FACT SHEET

Intersex

FREE & EQUAL
UNITED NATIONS FOR LGBT EQUALITY

What does 'intersex' mean?

Intersex people are born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies.

Intersex is an umbrella term used to describe a wide range of natural bodily variations. In some cases, intersex traits are visible at birth while in others, they are not apparent until puberty. Some chromosomal intersex variations may not be physically apparent at all.

According to experts, between 0.05% and 1.7% of the population is born with intersex traits – the upper estimate is similar to the number of red haired people.

Being intersex relates to biological sex characteristics, and is distinct from a person's sexual orientation or gender identity. An intersex person may be straight, gay, lesbian, bisexual or asexual, and may identify as female, male, both or neither.

Because their bodies are seen as different, intersex children and adults are often stigmatized and subjected to multiple human rights violations, including violations of their rights to health and physical integrity, to be free from torture and ill-treatment, and to equality and non-discrimination.

Physical integrity

It has become common practice to subject intersex children to unnecessary surgical and other procedures for the purpose of trying to make their appearance conform to binary sex stereotypes.

These often irreversible procedures can cause permanent infertility, pain, incontinence, loss of sexual sensation, and lifelong mental suffering, including depression. Regularly performed without the full, free and informed consent of the person concerned, who is frequently too young to be part of the decision-making, these procedures may violate their rights to physical integrity, to be free from torture and ill-treatment, and to live free from harmful practices.

Such procedures are frequently justified on the basis of cultural and gender norms and discriminatory beliefs about intersex people and their integration into society.

Discriminatory attitudes can never justify human rights violations, including forced treatment and violations of the right to physical integrity. States have a duty to combat harmful stereotypes and discrimination, rather than reinforcing them. Such procedures may sometimes also be justified on the basis of alleged health benefits, but these are often proposed on the basis of weak evidence and without discussing alternative solutions that protect physical integrity and respect autonomy.

Unfortunately, such beliefs and societal pressures are often reflected by doctors, as well as parents of intersex children, who may encourage and/or give their agreement to such procedures, despite the lack of medical indication, necessity or urgency, and despite the fact that such procedures may violate human rights standards. Agreement is frequently given in absence of information on the short and long-term consequences of such surgery and lack of contact with peers, including intersex adults and their families.

Many intersex adults exposed to such surgery as children emphasize the shame and stigma linked to attempts to erase their intersex traits, as well as significant physical and mental suffering, including as a result of extensive and painful scarring. Many also feel that they were forced into sex and gender categories that do not fit them.

Given their irreversible nature and impact on physical integrity and autonomy, such medically unnecessary, unsolicited surgery or treatment should be prohibited. Intersex children and their families should receive adequate counselling and support, including from peers.

Discrimination

Intersex persons are often subjected to discrimination and abuse if it becomes known that they are intersex, or if they are perceived not to conform to gender norms. Anti-discrimination laws do not typically ban discrimination against intersex persons, leaving them vulnerable to discriminatory practices in a range of settings, including access to health services, education, public services, employment and sports.

Health-care professionals often lack the needed training, knowledge and understanding to take into account the specific health needs of intersex persons, provide appropriate healthcare, and respect the autonomy and rights of intersex persons to physical integrity and health.

Some intersex people also face barriers and discrimination if they wish to or need to amend sex markers on birth certificates and official documents.

Intersex athletes face a specific set of obstacles. There have been several cases of female intersex athletes who have been disqualified from sports competitions on the basis of their intersex traits. However, being intersex of itself does not entail better performance, whereas other physical variations that do affect performance, such as height and muscle development, are not subjected to such scrutiny and restrictions.

Protection and Remedy

Intersex people should be protected from violations of their rights. Whenever such violations occur, they should be investigated and alleged perpetrators prosecuted. Victims should have access to effective remedy, including redress and compensation.

Intersex people should also be consulted in the development of legislation and policies that impact on their rights.

Positive developments

In 2013, Australia adopted the Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act – the first law to include intersex status as a stand-alone prohibited ground of discrimination. The Australian Senate has also carried out an official inquiry into the involuntary or coerced sterilization of intersex people.

In 2015, Malta adopted the Gender Identity, Gender Expression and Sex Characteristics Act – the first law to prohibit surgery and treatment on the sex characteristics of minors without informed consent. It also prohibits discrimination on the basis of sex characteristics.

