



Abusing Patients: Health Providers' Complicity in Torture and Cruel, Inhuman or Degrading Treatment

By Joseph Amon

In 2002 Human Rights Watch documented a network of Chinese psychiatric facilities where dissidents were detained alongside the mentally ill. One “patient,” Tan Guihua, was detained on September 12, 1999. She was sent to the Jiaozhou Mental Hospital in Shandong province for supporting and practicing Falungong, a form of spiritual meditation. Because she refused to renounce her beliefs she was repeatedly tortured by medical personnel using electroshock therapy, and was force-fed antipsychotic medicines.¹

The human rights community’s attention to the complicity of doctors and other health workers in torture or cruel and inhuman treatment has generally been focused on cases like that of Tan Guihua and other political prisoners in detention settings. Most notorious was the “Doctor’s Trial” of Nazi physicians at Nuremberg in 1946-47. More recently, the participation of US military psychiatrists and psychologists in “Behavioral Science Consultation Teams” to prepare and provide feedback to interrogators at the Guantanamo Bay detention facility has drawn attention and controversy.

Yet torture and cruel, inhuman, or degrading treatment conducted by medical providers is not confined to political prisoners or counterterrorism efforts. Increasingly, attention has focused on the complicity of medical personnel in such abuses in medical or rehabilitation settings. In healthcare facilities, juvenile detention centers, orphanages, drug treatment centers, and so-called social rehabilitation centers, health providers unjustifiably, discriminatorily, or arbitrarily withhold treatment, or engage in treatment that intentionally or negligently inflicts severe pain or suffering and has no legitimate medical purpose. These actions—and inactions—may be done in compliance with state medical policies, in contradiction to them, or in their absence, but when they do occur they can be described as torture or cruel, inhuman, or degrading treatment (CIDT), in which case both the medical provider and the state must be held accountable.

A precise definition of CIDT has yet to be articulated, but the possibility of CIDT being inflicted in health settings has been clearly anticipated. The International Covenant on Civil and Political Rights (ICCPR), the first international treaty to explicitly address torture and CIDT, provides, in article 7, 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.” Article 16 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), and interpretations by the European Court of Human Rights and the United Nations special rapporteur on torture and other cruel, inhuman or degrading treatment or punishment suggest that, at a minimum, CIDT covers “treatment as deliberately caus[ing] severe suffering, mental or physical, which in the particular situation is unjustifiable.”² The special rapporteur, Manfred Nowak, suggests that CIDT is distinguished from torture in that CIDT may occur out of intentional and negligent actions.³

The ethical guidelines of health providers also uniformly prohibit providers from any form of participation in torture or CIDT. The World Medical Association’s Declaration of Tokyo expressly condemns medical participation in torture, cruel and inhuman or degrading treatment, or “any act to diminish the ability of the victim to resist such treatment.”⁴ The Hippocratic Oath declares that physicians must treat all patients to the best of their abilities, respect patient privacy, and do them “no harm or injustice.”

Despite these declarations and oaths, and calls for a permanent “International Medical Tribunal” to prosecute medical personnel who violate human rights, the complicity of medical providers in torture or CIDT is routinely reported, and states and professional associations have shown little interest in or ability to ensure accountability. Where specific medical practices are questioned, courts have traditionally shown deference to medical “expertise” or been reluctant to evaluate competing claims of appropriate medical practice. International human rights bodies like the European Court of Human Rights have had few opportunities to adjudicate on whether particular acts by medical practitioners constitute torture or CIDT.

What, then, can be done?

Recognize Abuses of Patients as Torture and Cruel, Inhuman, or Degrading Treatment

Human Rights Watch has reported on a wide range of abuses against patients and individuals under medical supervision, including the practice of forcible anal and vaginal exams, female genital mutilation, and the failure to provide life-saving abortion, palliative care, and treatment for drug dependency. While these abuses are sometimes understood as torture or CIDT, too often the denial of care resulting in torture or CIDT is understood more narrowly—both by the human rights community and the medical community—as abuses interfering with the “right to health.” This interpretation puts these abuses within a context of the vast demands upon the state, and undermines the absolute prohibition required of states to prevent and protect individuals from torture and CIDT. Health providers, their respective professional associations, and human rights actors therefore too rarely act forcefully to stop provider abuse and end abusive state policies.

