

American University Washington College of Law

From the Selected Works of Claudio M. Grossman

March, 2014

The U.N. Committee Against Torture and Eradication of Torture in Health Care Settings

Claudio M. Grossman



Available at: https://works.bepress.com/claudio_grossman/92/

The U.N. Committee Against Torture and Eradication of Torture in Health Care Settings

CLAUDIO GROSSMAN*

Abstract

This article explains that the United Nations Committee against Torture (hereinafter “the Committee”) has played a significant role in addressing the serious problem of torture in health care settings. In particular, the Committee’s Concluding Observations and Recommendations under Article 19 of the Convention against Torture have been an important tool in this area. The Committee has used these means to remind States parties of their obligation to provide adequate health care for persons held in detention centers and prisons, to address abuses and poor conditions in mental health institutions and psychiatric facilities, and to denounce the practice of punishing or denying care to women who seek post-abortion health services. Additionally, the substantive and procedural obligations outlined in the Committee’s recently adopted General Comment No. 3, which addresses the issue of redress and rehabilitation of victims of torture, are also identified as an important step in the quest to prevent torture and provide redress to all victims of torture, including those in health care settings.

Introduction

The Committee is a treaty body with ten independent experts elected by the States parties. Its mandate is to supervise compliance with the United Nations Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (“Convention”).¹ The Convention establishes obligations for States to prevent torture or ill-treatment inflicted by or at the instigation of or with the consent or acquiescence of a public official.² Accordingly, torture and ill-treatment can also take place in health care settings when a State fails to perform its duties of prevention or investigation and punishment if there is a violation of the Convention.

Health care settings present a highly sensitive situation as people could be placed in vulnerable settings that limit a person’s ability to consent. Additionally, individuals in places of detention must fully rely on a third party to provide any needed health care. The consequences of denial of

*Claudio Grossman is Dean of American University Washington College of Law, Chairperson of the United Nations Committee against Torture, and Chairperson of the UN human rights treaty bodies. The views expressed by Dean Grossman are his own and not necessarily those of the Committee against Torture or the other UN human rights treaty bodies.

¹ U.N. Convention against Torture, Dec. 10, 1984, 1465 U.N.T.S. 85, available at <http://www2.ohchr.org/english/law/cat.htm> [hereinafter *Convention*].

² *Id.*, arts. 1, 2 and 16.

health services in such a vulnerable situation are often devastating and dramatic. The Committee has addressed torture in health care settings mostly through its Concluding Observations and through the recently published General Comment No. 3: Implementation of Article 14 by States Parties that address the issue of redress and rehabilitation of victims of torture. This paper will highlight recent examples of the Committee's efforts.³

Concluding Observations and Recommendations under Article 19

The Committee's Concluding Observations and Recommendations are an important tool in addressing torture in health care settings. Article 19 creates an obligation for State party periodic reporting and is the Committee's primary tool to assess compliance with the Convention. The Committee considers and evaluates reports submitted by States parties and formalizes its findings in an official document known as the Committee's Concluding Observations. Through the process of adopting Concluding Observations, issues are identified, recommendations are formulated, and a participatory process is created that allows for dialogue and exchanges with government officials, NGOs, and the international community. In this context, the Committee has submitted observations and recommendations to States parties that deal directly with torture in health care settings.

