines. However, the medical guidelines are not mandatory. The policy of an organisation will only have an effect on the health care professionals that are actual members. If they never joined, or got ejected, than there is nothing in the guidelines that can stop them.

However, there are directions that, if not followed, are punishable by law.
An example of this can be article 31 of the Third Geneva Convention, that states: *"Medical inspections of prisoners of war shall be held at least once a month. They shall include the checking and the recording of the weight of each prisoner of war. Their purpose shall be, in particular, to supervise the general state of health, nutrition and cleanliness of prisoners and to detect contagious diseases, especially tuberculosis, malaria and venereal disease. For this*

[35] *Institutional Hearing: The Health Sector*,Truth and Reconciliation Commission
[36] *Institutional Hearing: The Health Sector*,Truth and Reconciliation Commission
[37] *South Africa: Criminal Procedure Act No. 51 of 1977,* World Corporal Punishment Research

purpose the most efficient methods available shall be employed, e.g. periodic mass miniature radiography for the early detection of tuberculosis"[38]. The difference between this article, and a general medical policy, is that is applies all over the world, in all detention centers, at all times. Unlike the guidelines of medical ethics, international law has to a far larger extent the power to punish and sentence perpetrators.

Part 5: International Law

Prohibition of torture by International Law

Universal Declaration of Human Rights

After the atrociousness of the Second World War, torture has, for the first time, become part of an international declaration. Therefore, the ***Universal Declaration of Human Rights*** (UDHR) states, in its article 5, that *"No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment"*[39]. After the UDHR of 1948, there was a codification process of torture, reflecting a global concern for condemning this practice.

European convention

The first regional treaty to denounce torture was the ***European convention*** of 1950[40]. According to article 3, "*No one shall be subjected to torture or to inhuman or degrading treatment or punishment.*" The European Convention is also the only one to allow an individual to take a state party to court.

International Covenant on Economic, Social and Cultural Rights

At the international level, soon after 1948, the United Nations apprehended the need to slot the Human Rights, mentioned in the UDHR, into an enforceable international instrument. Facing the difficulty to create a single treaty that would include the 30 articles of the UDHR, the General Assembly ended up adopting two distinct covenants in 1966: the ***International Covenant on Civil and Political Rights***, and the ***International Covenant on Economic, Social and Cultural Rights*** (***ICCPR***) that both came into force in 1976. The two covenants were made separately, so to bypass the problem of differing perceptions expressed by the involved states. This way, states with different concepts of for instance economic rights could still agree on political issues, and sign a covenant. ICCPR devotes its article 7 to the prohibition of torture, saying that: "*No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.*"[41]

[38] *Geneva Convention relative to the Treatment of Prisoners of War*, Article 31
[39] *Universal declaration for human rights*
[40] *European convention*
[41] *UN covenant on civil and political rights*

UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

The ***UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*** (***UNCAT***) came into force in 1987. Ratified by 144 states, the UNCAT is the first international treaty entirely devoted to the prohibition of torture, which expresses the increasing international concern for this topic. In Article 2 it states that:
"1. Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.
2. No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.
3. An order from a superior officer or a public authority may not be invoked as a justification of torture."[42]

Special Rapporteur on Torture and other Conventions

The UN appointed a special rapporteur on the issue of torture, in order to look at all questions regarding this topic. This special rapporteur has a mandate for all countries.

Several other specialized international conventions mention the prohibition of torture, like the ***Convention on the Rights of the Child***, in its article 37[43].

Humanitarian Law and Geneva Conventions

Torture is banned at all time, and there are no exceptions, since Humanitarian Law also covers the topic. The ***Third Geneva Convention relative to the Treatment of Prisoners of War***, that came into force on the 21st of October 1950, states in its article 17, that "*No physical or mental torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever. Prisoners of war who refuse to answer may not be threatened, insulted, or exposed to any unpleasant or disadvantageous treatment of any kind*"[47].

What can be concluded from the different international laws is that it is illegal to perform torture and other cruel, inhuman or degrading treatment or punishment under any circumstance, no matter the location.

General Issues and Problems Related to Torture

There are deeper issues that needs to be adressed in the process of eliminating passive participation in torture. These are systematic, as well as social and juridicial flaws that can be corrected when adressed.

