The Role of Physicians in Conflicts and Humanitarian Crises

Case Studies From the Field Missions of Physicians for Human Rights, 1988 to 1993

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Violations of human rights in wars, civil conflicts, and brutal repression mounted by governments against their own citizens often have profound consequences to individual and public health and may, in turn, produce humanitarian crises. The skills of physicians, medical and forensic scientists, and other health workers are uniquely valuable in human rights investigations and documentation, producing evidence of abuse more credible and less vulnerable to challenge than traditional methods of case reporting. Only in recent decades, however, have physicians organized specifically to meet this responsibility. This article presents case studies from the field missions of Physicians for Human Rights to illustrate the investigation and documentation of violations of medical neutrality, refugee health crises, the use of indiscriminate weapons, torture, deliberate injury and rape, and mass executions. Participation of health workers in the defense of human rights now includes investigation and documentation of health effects in threatened populations as well as individual victims.

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RESPECT for the rights of the individual and the protection of the health of human populations are deeply rooted in the traditions of medicine, whether in peacetime or during armed conflict. Physicians and other health professionals have long dealt with the ravages of war and civil conflict through the medical corps of military organizations. As the civilian casualties of modern warfare have increasingly dwarfed military losses, volunteers have formed medical relief organizations committed to the alleviation of the civilian suffering, hunger, disease, and displacement that almost inevitably accompany conflict. The International Committee of the Red Cross, Médecins sans Frontières, Médecins du Monde, the International Rescue Committee, CARE (Cooperative for American Relief Everywhere), and many other private humanitarian organizations have long struggled to provide health care to those injured and to bring relief to endangered populations.

These tasks have been made increasingly difficult by the diversity of conflict in the second half of this century: declared and undeclared wars between nations, full-scale civil wars, low-intensity conflicts between competing national political groups, and “dirty wars” of repression mounted by governments against their own citizens. Each of these conflicts puts civilian populations at risk for trauma, illness, or death; threatens to create humanitarian crises; and creates obligations for the investigation of war crimes and other violations of international law.

Only in the last few decades, however, have health professionals organized specifically to conduct the systematic investigation and documentation of human rights violations in war and civil conflict, to publish their findings, and to mobilize national and international medical communities to join in efforts to prevent further abuses and to hold perpetrators accountable.

In the 1960s in the United States, for example, the Medical Committee for Human Rights brought health workers to Mississippi and other southern states to protect civil rights workers, assure medical care of those injured, and perform autopsies for forensic evidence on those who were killed. In the 1970s, the Emergency Committee to Save Chilean Health Workers struggled to document and publicize the imprisonment and torture of health professionals under the Pinochet regime and mobilized support for their release. In the 1980s, the anti-apartheid National Medical and Dental Association of South Africa systematically documented torture, denial of health care, and other abuses of political detainees and provided rehabilitative services. A variety of health rights organizations performed the same functions during conflicts in Central and Latin America. Many physicians supported the work of traditional human rights organizations such as Amnesty International and Human Rights Watch.

In 1986, Physicians for Human Rights (PHR) was established in the United States, marking the formal addition of organized medical scientists in the United States to the growing international human rights movement. Health professionals have subsequently formed PHR organizations in the United Kingdom, Denmark, and Israel and the Occupied Territories, as well as the Johannes Wier Institute in the Netherlands and are developing similar organizations in Africa and Asia.

**THE UNIQUE CONTRIBUTION OF HEALTH PROFESSIONALS**

Two realizations stimulated these developments. First was the recognition that many human rights violations had significant health consequences. These include the physical and psychological trauma of individual victims of violence, torture, and rape, but also stem from breaches of medical neutrality, forced deportations, the use of indiscriminate weapons, mass executions, and other violent actions that affect entire populations. The purposeful destruction of health facilities and essential civilian infrastructures also leads to slower forms of death—from epidemic infectious diseases, untreated chronic disease, or starvation.

The second realization was that the skills of physicians, other health workers, and medical and forensic scientists are uniquely valuable in human rights investigation and documentation. The many relevant medical tasks, ranging...
from physical examination of individuals to forensic examination of mass graves, are listed in the Table. These can often produce evidence of abuse more credible and less vulnerable to challenge than traditional methods of case reporting. Such medical documentation is far more difficult to refute than oral or written testimonies of abuse, no matter how well corroborated by witnesses.

