DISCUSSION

The crime of medical complicity in penal amputation

ADRIAAN VAN ES

Professor Das writes a challenging article about the ethical dilemma of the prohibition on inflicting of harm versus the utilisation of surgical expertise in carrying out penal amputations under Sharia law (1).

This dilemma has a very long history and the list of medical "humanisation" of cruel forms of punishment is equally long. The appropriate length of the rope and the consequent drop of the body in cases of hanging, with the aim of achieving a quick death, was established by a commission of English and Irish doctors in the 19th century. The guillotine, designed to effectively decapitate the convict, was promoted by the French doctor Guillotin in the late 18th century; the electric chair was invented by a New York dentist in the 19th century and the appropriate mix of chemicals for lethal injections, developed in the late 20th century, is procured and often monitored by physicians.

The argument over whether to utilise medical and/or psychological knowledge in torture and cruel, inhuman and degrading practices has been, and is being, repeated time and again all over the world. Besides the argument in support of "humanising" punitive procedures, there is also the difficulty faced by medical and psychological personnel under the pressure or coercion of national law and/or terms of employment.

The dilemma and its often horrific consequences have been investigated and exposed by human rights and professional organisations, always leading to moral, legal and professional condemnation. Some examples are: the outcomes of the health sector hearings of the Truth and Reconciliation Commission in South-Africa after the end of apartheid (2); the exposure of medical and psychological collusion in de-facto torture (''interrogation" of prisoners) in the Guantanamo Bay and Abu-Ghraib prisons by US military personnel (3,4); the cooperation under duress, in Iraq under Saddam Hussein, of doctors who were forced to cooperate in mutilating punishments (5).

Medical ethics are paramount regardless of non-medical considerations

The sanctity of medical ethics and the prohibition against inflicting harm is reflected in many professional codes of conduct and human rights conventions, including the Islamic Code of Medical Ethics.

The International Conference on Islamic Medicine in Kuwait in 1981, which resulted in the Islamic Code of Medical Ethics, states: "He [the doctor] should be an instrument of God's justice, forgiveness and not punishment, coverage and not exposure." The conference also stated: "The medical profession shall not permit its technical, scientific, or other resources to be utilised in any sort of harm or destruction or infliction upon man of physical, psychological, moral, or other damage ... regardless of all political or military considerations."(6)

The World Medical Association Declaration of Tokyo (1975) on torture and cruel, inhuman and degrading treatment or punishment states: "The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife". It is noteworthy to remember that the Malaysian Medical Association is a member of the World Medical Association (7).

The United Nations adopted in 1982 the Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The 2nd principle states that: "It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment", and in principle 6: "There may be no derogation from the foregoing principles on any ground whatsoever, including public emergency" (8).

A well documented case is the cross-limb amputation of the 30-year-old Adam Al-Muthna by surgeons on February 14, 2013 in Sudan. He had been convicted of armed robbery. This triggered outrage and protests from professionals and human rights organisations. "Cross amputation is a form of state-

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To cite: van Es A. The crime of medical complicity in penal amputation. *Indian J Med Ethics.* 2020 Apr-Jun;5(2) NS: 149-51. DOI: 10.20529/IJME.2020.034.

Published online on April 7, 2020.

sponsored torture," said Dr. Vincent Iacopino, senior medical advisor at Physicians for Human Rights. "The complicity of medical personnel in such practices represents a gross contravention of the UN Principles of Medical Ethics for health personnel, particularly medical doctors who engage, actively or passively, in acts of torture or other cruel, inhuman or degrading treatment or punishment."(9)

Individual physicians may feel isolated or frightened when faced with pressure to participate in corporal punishment. History shows that a well organised, strong and independent professional (medical) organisation is essential and can provide a strong force in upholding medical ethics and opposing medical complicity in corporal punisment. The British Medical Association report *Medicine betrayed* mentions several cases of medical professional opposition against corporal punishment and medical involvement (10).

An example of effective medical professional opposition to complicity in human rights violations and upholding medical ethics is the case of the Turkish Medical Association. The board of the TMA forbade its members from participating in capital punishment in 1984. The board was subsequently brought before court for its stance, but the charges were dropped in the course of time under strong international pressure.

