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 Guest editorial

# Medical involvement in torture

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In 1988 the Institute of Medical Ethics established a working party to report on Medical Involvement in Torture. Their deliberations were discussed at a meeting held at the Royal College of Physicians in 1991, at which a paper was presented by Professor Robin Downie. In amended form, this is published in this issue of the journal, accompanied by a critique by Professor Richard Hare.

The issues raised by Downie and the working party fell into several clear categories. First, came the difficult task of defining torture. One may start with the simple concept of torture as the deliberate infliction of pain or any other kind of suffering by one individual on another, but, as Downie argues, this takes no account of motive or the question of consent. Hare regards it as 'fruitless' and 'positively confusing' to look for a single definition and suggests that we should rather recognise various forms or degrees of torture, as we do with murder or homicide; it follows that the extent of our condemnation would reflect our view of the heinousness of the act. Anatoly Koryagin, a physician who suffered in detention in Soviet prisons and camps, says we must recognise torture 'as a condition suffered by the victim' as well as 'an action perpetrated by the torturer' (1). In applying Hare's concept of degrees of torture it is therefore necessary to see things from the victim's point-of-view as well; psychological suffering through humiliation, fear, isolation can outweigh pain and physical distress.

That medical involvement in torture should be taken seriously by the profession is supported by two recent publications, the BMA's *Medicine Betrayed* (2) and Amnesty International's *Doctors and Torture* (3). Both record many instances of medical involvement, covering a wide range of complicity. At its simplest it may be attempting to heal the victim after torture. Not a problem, most people would argue, quite properly within a doctor's professional remit. It becomes a problem, however, if a doctor knows or suspects that by treating (or reviving) someone who has been tortured he or she is 'repairing' the victim for further abuse. In such circumstances the doctor often comes to be regarded by the victim as one of the team of torturers. At the other end of the scale is direct involvement, doctors applying torture

themselves, or standing by while it is going on, or devising techniques of torture, both physical and psychological. Commonly, doctors assist the torturers by failing to report the injuries they have found on victims or by filling in false medical certificates. I know of two egregious examples from South Africa. First, after the death in security police custody of Imam Haroon, a respected Muslim leader, a post-mortem examination showed multiple bruises of varying age and a broken rib but the district surgeon attributed death to natural causes (a coronary thrombosis); second, the appalling case of Steve Biko, who died of massive brain injury sustained in police custody, yet the attending doctors, Ivor Lang and Benjamin Tucker, failed to mention his injuries in their reports. Lang, indeed, said he found 'no evidence of any abnormality or pathology' in the dying Biko. (Eight years later Tucker was found guilty of 'disgraceful conduct', Lang of 'improper conduct'; the failure of the South African Medical and Dental Council to take action against these doctors – despite overwhelming evidence of their disgraceful conduct – became a cause célèbre in South Africa. I shall refer later to the need for professional bodies to take the highest possible moral stance when issues of torture arise.)

In the second half of his paper Downie asks whether doctors ever *should* become involved with torture. He concludes that this would be incompatible with 'being a doctor'. Even where there might seem to be justification, for example to prevent an act of terrorism, doctors should desist; their skills must only be used for healing or relieving suffering. A doctor cannot cease to be a doctor while he engages in or connives at torture, and then resume his doctoring role later. Hare, not convinced by this argument, concedes that a doctor might think his duty to be involved in '(supposedly) justified torture' overrode his role-duties as a doctor. He argues that in the real world such situations are highly unlikely to occur. 'In the world as it is, [torture] never will be the right course. Therefore, policemen should not even contemplate it; and the same is even more true of doctors'. He then goes on to admit that, in spite of this, torture *is* practised and doctors *can* get involved. In such circumstances doctors should

'make for themselves some firm rules which they do not depart from', and these should be supported by the governing bodies of their profession.

What rules can doctors make for themselves? Hare suggests they should refuse to treat torture victims until they are free, 'distasteful as this policy may be', and give only such treatment as is for the good of the victim. This presupposes that doctors are able to lay down rules and act by them. Unfortunately, in the sort of societies that practise or condone torture, the voice of a single resistant doctor is unlikely to be listened to, and there are many ways of coercing doctors to carry out the torturers' wishes, either by assisting in their activities or by remaining silent when they should be speaking out.

This brings me to what I see as a major omission in Downie's paper. He has concerned himself only with the ethics of medical involvement in torture from the participant angle. He considers 'involvement' under three headings: attempts to heal the victims; engagement in torture (direct or indirect); and examination of victims knowing that torture will follow. He fails to address 'non-participant involvement' where a doctor knows or suspects that torture has taken or is taking place, perhaps through his position as medical officer to a prison or army service or, even – as once happened to me – through a routine examination of a patient referred for an unconnected illness. What is one's professional duty? Should one protest? Or keep quiet? (My patient begged me not to say anything, terrified that it might lead to further arrest and torture. I kept quiet – and have felt uneasy about it ever since!) Dr Wendy Orr, a district surgeon in Port Elizabeth, most courageously filed an affidavit to prevent police from assaulting political detainees who were under her responsibility. In her affidavit she said 'to stand by and do nothing' would compromise 'my moral beliefs and my perception of my professional responsibility' – a fine courageous statement that brought down the wrath of her employers.

Doctors who have the courage to speak out must be given the strongest possible support from their professional bodies. This has not always been the case. Medical associations in South America, Russia and South Africa have on occasions failed to adhere to internationally agreed statements about medical aspects of torture, the most cogent of which is the World Medical Association's Tokyo Declaration of 1975, and have not always supported brave whistle-blowers. If progress is to be made in reducing the extent of torture, it is essential for official medical organisations to take a firm stand against its use, to encourage doctors to inform them when they suspect it is being applied and to support their protests with full authority, appealing if necessary to international bodies to strengthen their position; above all, they must protect informants against possible recrimination.

Ethical issues in medicine seldom have clear black-or-white, right-or-wrong solutions. In the case of torture we get as close as possible to certainty. The Tokyo Declaration starts off with the sentence quoted by Downie: 'The doctor shall not countenance, condone or participate in the practice of torture ...'. This seems to say it all; but, as Downie and Hare demonstrate in their essays, it isn't quite so simple.

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- (1) Koryagin A. Toward truly outlawing torture [letter]. *Science* 1988; 241: 1277.
- (2) *Medicine betrayed*. Report of a working party of the British Medical Association. London: Zed Books and BMA, 1992.
- (3) Amnesty International. *Doctors and torture*. Paris: Editions La Découverte, 1989.