Prevention of Torture and Cruel or Inhuman and Degrading Treatment in Healthcare

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1. INTRODUCTION

Torture and healthcare are – at first sight – contradictory realities. In healthcare sick, wounded and vulnerable people are given attention, treatment and safety, while in torture human beings are intentionally submitted to cruelties and methods to destroy their integrity.

However, over and over in time, healthcare professionals have been complicit in grave human rights violations voluntarily or under pressure, for instance by lending their expertise to torture methods. This was and is a gruesome reality, especially since health professionals are in positions, where they are often the first, or even only one to notice and witness torture or maltreatment, being in the position to document these human rights violations authoritatively.

Increasingly medical expertise has been developed and made available for the investigation of human rights violations. Internationally accepted authoritative protocols have been developed for the investigation and documentation of extra-judiciary killings (Minnesota Protocol)[1] and the investigation and documentation of torture (Istanbul Protocol)[2]. Medical expert

1 »Minnesota Protocol«, ST/CSDHA/12, 1991.

2 »Istanbul Protocol«, HR/P/PT/8/Rev.1, 9 August 1999. Frewer et al. (2009).

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opinion in human rights court rulings have increasingly proven to be instrumental in establishing the body of evidence.

Recent research, documentation and developments in international human rights law have shown that torture and/or cruel and inhuman treatment in (within the context of) healthcare occur on a daily basis and at a disquieting level. The human rights debate, stimulated by research, jurisprudence and reports of Special Rapporteurs have made it clear that application of the definition of torture and/or cruel or inhuman and degrading treatment on healthcare is appropriate and expedient. And this is a huge challenge to health professionals: How can they make sure to be part of the solution rather than to be part of the problem?

This paper discusses the 2011 campaign »Stop Torture in Health Care«, focusing on the denial of access to adequate pain treatment, forced and coerced sterilization of women and the detention of drug-users in lieu of adequate treatment. A number of examples is described where medical knowledge is abused, leading to large-scale ill-treatment or torture, and an example is given how medical knowledge can be decisive in human rights court cases to prove torture and/or ill-treatment. The paper then discusses the 2013 report of the Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment »Torture in healthcare settings« and the reactions this report aroused (mainly from organizations of health professionals). The problem of »torture language« in healthcare is discussed and the »dual loyalty concept« is presented. The paper ends with a challenging question: In what extent (and how) does the problem of torture in healthcare setting apply in healthcare settings at home (outside institutions), where volunteers and family members are involved?

2. CAMPAIGN »STOP TORTURE IN HEALTH CARE«

In 2011 a coalition of organizations, including the International Federation of Health and Human Rights Organizations (IFHHRO)[3] launched the campaign »Stop Torture in Health Care«. Although aware of the fact that torture and/or cruel or inhuman and degrading treatment may occur in all sectors of healthcare, the campaign highlighted three areas: (1) inaccessibility

3 See Homepage: www.ifhhro.org.

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of adequate pain treatment, (2) forced/coerced sterilization of women and (3) detention of drug users in lieu of adequate treatment.

2.1 The Right to Access to Adequate Pain Treatment

The International Association for the Study of Pain started to frame the problem of unrelieved pain as an ethical and legal problem in 2004,[4] and formulated its »Montreal Declaration«[5] in 2010:

»[…] recognizing the intrinsic dignity of all persons and that withholding of pain treatment is profoundly wrong, leading to unnecessary suffering which is harmful; we declare that the following human rights must be recognized throughout the world:
Article 1. The right of all people to have access to pain management without discrimination.
Article 2. The right of people in pain to acknowledgment of their pain and to be informed about how it can be assessed and managed.
Article 3. The right of all people with pain to have access to appropriate assessment and treatment of the pain by adequately trained health care professionals.«

The problem of inaccessibility of adequate pain treatment was extensively researched and mapped by Human Rights Watch. Their global research showed that in the vast majority of countries worldwide, access to adequate pain treatment is totally inadequate. In its report »Please do not make us suffer anymore«, Human Rights Watch describes the »pain treatment gap«, with the following background figures:

»[…] approximately 80 percent of the world population has either no or insufficient access to treatment for moderate to severe pain and tens of millions of people around the world […]. Approximately 89 percent of the total world consumption of morphine occurs in countries in North America and Europe. Low and middle income countries consume only 6 percent of the morphine used worldwide – while having about half of all cancer patients and 95 percent of new HIV infections. Thirty-two

4 Brennan et al. (2007).
5 IASP (2010).

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countries in Africa have almost no morphine distribution at all, and only fourteen have oral morphine.«[6]

The Human Rights Watch report shows that in 2009 the number of patients in need of opioid treatment was in many countries extremely low, in many cases below 1%. The figures are based on an estimate by Foley et al. that 80% of terminal cancer patients and 50% of terminal AIDS patients will require an average of 90 days of pain treatment with 60 mg to 75 mg of morphine per day These figures, applied on country estimates obtained from website of the International Narcotic Control Board and projections for annual cancer and AIDS deaths based on cancer and AIDS mortality figures reported by the WHO, provide horrific figures of the extreme »pain treatment gap« in many countries.[7]

