Torture: Understanding and Addressing a Highly Reprehensible Aspect of Prison Violence

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ABSTRACT

Torture, the infliction of severe physical or psychological pain upon an individual to obtain information, extract a confession, or as punishment, is prohibited by international law and is illegal in most countries. Nevertheless, documented instances of torture of prisoners currently occur in more than half of the world's countries, with devastating physical and psychosocial consequences on victims. This article examines the potential roles of physicians, medical associations, and governments in the perpetuation, and prevention, of torture. The author highlights several factors that have influenced the perpetuation of prisoner torture, even in countries that are signatories to the United Nations Convention Against Torture, and concludes with practical measures for surveillance and minimization of prisoner torture.

Key words: prisons, torture, medical workers, medical associations

INTRODUCTION

Torture - as a tool of prosecution, punishment and/or discipline - is closely linked to the evolution of penal systems, from the 'eye for an eye' dictum of Sumerian and Hammurabi penal codes (~1750 BCE), through Draco's regime of supervised harsh punishment (~400BCE), Emperor Justinian's prison edicts (533 CE), Pope Boniface's Poena carceris (1298 CE), to the birth of modern prisons in 18th century England (Telfer, 2003). Foucault (1995) opined that the degree and varieties of torture in any given society reflect, among other factors, the values and power of nations' leaders, and the cohesion of civil society. He outlined the shift in the use torture on the body as a public spectacle up to the 18th century, to its sequestration behind prison walls from the 19th century onwards, where torture was largely directed at prisoners' minds.

The horrors of Nazi prisons, unearthed after World War II, enhanced global awareness about the widespread use of torture to extract information as well as punish captives in prison settings. The global quest to prevent the occurrence of such cruel penal approaches stimulated the birth of the World Medical Association (WMA) in 1947 as well as the promulgation of major conventions against torture by the United Nations. Over the last 40 years, the list of local, regional, and international organizations and initiatives advocating against prisoner torture has grown exponentially, further focusing attention on this hitherto neglected aspect of imprisonment. Currently prison torture is illegal under international law. The United Nations Convention Against Torture defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, or incidental to lawful sanctions" (UN, 1984).
Although the 1948 Universal Declaration of Human Rights was the first international convention to prohibit the use of torture, torture is still commonly used worldwide, particularly in prison settings of societies with totalitarian regimes. In most of these countries, practices of torture in prison settings are hidden from the public or international community through denial of inspections by independent agencies, torture by proxy, legally sanctioning acts coterminous with torture, such as “moderate physical pressure” against prisoners, concealment of physical evidence of torture on victims, and death of tortured victims being ascribed to ‘natural causes’. Reporting of torture practices in prison settings shows a wide geographical bias, with Western nations having fewer but well publicized cases, while developing countries, and countries with totalitarian regimes, have more instances of torture, albeit among lower profile detainees, which hardly receive media attention. This article examines definitional issues related to prison torture, discusses the actions and inactions of governments and medical associations that have facilitated prison torture in the past, and suggests ways for ameliorating current shortcomings.

CONCEPT OF PRISON TORTURE

A prisoner is classified as someone who has transgressed the laws of a given society sufficiently for punishment to be imposed by depriving her or him of the universal human right of liberty. Other than the possibility of capital punishment, the loss of an individual’s liberty is the state’s morally accepted ultimate punishment, and additional punishments, including torture, are regarded as illegal under international law. The definition of prison torture is problematic, not least because imprisonment per se is a form of torture. As Oscar Wilde lamented in his 1896 Ballad of Reading Gaol “vile deeds like poison bloom well in prison. It is only what is good in man that wastes and withers there”. Recent reports on prison conditions by Amnesty International and the International Committee of the Red Cross indicate that a high proportion of prisoners worldwide are subjected to remarkable episodes of prison torture at some point during their incarceration (AI, 2005; ICRC 2004). As Foucault famously described in Discipline and Punish (1995), modern prisons were essentially an invention to sequester torture practices from public view. Some degree of torture is integral to the fact of imprisonment, and such torture practices only become illegal and reprehensible if extreme. Three are at least four major facets of prison torture: torture of prisoners by custodial staff; systematic violence among prisoners; inadequacy of health care provision, and sexual torture.