Since its founding in 1986, PHR has sent over 40 teams of volunteer physicians and scientists to 35 countries to explore violations of human rights and humanitarian law. Missions have been staffed by a wide variety of health professionals: internists, pediatricians, family practitioners, surgeons, trauma specialists, epidemiologists, pathologists, forensic anthropologists, radiologists, odontologists, nurses, and social workers. The diversity of mission personnel reflects the wide variety of skills that health workers can bring to human rights tasks.

This article provides a brief overview of work in the field, concentrating on case studies drawn primarily from PHR missions, some conducted jointly with other human rights organizations, from 1988 to 1993. The cases reviewed herein illustrate the diverse ways in which medical expertise has helped to document human rights abuses associated with war, large-scale internal conflicts, and humanitarian crises (Table).

**EXPOSING VIOLATIONS OF MEDICAL NEUTRALITY**

Conflict often produces both urgent needs for medical aid and intensified efforts to interfere with it. The Geneva Conventions of 1949 and the Additional Protocols of 1977 mandate the protection of medical facilities, personnel and patients, the humane treatment of civilians, the right of access to care, and the nondiscriminatory treatment of the ill and wounded in time of war. Unfortunately, these international laws for the most part do not apply to internal armed conflicts, coups, or repression of internal opposition, and many nations still limit the applicability of human rights obligations to such situations.

In every type of conflict, there are frequent violations of medical neutrality. All too often, hospitals have been bombed, shelled, or invaded and their equipment and supplies looted or destroyed. Patients, medical personnel, and relief workers alike have been assaulted, abducted, tortured, or murdered. Ambulances have been attacked. Both military and civilian wounded have been denied treatment. Delivery of medical supplies, food, and other humanitarian aid has been deliberately and repeatedly blocked.

In recent years, PHR missions have documented these problems in many areas of conflict. In 1991, for example, a mission to Haiti jointly sponsored by PHR, Americas Watch, and the National Coalition for Haitian Refugees found that "soldiers occupied the [largest public] hospital, rounding up wards and corridors, shooting their guns above or at the wounded ... and conducting searches that went as far as to enter the surgical operating areas." In 1990 mission to El Salvador, where civil conflict was marked by almost every conceivable violation of medical neutrality, PHR investigators described the beating, imprisonment, torture, or murder of health and relief workers for activities as innocent as the vaccination of children. Other missions have documented similar abuses and other violations in Iraq, occupied Kuwait, 

DOCUMENTING REFUGEE HEALTH CRISSES

Most conflicts cause a displacement of inhabitants, either within a country's borders (displaced persons) or across national borders (refugees). The world now has an estimated 15 million refugees and over 25 million displaced persons. A growing medical and public health literature is devoted to the assessment of health needs and the organization of medical care for those who have lost their homes and often lack sufficient food, potable water, shelter, and sanitation facilities. Refugees or displaced persons are often clustered in densely populated camps, where they are at risk of epidemic outbreaks of diarrheal disease, measles, hepatitis, typhoid, cholera, and other life-threatening maladies. The trauma of displacement and the stresses of prolonged stays in camp environments may also lead to increased incidence of anxiety disorders, depression, and suicide.
lief supplies. This rapid assessment revealed a public health disaster. The PHR team reported its findings to the US embassy in Ankara and to television and print media. Along with reports from other nongovernmental organizations and the Centers for Disease Control and Prevention, the PHR report contributed to a governmental decision to mount an effective relief effort and declare a "no-fly" zone in northern Iraq so that refugees could move into lower and more accessible regions.