As a first step toward addressing these abuses, human rights advocates and medical practitioners and associations need to recognize how medical provider behaviors and state health policies can constitute torture or CIDT. The following represent just a few examples from Human Rights Watch’s own research.

Forcible Anal and Vaginal Exams

State-sponsored forcible anal exams have been recognized as torture by the United Nations Committee against Torture, and invasive virginity exams have been recognized as torture by the Inter-American Court of Human Rights. Human Rights Watch found that medical providers in Egypt, Libya, and Jordan have engaged in such procedures with impunity.

In Egypt, men arrested on suspicion of engaging in homosexual activity in violation of that country’s legal codes banning “debauchery” are subject to forcible anal exams by physicians. Exams involve anal probing, dilating, and penetration. While prosecutors describe the exams as integral to establishing criminality, examining physicians have admitted that the exams do not determine whether sexual activity took place. In 2003 Human Rights Watch documented the use of such exams by police officials and medical personnel in a report entitled “In a Time of Torture.”⁵ One man, Ziyad, described the humiliation and abuse he suffered during such an exam. Ziyad said that upon entering the examination room the “head man” commanded him to strip and kneel. The man shouted at Ziyad, commanding him to bend over, and to raise his buttocks into the air. While Ziyad cried and protested, the head man and six other doctors forcibly pulled his buttocks apart and examined him using fingers and other objects.

In both Libya and Jordan Human Rights Watch documented how medical providers conduct “virginity exams” without consent. In Libya these took place in “social rehabilitation” centers, where women and girls were detained under suspicion of transgressing moral codes, sometimes indefinitely.⁶ In Jordan Human Rights Watch research found that police referred women, including in cases where no evidence of a crime was present, to medical providers who conducted such tests, upon the request of their families.⁷ In both countries, medical personnel play an indispensable role in establishing these women’s “culpability.” Although they have no medical accuracy, the exams were performed to establish virginity for prosecutorial purpose or to inform the family’s decision on whether to abandon, institutionalize, or harm the woman.

Female Genital Mutilation (FGM)

In 2009 Human Rights Watch found that health providers in Iraqi Kurdistan were involved in both performing and promoting misinformation about the practice of female genital mutilation. FGM is defined by the World Health Organization (WHO) as all practices “involving partial or total removal of the external female genitalia or injury to the female genital organs for non-medical reasons.”

The investigation found that FGM was practiced by midwives, but that its prevalence and harm were routinely minimized by physicians and government medical officials. For example, one physician explained to Human Rights Watch that she counselled patients that “circumcision is nothing; it does not influence life because a woman is sensitive in all her parts.”⁸ Government medical providers routinely told Human Rights Watch that FGM was uncommon—despite surveys finding nearly half of all girls to be circumcised—and promoted false information in media campaigns. One woman told Human Rights Watch that on television “a [government] doctor explained that FGM is normal.... The doctor said, ‘If you do it or not it’s still the same.’”

The UN Human Rights Committee has said that FGM violates protections against torture or cruel, inhuman, or degrading treatment found in the ICCPR. The UN Committee against Torture has repeatedly said that practices such as FGM violate the physical integrity and human dignity of girls and women. In Iraqi Kurdistan, medical personnel are both complicit in action, performing FGM or providing patients patently false information about it, and inaction, failing to halt the practice in their role as government officials.

Drug Dependency Treatment

The withholding of medical treatment for drug dependency and withdrawal has also been identified by some medical professionals and human rights experts and courts as amounting to CIDT. Yet, as with FGM, medical providers often minimize or dismiss the suffering that can result from this denial of care.⁹ Government policies that prohibit effective treatment for individuals who use drugs, and instead endorse forced labor and detention, can meet the specific criteria of torture as set out in article 1 of the Convention against Torture: the intentional infliction of severe pain and suffering by government officials as punishment for addiction, or based upon discrimination due to a characterizing feature (in these cases, drug use).

