Violence and the ethical responsibility of the medical profession

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Prof. Upendra Baxi, a well known expert on law and a former vice chancellor of Delhi and South Gujarat universities, in his comments on Women's Studies in the ICSSR Newsletter seven years back, made some incisive and disturbing comments on the coverage of violence in social science discourses in India. "Mainstream social sciences in India have altogether ignored the fact that India is a very violent society. There do not exist even pre-theoretical discourses on violence in India. Compared with the practice of violence in India, there is a total denial of discourse on violence." [1]

Health care professionals have fared even worse than social scientists.

The concern for violence is conspicuous by its virtual absence in medical discourses. The special medical needs and rehabilitation of victims and survivors of violence are hardly ever discussed by doctors. Is this because health care workers do not come in contact with the victims and survivors of violence? The answer is a categorical no. Violence invariably inflicts physical or psychological trauma and in any violence, the victims and survivors come in contact with health care workers, the last and extreme contact being established during autopsies on victims of violence. The apathy of medical personnel is all the more disturbing simply because of the many professions in our country, medicine has the greatest claim to nobility, compassion, humanity, rationality and scientific attitudes.

Unlike some extremely backward countries, we have nearly a million (9,27,624 in 1991) formally trained doctors, 42% of whom are trained in modern medicine' - a ratio of one doctor for less than a thousand persons in the country as whole and one doctor for less than five hundred in the urban areas. An estimated 85% of all trained doctors work in the private sector[3]. Yet, the conscious response of the profession to one of the bigger epidemics of violence in recent times in our country has been grossly inadequate. We have either shown plain indifference or clumsy and ad hoc crisis management when faced with violence. This does not auger well for a profession claiming to have scientific basis for its practice. The implied failure in discharging social responsibility raises ethical questions for the profession at large in the country.

Violence and the medical profession

The science of medicine incorporates sociological and epidemiological understanding. Medicine, and for that matter any science, not geared to real social and epidemiological issues loses its humanitarian content.

The violence described and documented by voluntary groups is not that by common criminals. The violence covered here includes the deprivation of human and democratic rights, is associated with social and political mobilisation, is often inflicted on helpless, oppressed, unarmed or innocent persons and has notable ideological underpinnings. There are strong, extreme and sometimes genuine differences within the social groups on the attitude society should take on the subject. One finds strong defenders (and opponents) of third degree methods, an euphemism for torture, almost routinely employed by the police. Similar divergence prevails in debates on caste, communal, gender and other forms of violence.

One's social position and ideological orientation, rather than the fact of the violence and the plight of victims and survivors, seem to determine the stand taken on violence. Of course there is also a big segment that has either become emotionally numb due from excessive exposure to violence or is indifferent as at present it is not directly affected.

Such trends prevail in the medical profession as well. To what extent is the attitude of doctors to violence shaped by their social positions and ideological orientation? There has been very little research on doctors' attitudes on violence and the extent to which individual biases get reflected in medical practice. Some indication on what is happening at the ground level within the profession is available from the recent reports of various local, national and international groups. These reports were prepared for specific purposes and their findings on the acts of commission and omission cannot and should not be generalised. Nevertheless, they do serve as pointers. The few examples given below on post-mortems and torture and rape are purposefully selected by me in order to illustrate issues. I understand that there is always the other side to every story.

(a) Autopsy: The way autopsies are conducted, findings recorded and access to reports denied has been a bone of contention for long. There have been reports in the press about the pressure exerted on doctors by the police to give findings favorable to them. The death of Dayal Singh in police custody made the Resident Doctors' Association of All India Institute of Medical Sciences (AIIMS) protest against such pressure. This is referred to in Amnesty International's (AI) report titled Torture, Rape and Deaths in Police Custody[4]. The autopsy reports on two nuns murdered in a Bombay suburb and the role of doctors in unscientific interpretation of its findings is also fresh in many minds.[5] On study of

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autopsy reports on victims dying in police custody and on so-called deaths during 'encounters' in the past few years, I found several disturbing issues which have grave implications on the unethical behavior of doctors conducting autopsies:

(1) Autopsies are generally conducted by police surgeons in police hospitals to which lay people and other doctors have no access. An independent medical audit of work being done there is unheard of. This situation is neither conducive to good science nor to ethics.

(2) A study of autopsy reports (no such study is available, hence the need for it) of victims of violence would probably show incomplete and unscientific documentation. The Supreme Court had to order, in 1989, that all postmortem examinations held at AIIMS be standardised. On making inquiries I learn that this Court order has remained inadequately implemented.

There is a crying need to adopt (with suitable modifications) the United Nations' manual on the effective prevention and investigation of extra-legal, arbitrary and summary executions.! Such routine, standardised and scientific investigation by the medical profession would go a long way in checking arbitrary killings and in upholding medical impartiality and neutrality'

(3) There is also need to make the whole process more accessible to other doctors and the public. The profession could allow a doctor appointed by the relatives of the deceased to remain present at autopsy. They should make the official report available to the family doctor and the patient's relatives. This is an issue on which the profession can easily assert its authority.

(b) Torture and rape: There have been numerous official denials that the so-called third degree methods of interrogation or torture are practiced by our police and security personnel. The evidence accumulated so far does not support such a claim. Some of the retired police officers, reared in the old school of correct policing, have publicly criticised the 'new methods of policing' which condone the use of torture, illegal detention and tampering with records and in worst cases even condone execution of hard core criminals by police officers[7].

