LETTERS

The revised Declaration of Geneva, 2017, and India's contradictory legal provisions

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The World Medical Association (WMA) provides ethical guidance to physicians through its declarations, resolutions and statements. WMA first adopted its *Resolution on physician participation in capital punishment* in 1981, which was then amended in 2000, and 2008. The revised Declaration of Geneva was adopted by the WMA General Assembly on October 14, 2017, in Chicago. WMA reaffirmed that it is unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process, including its planning and the instruction and/or training of persons to perform executions (1). The Indian Medical Association (IMA) is a signatory to all these policies and resolutions since it is a founder member of WMA (2). Most other national and international associations of medical and other health professionals also forbid the participation of their members in capital punishment (3).

However, a 1995 Supreme Court judgment and the 187th Report of the Law Commission of India (2003) both require the presence of a doctor during execution of capital punishment (3). Physicians have two primary responsibilities in execution. First, they are expected to certify a person "fit to be executed". Second, doctors are expected to witness the hanging and certify the death of the convict (2). Physician involvement in the administration of capital punishment is ethically proscribed because it is an abhorrent and repugnant act and violates the tenets of medical ethics. The IMA joined its global counterpart and asked the Medical Council of India (MCI) to include a statement to this effect in India's code of medical ethics. A physician should only be summoned to certify death, after execution of the punishment, because for certification of death the presence of a doctor is required (2). By asking doctors to certify if a person is fit enough to be hanged, the government is forcing us to violate our medical ethics. By certifying someone fit, we are pushing them towards execution Dr KK Aggarwal, president of IMA said (4).

However, twenty-three states of the USA require physicians to "determine" or "pronounce" death during execution. Participation in executions does not make the physician the executioner but is their duty, just as providing comfort care to a terminally ill patient does not make the doctor the bearer of the disease (4). Doctors working as medical officers in jails are expected to follow the jail manual which demands their participation in the execution. Barring doctors from executions will only increase the risk that prisoners will unduly suffer. By not participating in executions, doctors will obstruct the course of justice and IMA is undermining the law of the country by refusing to participate in an execution ordered by the court said Dr GS Grewal, former president of the Punjab Medical Council (4). Dr Amar Jesani, editor of the *Indian Journal of Medical Ethics* pointed out that the IMA seems to have woken up to this ethical conflict rather late given that the WMA passed the resolution first in 1981. Simultaneously, medical ethics experts have raised the question as to why IMA has decided to raise *this* issue, when it has remained silent on rampant commercialisation of medical practice and gross violations of medical ethics such as unnecessary and irrational prescription of drugs, accepting "incentives" from pharmaceutical companies, etc (4).

Now, Indian physicians face a dilemma: be ethical or obstruct "justice". Ethics and law are colliding head-on over physicians' participation in capital punishment. It is time to apprise the judiciary and lawmakers of the implications of such participation for the medical profession and society. And doctors - cutting across territorial barriers, position in the medical hierarchy, and political allegiance - should unite to protest this inhuman act that is antithetical to the profession (2).

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Need for gender sensitive health system responses to violence against women and children

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Five years since Nirbhaya, and nearly as long since the Justice Verma Committee Report, amendments to the Criminal Law Amendment Act 2013, and the National guidelines and protocols on medico-legal care for survivors of sexual violence by the Ministry of Health and Family Welfare (MoHFW) 2014, we, concerned individuals, women's groups, health organisations, ethicists, and academicians, urgently demand

the attention of the central and state governments - to the continuing injustice, violations and discrimination against survivors of gender-based violence.

While the above progressive legal amendments and protocols mandated a comprehensive understanding and an urgent response to gender-based violence, and seek to enable survivors to access healthcare, critical support services and legal justice, the current evidence indicates otherwise.