In China our research has found that alleged drug users could be forcibly confined to drug detoxification centers for up to seven years under administrative law for a single “dirty urine.” As in Cambodia, where we have also investigated government-run compulsory drug detention centers, the purpose of detention is supposedly for “treatment.” Yet there is no need for treatment for many individuals in these centers who are not actually dependent upon drugs, and no treatment available for those who are. In both countries, we found that drug detention centers typically provide neither medicated withdrawal nor evidence-based, effective drug dependency therapy.¹⁰ Instead, individuals in these centers are physically and sometimes sexually abused, and forced to work long hours without pay.

Abortion

Absolute prohibitions on abortion, even in life-saving emergencies, further illustrate the potentially harmful and coercive effects of state medical policies. Nicaragua is one of the few remaining countries in the world where abortion is unlawful under all circumstances, including to save the life of the mother. Human Rights Watch found in 2007 that a blanket ban on abortion (and the criminalization of doctors who perform abortions) results in the denial of life-saving care and avoidable death.¹¹ A physician in Managua told us, “It was clear that [a woman] needed a therapeutic abortion. No one wanted to carry out the abortion because the fetus was still alive. The woman was here two days without treatment until she expelled the fetus on her own. And by then she was already in septic shock and died five days later.”

The Human Rights Committee has found that criminalization of abortion, including in cases of rape, violates the prohibition against cruel, inhuman, and degrading treatment in article 7 of the ICCPR. Some human rights groups have argued that Nicaragua’s enactment of the ban despite forewarning of the law’s detrimental effect on women’s health constitutes intent by

the government to inflict harm for discriminatory purpose—meeting the Article 1 definition of torture.

Palliative Care

In 2009 Human Rights Watch documented the failure of the government of India to take steps to ensure that patients suffering from severe, treatable pain were able to access adequate pain medication.¹² Our report found that fewer than 4 percent of the roughly 1 million terminal cancer patients in India who suffer severe pain every year were able to receive adequate treatment. Even though the majority of patients who arrive at regional cancer centers come at an advanced stage of cancer, and in severe pain, most cancer hospitals have no palliative care departments, do not offer any palliative care services, and do not even stock morphine—globally recognized as an inexpensive and effective drug for pain relief.

HIV and tuberculosis (TB)-infected patients also spoke to Human Rights Watch of the pain they experienced. In the case of one patient we met, TB had infected his spine and caused his legs to twist abnormally, forcing his toes up and causing excruciating pain. Despite the fact that TB requires lengthy, sustained treatment, his doctors prescribed only a weak painkiller and assured him that the pain would subside on its own as his TB improved. The pain continued, unabated, for six months.

The UN special rapporteur on torture recently recognized that outdated and unnecessarily restrictive drug control laws contribute to widespread failures of states to provide pain relief to patients in moderate and severe pain. The special rapporteur further categorized the “de facto denial of access to pain relief, where it causes severe pain and suffering” as CIDT, saying that “all measures should be taken to ensure full access and to overcome current regulatory, educational and attitudinal obstacles to ensure full access to palliative care.”¹³

Empower Medical Providers to Challenge Abusive State Policies

After recognizing the forms of abuse described above—both the specific acts and the denial of care—as torture or CIDT, a crucial next step is eliminating laws and policies that require, condone, or facilitate these abuses. Empowering medical providers and their professional associations to challenge these laws and policies is essential to reform efforts.

Healthcare providers are naturally caught in a difficult bind when there is conflict between their obligations to their patients and abusive laws and policies that restrict their actions. In Nicaragua, as noted above, providers may face criminal charges if they perform life-saving

abortions. In settings with repressive drug laws, medical providers can also be harassed or prosecuted for simply trying to comply with patients' medical needs—whether for pain relief or effective drug dependency treatment.