Table 1: Morphine estimates, mortality and pain treatment need

Country	Cancer Deaths 2002 Estimate	AIDS Deaths 2005 Estimate	# of Individuals expected to need Pain Treatment in 2009	Estimate total morphine need in 2009 (kgs)	Estimate of morphine need provided by country to INCB for 2009 (kgs)	# of Individuals estimate is sufficient for	% of those needing treatment who would be covered by estimate
Benin	13,490	9,986	15,786	96	0.5	83	0.50
Senegal	17,625	5,432	16,816	102	0.6	99	0.60
Rwanda	14,196	21,956	22,335	136	0.8	132	0.60
Gambia	2,395	1,430	2,631	16	0.18	31	1.20
Bhutan	727	>10 per 100,000	582	3.5	0.08	14	2.30

6 Human Rights Watch (2009).

7 Lohman et al. (2010).

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Burkina Faso	23,262	13,067	25,143	153	0.05	8	0.03
Eritrea	6,240	5,959	7,972	48	0.075	12	0.15
Gabon	2,071	4,457	3,886	24	0.088	14	0.40
Swazi Land	1,837	17,577	10,258	62	0.5	82	0.80
Egypt	62,299	>10 per 100,000	49,840	303	10	1,646	3
Philip-pines	78,500	>10 per 100,000	62,800	382	31	5,103	8
Kenya	50,809	149,502	115,398	701	30	4,938	4
Russian Federa-tion	21,7696	N/A	174,157	1,058	200	32,922	15
Mexico	92,701	6,321	77,321	470	180	29,630	38

Source: Lohman et al. (2010)

2.2 Non-accessibility of Adequate Pain Treatment: Violation of the *Right to the Highest Attainable Standard of Health* (»the Right to Health«)

The human right to health is recognized in numerous international instruments, including the Universal Declaration of Human Rights, Article 25:

»Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services […]«.

The relevant General Comment No. 14 of the Committee on Economic, Social and Cultural Rights elaborates extensively on Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR),

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which provides the most comprehensive article on the right to health in international human rights law:

»States parties recognize ›the right of everyone to the enjoyment of the highest attainable standard of physical and mental health‹«, and »enumerates […] a number of ›steps to be taken by the States parties ... to achieve the full realization of this right‹.«[8]

Besides the General Comment, the right to health is also based on Article 24 of the Convention on the Rights of the Child (CRC); Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); Article 5 of the International Covenant on the Elimination of Racial Discrimination (ICERD); Article 25 of the Convention on the Rights of Persons with Disabilities (CRPD); and Article 28 of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW). In addition to the international standards, the right to health is recognized in various regional human rights treaties.

The right to health includes freedoms (e.g. from torture and cruel or inhuman and degrading treatment) and entitlements and ascertains in the »triple A« (availability, affordability, accessibility) and »Q« (quality): the availability of functioning public health and healthcare facilities, goods and services, as well as programmes, the accessibility (non-discrimination, physical accessibility, economic accessibility or affordability, and information accessibility), and accessibility (cultural and gender), as well as quality.

The State (the accountable party) has specific legal obligations (trias: the obligations to respect, to protect and to fulfil), and the obligation to immediately implement the core obligations and ensure the progressive realization of the right to health.

Among the core obligations is the provision of essential drugs, as defined under the WHO Action Programme on Essential Drugs.[9] This »essential medicines list« includes opioids and other pain medication. Non-accessi-

8 E/C.12/2000/4, 11 August 2000, para. 2.

9 WHO (1998).

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bility of opioids is therefore a violation of a core obligation under the right to the highest attainable standard of health.

2.3 Denial of Access to Pain Treatment: Violation of the Right to be Free from Torture and/or Cruel or Inhuman and Degrading Treatment

In January 2009, the then Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment Manfred Nowak, wrote in his report to the Human Rights Council that: »the de facto denial of access to pain relief, if it causes severe pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment.«[10] This first time application of the torture framework on healthcare settings by the Special Rapporteur was a major step forward in international law. The present Special Rapporteur on torture and cruel, inhuman and degrading treatment Juan Mendez reiterated this position is his report to the General Assembly of the UN of February 2013:

> »failure to ensure access to controlled medicines for the relief of pain and suffering threatens fundamental rights to health and to protection against cruel, inhuman and degrading treatment.«[11]

Denial of access to adequate pain treatment and failure to ensure access to controlled medicines for the relief of pain are thus a two-sided or two-level violation of international law (the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. The *jus cogens* character of the right to be free from torture and/or cruel or inhuman and degrading treatment gives the struggle for the right to access to adequate pain treatment urgency and high profile.