Currently, only about seven states in the country (Chhattisgarh, Delhi, Madhya Pradesh, Maharashtra, Meghalaya, Odisha, and Uttar Pradesh) have issued orders for the implementation of the MoHFW protocols released in 2014. This continued inaction by the governments (central as well as state), and even subversion of these mandates exemplified by the recent *Kerala Medico-legal Protocol for Examination of Survivor of Sexual Offences* (1), is appalling and extremely disturbing.

The wilful ignoring of the MoHFW protocol by the Kerala government is unfathomable, paving the way for a version that is in outright violation of the legal and health rights of the survivors. The MoHFW protocol is consistent with the legal amendments on sexual assault/rape; with a comprehensive healthcare response to survivors; excludes gendered biases; and attempts to promote ethical practices. It reaffirms the healthcare system's preparedness for attending to the survivors, ensuring dignity, privacy and informed consent of the survivor, while dispelling the existing gender-biased practices such as conducting the 'two finger test' or commenting on the past sexual history of the survivor. In complete contradiction to this, the Kerala version is in clear contravention of the MoHFW guidelines meant to safeguard the health and legal rights of survivors, and disproportionately emphasises the forensic role of the healthcare system. For example, it focuses excessively on recording genital injuries and describing the hymen (which is unnecessary), and sidelines the therapeutic role of doctors, including psycho-social care and support. It also seeks other irrelevant details like "history of psychiatric illness or any such mental disability in the past". Psycho-social support or referrals, and other critical guidelines for care of vulnerable groups that find space in the MoHFW protocol are conspicuous by their absence, indicating a very limited and biased protocol. While efforts by the states to comprehensively address GBV and respond to survivors is appreciable, any compromise in the standards set by the MoHFW protocol is completely unacceptable.

However, mere orders for implementation of the protocol in the absence of systematic efforts to equip the healthcare system with quality infrastructure and human resources to implement them in a manner beneficial to affected individuals, is grossly insufficient. For example, even some states which have adopted the MoHFW protocols have not even made printed copies available for use in health facilities.The implementation is mostly confined to a few urban tertiary level facilities. The focus has disproportionately been on forensics – on examination and evidence collection. Access to services for other health needs – both physical and psychological - continue to be inadequate or completely absent. Despite the MoHFW protocol, the healthcare system routinely undermines the narrative of the women survivors, is preoccupied with genital injuries, and the absence of injuries is frequently equated with the absence of assault and denies their rights and autonomy. The implementation of the MoHFW protocol true to its letter and spirit thus necessitates an empathetic, efficient and accountable healthcare system to prevent survivors being denied healthcare and justice.

Moreover, alongside a comprehensive response to sexual violence, there is an urgent need for the health system to respond to domestic violence. The MoHFW should urgently initiate development of a protocol for a health system response to domestic violence and ensure its implementation. Several examples of public hospital-based crisis intervention centres as well as models of capacity building and engagement with the health sector already exist in various states. Lessons learned from these existing initiatives and models responding to sexual and domestic violence in the health sector can substantially inform the protocol.

The implementation of protocols must be supported by training of all healthcare providers to recognize the impact of gendered violence on health and provide the necessary care, support and referrals to other requisite services.

Other efforts have been initiated, like the setting up of one-stop centres (OSC) by the Ministry of Women and Child Development (MWCD) in the premises of public hospitals. Where OSCs have been set up, they need to be integrated with the functioning of the hospital. It is important that the public health system proactively builds these linkages and the MOHFW provides a directive for this to the hospitals. Moreover, such services need to be available and functional in every district of every state in order to be effective.

Finally, we reiterate our demand that the Kerala protocol be immediately revoked, and that the MoHFW protocol be implemented by all States without further delay. Information about the protocol must be disseminated widely and publicly towards accountability and ethical implementation. Delays in the implementation of the protocol and in enabling health systems imply gross violation of the human rights of survivors, denial of healthcare and justice; such delays must be urgently addressed.

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Note *This statement has been endorsed by 78 individuals and groups from all over India.*

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