[42] *UN Conventions against torture*
[43] *Convention on the Rights of the Child*
[47] *3 Geneva Convention*

The living conditions of the torture victims

When the interrogation was performed by the state, the victim feels helpless, and may not report the crime to any authority, since this may put the victim into further risk. In Turkey there have been reported cases where physicians were threatened to change documents that indicated torture. When a victim experiences a lack of support from all layers of society, it is easy to give up. It is for this reason there should be centers available for torture-victims, functioning as safehavens.

The negligence by society as a whole

There is an automatic belief that the torture-victim "had it coming", and the flawlessness of the governing state. More information regarding reasons for getting tortured should be easily available to read. Some examples of reasons to torture may be the suppression of political activists, forcing false testimonies on scapegoats, and the threat of torture as a social suppression of an entire population.

Mandatory classes of medical ethics

All faculties related to health profesionnals should have mandatory classes of medical ethics. Then it will be easy for any medical association to exclude a member, since the member knew better than breaching human rights.

Pressure from dual loyalty

Dual loyalty puts an immense expectation on the health care professional to act in accordance with a third party. This paper specifies dual loyalty related to torture, but there are hundreds, maybe thousands, of different situations that might challenge a health care professionals ethical stand. For this reason, any systematic change of procedure that could be done in a medical institution to prevent possible situations of dual loyalty should be taken.

Lack of transparency

All organisations and institutions should have open records at all times. If there is a request to see who worked at a specific time, this information should be made available. That way it would be possible to verify or disprove an accusation from a possible torture-victim. The public should have access to all information related to financial affiliations, work-locations and staff-records.

A problem with torture in general

Torture is often performed under state regulation. That means, like in the South African case, that health care professionals are expected to obey to a third party, and not to the best interest of their patient.This, as was mentioned under the living conditions for the torture-victim, has a grave effect on those that have had their human rights violated. Documents regarding torture is much harder to find, since the government does not want to expose itself as torturous. For this reason it is very difficult to find any records that can reveal torturers. It is for this reason

that the international community should be more involved in the actions of torturous countries, and help the people in the country to change the culture of torture.

The nature of passive participation

Passive participation does not leave any trace, and does not demand any physical involvement. It is for this reason very difficult to trace. If a health care professional sees any indication of this behavior, he or she should inform any authority that might be able to stop it.

Lack of reinforcement in international law

There has not been taken much action on the issue of passive participation, and the only way to change this is a hightened interest from the international court to adress the problem.

Conclusion and Recommendations

What doctors can do

- Be prepared to work in a situation that is highly influenced by a culture of dual loyalty, and always remember the legal duties to their clients as health care professionals, and not to a third party.
- Promote and reinforce human rights by warning international authorities or human rights organisations about any irregularities.
- Demand that all treatment is done withouth a third party in the room (see the Istanbul protocol, for proper procedure[21]).
- Follow at all time the ethical principles designed for health care professionals in both ancient guidelines and modern international law.

What institutions and organizations can do

- Promote transparency in all records.
- Reinforce human rights by expelling and prosecuting members that are proven to be in breach of human rights.
- Stay financially independent from any governmental institution.
- The faculties for health care professionals should provide a class of Human Rights, in order for the future health staff to be more aware about their duties and obligations regarding International Human Rights.
- Work on a clear definition of torture. Not to mistake torture for other cruel, inhuman or degrading treatment or punishment.
- Not use the word torture excessively, since this weakens the meaning.

What International Law can do

[21] Istanbul protocol

- Search and punish examples of passive participation, to reinforce the existing laws.
- Demand more from institutions and organisations, and create a check-list of minimum responsibility.
- Implement preventive systems to search in institutions and organisations for signs of dual loyalty.
- More norms regarding health personnel's obligation to their patients.
- Dual loyalty should not be allowed as an excuse for the participation in torture. Human Rights should be, by nature and in essence, superior to any governmental policy.
- The court should be less lenient with the accused that does not have any hard evidence against them. However, this trend is turning. International courts are starting to take the stand that should there be no evidence to the contrary, it is the victim that should be believed.

What you can do

- Help society to understand the reality of torture by bringing it up in debates.
- Help victims of torture to be reinserted into society by supporting and helping them to give their testimony.

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