Action points

States:

» Prohibit medically unnecessary surgery and procedures on the sex characteristics of intersex children, protect their physical integrity and respect their autonomy.
» Ensure that intersex people and their families receive adequate counselling and support, including from peers.
» Prohibit discrimination on the basis of intersex traits, characteristics or status, including in education, health care, employment, sports and access to public services, and address such discrimination through relevant anti-discrimination initiatives.
» Ensure that human rights violations against intersex people are investigated and alleged perpetrators prosecuted, and that victims of such violations have access to effective remedy, including redress and compensation.
» National human rights bodies should research and monitor the human rights situation of intersex people.
» Enact laws to provide for facilitated procedures to amend sex markers on the birth certificates and official documents of intersex people.
» Provide health care personnel with training on the health needs and human rights of intersex people and the appropriate advice and care to give to parents and intersex children, being respectful of the intersex person's autonomy, physical integrity and sex characteristics.
» Ensure that members of the judiciary, immigration officers, law enforcement, healthcare, education and other officials and personnel are trained to respect and provide equal treatment to intersex persons.
» Ensure that intersex people and organizations are consulted and participate in the development of research, legislation and policies that impact on their rights.

Media:

» Include the voices of intersex people and groups in newspaper, TV and radio coverage.
» Give an objective and balanced picture of intersex people and their human rights concerns.
» Do not make assumptions about the sexual orientation or gender identity of intersex people.

You, your friends and other individuals can make a difference too:

» Speak out when you see any form of discrimination or violence against intersex people.
» Remember that intersex people may have any sexual orientation and gender identity.

ENDING VIOLENCE AND DISCRIMINATION AGAINST LESBIAN, GAY, BISEXUAL, TRANSGENDER AND INTERSEX PEOPLE

United Nations entities call on States to act urgently to end violence and discrimination against lesbian, gay, bisexual, transgender and intersex (LGBTI)[1] adults, adolescents and children.

All people have an equal right to live free from violence, persecution, discrimination and stigma. International human rights law establishes legal obligations on States to ensure that every person, without distinction, can enjoy these rights. While welcoming increasing efforts in many countries to protect the rights of LGBTI people, we remain seriously concerned that around the world, millions of LGBTI individuals, those perceived as LGBTI and their families face widespread human rights violations. This is cause for alarm – and action.

Failure to uphold the human rights of LGBTI people and protect them against abuses such as violence and discriminatory laws and practices, constitute serious violations of international human rights law and have a far-reaching impact on society – contributing to increased vulnerability to ill health including HIV infection, social and economic exclusion, putting strain on families and communities, and impacting negatively on economic growth, decent work and progress towards achievement of the future Sustainable Development Goals. States bear the primary duty under international law to protect everyone from discrimination and violence. These violations therefore require an urgent response by governments, parliaments, judiciaries and national human rights institutions. Community, religious and political leaders, workers' organizations, the private sector, health providers, civil society organizations and the media also have important roles to play. Human rights are universal – cultural, religious and moral practices and beliefs and social attitudes cannot be invoked to justify human rights violations against any group, including LGBTI persons.

PROTECTING INDIVIDUALS FROM VIOLENCE

States should protect LGBTI persons from violence, torture and ill-treatment, including by:

- *Investigating, prosecuting and providing remedy for acts of violence, torture and ill-treatment against LGBTI adults, adolescents and children, and those who defend their human rights;*
- *Strengthening efforts to prevent, monitor and report such violence;*
- *Incorporating homophobia and transphobia as aggravating factors in laws against hate crime and hate speech;*
- *Recognizing that persecution of people because they are (or are perceived to be) LGBTI may constitute a valid ground for asylum, and not returning such refugees to a place where their life or freedom might be threatened.*

The United Nations and others have documented widespread physical and psychological violence against LGBTI persons in all regions - including murder, assault, kidnapping, rape, sexual violence, as well as torture and ill-treatment in institutional and other setting. LGBTI youth and lesbian, bisexual and transgender women are at particular risk of physical, psychological and sexual violence in family and community settings. LGBTI persons often face violence and discrimination when seeking refuge from persecution and in humanitarian emergencies. They may also face abuse in medical settings, including unethical and harmful so-called "therapies" to change sexual orientation, forced or coercive sterilization, forced genital and anal examinations, and unnecessary surgery and treatment on intersex children without their consent. In many countries, the response to these violations is inadequate, they are underreported and often not properly investigated and prosecuted, leading to widespread impunity and lack of justice, remedies and support for victims. Human rights defenders combatting these violations are frequently persecuted and face discriminatory restrictions on their activities.

[1] While this statement refers to lesbian, gay, bisexual, transgender and intersex people, it should also be read to refer to other people who face violence and discrimination on the basis of their actual or perceived sexual orientation, gender identity and sex characteristics, including those who may identify with other terms.