The Committee has specifically addressed abuses and poor conditions in mental health institutions and psychiatric facilities. Patients with psychosocial, mental, or psychological disabilities are among the most vulnerable patient populations. The Committee's primary concerns include the deprivation of liberty and related fundamental safeguards, use of physical restraints, and lack of investigations when violations are denounced. The Committee has expressed concern, as in the case of the Czech Republic, that patients in these facilities are often deprived of liberty without free and informed consent.⁴ Likewise, the Committee identified that numerous persons with disabilities were held in mental and psychiatric institutions, for example in Russia and Japan, for extended periods of time and on an involuntary basis.⁵ The Committee has determined that consent to be treated is crucial to guarding a patient's fundamental rights; this also extends to the use of physical restraints. The Committee denounced the widespread use of physical restraints in the cases of Norway and the Czech Republic, including the use of cage-beds, net-beds, bed strapping, manacles, and solitary confinement.⁶ In all of the above examples, the Committee highlighted the need for independent monitoring and investigation and proper training in all psychiatric and mental health institutions. The Committee's views show that, in accordance with the Convention, it is crucially important that patients in these institutions be granted full rights of appeal and that state authorities provide clear regulations and training for medical and non-medical staff in order to safeguard and prevent torture or ill-treatment of patients. The Committee will continue to review

³ This paper provides an overview of recent efforts by the Committee and is by no means exhaustive. In addition to Article 19, the Committee has additional supervisory mechanisms including individual communications (Article 22) and confidential visits to States parties for which the Committee has received "reliable information which appears to it to contain well-founded indications that torture is being systematically practiced ..." (Article 20).

⁴ U.N. Committee against Torture [UNCAT], *Concluding Observations on the Czech Republic* [hereinafter *Czech Republic*], para. 21, U.N. Doc. CAT/C/CZE/CO/4-5 (2012).

⁵ UNCAT, *Concluding Observations on the Russian Federation Republic*, para. 22, U.N. Doc. CAT/C/RUS/CO/5 (2012); UNCAT, *Concluding Observations on Japan* [hereinafter *Japan*], para. 22, U.N. Doc. CAT/C/JPN/CO/2 (2013).

⁶ Czech Republic, *supra* note 4, at para. 21; UNCAT, *Concluding Observations on Norway*, ¶ 14, U.N. Doc. CAT/C/NOR/CO/6-7 (2012).

the issue of consent, clearly establishing that the existence of a disability, no matter how severe, does not negate the requirement of consent.

The Committee has also reminded States parties of their obligation to provide adequate health care for persons held in detention centers and prisons. For example, the Committee in the case of Madagascar called upon the state to ensure that prisoners have access to decent food and health care given the poor living conditions, malnutrition, and disease in state prisons.⁷ Japan, Belarus, and Chile were also reminded of their duties to ensure adequate health care in centers of detention, including access to mental health care for all prisoners.⁸ The Committee also specifically identified one community health center in Vienna, Austria that failed to provide privacy when administering mandatory exams for sex workers. The Committee recommended that Austria ensure privacy in all examination centers and safeguard the dignity of women.⁹ As noted above, detained persons must rely on state authorities for care, and as such, States parties are obligated to provide access to adequate health and medical services to those who need them.

The Committee denounced the practice of punishing or denying care to women who seek post-abortion health services, as well as the practice of extracting information from women for the purpose of prosecuting those providing abortion related services.¹⁰ The Committee has fallen short of endorsing abortion as a legal right. However, the Committee has expressed serious concerns that illegal abortions are one of the main causes of high maternal mortality and that overly restrictive interpretations of therapeutic and legal abortion in cases of medical necessity lead women to seek unsafe illegal abortions.¹¹ The Committee is also concerned, as noted to Chile, with the practice of requiring women suffering complications from illegal abortions to disclose information as a requirement to receive health care.¹² The Committee's Concluding Observations follow these concerns, stating that States parties should clarify legislation regarding therapeutic or legal abortions and ensure that patients in need of care are provided care without restriction.¹³ The doctor-patient relationship must be protected and no doctor or patient should be required to disclose information as a requirement of receiving or providing care.¹⁴ The Committee has further urged states to prohibit the practice of extracting confessions from women seeking emergency medical care for prosecution purposes.¹⁵ Additionally, the Committee has urged States to authorize abortions in the case of pregnancy resulting from rape or incest or for cases where the pregnancy threatens the life of the mother.¹⁶

⁷ UNCAT, *Concluding Observations on Madagascar*, para. 10., U.N. Doc. CAT/C/MDG/CO/1 (2011).