AI's report (1992) cites 13 cases of custody deaths due to torture in the period 1985-89 in Maharashtra. A Bombay newspaper reported a study by the prestigious Karve Institute of Social Work, Pune giving the toll of custody deaths in Maharashtra in 1980-89 as 155[8]. On inquiry I find that of these 155 deaths, 102 had taken place in the five year period 1985-89 for which AI had reported only 13. On analysing the causes of the 155 custody deaths, I find that only 9.7% (15) were admitted as due to police action, 44.5% (69) were attributed to suicide or acts of the accused, 7% (11) to acts of the public, 22.6% (35) to disease and illness. 13.6% (21) were termed natural deaths and in 2.6% (4) the cause was not known or record not available. I was astonished to learn some of specific causes listed: alcohol consumption (9 cases), hanging (45), jumped in well (3), jumped under the train (2), jumped under the awtorickshaw (3), jumped under the bus (1), fell from the cot (1), skin disease (1), giddiness (1), unconsciousness (1) and so on. Given the norm that every death in custody ought to be investigated- and proper autopsy done, such causes are not only incomprehensible but also lead to suspicion about a larger proportion of deaths due to torture.

In an investigation of death in police custody in Bombay, I, along with two journalists and a lawyer, found that the young victim accused of petty theft was in the course of interrogation brought to the hospital in a serious condition with, as per hospital records, inflicted injuries on his wrists and thighs typical of torture, bloody vomiting, pain in the region around kidney etc. He was given some treatment and asked to go back to his cell by the doctor. It was also found that the doctor had taken case history and examined this patient in the presence of the police officer who had accompanied the victim.

The doctor did not consider the presence of the police as violating the doctor-patient relationship. He insisted that he did not suspect torture as the victim never reported it to him. The victim died in his cell.

Similar findings were made by us in an investigation of a victim of gang rape wherein, inspite of the visible signs of injuries around the vagina, which could make any medical person suspect rape, the male doctor turned away the patient after treating her injuries simply because the woman could not tell him that she was raped'. The woman had reported rape to the nurse on duty but could not communicate this to the male doctor.

In another case of custodial gang rape and torture of a tribal woman by police in Gujarat, the commission of inquiry constituted by the Supreme Court found that two doctors at the government hospital were guilty of shielding the policemen and issuing a false certificate[10].

These examples only represent the tip of the iceberg. Doctors who come in contact with survivors and victims of violence are not always conscious accomplices in ignoring or covering up the cases. I have been given the following reasons for non-reporting and conspicuous silence by medical doctors on torture and rape:

(1) A section of doctors involved are plainly ignorant about this aspect of medical work. If it is true that it never occurs to a doctor that a policeman should not be allowed to remain present during the doctor-patient interaction, or that certain signs and

symptoms should make him/her suspicious of possible torture, it shows crass ignorance in the profession and a grave lacuna in their training.

(2) Another section is indifferent to the plight of sufferer due to their own social biases against the victims and survivors. Such indifference is also produced by social pressure to conform to the dominant belief. In cases of torture inflicted on persons labeled as terrorists, I have found doctors faithfully treating the injuries of the victims but showing great reluctance in mentioning torture due to the fear of being seen as opposed to the state's efforts at fighting terrorism and separatism.

(3) A third section simply believes that by being in the employment of the government, the police department or the prison, they are bound by the orders of their superiors and feel that the code of their service does not allow them to 'blow the whistle'.

The profession has failed to take the unequivocal position that when a doctor has to choose between an administrative order and professional ethics, the latter must prevail. The profession has also failed to protest when doctors are transferred as punishment for cri ticising gimmicky and unscientific measures taken by the authorities during epidemics, or when security forces harass and raid hospitals, interfering with the treatment of patients as in Kashmir [11]. Such lack of collective assertion of professional independence and neutrality on crucial issues has left individual doctors defenseless, cynical and by default subservient to the authorities.

(4) Another reason for doctors' apathy to these issues is their unwillingness to 'get involved'. Many remark, "We are doctors. We treat illness. We are not interested in torture or rape." This is both inadequate science and poor ethics.

Treatment, rehabilitation and documentation

Recognition of the fact that the reported instances of torture represent only a tip of the iceberg emphasises the need to document the problem in a systematic manner. There is a need to put together experiences in treatment and rehabilitation of such victims, create a clearing house for such information to be disseminated among interested professionals, and thus systematise corrective medical intervention.

This would also provide precious information on the extent of problem encountered, the individuals and agencies (state, terrorists, armed groups, gangs) involved in torture, type of people affected, type of torture methods used and so on. This information in turn would sensitise the profession and make it easier for medical associations and groups to successfully campaign for rooting out conscious or unconscious complicity of doctors in torture or its cover up. Such information will also sensitise other professionals in the media, law, social work etc. to play active and meaningful roles in creating public awareness, in punishing the guilty and in rehabilitating survivors.

Code of medical ethics and torture

The code laid down by the Medical Council of India is a good but greatly neglected document. Despite debates about commercialisation and sensational revelations in the press on various allegedly unethical practices by doctors, very little has been done by the medical associations to popularise and enforce this code.

Although the principles enunciated in the code are universal and exhort doctors to refrain from participating or colluding in anything that harms the individual, there is a need to make them specific and directive, particularly in relation to the victims and survivors of violence. This could be easily done by incorporation of the international declaration on the subject in our code.

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