REPEALING DISCRIMINATORY LAWS

States should respect international human rights standards, including by reviewing, repealing and establishing a moratorium on the application of:

- *Laws that criminalize same-sex conduct between consenting adults;*
- *Laws that criminalize transgender people on the basis of their gender expression;*
- *Other laws used to arrest, punish or discriminate against people on the basis of their sexual orientation, gender identity or gender expression.*

In 76 countries, laws still criminalize consensual same-sex relationships between adults, exposing individuals to the risk of arbitrary arrest, prosecution, imprisonment – even the death penalty, in at least five countries. Laws criminalizing cross-dressing are used to arrest and punish transgender people. Other laws are used to harass, detain, discriminate or place restrictions on the freedom of expression, association and peaceful assembly of lesbian, gay, bisexual and transgender people. These discriminatory laws contribute to perpetuating stigma and discrimination, as well as hate crime, police abuse, torture and ill-treatment, family and community violence, and negatively affect public health by impeding access to health and HIV services.

PROTECTING INDIVIDUALS FROM DISCRIMINATION

States should uphold international human rights standards on non-discrimination, including by:

- *Prohibiting discrimination against LGBTI adults, adolescents and children in all contexts – including in education, employment, healthcare, housing, social protection, criminal justice and in asylum and detention settings;*
- *Ensuring legal recognition of the gender identity of transgender people without abusive requirements;*
- *Combating prejudice against LGBTI people through dialogue, public education and training;*
- *Ensuring that LGBTI people are consulted and participate in the design, implementation and monitoring of laws, policies and programmes that affect them, including development and humanitarian initiatives.*

LGBTI people face widespread discrimination and exclusion in all contexts - including multiple forms of discrimination based on other factors such as sex, race, ethnicity, age, religion, poverty, migration, disability and health status. Children face bullying, discrimination or expulsion from schools on the basis of their actual or perceived sexual orientation or gender identity, or that of their parents. LGBTI youth rejected by their families experience disproportionate levels of suicide, homelessness and food insecurity. Discrimination and violence contribute to the marginalization of LGBTI people and their vulnerability to ill health including HIV infection, yet they face denial of care, discriminatory attitudes and pathologization in medical and other settings. Transgender people are frequently denied legal recognition of their preferred gender or face abusive requirements such as forced sterilization, treatment or divorce to obtain it, without which they suffer exclusion and marginalization. The exclusion of LGBTI people from the design, implementation and monitoring of laws and policies that affect them perpetuates their social and economic marginalization.

UNITED NATIONS SUPPORT

Our organizations stand ready to support and assist Member States and other stakeholders as they work to address the challenges outlined in this statement including through constitutional, legislative and policy changes, strengthening of national institutions, and education, training and other initiatives to respect, protect, promote and fulfil the human rights of all LGBTI people.

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Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez

Summary

The present report focuses on certain forms of abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment. It identifies the policies that promote these practices and existing protection gaps.

By illustrating some of these abusive practices in health-care settings, the report sheds light on often undetected forms of abusive practices that occur under the auspices of health-care policies, and emphasizes how certain treatments run afoul of the prohibition on torture and ill-treatment. It identifies the scope of State's obligations to regulate, control and supervise health-care practices with a view to preventing mistreatment under any pretext.

The Special Rapporteur examines a number of the abusive practices commonly reported in health-care settings and describes how the torture and ill-treatment framework applies in this context. The examples of torture and ill-treatment in health settings discussed likely represent a small fraction of this global problem.

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I. Introduction

1. The present report is submitted to the Human Rights Council in accordance with Council resolution 16/23.

2. Reports of country visits to Tajikistan and Morocco are contained in documents A/HRC/22/53/Add.1 and Add.2, respectively. A/HRC/22/53/Add.3 contains an update on follow-up measures and A/HRC/22/53/Add.4 contains observations made by the Special Rapporteur on some of the cases reflected in the communication reports A/HRC/20/30, A/HRC/21/49 and A/HRC/22/67.

II. Activities of the Special Rapporteur

A. Upcoming country visits and pending requests

3. The Special Rapporteur plans to visit Bahrain in May 2013 and Guatemala in the second half of 2013 and is engaged with the respective Governments to find mutually agreeable dates. The Special Rapporteur has accepted an invitation to visit Thailand in February 2014. He also notes with appreciation an outstanding invitation to visit Iraq.

4. The Special Rapporteur has reiterated his interest to conduct country visits to a number of States where there are pending requests for invitations: Cuba; Ethiopia; Ghana; Kenya; United States of America; Uzbekistan; Venezuela (Bolivarian Republic of) and Zimbabwe. The Special Rapporteur has also recently requested to visit Chad, Côte d'Ivoire, Dominican Republic, Georgia, Mexico and Viet Nam.