**DOCUMENTING INJURIES CAUSED BY CHEMICAL WEAPONS AND LAND MINES**

Some chemical agents kill within minutes. Others cause serious burns. Some persist in the environment and cause injury days or weeks later. The dispersion of all chemical weapon agents, once released, is difficult to control. The result is indiscriminate damage, with infants, the elderly, and the chronically ill particularly vulnerable. Dangerous health effects are shared by all chemical weapons agents including, under some circumstances, the supposedly innocuous lacrimating agents (tear gases) that are often used by police forces against civilians as a means of crowd control. In 1987, PHR missions to South Korea and Panama investigated the medical effects of use of massive quantities of o-chlorobenzylidene malononitrile (CS) gas and other forms of tear gas. The teams reported that CS gas caused skin burns, eye injuries, and exacerbation of underlying heart and lung disease, with effects both on demonstrators and on civilians at sites far removed from crowd gatherings. Similar effects were found in the West Bank and Gaza Strip, and in 1990 PHR medical investigators also reported several documented cases of deaths from respiratory arrest due to exposure to high concentrations of tear gas after canisters had been thrown into the confined spaces of homes and shops.

In April 1998, in what was then Soviet Georgia, troops from the Soviet Ministry of Defense and Interior used trenching spikes and, it was alleged, toxic gas to break up a peaceful demonstration of 8000 to 10 000 people in the capital city of Tbilisi. At least 20 people died and hundreds were injured and admitted to hospitals. At the request of Dr Andrei Sakharov and Georgian public health authorities, a three-person PHR medical team arrived in May 1989 to investigate. The physicians administered a questionnaire to 119 hospitalized patients and interviewed and examined 22 of the most seriously ill. A gas canister allegedly recovered at the scene of the disturbance was analyzed by mass spectroscopy at the University of Tbilisi.

The clinical and toxicologic evidence led the PHR team to conclude that the Soviet troops probably had used both tear gas and a toxic gas called chloropicrin, which can cause skin and mucosal blisters, bronchoconstriction, and pulmonary edema, all of which were reported among the casualties of the demonstration. Mustard gas and nerve gases are among the most lethal of chemical weapons. In August 1988, Iraq mounted an assault on the Kurds of northern Iraq. Poison gas attacks were reported, but these were adamantly denied. Physicians for Human Rights sent three physicians, including one who spoke Kurdish, to interview and examine Kurds who had fled to Turkish refugee camps, in the hope of reconstructing the events of late August. The team prepared a survey instrument, adapted from World Health Organization, United Nations, and United Nation Human Rights Commission reports. The team traveled to the border and interviewt and translated into Kurdish to explore the symptoms of chemical weapons exposure and to compare the accounts of different refugees, some of them from the same villages in Iraq but residing in different camps in Turkey. The survey corroborated evidence from soil samples, physical examination of survivors, and other sources to suggest that Iraq had used poison gas against its own citizens. Limitations in the method precluded the precise identification of the agents used, but the evidence pointed to a sulfur mustard and probably at least one additional, more rapidly acting agent.

In 1991 and 1992, PHR and Middle East Watch mounted three missions to Iraq, Kurdistan, by then protected as a safe haven by the United Nations, to document the alleged 1988 mass murder of Kurds by Iraqis in what was known as the "Anfal" campaign—a village-by-village assault that included "large-scale murders, disappearances, forbible relocations, and destruction with the intent to destroy the village population of Kurds as such." On June 10, 1992, members of the mission took soil samples from four bomb craters—reported by eyewitnesses to be the result of an Iraqi attack on the village of Birjimi on August 26, 1988, nearly 4 years earlier. The samples were delivered to the United Kingdom for analysis by the Chemical and Biological Defence Establishment, Ministry of Defence, which found traces of mustard agent and/or thioglycolic acid in six of the samples from the first two craters and traces of the degradation products of the nerve agent Sarin in six samples from the second two craters. These results demonstrated—for the first time—that environmental samples collected from appropriate locations can indicate unequivocally the presence of chemical warfare agents or their degradation products even 4 years after an attack, corroborating the conclusions in the 1988 PHR report. This is a finding that should spur additional investigations of chemical warfare and make it more difficult to escape detection when such weapons, outlawed both by the Chemical Weapons Convention and the Geneva Convention, are used.

The damage resulting from the increasing use of land mines in war and civil conflict has become a worldwide public health problem. Missions to Cambodia and northern Somalia have documented the frequent disemberrment of children and adult civilians, often years after the conflicts had ended, in regions where mines had been placed. Many of the explosive devices are made of plastic, making metal detectors useless and x-ray examination difficult. Amputees number in the tens of thousands, placing a heavy burden on health facilities and slowing economic recovery from war.