A major cause of the inaccessibility of adequate pain treatment is the dominant »war on drugs« component in the control of illicit drugs and substances. The International Narcotic Control Board (INCB) controls the amount of »illicit substance« that individual countries are allowed to use for the procurement of opioids. The same agency is also the world body

10 A/HRC/10/44, 14 January 2009, para. 72.

11 A/HRC/22/53, 1 February 2013, para. 56.

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controlling »illicit substances« that are used for the illegal trade in drugs (the »war on drugs«). This dual responsibility, namely to wage the »war on drugs« and at the same time to make sure that opioids are available in sufficient quantity for every person in need of pain control, has proven to be a very difficult, if not impossible combination. The Special Rapporteur on the right to health has repeatedly criticized this mechanism for the provision and control of opioids.[12]

During the campaign »Stop Torture in Healthcare« a conference was held in the Netherlands, co-hosted by the International Federation of Health and Human Rights Organizations, the International Association for the Study of Pain and facilitated by the Open Society Foundation, where international pain and palliative organizations, human rights organizations and organizations of health professionals discussed on the right to access to adequate pain treatment and prepared a draft resolution for the World Medical Association (WMA). The resolution was adopted by the WMA on 11 October 2011 during its 62th session in Montevideo, Uruguay. The WMA is the world body of physicians, and represents almost all doctors in the world. The resolution recognizes the right to

> »[…] access to pain treatment for all people without discrimination«, emphasizes that »[…] physicians and other health care professionals have an ethical duty to offer proper clinical assessments to patients with pain and to offer appropriate treatment« and recommends that »[…] instruction on pain management, including clinical training lectures and practical cases, should be included in mandatory curricula and continuing education for physicians and other health professionals« and that »[…] government should provide the necessary resources for the development and implementation of a national pain treatment plan, including a responsive monitoring mechanism and process for receiving complaints when pain is inadequately treated.«[13]

2.4 Forced/Coerced Sterilization of Women

Not only in history, but still today women are undergoing forced or coerced sterilization. Some are forcibly sterilised, not knowing the procedure, not having been given the opportunity to consent. Others were coerced into

12 Grover (2012).

13 WMA (2011).

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sterilisation by financial or other incentives, denial of medical services, or by being misinformed or otherwise compelled to undergo the procedure. The case of A.S. v. Hungary is a clear illustration of this issue:

»Upon going into labor, Ms. A.S., a member of the Roma community, needed an emergency Caesarian section. Immediately before the surgery, a doctor asked Ms. A.S. to sign consent forms on which the doctor had hand-written a statement that Ms. A.S. consented to a sterilization procedure. Ms. A.S. did not understand the statement or that she had been sterilized until after the operation took place. Her claim of civil rights violations and negligent sterilization was rejected at the local level. In her communication to the CEDAW Committee, it found that the Ms. A.S. exhausted her domestic remedies because under Hungarian law she was unable to appeal this decision to the Constitutional Court given the nature and facts of her case. Hungary was found to have violated Ms. A.S.'s rights to (1) fully informed consent to medical procedures; (2) right to information on family planning; (3) right to appropriate services in connection with pregnancy and the post-natal period; and (4) right to determine the number and spacing of her children, under Articles 10(h), 12 and 16(1)(e) of the Convention on the Elimination of Discrimination Against Women.«[14]

This significant ruling of 2006 on behalf of a victim of forced sterilization before an international body (the Committee on Elimination of all forms of Discrimination Against Women, CEDAW) hold the State responsible for »failing to provide a woman with necessary information and obtain full consent for reproductive health procedures«. The ruling was a milestone and a strong stimulus in the struggle against this form of torture or cruel or inhuman and degrading treatment in healthcare.

In its Position Statement on Forced and/or Coerced Sterilization of 2011, the International Federation of Health and Human Rights Organizations describes the background of the problem:

»A sterilisation procedure performed safely, complying with medical and ethical standards after the full informed choice of the patient is an acceptable option of contraception for people who wish to have no more children.

14 CEDAW/C/36/D/2004, Communication No. 4/2004, 12 February 2004.

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However in recent years, cases of coerced and forced sterilization have been reported in countries across the globe. […] In Africa, recent cases of forced sterilization were documented by the International Community of Women Living with HIV/AIDS. The organisation found that since 2008 women living with HIV/AIDS had undergone forced or coerced sterilization by tubal ligation. Practices of forced and coerced sterilization performed on women living with HIV/AIDS have also been recently documented in Chile, Dominican Republic, Mexico, South-Africa and Venezuela.
In Europe cases of forced and coerced sterilization have been documented against women of ethnic minorities. In 2005, the Czech Ombudsman issued a report in which he reviewed more than 80 allegations of forced and coerced sterilization of women, most of whom are members of the Roma minority.«[15]

In October 2012, the World Medical Association adopted a similar position statement in its Statement on forced and coerced sterilization in Bangkok.[16] The International Organization of Gynaecologists and Obstetrics also adopted ethical guidelines in accordance with human rights provisions.[17]