B. Highlights of key presentations and consultations

5. On 10 September 2012, the Special Rapporteur participated in a Chatham House event in London hosted by REDRESS on "Enforcing the absolute prohibition against torture".

6. On 26 September 2012, the Special Rapporteur met the Director General of the National Human Rights Commission of the Republic of Korea, who was visiting Washington D.C.

7. Between 22 and 24 October 2012, the Special Rapporteur presented his interim report (A/67/279) to the General Assembly and participated in two side events: one, held at the Permanent Mission of Denmark to the United Nations in New York, on "Reprisals against victims of torture and other ill-treatment" and the other organized jointly with the World Organisation Against Torture, Penal Reform International, the Centre for Constitutional Rights and Human Rights Watch on "The death penalty and human rights: the way forward". He also met with representatives of the Permanent Missions of Guatemala and Uruguay.

8. On 17 November 2012, the Special Rapporteur participated in a symposium organized by New York University on the practice of solitary confinement, entitled "Solitary: wry fancies and stark realities".

9. From 2 to 6 December 2012, the Special Rapporteur conducted a follow-up visit to Uruguay (A/HRC/22/53/Add.3), at the invitation of the Government, to assess improvements and identify remaining challenges regarding torture and other cruel, inhuman or degrading treatment or punishment.

10. From 13 to 14 December 2012, the Special Rapporteur convened an expert meeting on "Torture and ill-treatment in healthcare settings" at the Center for Human Rights and Humanitarian Law, American University in Washington, DC.

III. Applying the torture and ill-treatment protection framework in health-care settings

11. Mistreatment in health-care settings[1] has received little specific attention by the mandate of the Special Rapporteur, as the denial of health-care has often been understood as essentially interfering with the "right to health".

12. While different aspects of torture and ill-treatment in health-care settings have been previously explored by the rapporteurship and other United Nations mechanisms, the Special Rapporteur feels that there is a need to highlight the specific dimension and intensity of the problem, which often goes undetected; identify abuses that exceed the scope of violations of the right to health and could amount to torture and ill-treatment; and strengthen accountability and redress mechanisms.

13. The Special Rapporteur recognizes that there are unique challenges to stopping torture and ill-treatment in health-care settings due, among other things, to a perception that, while never justified, certain practices in health-care may be defended by the authorities on grounds of administrative efficiency, behaviour modification or medical necessity. The intention of the present report is to analyse all forms of mistreatment premised on or attempted to be justified on the basis of health-care policies, under the common rubric of their purported justification as "health-care treatment", and to find cross-cutting issues that apply to all or most of these practices.

A. Evolving interpretation of the definition of torture and ill-treatment

14. Both the European Court of Human Rights (ECHR) and the Inter-American Court of Human Rights have stated that the definition of torture is subject to ongoing reassessment in light of present-day conditions and the changing values of democratic societies.[2]

15. The conceptualization of abuses in health-care settings as torture or ill-treatment is a relatively recent phenomenon. In the present section, the Special Rapporteur embraces this ongoing paradigm shift, which increasingly encompasses various forms of abuse in health-care settings within the discourse on torture. He demonstrates that, while the prohibition of torture may have originally applied primarily in the context of interrogation, punishment or intimidation of a detainee, the international community has begun to recognize that torture may also occur in other contexts.

16. The analysis of abuse in health-care settings through the lens of torture and ill-treatment is based on the definition of these violations provided by the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its authoritative interpretations. In order to demonstrate how abusive practices in health-care

[1] Health-care settings refers to hospitals, public and private clinics, hospices and institutions where health-care is delivered.

[2] World Organization Against Torture (OMCT), *The Prohibition of Torture and Ill-treatment in the Inter-American Human Rights System: A Handbook for Victims and Their Advocates* (2006), p. 107, citing Inter-American Court of Human Rights, *Cantoral-Benavides* v. *Peru*, Series C, No. 69 (2000) para. 99; ECHR, *Selmouni* v. *France*, Application No. 25803/94 (1999), para. 101.

settings meet the definition of torture, the following section provides an overview of the main elements of the definition of torture.

B. Applicability of the torture and ill-treatment framework in health-care settings

1. Overview of key elements of the definition of torture and ill-treatment

17. At least four essential elements are reflected in the definition of torture provided in article 1, paragraph 1, of the Convention against Torture: an act inflicting severe pain or suffering, whether physical or mental; the element of intent; the specific purpose; and the involvement of a State official, at least by acquiescence (A/HRC/13/39/Add.5, para. 30). Acts falling short of this definition may constitute cruel, inhuman or degrading treatment or punishment under article 16 of the Convention (A/63/175, para. 46). The previous Special Rapporteurs have covered in great detail the main components of the definition of torture. Nevertheless, there are a few salient points worth elaborating for the purpose of the present report.

