Torture has been practised since time began. One might have expected that, with the rise of civilisation, it would have diminished and indeed, legal torture by the state attempting to find the 'truth' in interrogation, was largely abandoned by many countries during the Age of Enlightenment. After the Second World War, state torture was outlawed in most of the world's nations when they signed up to the Universal Declaration of Human Rights and the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. But today, torture has gone underground and is practised, not only to obtain information and confessions, (which are notoriously unreliable), but to terrify and subdue whole populations or ethnic groups (at which it is appallingly successful).1

When questioning is being carried out in police stations, interrogation centres or prisons, officers have an abundance of techniques at their disposal, the origins of some of which are lost in antiquity. An example is falaka, also known as falanga or bastinado, that is beating the soles of the feet. It combines the twin advantages of being exquisitely painful and leaving little visible evidence. Other more modern methods such as electric shocks, usually delivered to sensitive parts such as the genitalia, finger-tips or ear-lobes, also leave little physical evidence. This feature is essential in countries where the victim may be brought before an impartial court or where human rights investigators are active. There are plenty of countries, though, where the torturers have no fear of being stopped. Indeed, in many cases, they try to mutilate their victims as much as possible before dumping them, alive or dead, in front of their home, with the aim of terrorising the population into submission.

Doctors' Involvement

Doctors and other health workers are particularly vulnerable and may become involved in torture in one of three ways. Firstly, they may be called upon by the interrogating officers to advise on techniques of torturing which will inflict the maximum of pain, both physical and mental, without causing death. In several South American dictatorships in the 1970s, doctors were an integral part of the interrogation process. They advised on methods, especially psychological ones and warned the torturers when the victim was nearing death and needed a respite. In the Soviet Union it was assumed, with simple logic, that any person who disagreed with official policy must be mad, and was diagnosed as suffering from 'sluggish schizophrenia'. Such individuals were incarcerated in such notorious psychiatric institutions as the Serbsky Institute. Since the condition was by definition incurable, these victims were doomed to a lifetime of abuse.

Secondly, a doctor who objects to writing false certificates is in danger of himself being detained, tortured and killed, or at the very least, losing his livelihood. Thirdly, guerrillas, outlaws and 'terrorists', by the very nature of their activities, are liable to be wounded and require medical aid. Doctors and other health workers who offer assistance are in great danger. If they refuse, they may be killed by the 'terrorists'; if they give aid, the security forces will soon come looking for them. Many doctors and nurses 'disappeared' in Central and South America after aiding dissidents, but the Vicaria de la Solidaridad in Chile bravely resisted when the authorities tried to seize the medical records of the dissidents they had treated.
Giving assistance to sick or wounded suspects is never easy and the result is that many victims go untreated. At the Medical Foundation for the Care of Victims of Torture in London I have seen a number of Sikhs from the Punjab who claim that after they were released from detention hardly able to walk, they were turned away by hospital doctors because they were 'police cases'.

In 1980 doctors in Syria held a protest strike against human rights abuses. Over a hundred were arrested and remained in prison without charge or trial for up to fifteen years. Many died in prison and those who were eventually released have been unable to resume their careers.

**Doctors in the UK**

While one may admire doctors living under oppressive regimes who have the courage to continue treating victims of torture, and sympathise with those who are unable to resist pressure to participate in abuses, it is easy to conclude that, working in the comfortable atmosphere of a country such as the United Kingdom, there is no need to become involved. This is not necessarily the case. Many doctors, especially those working in the police or prison services or the armed forces, and also casualty officers and general practitioners, will see instances of ill-treatment, if not frank torture. Though all doctors must work within the ethical codes of the profession, it may not be easy for doctors to complain if their immediate boss is a senior army or police officer who works to a different code. Even in democracies, there is continual pressure for the police and others to increase the severity of interrogation of suspects. This is aggravated in situations where there is an actual or perceived 'terrorist' threat. In Northern Ireland in the early 1970s, increasing violence led to the use of interrogation techniques by the British army that bordered on torture. They included hooding, prolonged wall standing, subjection to continuous noise, isolation and sleep deprivation. When the Parker Committee was set up to look into complaints of brutal interrogation, it was only the minority report of Lord Gardiner that prevented such practices from being perpetuated.23

**The after-effects of torture**

A significant percentage of refugees coming to the UK allege that they were tortured in their own country and that may constitute part of their claim to asylum. In the 1970s, the Medical Group of Amnesty International was often asked to examine and treat such refugees. The demands soon became excessive, so at the end of 1985 members set up a separate charity, the Medical Foundation for the Care of Victims of Torture, which has continued to thrive in London. We see over 2,000 new clients each year, using an army of volunteer clinicians as well as paid staff. Though treatment and rehabilitation is the primary aim, there is a growing demand for medical reports to assist asylum claims as well as documentation of torture methods in different countries. We have produced a handbook on the examination of torture victims.4

It is likely that most GPs have one or more refugee on their books, and it is probable that they will not reveal the fact that they have been tortured. They usually present with non-specific symptoms such as headache, backache and sleeplessness. They may suffer panic attacks at the sight of a percussion hammer or syringe. Discreet questioning may reveal the true history but it is often difficult for the survivors to speak of their experiences, especially
if, as is often the case, there has been sexual abuse. Many rape victims have never even told their spouse what happened. Effective treatment is impossible until some idea of the history can be obtained.

Clearly, though London has the biggest concentration of refugees, there are also many in all centres with ethnic groups, so it is not just in London that an organisation such as the Medical Foundation is needed. Many GPs within reach of London show an interest in giving a free weekly session for the stressful but rewarding work of examining, documenting and treating torture survivors. I believe that there is room for one or more centres in Scotland. Anyone interested in forming a nucleus of volunteer doctors could contact the Scottish Refugee Council, 43, Broughton Street, Edinburgh, EH1 3JU, who are at present trying to set something up.

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References