2.5 Detention of Drug Users in Lieu of Adequate Treatment

»A new report from UNAIDS,[18] the United Nations program on HIV/AIDS, estimates that in 2014 – the last year for which the agency has data – about 450,000 people were being held in centers in China and other countries in Southeast Asia. These centers are supposed to provide treatment for people who use drugs, although their ›treatment‹ consists primarily of arduous physical exercises and military-like drills. Former detainees also describe sadistic violence – being shocked with electric batons, whipped with twisted electrical wire, beaten, and being chained while standing in the sun.«[19]

Stigmatization and criminalization of drug-users has led in many countries to inhuman treatment of drug-users. Instead of providing state-of-the-arts

15 IFHHRO (2011), 2.
16 WMA (2012).
17 FIGO (2012).
18 UNAIDS (2016).
19 Pearshouse (2016).

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treatment, they are committed to detention facilities where they are forced to slavery-like working conditions, and where adequate medical treatment is withheld or absent.

Such practices are deeply in contradiction with medical ethics and international guidelines. In the International Federation of Health and Human Rights Organization's position statement:

»The medical community has recognized that ›treatment of addiction, like treatment for any disease or condition, should be undertaken in the best interests of the patient and according to established principles of medical ethics.‹ Drug therapy should be administered according to professional guidelines and supervised by specially trained physicians. Community-based services such as substitution therapy are recognized as effective, evidence-based rehabilitation and treatment strategies. Such services also decrease the risk of HIV transmission.
The human rights of individuals who use or are addicted to controlled substances should always be respected, including the right to the highest attainable standard of health and freedom from discrimination, arbitrary detention, torture and cruel, inhuman or degrading treatment. They have a right to equitable access to medical treatment and allied rehabilitation services in accordance with generally approved medical principles.«[20]

2.6 Abuse of Medical Expertise

Medical skills and knowledge has been (and is being) abused on a large scale (see also the chapter on Dual Loyalty). Participation in torture is perhaps the most pervasive and disturbing practice. The UN 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 are very explicit in the prohibition of such participation, even under pressure. This is mentioned in principle 6: »There may be no derogation from the foregoing principles on any ground whatsoever, including public emergency.«[21]

Doctor's complicity in torture and ill-treatment has been described many times, for example in the USA, where Iacopino et al. found that

20 IFHHRO (2011), 2.

21 A/RES/37/194, 18 December 1982.

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»medical personnel neglected and/or concealed medical evidence of intentional harm«.[22] Physicians for Human Rights investigated and documented complicity of psychologists in interrogation techniques amounting to torture.[23]

This article does not allow to mention all examples of medical complicity in torture and/or ill-treatment. However, I will mention two examples of initiatives from »medical side« that help to expose abuses of »medical expertise« which are completely unfounded and amount to torture: virginity testing and rectal examination to »prove homosexual intercourse«.

The International Forensic Expert Group published a statement on virginity testing:

»The practice of forcibly conducting virginity testing to determine whether a woman is still a virgin is a clear human rights violation that is likely to leave the victim with significant physical and psychological scars, and constitutes ill-treatment and possibly torture says the Independent Forensic Expert Group (IFEG).«[24]

Despite the illegality of the practice in many states and the clear violation of international human rights standards, women around the world are still forced to undergo virginity examinations. Recent cases in Indonesia, Egypt and Afghanistan confirm the continuing use of this practice.

»The expert opinion concludes that ›forcibly conducted virginity examinations have no clinical or scientific value and constitute cruel, inhuman and degrading treatment, and may amount to torture depending on the individual circumstances‹. ›Virginity examinations are medically unreliable and inherently discriminatory‹, states the IFEG. […] According to the experts, due to its invasive and sexual nature, forcibly conducted virginity testing is likely to cause severe and lasting psychological symptoms and disabilities that remain over time.«[25]

22 Iacopino/Xenakis (2011).

23 See http://physiciansforhumanrights.org/issues/torture/us-torture/ [27.03.2017].

24 IRCT (2012).

25 Ibid.

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The same International Forensic Expert Group published an expert statement on forced rectal examination with suspects of homosexuality in countries where homosexuality is criminalized. The statement

»strongly condemns the practice of anal examinations in cases of alleged homosexual activity. The statement categorically asserts that forcibly conducted anal examinations are medically and scientifically worthless in establishing whether consensual anal intercourse has occurred and that the practice constitutes cruel, inhuman and degrading treatment and possibly torture […] anal examinations to ›detect homosexuality‹ have no scientific value, are unethical, and constitute cruel, inhuman and degrading treatment and possibly torture. Sexual identity and orientation is not a disease or a crime and health professionals have no business diagnosing it or aiding State officials in policing and punishing people on the basis of their sexuality.«[26]

2.7 Forensic Evidence in Exposing Ill-treatment

The opposite of the above mentioned examples is the use of medical knowledge in court cases where human rights violations have to be established. Perhaps the best known examples are those where the Istanbul Protocol has been used. This UN Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[27] was written by medical and legal experts in 1999 and has been an authoritative instrument in numerous court cases.