⁸ Japan, *supra* note 5, at para. 13; UNCAT, *Concluding Observations on Belarus*, para. 19, U.N. Doc. CAT/C/BLR/CO/4 (2012); UNCAT, *Concluding Observations on Chile* [hereinafter Chile], para. 22, U.N. Doc. CAT/C/CHL/CO/5 (2009).

⁹ UNCAT, *Concluding Observations on Austria*, para. 22, U.N. Doc. CAT/C/AUT/CO/4-5 (2010).

¹⁰ UNCAT, *Concluding Observations on Chile* [hereinafter Chile 2004], para. 6(j)-(m), U.N. Doc. CAT/C/CR/32/5 (2004); UNCAT, *Concluding Observations on Paraguay* [hereinafter Paraguay], para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); UNCAT, *Concluding Observations on Ireland* [hereinafter Ireland], para. 26, U.N. Doc. CAT/C/IRL/CO/1 (2011); UNCAT, *Concluding Observations on Peru* [hereinafter Peru], para. 15, U.N. Doc. CAT/C/CO/5-6 (2013).

¹¹ Peru, *supra* note 10, at para. 15.

¹² Chile 2004, *supra* note 10, at para. 6(j)-(m).

¹³ Peru, *supra* note 10, at para. 15(a); Ireland, *supra* note 10, para. 26; Paraguay, *supra* note 10, para. 22.

¹⁴ Paraguay, *supra* note 10, at para. 22.

¹⁵ Peru, *supra* note 10, at para. 15(d); Chile, *supra* note 10, at para. 6(j).

¹⁶ Paraguay, *supra* note 10, at para. 22. The Committee echoes the recommendations of the Human Rights Council, the Human Rights Committee, the Committee on the Elimination of Discrimination against Women, and the Committee on Economic, Social and Cultural Rights.

General Comment No. 3 on Redress under the Convention

The Committee recently adopted General Comment No. 3 (December 2012), the aim of which is to interpret the obligations of States parties in accordance with Article 14 of the Convention to provide redress to victims of torture and ill-treatment. The General Comment clarifies the obligations of States parties in relation to Article 14 and also contributes to specifying states' obligations in individual cases of torture and other forms of cruel, inhuman or degrading treatment (hereafter "ill-treatment") that have been the object of communications to the Committee under Article 22. The Committee's experiences in dealing with redress to victims of torture led to the adoption of the General Comment; it was the Committee's goal to increase the impact of the Convention and provide guidance for all stakeholders involved that would assist them in evaluating the obligations under the Convention.

1. Substantive Obligations Outlined in General Comment No. 3

General Comment No. 3 explains that States parties have substantive obligations to ensure in accordance with Article 14 that victims of torture or ill-treatment shall obtain full and effective redress and reparations and be provided the means for as full rehabilitation as possible. These substantive obligations for the right to redress include restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition.¹⁷ The General Comment defines the term victim in relation to torture in paragraph three: "Victims are persons who have individually or collectively suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that constitute violations of the Convention."¹⁸ In defining the term "victim" broadly, the Committee made it clear that torture is a pervasive evil that touches all aspects of the human society. This broad definition certainly encompasses victims of torture and ill-treatment in health care settings.

The Committee strongly emphasizes that victim participation is essential in the redress process. The right to redress is one that, by its nature, centers on the victim of torture. This point is specifically important in relation to health care settings as hospitals, doctors, and medical professionals are often a key component of any successful victim-centered rehabilitation. Additionally, state authorities have an affirmative obligation to prevent, prosecute, investigate, and punish non-state actors or private individuals who commit torture, which is of specific importance in health care settings as many hospitals, mental institutions, doctors' offices, and medical providers are often privately owned.¹⁹

Rehabilitation is a particularly relevant obligation of States parties in regard to torture in health care settings. General Comment No. 3 explains in detail States' affirmative obligation to provide means for as full of a rehabilitation as possible for victims of torture.²⁰ Health care institutions are a key component of any successful rehabilitation as victims of torture suffer life altering physical and mental harm. States parties are required to adopt a long-term integrated approach to rehabilitation that requires health care settings to be safe and free from abusive practices as well as to be

¹⁷ UNCAT, *General Comment No. 3: Implementation of Article 14 by States Parties*, para. 6, U.N. Doc. CAT/C/GC/3 (Nov. 16, 2012).