18. The jurisprudence and authoritative interpretations of international human rights bodies provide useful guidance on how the four criteria of the definition of torture apply in the context of health-care settings. ECHR has noted that a violation of article 3 may occur where the purpose or intention of the State's action or inaction was not to degrade, humiliate or punish the victim, but where this nevertheless was the result.[3]

19. The application of the criteria of severe pain or suffering, intent, and involvement of a public official or other person acting in an official capacity, by consent or acquiescence to abuses in health-care settings, is relatively straightforward. The criterion of the specific purpose warrants some analysis.[4]

20. The mandate has stated previously that intent, required in article 1 of the Convention, can be effectively implied where a person has been discriminated against on the basis of disability. This is particularly relevant in the context of medical treatment, where serious violations and discrimination against persons with disabilities may be defended as "well intended" on the part of health-care professionals. Purely negligent conduct lacks the intent required under article 1, but may constitute ill-treatment if it leads to severe pain and suffering (A/63/175, para. 49).

21. Furthermore, article 1 explicitly names several purposes for which torture can be inflicted: extraction of a confession; obtaining information from a victim or a third person; punishment, intimidation and coercion; and discrimination. However, there is a general acceptance that these stated purposes are only of an indicative nature and not exhaustive. At the same time, only purposes which have "something in common with the purposes expressly listed" are sufficient (A/HRC/13/39/Add.5, para. 35).

22. Although it may be challenging to satisfy the required purpose of discrimination in some cases, as most likely it will be claimed that the treatment is intended to benefit the "patient", this may be met in a number of ways.[5] Specifically, the description of abuses

[3] See *Peers v. Greece*, Application No. 28524/95 (2001), paras. 68, 74; *Grori v. Albania*, Application No. 25336/04 (2009), para. 125.

[4] Open Society Foundations, *Treatment or Torture? Applying International Human Rights Standards to Drug Detention Centers* (2011), p. 10.

[5] Ibid., p. 12.

outlined below demonstrates that the explicit or implicit aim of inflicting punishment, or the objective of intimidation, often exist alongside ostensibly therapeutic aims.

2. The scope of State core obligations under the prohibition of torture and ill-treatment

23. The Committee against Torture interprets State obligations to prevent torture as indivisible, interrelated, and interdependent with the obligation to prevent cruel, inhuman, or degrading treatment or punishment (ill-treatment) because "conditions that give rise to ill-treatment frequently facilitate torture".[6] It has established that "each State party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm".[7]

24. Indeed, the State's obligation to prevent torture applies not only to public officials, such as law enforcement agents, but also to doctors, health-care professionals and social workers, including those working in private hospitals, other institutions and detention centres (A/63/175, para. 51). As underlined by the Committee against Torture, the prohibition of torture must be enforced in all types of institutions and States must exercise due diligence to prevent, investigate, prosecute and punish violations by non-State officials or private actors.[8]

25. In *da Silva Pimentel* v. *Brazil*, the Committee on the Elimination of Discrimination against Women observed that "the State is directly responsible for the action of private institutions when it outsources its medical services" and "always maintains the duty to regulate and monitor private health-care institutions".[9] The Inter-American Court of Human Rights addressed State responsibility for actions of private actors in the context of health-care delivery in *Ximenes Lopes* v. *Brazil*.[10]

26. Ensuring special protection of minority and marginalized groups and individuals is a critical component of the obligation to prevent torture and ill-treatment. Both the Committee against Torture and the Inter-American Court of Human Rights have confirmed that States have a heightened obligation to protect vulnerable and/or marginalized individuals from torture, as such individuals are generally more at risk of experiencing torture and ill-treatment.[11]

C. Interpretative and guiding principles

1. Legal capacity and informed consent

27. In all legal systems, capacity is a condition assigned to agents that exercise free will and choice and whose actions are attributed legal effects. Capacity is a rebuttable

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[6] General comment No. 2 (2007), para. 3.

[7] Ibid., para. 15.

[8] General comment No. 2, paras. 15, 17 and 18. See also Committee against Torture, communication No. 161/2000, *Dzemajl et al.* v. *Serbia and Montenegro*, para. 9.2; Human Rights Committee, general comment No. 20 (1992), para. 2.

[9] Communication No. 17/2008, para. 7.5.