Medical expert opinions can make a substantive and decisive difference in human rights court cases. An illustrative example of a court case where a State has been held accountable for gross medical negligence is the case of Valentin Câmpeanu v. Romania.

»On 17th July, 2014, the European Court of Human Rights (ECHR) held the Romanian government accountable for violating the human rights of Valentin Câmpeanu, a youth with severe mental disabilities and HIV positive, who died in 2004. Abandoned at birth, he lived in public institutions all his life. When he turned eighteen, he was shifted to a social care home for adults, and afterwards, to a mental hospital. Here, left in isolation, and in the cold, without necessary health care and treatment,

26 IRCT (2016).

27 United Nations (2004).

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and deprived also of food and proper clothing, he died within seven days. […] This case is a groundbreaking disability rights case concerning both access to justice for individuals with disabilities and also, their ill-treatment in long-term stay institutions. The decision shines a light on the plight of people with disabilities who face institutional abuse and are particularly vulnerable since due to their disability they are often unable to complain or seek judicial remedies to ameliorate their situation. The decision will impact legal systems across Europe as the ECHR has held that NGOs can represent people with disabilities who died due to violations of their rights, when there was no one else to seek justice on their behalf.«[28]

The European Court of Human Rights ruling[29] extensively quoted the expert opinion end relied on the medical expert's conclusion of gross medical negligence.[30]

3. THE 2013 REPORT OF THE SPECIAL RAPPORTEUR ON TORTURE AND CRUEL, INHUMAN AND DEGRADING TREATMENT AND PUNISHMENT

This report to the General Assembly in January 2013 by the Special Rapporteur on Torture and cruel, inhuman and degrading treatment and punishment[31] Juan Mendez is generally viewed as a most comprehensive and authoritative »milestone« report on torture and cruel or inhuman and degrading treatment in healthcare setting. The report applies the torture framework systematically on healthcare settings and provides clear and far-reaching recommendations. It has also raised questions and reservations, notably from the health sector and organizations of health professionals, and has raised fierce debate on some crucial elements in the report such as the absolute ban on seclusion and restraint. Mendez has

28 ECHR: »Case of Centre for Legal Resources on Behalf of Valentin Câmpeanu v. Romania« (GC), Judgement 17 July 2014, No. 47848/08.

29 Ibid.

30 IRCT (2014).

31 A/HRC/22/53, 1 February 2013.

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»[…] examined the key elements of the definition of torture and ill-treatment and its applicability to the abuses in health-care settings« and found that »[…] the application of the criteria of severe pain or suffering, intent, and involvement of a public official or other person acting in an official capacity, by consent or acquiescence to abuses in health-care settings, is relatively straightforward and that the criterion of the specific purpose warrants some analysis.«[32]

3.1 Concerns and Criticism from the Medical Community

Some of the recommendations in Mendez' report that raised fundamental discussions are under the paragraphs 85(e) and 89(b):

»Safeguard free and informed consent on an equal basis for all individuals without any exception, through legal framework and judicial and administrative mechanisms, including through policies and practices to protect against abuses. Any legal provisions to the contrary, such as provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must be revised […] [and] [p]aragraph 89 (b)[:] Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application. The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation […].«[33]

Criticism from the medical community focused on the absolute ban on seclusion and surrogate consent without any exception. In his response of May 2013 to the report of Mendez, the secretary-general of the World Medical Association, Dr. Otmar Kloiber, referring to Recommendation No. 85(e):

»[...] provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must

32 Centre for Human Rights & Humantarian Law (2014), XVI.

33 Ibid., 145.

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be revised.«[34] Furthermore, he emphasizes: »The patient's judgment should be respected in areas where he/she is legally capable of making decisions, unless they present a risk of serious harm to themselves or others. […] If the patient lacks the capacity to make a decision as to his/her medical care, surrogate consent should be sought from an authorized representative in accordance with applicable law.«[35]

In exceptional circumstances, surrogate consent can constitute a medical necessity for the safety of the patient and/or the society. And on the absolute ban on the use of restraint and solitary confinement Kloiber writes:

»[H]ere again, in exceptional circumstances […] restraining the movement of the patients can constitute a medical necessity. Medical ethics principles require the following conditions: ›*(a) a severe mental disorder that prevents the individual from making his/her own treatment decisions; and/or (b) the likelihood that the patient may harm him/her self or others*‹«. He continues: »[…] the recommendations of the report advocate that measures restricting movements of ›persons with psychosocial disabilities‹ should be prohibited. According to us, this affirmation is invalid and risky, in suggesting that the medical necessity never justifies coercive measures. It reflects clear unawareness of the degree of illness of some patients, and an alarming negligence likely to endanger the patient him/herself and others. It also misinterprets the function of doctors as backbone of the health care system and indirectly undermines the expected privileged relationship between physicians and patients based on trust, professionalism and confidentiality. […] More generally, we are concerned that your report generates prejudice and distress on psychiatric services, while supporting the current trend to consider mental disorders, not anymore as real diseases to be treated by psychiatrists, but rather as social deviation or just psychological suffering to be treated by psychologists and other mental health professionals. […] Health professionals work often under very precarious situations. Blaming them for these abuses is unfair and inappropriate.«[36]