**DOCUMENTING TORTURE, DELIBERATE INJURY, AND RAPE**

Treating and documenting the physical and psychological sequelae of torture have been the province of health workers for several decades. Torture treatment centers have been developed throughout the world in the wake of initial efforts by a group of Danish physicians associated with Amnesty International. Some of the largest and best-funded centers are now based in Western Europe and North America, and thus treat mainly refugee populations or victims flown in for special care. In countries where torture takes place, physicians typically have difficult working conditions. They routinely put themselves at risk of arrest, interrogation, imprisonment, and even execution for treating those who have been tortured for political reasons (or wounded by government forces).

Conversely, a disturbing problem is presented by repeated allegations in some countries that physicians have been complicit in torture, advising the torturers whether or not it is "safe" to continue and even suggesting specific methods of abuse. For example, a 1986 Brazilian report prepared under the sponsorship of the Catholic Church of Sao Paulo cited court reports describing physicians examining, reviving, treating, and observing prisoners during and after torture. A survey of 200 torture survivors from many countries, receiving treatment at a Danish rehabilitation center, reported that 41 survivors described the involvement of medical personnel in their torture. Medical associations in
Turkey, Chile, *7* Uruguay, *8* Greece, and other nations have investigated such violations, but only a small number of physicians have been prosecuted or disciplined. A 1988 review found evidence of physician complicity in many nations. *9*

In recent years, human rights organizations have sent health professionals to many countries to document torture and other human rights abuses. Case studies and documentation of torture were an important aspect of the work of PHR missions to Chile, *10* Haiti, Kashmir, Iraqi Kurdistan, Kuwait, and the former Yugoslavia. The special skills of physicians and other health professionals have proved to be extremely useful in determining and verifying both individual cases and broader patterns of abuse through medical histories and physical examinations of former prisoners and detainees and, when possible, inspection of prison and camp facilities. *11* In a number of cases, autopsies on prisoners who died in custody have refuted the claims of captors that deaths were due to natural causes, and forensic examination of skeletons in mass graves has also revealed clear signs of torture. *12* *13*

A history of torture may be central to a refugee's appeal for political asylum, but without documentation may be ignored by immigration authorities. The findings of medical and psychological examination by a physician often constitute significant supporting evidence. Physicians for Human Rights has published a physician's guide to medical testimony in political asylum cases, with detailed instructions on taking a history of torture, performing relevant examinations, and meeting the evidentiary requirements for the admission of expert medical testimony. *14*

Health professionals can also detect patterns of deliberate injury that might otherwise be missed, in the absence of detailed medical analysis, by the best-trained human rights investigators and journalists. The 1988 PHR report on the Intifada in the West Bank and Gaza Strip, at a time when a reported Israeli policy of “breaking arms and hands” had been officially denied, documented a high incidence of metacarpal and midshaft radial fractures to individuals' dominant hands and arms in an unselected series of more than 100 cases of trauma. The report described the pattern as “indiscriminate in choice of victim but precise in choice of injury.” *15* Media attention was immediate and widespread, and descriptions of responses to the Intifada, and specific instructions to avoid inflicting such injuries were subsequently issued to Israeli soldiers.

Rape is prevalent in war-torn regions, but all too often ignored as a “normal” or “inevitable” accompaniment of conflict. As described in this issue of *JOURNAL* by Swiss and Giller, *16* rape has been used as a means of intimidation to promote “tactile cleansing” in former Yugoslavia. Health professionals have come to play a central role in documenting the occurrence of rape, estimating its incidence, assessing its physical and psychological consequences, and helping to devise community-based networks to help survivors. The Women's Program of PHR, described by Swiss and Giller, *17* helped to assemble the investigative team for a United Nations mission on rape in Yugoslavia *18* and is continuing to work in Liberia and other nations where this form of abuse is common.