[10] Inter-American Court of Human Rights. (Series C) No. 149 (2006), paras. 103, 150; see also Committee on the Elimination of Discrimination against Women, general recommendation No. 19 (1992), para. 9.

[11] Committee against Torture, general comment No. 2, para. 21; *Ximenes Lopes* v. *Brazil*, para. 103.

presumption; therefore, "incapacity" has to be proven before a person can be designated as incapable of making decisions. Once a determination of incapacity is made, the person's expressed choices cease to be treated meaningfully. One of the core principles of the Convention on the Rights of Persons with Disabilities is "respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons" (art. 3 (a)). The Committee on the Rights of Persons with Disabilities has interpreted the core requirement of article 12 to be the replacement of substituted decision-making regimes by supported decision-making, which respects the person's autonomy, will and preferences.[12]

28. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health observed that informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision. Guaranteeing informed consent is a fundamental feature of respecting an individual's autonomy, self-determination and human dignity in an appropriate continuum of voluntary health-care services (A/64/272, para. 18).

29. As the Special Rapporteur on the right to health observed, while informed consent is commonly enshrined in the legal framework at the national level, it is frequently compromised in the health-care setting. Structural inequalities, such as the power imbalance between doctors and patients, exacerbated by stigma and discrimination, result in individuals from certain groups being disproportionately vulnerable to having informed consent compromised (ibid., para. 92).

30. The intimate link between forced medical interventions based on discrimination and the deprivation of legal capacity has been emphasized both by the Committee on the Rights of Persons with Disabilities and the previous Special Rapporteur on the question of torture.[13]

2. Powerlessness and the doctrine of "medical necessity"

31. Patients in health-care settings are reliant on health-care workers who provide them services. As the previous Special Rapporteur stated: "Torture, as the most serious violation of the human right to personal integrity and dignity, presupposes a situation of powerlessness, whereby the victim is under the total control of another person."[14] Deprivation of legal capacity, when a person's exercise of decision-making is taken away and given to others, is one such circumstance, along with deprivation of liberty in prisons or other places (A/63/175, para. 50).

32. The mandate has recognized that medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned (ibid., paras. 40, 47). This is particularly the case when intrusive and irreversible, non-consensual treatments are performed on patients from marginalized groups, such as persons with disabilities, notwithstanding claims of good intentions or medical necessity. For example, the mandate has held that the discriminatory character of forced psychiatric interventions, when committed against persons with psychosocial disabilities, satisfies both intent and purpose required under the article 1 of the Convention against Torture, notwithstanding claims of "good intentions" by medical professionals (ibid., paras. 47, 48). In other examples, the administration of non-consensual medication or involuntary

[12] See CRPD/C/ESP/CO/1.

[13] Convention on the Rights of Persons with Disabilities, art. 25 (d); see also CRPD/C/CHN/CO/1 and Corr.1, para. 38; A/63/175, paras. 47, 74.

[14] A/63/175, para. 50.

sterilization is often claimed as being a necessary treatment for the so-called best interest of the person concerned.

33. However, in response to reports of sterilizations of women in 2011, the International Federation of Gynecology and Obstetrics emphasized that "sterilization for prevention of future pregnancy cannot be ethically justified on grounds of medical emergency. Even if a future pregnancy may endanger a woman's life or health, she ... must be given the time and support she needs to consider her choice. Her informed decision must be respected, even if it is considered liable to be harmful to her health."[15]

34. In those cases, dubious grounds of medical necessity were used to justify intrusive and irreversible procedures performed on patients without full free and informed consent. In this light, it is therefore appropriate to question the doctrine of "medical necessity" established by the ECHR in the case of *Herczegfalvy* v. *Austria* (1992),[16] where the Court held that continuously sedating and administering forcible feeding to a patient who was physically restrained by being tied to a bed for a period of two weeks was nonetheless consistent with article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms because the treatment in question was medically necessary and in line with accepted psychiatric practice at that time.

35. The doctrine of medical necessity continues to be an obstacle to protection from arbitrary abuses in health-care settings. It is therefore important to clarify that treatment provided in violation of the terms of the Convention on the Rights of Persons with Disabilities – either through coercion or discrimination – cannot be legitimate or justified under the medical necessity doctrine.

3. Stigmatized identities

36. In a 2011 report (A/HRC/19/41), the United Nations High Commissioner for Human Rights examined discriminatory laws and practices and acts of violence against individuals based on sexual orientation and gender identity in health-care settings. She observed that a pattern of human rights violations emerged that demanded a response. With the adoption in June 2011 of resolution 17/19, the Human Rights Council formally expressed its "grave concern" regarding violence and discrimination based on sexual orientation and gender identity.