In response to the report of the Special Rapporteur, the World Psychiatric Association and the American Psychiatric Association also expressed concern that

34 WMA (2013), 1.

35 Ibid., 2.

36 Ibid., 2–3.

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»the adoption of these perspectives and recommendations may be detrimental to the interests of individuals with serious mental disorders, and likely to cause serious harm to the very groups it intends to protect.«[37]

Mendez responded to these concerns in January 2014:

»[…] I did not mean to propose an absolute ban on non-consensual interventions (including institutionalization and restraints) under any and all circumstances. I meant to restrict my condemnation to non-consensual treatment based exclusively on discrimination against persons with disabilities. In other words, the fact that a person is diagnosed as having a psychosocial disability should not by itself be enough to justify non-consensual treatment. Unfortunately, in many countries that is standard practice, often validated by domestic courts and even by international tribunals (in some decisions that my report criticizes). As you point out, elsewhere in my report (paragraphs 68 and 69) I do mention that involuntary detention and treatment is legitimate if its purpose is to prevent the patient harming him or herself or causing serious harm to others, and then for the limited time and scope necessary to prevent such harm. I firmly believe, however, that legislation should be revised to place the burden on the State to justify each decision to apply non-consensual treatment under such narrow grounds.
I do not doubt that my proposal coincides – in large part, at least – with the highest professional standards of your profession as reflected in the policy statements relevant to this topic that you have attached. My concern is with the many parts of the world where those professional standards are not applied.«[38]

The milestone 2013 thematic report of the Special Rapporteur and the subsequent concerns of and communications with (organizations of) health professionals illustrate the existing and potentially continuing gap between evolving international law (focussed on healthcare) and perceptions and convictions of health professionals. In my opinion, it is of utmost importance to bridge this gap, because of the necessity to have health professionals »on board« in the struggle against torture and cruel or inhuman and degrading treatment in healthcare. Health professionals should be part of

37 Levin (2014).

38 Méndez (2014), para. 32.

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and be perceived as part of the solution rather than (only) be seen as part of the problem.

3.2 The Problem of »Torture Language«

In a substantive and principal contribution »Torture in Health Care Settings: Urgent Issues and Challenging Questions« in the »Reflections on the Special Rapporteur on Torture's 2013 Thematic Report« Yuval Ginbar and James Welsh argue that

»the torture/other ill-treatment legal framework must be applied carefully and precisely, taking into account that the human rights of persons, other than those being treated, may be involved. This requires maintaining openness to the possibility that other legal frameworks for the protection of human rights may at times be better equipped to address certain issues within healthcare settings. It also requires considering the far-reaching legal consequences of a finding of any ill-treatment, particularly torture, in cases where law and professional regulations are being followed. Whereas international law obviously prohibits torture and ill-treatment absolutely and in all circumstances, we are concerned that framing positions on certain measures which are not inherently torturous in absolute terms would not serve the rights of persons with disabilities; nor would linking such sweeping positions to the prohibition on torture and other ill-treatment encourage observance of that prohibition, which is indeed absolute.«[39]

The problem of »torture language« is also acknowledged by Tamar Ezer, Jonathan Cohen and Ryan Quinn in their contribution »The Problem of Torture in Healthcare«, discussing the application of the »torture framework« on healthcare settings: Before applying the norms against torture and cruel or inhuman and degrading treatment systematically to the field of healthcare, it is necessary to review them and consider the similarities and differences between (1) torture; (2) cruel and inhuman treatment; and (3) degrading treatment. This is particularly important because the stigma that results from applying the label of »torture« to acts involving medical professionals can be counterproductive if applied carelessly. Moreover, it is important to recognize that applying a human rights approach focuses atten-

39 Centre for Human Rights & Humantarian Law (2014), 264.

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tion on state responsibility and systemic violations and not on penalizing individual healthcare providers. A useful concept when considering the application of anti-torture norms to the healthcare context is that of dual loyalty, defined as

»simultaneous obligations, express or implied, to a patient and a third party, often the state. Where the interests of the patient and the state are aligned, dual loyalty imposes little risk. Where they conflict, however, this creates potential for abuse, including torture.«[40]

4. THE DUAL LOYALTY CONCEPT

The International Dual Loyalty Working Group, convened by Physicians for Human Rights and the University of Cape Town in 2002, has identified common situations where dual loyalty conflicts arise and has provided recommendations for preventing them.