**EXAMINING THE DEAD, LINKING THE LIVING**

In the 1970s, a virulent strain of abuse began to proliferate in Latin America. Those under suspicion by their government began to “disappear,” victims of extrajudicial execution. Reports of disappearances became especially widespread in Argentina during the military regimes of the late 1970s and early 1980s. Two groups of brave women, the “Mothers of the Plaza de Mayo” *19* and later the “Grandmothers of the Plaza de Mayo,” *20* formed to protest and to pressure the government. When a new civilian government replaced the military, it appointed a national commission to conduct a “wrenching investigation of human rights abuses under previous regimes.” *21* Forensic techniques were central to determining the manner of death of many who were buried in graves marked [**Ninjan Nombre**](https://www.gov.ja) (no name). Graves were opened and skeletons exhumed and analyzed by the methods of forensic anthropology to confirm execution-style killings and, in many cases, the signs of partially healed injuries from torture. Dental and medical experts were employed to establish identity, and biochemical methods were used in attempts to link the living children of those who had been killed to their grandparents. (Children of murdered parents had often been secretly adopted, at times even by those suspected of performing the tortures and executions.) Molecular biologists in North and South America collaborated to bring the power of their techniques to bear, first using HLA typing and, more recently, using mitochondrial DNA sequences. *22* Many of these forensic science techniques were later fixed in Brazil, *23* Guatemala, *24* and Kuwait.

The conflict in former Yugoslavia has produced repeated and detailed testimony describing scores of mass executions and mass graves, some allegedly containing as many as 3000 victims. Eye-witness descriptions of the abduction of more than 200 Croatian patients and staff from a Vukovar hospital during the Serbian-Croatian war in 1991, together with the testimony of two men who escaped moments before execution, led to the identification, by forensic anthropologists, of a mass grave in a nearby farming village by two PHR members of a United Nations Human Rights Centre mission in November 1992. *25* Under contract with the United Nations, subsequent PHR teams have already exhumed part of the site, identified the kinds of ammunition used and the lines of fire, and begun the forensic analysis of skeletons, many of which bear the signs of execution-style head wounds. Investigations of this sort are an important adjunct to oral and written testimony in any effort to hold those who commit war crimes accountable. Witnesses may die or disappear, but the physical evidence still will speak powerfully for them.

**LIMITATIONS OF PHR MISSIONS**

While many PHR missions have successfully documented human rights abuses, almost all have been subject to limitations in duration, scope, and access, and there are many factors that can cause at least partial failure. In some instances, offending governments have simply denied visas to investigators. In other cases, access to areas of conflict, to prisoners, and to civilians and others who may report abuses has been restricted or denied. In the 1988 mission to southeastern Turkey, for example, the PHR team was allowed by the regional government to enter only two of five Kurdish refugee camps, and then only for 6 hours in each. In Iraq, some mission members have been followed and constrained by government agents. In the former Yugoslavia, mission members have faced both real and threatened violence.

The thoroughness of documentation is almost always subject to concerns about both the representativeness and the safety of those interviewed and examined. For every person who steps forward, there may be many who do not, for fear of reprisal, to avoid further stigmata, or to avoid recounting an extremely traumatic experience. Fabrications and rumors present constant challenges. Even when a mission includes an epidemiologist, some PHR surveys have been "quiet and dirty," limited by access who can and cannot be interviewed by physicians for Human Rights mission reports, like those of nonmedical human rights organizations, must therefore be understood as snapshots in time, partial rather than complete accounts or prevalence reports of human rights viola...
tions. Despite these obstacles, most missions produce enough firm data to make informed recommendations.

CONCLUSION

Each day's headlines announce ongoing humanitarian and human rights disasters in Bosnia, Sudan, Angola, Mozambique, Iraq, and Guatemala, to name but a few examples. This brief review of a mere half-decade's work demonstrates that the skills of medicine and public health have important and often unique contributions to make in the exposure and documentation of such abuses and in attempts at prevention. But the involvement of health workers depends on more than just the mastery of relevant technical skills and the evidence they can produce. Such involvement reflects an assertion of professional commitment that transcends national borders and ethnic, cultural, or political differences. In a world in which profound violations are likely to continue, the participation of physicians and other health workers in human rights work may be viewed as an increasingly necessary extension of the traditional professional responsibilities.

References