¹⁸ *Id.*, para. 3.

¹⁹ *Id.*, para. 7.

²⁰ *Id.*, paras. 11-15.

accessible, effective, and holistic.²¹ States parties must ensure that all health care settings are free from torture and ill-treatment, as well as ensure that both private and public health care facilities and personnel are trained, able, and ready to provide victims of torture means for as full a rehabilitation as possible, including direct health care, psychosocial services, re-integrative and social services, community and family assistance, and physical and mental rehabilitative services.²² This obligation for States parties to provide rehabilitation to victims of torture encompasses all individuals found within a State's territory.

States parties' other substantive obligations under Article 14 are also important in preventing torture and providing redress to victims of torture in health care settings, including restitution, compensation, satisfaction and right to truth, and guarantees of non-repetition. These obligations are important generally to all victims of torture, including those in health care settings, and also obligate state authorities to take specific measures to guarantee non-repetition. General Comment No. 3 explains that States parties must provide a guarantee of non-repetition, which in health care settings requires independent monitoring, training public servants and health care professionals on human rights law, promoting the observance of international standards for correctional, medical, psychological and social service public servants, and ensuring the availability of temporary services for victims of torture and ill-treatment.²³

2. Procedural Obligations Outlined in General Comment No. 3

As explained in the General Comment, States parties have several procedural obligations under Article 14 of the Convention. These procedural obligations include the obligation to enact domestic legislation, provide effective mechanisms for complaints and investigations, and ensure access to mechanisms for obtaining redress. States have an obligation under Article 14 to enact legislation that criminalizes torture and ill-treatment in all settings, including health care.²⁴ Domestic legislation should also incorporate health care providers and institutions in a holistic and integrated approach to provide victims of torture with full and effective redress. States parties are obligated to ensure that victims of torture have full access to institutions that are capable of investigating complaints and rendering enforceable final decisions in compliance with the Convention.²⁵ These mechanisms include judicial proceedings, state investigations, and proceedings under Article 22 of the Convention. Health care settings cannot be excluded from investigation or civil or criminal proceedings. General Comment No. 3 also highlights the importance of States parties affirmatively ensuring that victims of torture have full access to mechanisms for obtaining redress. Of specific relevance to health care settings, all medical staff dealing with victims of torture should receive special training, including training on the Istanbul Protocol.²⁶ These procedural obligations under Article 14, and the substantive obligations explained above, serve to prevent torture and provide redress to all victims of torture, including those in health care settings.

²¹ *Id.*, para. 13.

²² *Id.*, paras. 13-14.

²³ *Id.*, para. 18.

²⁴ *Id.*, para. 19.

²⁵ *Id.*, paras. 23-28.

²⁶ *Id.*, para. 35.

Conclusion

It is extremely difficult to accurately assess the impact of the Committee's work in terms of transformation of societal norms and practices. However, the Committee has taken an active role in advocating for the eradication of torture in health care settings through its Concluding Observations and the guidelines and obligations articulated in General Comment No. 3. By adopting General Comment No. 3, the Committee has provided governmental entities, civil society, and other international organizations with additional normative legitimacy. Through its activities, the Committee has shown that compliance with State obligations is not only a moral duty, but a legal requirement. Additionally, the constant dialogue that takes place between the Committee and the States, a dialogue that takes into account the views of civil society, creates a possibility of an ongoing supervision designed to achieve the vital goals of the Convention against Torture.