Confusing and illogical analogies

The article by Das, in the section "Analogous situations" (1), refers appropriately to the situation in the United States where medical complicity in capital punishment exists. However the comparison with the case of the Scottish surgeon Robert Smith who amputated a healthy leg of a man suffering from the psychiatric condition acrotomophilia, is not relevant to this debate (1). This comparison is, in my opinion, confusing and illogical, since this (psychiatric) patient had expressed his free will and desire to undergo this procedure. Secondly, there was no juridical system and court sentence forcing him to undergo the amputation.

Das refers to Alper's paper about physicians and capital punishment in the USA, stating

> "… while there are non-binding ethical objections to participation in the US, it is not difficult to find physicians who are willing to flout these guidelines", but seems to forget the position of the professional associations: the American Medical Association's *Code of Medical Ethics* states " as member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution."(11) The American College of Correctional Physicians, American College of Physicians, American Public Health Association, American Society of Anesthesiologists and the World Medical Association have all said it is unethical for physicians to participate in capital punishment (12).

Das quotes the point of view of Baum, who argues in favour of physician participation in executions since patients facing execution are akin to terminally ill patients and that doctors have an ethical obligation to reduce the suffering of, say, a dying cancer patient. But this is also confusing and illogical. In the case of terminally ill patients, there is no alternative to the patient's outcome. In the case of executions, there *is*: to abandon the man-made practice of executions. The same critique applies to the unfortunate analogy with euthanasia. Living and working (ie as an end-of-life consultant) in a country that has legalised euthanasia under strict regulation, I deplore the analogy. Euthanasia is only given at the request of a competent patient in highly regulated and reviewed cases of terminally ill persons, where there is no alternative option than to allow the patient to continue to experience unwanted and intolerable suffering. This too is not comparable with penal amputations; firstly since euthanasia is intended to end suffering, and secondly, the suffering involved in the infliction of amputation can be prevented – by abandoning amputations.

It is dangerous to argue in favour of involving medical expertise in practices that violate medical ethics. Where does it stop? Do we, since torture is a "given practice" in many countries, allow, tolerate, or promote medical involvement?

One point has not yet been mentioned. Das is right in arguing that Hudud punishments, in a decent society, are rarely applied, since the burden of proof is extremely high. Time and again we see, however, that such punishments rise in number and harshness in cases of civil unrest and in times of oppression. Do we want doctors to follow? Or do we need international solidarity with and support for those colleagues and professional organisations that refuse to violate their ethics?

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Response to commentary by Adriaan van Es

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I would like to thank Dr Adriaan Van Es for his commentary (1) on my article (2). To start with, let me make one thing clear: I am not sure why he thinks that I am condoning the practice of penal amputation. As I clearly state in my conclusion, the arguments that may (or may not) justify penal amputation are "abhorrent" in liberal societies. We are on the same side here. But what of those who live in less secular societies where religious faith may be unquestioned? In my opinion, van Es has resorted to a typical example of a "tortured form of ethical logic" (3), which researchers from countries that have different value systems and different problems have deplored, albeit in a different context.

Some other points: I have made it clear that the Malaysian Medical Association (MMA) has strongly opposed the move of the Kelantan government and while the American Medical Association's code of medical ethics does mention many inspiring ideals the fact remains that no sanctions have been imposed on physicians who are participating in penal amputations.

While euthanasia is carried out after informed consent, it is still a form of harm to the patient; I am not sure how we can get around this ethical dilemma. And I also notice that van Es has carefully sidestepped my query about what happens if the patient gives consent to his amputation. If a religious man acknowledges the authority of a religious court and consents to its punishment, then it is not clear to me why this is not analogous to euthanasia or for that matter, to Robert Smith's surgeries.

We do not live in an ideal world. If we did, there would be no crime and no punishment and this entire argument would be infructuous. However in this imperfect world we are forced to compromise and it is my belief that agreeing to some forms of harm while refusing to acknowledge the possibility that other forms of harm may be protected by the same ethical arguments only inhibits healthy debate.

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To cite: Das AK. Response to Adriaan van Es. *Indian J Med Ethics.* 2020 Apr-Jun;5(2) NS;151. DOI:10.20529/IJME.2020.043.

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