This working group on dual loyalty was formed after the hearings of the health sector by the Truth and Reconciliation Committee in South Africa, where the dual loyalty problem had become extremely evident.[41]

»This project grew out of a disturbing trend: Governments and other third parties often demand that health professionals put allegiance to their patients aside, in deference to the demands of these powerful actors […]. The report of South Africa's Truth and Reconciliation Commission (TRC) documenting the complicity of health professionals in the apartheid regime, provides a particularly compelling illustration of the problem. […] The report urged the adoption of effective standards of conduct in situations of potential dual loyalty, as well as institutional arrangements and educational programs to ameliorate the problem.«[42]

40 Centre for Human Rights & Humantarian Law (2014), 43.

41 Baldwin-Ragaven et al. (1999).

42 Physicians for Human Rights/School of Public Health and Primary Health Care (2002), 5.

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The project focussed on areas where human rights violations out of dual loyalty are most likely to happen: settings of forensic medicine, prisons, refugees and asylum seekers, the work floor and the military.

The working group identified a variety of situations where medical ethics and human rights were violated in the context of dual loyalty conflicts: using medical skills or expertise on behalf of the State to inflict pain, physical or psychological harm on an individual that is not a legitimate part of medical treatment, participating in torture and punishment, participation of health professionals in administration of the death penalty, participation in forced abortion, sterilization and contraception and other violations of reproductive health rights relating to bodily integrity, degrading physical examinations that violate human rights, such as virginity testing, female genital mutilation, use of chemical and physical restraints and intrusive examinations to enhance security interests of a prison, detention centre, or other institutions, subordinating independent medical judgment, in therapeutic or evaluative settings, to support medical conclusions favourable to the State, limiting or denying medical treatment or information related to treatment to an individual to effectuate policy of the State in a manner that violates the patient's human rights, denial of or restrictions on care based on gender, ethnic or racial discrimination, sexual orientation or immigration status, denial of care for political reasons and during armed conflicts, denial of appropriate care to prisoners, detainees, and institutionalized people, withholding information about health or health services, the special problem of hunger strikers, denial of care because of inequities in healthcare in society, disclosing confidential patient information to state authorities or powerful non-state actor, performing evaluations for legal or administrative purposes in a manner that implicate human rights, remaining silent in the face of human rights abuses committed against individuals and groups in the care of healthcare professionals. The working group has proposed a large number of general guidelines and guidelines tailored to the five fields mentioned above. The size of this article does not allow detailed mention of all guidelines. The working groups also provided institutional mechanisms, varying from national and international legal mechanisms, participation of health professionals in monitoring mechanisms such as shadow reporting to supervising bodies of international covenants, and stressing the importance of a well-functioning, independent, human rights oriented professional organization or association.

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5. CONCLUSION

5.1 The Problem of Domain: What is the Definition of a »Healthcare Setting«?

There is a number of questions in the struggle to end torture and ill-treatment in healthcare settings, namely the definition of »healthcare settings« and »health worker«. In my view, the report of the Special Rapporteur seems to limit healthcare settings to »institutions«, while in reality many healthcare settings can be identified in the community and in private homes. The Special Rapporteur recommends replacement of institution-based care to community based care, but does not extend the prevention of torture and/or ill-treatment to the »non-institution« domain.

In his focus on torture and/or ill-treatment in healthcare settings, the Special Rapporteur writes:

»each State party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions *as well as contexts* where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm.«[43] [emphasis added, A.v.E.]

What these »contexts« are, is not further elaborated. And on potential perpetrators of torture and/or ill-treatment, the Special Rapporteur writes:

»Indeed, the States obligation to prevent torture applies not only to public officials, such as law enforcement agents, but also to doctors, healthcare professionals and social workers, including those working in private hospitals, other institutions and detention centres […]. Here too, there is no elaboration as to whether volunteers and family members involved in healthcare are included in these categories.«[44]

43 A/HRC/22/53, 1 February 2013, para. 23.

44 Ibid., 24.

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In his recommendations, the Special Rapporteur views a shift from »institutions« to »community« as a desirable goal. On compulsory drug detention centres, his recommendation is: »Close compulsory drug detention and ›rehabilitation‹ centres without delay and implement voluntary, evidence-based and rights-based health and social services in the community«.[45] For people with disabilities he recommends:

> »Replace forced treatment and commitment by services in the community. Such services must meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned, with an emphasis on alternatives to the medical model of mental health, including peer support, awareness-raising and training of mental health-care and law enforcement personnel and others.«[46]

I welcome this recommendation wholeheartedly. However, I miss the next step: How to prevent torture and/or cruel or inhuman and degrading treatment in the recommended services in the community? If not specified precisely, the mention of »community services« may well be an empty phrase or a romantic irreality. Obviously, the recommended replacement is not in itself a guarantee for freedom from torture. In many countries such replacements from institutions to community are taking place, not in the least for financial reasons. The result is often home-based care, where healthcare professionals, but also volunteers and relatives are responsible for the (health)care. The question is: Can the torture and ill-treatment concept be applied in those situations as well?