37. Many policies and practices that lead to abuse in health-care settings are due to discrimination targeted at persons who are marginalized. Discrimination plays a prominent role in an analysis of reproductive rights violations as forms of torture or ill-treatment because sex and gender bias commonly underlie such violations. The mandate has stated, with regard to a gender-sensitive definition of torture, that the purpose element is always fulfilled when it comes to gender-specific violence against women, in that such violence is inherently discriminatory and one of the possible purposes enumerated in the Convention is discrimination (A/HRC/7/3, para. 68).

38. In the context of prioritizing informed consent as a critical element of a voluntary counselling, testing and treatment continuum, the Special Rapporteur on the right to health has also observed that special attention should be paid to vulnerable groups. Principles 17 and 18 of the Yogyakarta Principles, for instance, highlight the importance of safeguarding informed consent of sexual minorities. Health-care providers must be cognizant of, and adapt to, the specific needs of lesbian, gay, bisexual, transgender and intersex persons (A/64/272, para. 46). The Committee on Economic, Social and Cultural Rights has

[15] *Ethical Issues in Obstetrics and Gynecology* (2012), pp. 123–124.

[16] Application No. 10533/83, paras. 27, 83.

indicated that the International Covenant on Economic, Social and Cultural Rights proscribes any discrimination in access to health-care and the underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of sexual orientation and gender identity.[17]

IV. Emerging recognition of different forms of abuses in health-care settings

39. Numerous reports have documented a wide range of abuses against patients and individuals under medical supervision. Health providers allegedly withhold care or perform treatments that intentionally or negligently inflict severe pain or suffering for no legitimate medical purpose. Medical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman or degrading treatment or punishment, and if there is State involvement and specific intent, it is torture.

A. Compulsory detention for medical conditions

40. Compulsory detention for drug users is common in so-called rehabilitation centres. Sometimes referred to as drug treatment centres or "reeducation through labor" centres or camps, these are institutions commonly run by military or paramilitary, police or security forces, or private companies. Persons who use, or are suspected of using, drugs and who do not voluntarily opt for drug treatment and rehabilitation are confined in such centres and compelled to undergo diverse interventions.[18] In some countries, a wide range of other marginalized groups, including street children, persons with psychosocial disabilities, sex workers, homeless individuals and tuberculosis patients, are reportedly detained in these centres.[19]

41. Numerous reports document that users of illicit drugs who are detained in such centres undergo painful withdrawal from drug dependence without medical assistance, administration of unknown or experimental medications, State-sanctioned beatings, caning or whipping, forced labour, sexual abuse and intentional humiliation.[20] Other reported abuses included "flogging therapy", "bread and water therapy", and electroshock resulting in seizures, all in the guise of rehabilitation. In such settings, medical professionals trained to manage drug dependence disorders as medical illnesses[21] are often unavailable.

42. Compulsory treatment programmes that consist primarily of physical disciplinary exercises, often including military-style drills, disregard medical evidence (A/65/255, paras. 31, 34). According to the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC), "neither detention nor forced labour have been recognized by science as treatment for drug use disorders".[22] Such detention – frequently

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[17] General comment No. 14 (2000), para. 18.

[18] See World Health Organization (WHO), *Assessment of Compulsory Treatment of People Who Use Drugs in Cambodia, China, Malaysia and Viet Nam* (2009).

[19] Human Rights Watch (HRW), *Torture in the Name of Treatment: Human Rights Abuses in Vietnam, China, Cambodia, and LAO PDR* (2012), p. 4.

[20] See Daniel Wolfe and Roxanne Saucier, "In rehabilitation's name? Ending institutionalized cruelty and degrading treatment of people who use drugs", *International Journal of Drug Policy*, vol. 21, No. 3 (2010), pp. 145-148.

[21] United Nations Office on Drugs and Crime (UNODC) and WHO, "Principles of drug dependence treatment", discussion paper, 2008.

[22] Ibid., p. 15.

without medical evaluation, judicial review or right of appeal – offers no evidence-based[23] or effective treatment. Detention and forced labour programmes therefore violate international human rights law and are illegitimate substitutes for evidence-based measures, such as substitution therapy, psychological interventions and other forms of treatment given with full, informed consent (A/65/255, para. 31). The evidence shows that this arbitrary and unjustified detention is frequently accompanied by – and is the setting for – egregious physical and mental abuse.