Torture of prisoners by custodial staff is probably the most common form of prison torture world wide, and it may take passive or active forms. Passive forms of prison torture entail taking to the extreme, the major categories of deprivation described by Sykes (1958): deprivation of liberty, characterized by severe curtailment of free movement, the regulation of mail and visiting, loneliness and boredom; deprivation of goods and services, including living in a harshly Spartan environment and being denied the use of numerous personal possessions with important symbolic overtones, such as food cooked to individual preferences; deprivation of autonomy, including enforced deference and subjection to a large body of trivial custodial rules and regulations; deprivation of security and fear of being robbed, raped and beaten by other inmates – a result of forced association with lawbreakers in a setting where some inmates pursue the amenities of life by theft, physical coercion, and chicanery, and; deprivation of (hetero)sexual relationships. Technology-inspired forms of contemporary passive torture include the super-maximum (“supermax”) security facilities, where extended periods of solitary confinement are invariably compounded by psychological and medical neglect. These facilities share basic penological features with the “Separate” and “Silent” models of imprisonment that were pioneered in the United States in the late 18th century, and later in England and Australia. “Silent” and “Separate” systems of prolonged isolation were associated with high rates of mental illness and suicides among inmates (Brand, 1975). Contemporary “Supermax” facilities, such as California’s Pelican Bay Security Housing Unit.
Unit are the subject of litigation following allegations of prisoner torture (Haney, 2003).

Active forms of torture include beatings, and emotional hurt, most of which are usually inflicted in such a manner that they are difficult to detect physically. Also pertinent is excessive use of force, more as punishment than as restraint. For example, in New South Wales (NSW, Australia) prisons between 1943 and 1978, increasing tensions in the state’s prisons, and a number of serious assaults on prison officers, led the then NSW Prisons Department to use Grafton prison to house the state’s most intractable prisoners. The penal methods implemented there over the following thirty-three year period were described by a Royal Commissioner as a ‘regime of terror’, ‘... brutal, savage and sometimes sadistic’. The Commissioner referred to the period in question as ‘one of the most sordid and shameful episodes in NSW penal history’. The practices in question consisted of the systematic beating of prisoners upon their arrival at Grafton, euphemistically termed a ‘reception biff’, and further physical assaults in the event of breaches of gaol rules during their subsequent incarceration there (Grabowsky, 1989).

Another major facet of prison torture is systematic violence involving prisoners. In many contemporary prisons, the central axis of stratification inside prisons has shifted from the vertical cleavage between prisoners and guards, symbolized by the proscription to ‘rat on a con’ to horizontal cleavages among prisoners. Racial and gang-related violence are increasingly resulting in repeated severe torture of prisoners caught in the crossfire. In some contemporary Illinois (US) prisons, criminally and ethnically-based gangs and ‘supergangs’ such as the Disciples, El Rukn, Vice Lords, Latin Kings in Illinois, the Mexican Mafia, and Black Guerrilla Family have taken over the illicit economy of the prison and destabilized prison norms, leading to increased level of systematic interpersonal and group brutality (Wacquant, 2001).

A third major category of prison torture is failure to provide adequate health care to inmates. This varies from inadequate staffing of prison health services, prisoner co-payment systems that are unaffordable to indigent inmates, mental abuse through prison programs such as ‘re-education’ of Falum Gong member in China’s prisons and boot camp prisoners in the United States, to most prison Managed Health Care contracts (Awofeso, 2005; Lutze & Brody, 1999; Ingley, 2004; Robbins, 1999).