In Ukraine Human Rights Watch interviewed physicians specializing in drug dependency treatment who had been harassed by drug control authorities. One physician reported, “They inspected me every week. My name was discussed at meetings. They said that I was giving out drugs to drug users... [The] Department for Combating Illegal Drug Circulation told me not to play tricks. They said if they had found any violations, they would have put me in jail.” He said his patients had also been harassed, driving some away from treatment and back to illicit drug use.¹⁴

But laws and policies can also be used as a shield by health providers to evade their responsibility to protect their patients from harm, discrimination, torture, or CIDT. In these cases, outspoken advocacy from professional organizations is critical—to support those providers refusing to be complicit, to shame or stigmatize those who are, and to engage governments in the reform of abusive laws or policies. In advocating against conducting FGM in hospitals in Egypt or virginity exams by physicians in Turkey, advocacy by medical societies has been influential.

At a global level, the World Medical Association has encouraged doctors to “honour their commitment as physicians to serve humanity and to resist any pressure to act contrary to the ethical principles governing their dedication to this task; to support physicians experiencing difficulties as a result of their resistance to any such pressure or as a result of their attempts to speak out or to act against such inhuman procedures.” The organization has also explicitly criticized governments for “any involvement of, or any pressure to involve, medical doctors in acts of torture or other forms of cruel, inhuman or degrading treatment or punishment.”¹⁵ At the national level, healthcare providers and human rights advocates should encourage—and hold accountable—professional organizations to speak out about abusive laws and policies and the ethical and international legal obligations of their members.

Develop Stronger Accountability Mechanisms

Beyond the actions of healthcare providers, other actors—for example, victims, patients' rights, and broader human rights organizations, and the international human rights protection system—must also be empowered to combat abuses occurring in health settings. Prohibitions against torture and CIDT in international human rights treaties open multiple,

largely underused, international avenues of redress for victims of such abuses. In addition, stronger systems of accountability, especially at national and regional levels, that address abusive government health policies should be developed.

The UN Human Rights Committee emphasizes that article 7 of the ICCPR “protects, in particular ... patients in teaching and medical institutions.”¹⁶ The UN Manual on Reporting also notes, “Article 7 protects not only detainees from ill-treatment by public authorities or by persons acting outside or without any official authority but also in general any person. This point is of particular relevance in situations concerning ... patients in ... medical institutions, whether public or private.”¹⁷

Focusing attention on the absolute and non-derogable nature of torture and CIDT in examining health-related abuses strengthens the opportunity for accountability beyond mechanisms related to the right to health. Claims under the Convention against Torture provide aggrieved individuals with a specific forum to seek a remedy; and the treaty obligates states to take specific steps to prevent torture and CIDT from occurring. The Convention against Torture also contains a mechanism to permit the Committee against Torture to investigate systematic torture, and states must submit periodic reports for Committee review. Further, the Optional Protocol to the Convention against Torture (OPCAT) has a Sub-Committee for the Prevention of Torture, which can conduct its own country visits to signatory countries, and mandates that states that adopt OPCAT establish an independent body to monitor places of detention. The Human Rights Committee reviews reports concerning compliance with the ICCPR, including its prohibitions against torture, and the UN special rapporteur on torture is another mechanism to investigate and report on torture and CIDT. Increased recognition of the role of abuses in healthcare settings constituting torture or CIDT contrary to the Convention against Torture and ICCPR provisions therefore opens a range of expanded options for redress available to victims of such abuses.

In addition to capitalizing on the opportunities for redress under international human rights law, victims of health provider abuses also need to have available to them strengthened accountability mechanisms at the domestic level. Professional association ethical codes and state criminal codes should contain explicit prohibitions on the types of practices described above if they do not already, and disciplinary committees and state courts should expand investigatory and prosecutorial capacity to target abuses occurring in healthcare settings or under the supervision of healthcare providers. Additionally, at the regional and international level, state law and health policies that contravene torture and CIDT provisions need to be routinely addressed.