Ill-treatment is often taking place »behind the front-door« of this home-based care. In my own experience as family doctor I have witnesses many cases of ill-treatment »at home« (some of which may even amount to torture) and I have been involved in training courses on awareness-raising of ill-treatment of the (frail) elderly is a prominent issue. I found that even among experienced health workers there is a huge under-estimation of ill-treatment. Estimates in the Netherlands indicate that there are at least 160,000–200,000 cases of ill-treatment of elderly people. Ill-treatment may

45 A/HRC/22/53, 1 February 2013, para. 87(a).

46 Ibid., para. 89(c).

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be physical, psychological, sexual and financial by negligence and/or by deprivation of rights. Ill-treatment of the elderly is defined as

»treatment or neglect of by all persons having (repeated) a personal and/or professional relation with an elderly person, with the result of physical, psychological and/or material damage, and where the elderly is in a state of partial or total dependency«.[47] [translation A.v.E.]

The problem of ill-treatment is severely compounded by the fact that care is often informal (by family or volunteers). When it is a volunteer, or a family member who takes care (at home) of a person with a psychosocial disability, or (notably problematic) dementia, is overburdened and at a time loses his or her temper, this may be a form of »derailed care«, but is it also torture? In its appearance and/or outcome it may well be ill-treatment or even torture. The question then is whether the carer is a torturer, and if so, only in case of intent, or also in case of derailed care?

Is the torture and/or cruel or inhuman and degrading treatment framework applicable to this kind of situations? Does the Convention against Torture extend to the private homes of vulnerable, frail person, of persons with disabilities living at home? How does the urgently needed prevention of torture and ill-treatment relate to the right to privacy? These are, in my view, issues that warrant discussion urgently; they have largely been untouched by the report of the Special Rapporteur and the subsequent discussions.

5.2 Prevention of Torture in Healthcare

The report of the Dual Loyalty working group has published an extensive list of (institutional) mechanisms that can help to promote human rights in healthcare, and monitor human rights violations in healthcare. The mechanisms mentioned are (i.a.): employment relationships structured to avoid role conflicts and reduce interference with professional independence, administrative and legal arrangements to preserve professional independence, establishment of an ethos of peer review, professional credibility, support and inclusiveness in the profession that addresses the problem of dual loy-

47 Ministerie van Volksgezondheid, Welzijn en Sport.

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alty, monitoring, education and training, accountability, collective action by the profession. On monitoring mechanisms, the report stresses that:

»Independent oversight and reporting structures must be established to monitor and respond to practices in the health sector that threaten human rights. These structures should support audit activities undertaken by health professionals and should enable professionals to make independent reports of potential or actual violations of the human rights of patients or other victims. These structures would also have the capacity to refer appropriate cases to professional disciplinary structures […]«.[48]

Monitoring the complicity of health professionals in human rights abuses

»[…] should also be linked to monitoring the underlying human rights violations. Monitoring can take place at the local or national level (by national professional associations, statutory bodies, or human rights organizations) and may often be done as well by international bodies, including United Nations agencies, professional bodies, and human rights organizations.«[49]

In order to make sure that health professionals are part of the struggle against torture and/or ill-treatment in healthcare setting, rather than (only) part of the problem, it is of utmost importance that national (and international) professional organizations are strong and independent, and have a high profile human rights agenda in place. Licensing bodies must also be independent and have human rights provision included in their program and mandate. The organized profession should be part of a larger coalition of organizations that monitors the defense and promotion of human rights. Such coalitions of organizations should provide input to and cooperate with UN Special Rapporteurs (e.g. on Torture and cruel or inhuman and degrading treatment, and on the right to the highest attainable standard of health), cooperate on the production and publication of parallel or shadow reporting to the supervising committees of UN Covenants.

48 Physicians for Human Rights/School of Public Health and Primary Health Care (2002), 88.

49 Ibid.

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An important role for monitoring human rights violations (in Europe) is the European Committee for the Prevention of Torture. In numerous reports the Committee has listed human rights violations.

Also the visits of the Subcommittee for the Prevention of Torture under the Optional Protocol to the Convention Against Torture have contributed to identifying human rights violations. The National Preventive Mechanisms, required under Optional Protocol to the Convention Against Torture, and which have been formed in OPCAT countries in different manners, play (or are supposed to play) an important role. A research project in the Netherlands by the University of Groningen with support of the International Federation of Health and Human Rights Organizations indicated that the National Preventive Mechanisms are still to be improved:

»In terms of mandate, the National Preventive Mechanisms appear to fulfil the requirements, however there are doubts about the independence. In addition, the National Preventive Mechanisms assignment to existing monitoring bodies have not (yet) led to organizational accommodation or change.«[50] [translation A.v.E.]

My conclusion is that the prevention of torture in healthcare settings needs ongoing debate and elaboration both in international human rights law and in the health professional's domain. The application of medical expertise in the defence and promotion of human rights has achieved much, and should continue to be developed further. Existing mechanisms for monitoring human rights violations, including torture in healthcare setting should be utilized much more extensively, notably by health professionals.

50 University of Groningen (2013).

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