A fourth major facet of prison torture is sexual torture. As many pictures from the American-controlled Abu Ghraib prison torture scandal demonstrated, sexual torture is widely viewed by torturers to be a very potent weapon of humiliation and submissiveness. Sexual torture does not necessarily have to entail rape to achieve its aim – merely forcing an individual to perform sexual acts, or adopt sexual positions, that are inconsistent with her or his cultural, moral, or religious beliefs appears to be potent in precipitating severe psychological sequelae among victims. While sexual activity in prison settings take place in a number of circumstances that vary in their level of coerciveness, it appears that the majority of sexual acts among prisoners, and between prisoners and custodial officers, constitute statutory rape. Although most cases of prison rape in the media and learned journals are from Western countries (Human Rights Watch, 1996), this is by no means an accurate measure of the geographical prevalence of this form of torture. In South African prisons, Gear (2001), reported on the Numbers’ gangs, such as the ‘28s’ (a.k.a. ‘Nongoloza’), whose members consciously adopt homosexuality as a creed. Although gang recruitment is claimed to be voluntary, resignation from ‘Nongoloza’ is not tolerated, violent activities - including gang-rape - occur regularly, and to challenge gang leadership is to invite death.

Based on the core facets highlighted above, the author defines prison torture as “custodial practices that increase the likelihood of extreme deprivation in prison settings, facilitate traumatic stress on prisoners resulting from beatings or excessive force used more as punishment than as restraint, inadequate or unaffordable health care, and expose prisoners to heightened risk of interpersonal and inter-group violence as well as sexual assault”.

There are compelling legal and human rights reasons to urgently address
prisoner torture. At least a third of the over 130 countries that have already signed the convention against torture have had adverse reports concerning torture reported against them by Amnesty International and other Human Rights organizations. Although there are so far no efficient international sanctions against governments complicit in prison torture practices, such adverse reports diminish the international moral clout of implicated governments, as the Abu Ghraib prison torture incidents’ adverse impact on the United States’ international moral authority demonstrate. From the victims’ perspective, physical scars from beatings and other traumatic experiences, and psychological effects of torture, such as anxiety, depression, insomnia, nightmares, memory difficulties, social withdrawal, irritability, feelings of helplessness, affective numbing, flashbacks, and shame, commonly lead to disempowerment and disconnection from friends and family, and occasionally to suicide (Petersen & Jacobsen, 1985).

GOVERNMENTS AND PRISON MEDICAL WORKERS’ ROLES IN FACILITATING PRISON TORTURE

The vast majority of the world’s prisons are under State control. Medical workers lead most prison healthcare delivery teams, and are well positioned to appraise the extent of prison torture, and ensure that those responsible for such practices are held accountable. Unfortunately, in some societies, these two stakeholders have been actively involved in prison torture practices. Medical care of the confined was formalized in England since 1774, with the passage of the Health of Prisoners Act. The early years of medical workers’ collaboration with custodial authorities did not necessarily serve the health interests of prisoners. Historically, doctors of the early 18th century prisons collaborated with governments, psychologists and criminologists in correcting, disciplining, and normalizing the confined in a laboratory where punishment functioned openly as treatment. In fact, a primary duty of doctors during this period was to identify prisoners feigning madness to prison officers, who subsequently tortured them as punishment. Even John Howard, a prominent penal reformist of that era implicitly supported prisoner torture and the Principle of Less Eligibility in his 1777 book, The State of the Prison (Sim, 1990).