Conclusions

The actions and inactions of health providers—whether consistent with, in conflict with, or unregulated by, state laws and policies—that result in the intentional, unjustifiable infliction of severe physical or mental pain must be recognized, condemned, and combated. Only by expanding recognition of these abuses, engaging in joint advocacy between health and human rights activists, and strengthening accountability and redress mechanisms, will abusive laws and policies be effectively addressed and torture and CIDT in healthcare settings be prevented. Perhaps then, the Hippocratic pledge that providers do no harm or injustice can be realized.

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¹ Human Rights Watch and Geneva Initiative on Psychiatry, *Dangerous Minds: Political Psychiatry in China Today and its Origins in the Mao Era* (New York: Human Rights Watch, 2002), <http://www.hrw.org/en/reports/2002/08/13/dangerous-minds>.

² M. Nowak, “What Practices Constitute Torture?” *Human Rights Quarterly* 28(2006), p. 821, quoting from A. Boulesbaa, *The UN Convention on Torture and the Prospects for Enforcement* (Martinus Nijhoff Publishers, 1999).

³ M. Nowak and E. McArthur, *The United Nations Convention Against Torture. A Commentary* (New York: Oxford University Press, 2008), p. 553.

⁴ Declaration of Tokyo, World Medical Association G.A. Res (1975).

⁵ Human Rights Watch, *In a Time of Torture, The Assault on Justice in Egypt's Crackdown on Homosexual Conduct* (New York: Human Rights Watch, 2003), <http://www.hrw.org/en/reports/2004/02/29/time-torture-o>.

⁶ Human Rights Watch, *Libya – A Threat to Society? Arbitrary Detention of Women and Girls for “Social Rehabilitation,”* vol. 18, no. 2(E), February 2006, <http://www.hrw.org/en/reports/2006/02/27/libya-threat-society>.

⁷ Human Rights Watch, *Honoring the Killers: Justice Denied For “Honor” Crimes in Jordan*, vol. 16, no.1(E), April 2004, <http://www.hrw.org/en/reports/2004/04/19/honoring-killers-o>.

⁸ Human Rights Watch, *Iraq – They Took Me and Told Me Nothing* (publication pending).

⁹ See, for example: Human Rights Watch, *Rehabilitation Required: Russia’s Human Rights Obligation to Provide Evidence-based Drug Dependence Treatment*, vol. 19, no. 7(D), November 2007, <http://www.hrw.org/en/reports/2007/11/07/rehabilitation-required-o>, p. 46.

¹⁰ Human Rights Watch, *An Unbreakable Cycle: Drug Dependency Treatment, Mandatory Confinement, and HIV/AIDS in China’s Guangxi Province*, 1-56432-416-8, December 2008, <http://www.hrw.org/en/reports/2008/12/09/unbreakable-cycle-o>; and Human Rights Watch, *Cambodia – Skin on the Cable* (publication pending).

¹¹ Human Rights Watch, *Over Their Dead Bodies: Denial of Access to Emergency Obstetric Care and Therapeutic Abortion in Nicaragua*, vol. 19, no. 2(B), October 2007, <http://www.hrw.org/en/reports/2007/10/01/over-their-dead-bodies>.

¹² Human Rights Watch, *Unbearable Pain: India's Obligation to Ensure Palliative Care*, 1-56432-555-5, October 2009, <http://www.hrw.org/en/reports/2009/10/28/unbearable-pain-o>.

¹³ Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak to the Human Rights Council, A/HRC/10/44, January 14, 2009.

¹⁴ Human Rights Watch, *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight Against HIV/AIDS*, vol. 18, no. 2(D), March 2006, <http://www.hrw.org/en/reports/2006/03/01/rhetoric-and-risk-o>.

¹⁵ 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, Adopted by the 49th WMA General Assembly Hamburg, Germany, November 1997.

¹⁶ Committee on Economic, Social, and Cultural Rights, General Comment No. 20, UN Doc. A/47/40 (1992), paras. 5 and 7.

¹⁷ E. Rosenthal and C.J. Sundram, "International Human Rights in Mental Health Legislation," *New York Law School Journal of International and Comparative Law* 21/469 (2002), p. 515.