Although the torture and other atrocities by Germany’s doctors working in concentration camps may be considered unique to that era (Cargas, 2003) there have been recent suspicious instances of close collaboration between regimes espousing terror as state policy, and medical workers in countries like Nigeria under late President Abacha, Chile under late President Pinochet, Turkmenistan under late President Nirayov, Iraq under late President Hussein, and South Africa during the apartheid era (Veriava, 1989). In situations where repressive regimes are able to induce prison medical workers to support prison torture practices, such practices are generally pervasive, secretive and extremely difficult to redress. Totalitarian regimes commonly imprison and torture perceived opponents primarily to break down the victim’s personality and identity. Torture is aimed at strong personalities, people who have stood up against repressive regimes. Breaking down these perceived formidable opponents effectively cows the rest of the community into silence. Ultimately, in the hands of repressive governments, torture is a strategy designed to defeat democratic aspirations at the root, which makes it a tool of choice for unpopular regimes around the world. Under such circumstances, it is indeed dangerous for individual doctors to speak out against prison torture practices (Stephenson, 2004; Waitzkin et al, 2001). What is disconcerting, however, is that Medical Associations in these societies appear silent and somewhat indifferent to ex-prisoners’ torture claims. A minority of contemporary medical workers have also been actively involved with prisoners torture through the conduct of hazardous medical experiments on prisoners (Hornblum, 1998), while a few failed to report to higher authorities wounds that were clearly caused by torture and they failed to take steps to interrupt this torture. In addiction some doctors have been found to routinely pass on prisoners’ medical records
to torturers, who invariably use such information to exploit the prisoners’ weaknesses and vulnerabilities (Lifton, 2004; Hall, 2004). Employment of incompetent and unprofessional custodial staff and poorly qualified health personnel is likely to create an environment in which torture practices flourish in prison settings.

ADDRESSING THE PROBLEM OF PRISON TORTURE

The first step towards addressing the problem of prison torture is to work towards a consensus on the definition of prison torture that captures the wide range of violent practices perpetrated by, or against, prisoners. The author’s proposed definition is a step in this direction. Second, all doctors need to be made aware of national and international prison torture issues as part of their training. In particular, qualified medical workers in prison settings should be familiar with the provisions of the Istanbul Protocol: ‘Manual on Effective investigation and documentation of torture and other cruel, inhuman and degrading punishment’, and achieve at least minimum standards for effective documentation and reporting of torture (Heisler et al, 2003).

Third, all nations, particularly those with frequent reports of prison torture should be lobbied to ratify all United Nations anti-torture conventions. These conventions have provisions for establishment of oversight bodies and granting permission for international human rights organizations to undertake inspections. For example, in 2002, the UN General Assembly adopted an optional protocol to the Convention against torture that requires the establishment of new national and international oversight bodies for the prevention of torture. Interestingly, this protocol was agreed upon despite objections from countries like Cuba that argued that the protocol should not incorporate mandatory visits, and that it should not be binding on signatories.

Forth, Medical Associations should play more active roles in the surveillance, reporting, and prevention of prison torture. The Hippocratic oath, and various Medical protocols, notably the World Medical Association Tokyo Declaration (1975) prohibit all forms of medical complicity in torture. Documentation of trends in torture practices in prison settings, and appraisal of the roles of medical workers in reducing prison torture, should constitute a regular feature of annual reports of national and international medical associations. All deaths in custody should be fully investigated, in part to determine if torture played a part in a prisoner’s death. Doctors found to be complicit in prison torture should be held accountable. An example of such comprehensive investigation and documentation of prison torture practices is provided by Greeberg and Dratel’s Torture papers: the road to Abu Ghraib (2005), which traced the factors that led to the much publicized prisoner abuse scandals at Abu Ghraib and Guantanamo prisons.

Fifth, medical associations should work with civil society to highlight instances of prison torture, as well as work towards enhancing respect for democratic traditions and judicial independence in their various societies. As noted earlier, prison torture is more likely to be actively supported by totalitarian regimes, primarily as a political tool. At national and international levels, there is a need for more effective, and more consistent advocacy by medical associations against prison torture practices.

Finally, a humane prison environment is a major antidote to prison torture. Governments should aim to surpass minimum standards for the health, welfare, and accommodation of prisoners. A well-functioning prison is characterized by an institutional pattern of interaction between staff and prisoners, which prescribes effective ways of dealing with the normal stresses of imprisonment. Respect for other basic rights of prisoners short of the loss of liberty creates environments in which prison torture, and the rare but deadly prison riots are unlikely to thrive (Boin & Rattray, 2000).
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