Overview of developments to date

43. The numerous calls by various international and regional organizations to close compulsory drug detention centres,[24] as well as the numerous injunctions and recommendations contained in the recently released guidelines by WHO on pharmacotherapy for opiate dependence,[25] the UNODC policy guidance on the organization's human rights responsibilities in drug detention centres,[26] and resolutions by the Commission on Narcotic Drugs,[27] are routinely ignored.[28] These centres continue to operate often with direct or indirect support and assistance from international donors without any adequate human rights oversight.[29]

44. Notwithstanding the commitment to scale-up methadone treatment and evidence-based treatment as opposed to punitive approaches, those remanded to compulsory treatment in the punitive drug-free centres continue to exceed, exponentially, the number receiving evidence-based treatment for drug dependence.[30]

B. Reproductive rights violations

45. The Special Rapporteur has, on numerous occasions, responded to various initiatives in the area of gender mainstreaming and combating violence against women, by, inter alia, examining gender-specific forms of torture with a view to ensure that the torture protection framework is applied in a gender-inclusive manner.[31] The Special Rapporteur seeks to complement these efforts by identifying the reproductive rights practices in health-care settings that he believes amount to torture or ill-treatment.

46. International and regional human rights bodies have begun to recognize that abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering, inflicted on the basis of gender.[32] Examples of such violations include abusive treatment and humiliation in institutional settings;[33]

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[23] See for example WHO, UNODC, UNAIDS, *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users* (WHO, 2009).

[24] World Medical Association, "Call for compulsory drug Detention centers to be closed", press statement, 17 May 2011; United Nations entities, "Compulsory drug detention and rehabilitation centres", joint statement, March 2012.

[25] See Wolfe and Saucier, "In rehabilitation's name".

[26] "UNODC and the promotion and protection of human rights", position paper, 2012, p. 8.

[27] Such as resolutions 55/12 (2012); 55/2 (2012) and 55/10 (2012).

[28] See Wolfe and Saucier, "In rehabilitation's name".

[29] HRW, submission to the Special Rapporteur on the question of torture, 2012.

[30] See Wolfe and Saucier, "In rehabilitation's name".

[31] See A/54/426, A/55/290.

[32] CAT/C/CR/32/5, para. 7 (m); Human Rights Committee general comment No. 28 (2000), para. 11.

[33] See Center for Reproductive Rights, *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis* (2011).

involuntary sterilization; denial of legally available health services[34] such as abortion and post-abortion care; forced abortions and sterilizations;[35] female genital mutilation;[36] violations of medical secrecy and confidentiality in health-care settings, such as denunciations of women by medical personnel when evidence of illegal abortion is found; and the practice of attempting to obtain confessions as a condition of potentially life-saving medical treatment after abortion.[37]

47. In the case of *R.R.* v. *Poland*, for instance, ECHR found a violation of article 3 in the case of a woman who was denied access to prenatal genetic testing when an ultrasound revealed a potential foetal abnormality. The Court recognized "that the applicant was in a situation of great vulnerability"[38] and that R.R.'s access to genetic testing was "marred by procrastination, confusion and lack of proper counselling and information given to the applicant".[39] Access to information about reproductive health is imperative to a woman's ability to exercise reproductive autonomy, and the rights to health and to physical integrity.

48. Some women may experience multiple forms of discrimination on the basis of their sex and other status or identity. Targeting ethnic and racial minorities, women from marginalized communities[40] and women with disabilities[41] for involuntary sterilization[42] because of discriminatory notions that they are "unfit" to bear children[43] is an increasingly global problem. Forced sterilization is an act of violence,[44] a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment.[45] The mandate has asserted that "forced abortions or sterilizations carried out by State officials in accordance with coercive family planning laws or policies may amount to torture".[46]

49. For many rape survivors, access to a safe abortion procedure is made virtually impossible by a maze of administrative hurdles, and by official negligence and obstruction. In the landmark decision of *K.N.L.H.* v. *Peru*, the Human Rights Committee deemed the denial of a therapeutic abortion a violation of the individual's right to be free from ill-treatment.[47] In the case of *P. and S.* v. *Poland*, ECHR stated that "the general stigma attached to abortion and to sexual violence …, caus[ed] much distress and suffering, both physically and mentally".[48]

50. The Committee against Torture has repeatedly expressed concerns about restrictions on access to abortion and about absolute bans on abortion as violating the prohibition of torture and ill-treatment.[49] On numerous occasions United Nations bodies have expressed

[34] See CAT/C/PER/CO/4, para. 23.
[35] E/CN.4/2005/51, paras. 9, 12.
[36] A/HRC/7/3, paras. 50, 51, 53; CAT/C/IDN/CO/2, para. 16.
[37] CAT/C/CR/32/5, para. 6 (j).
[38] ECHR, *R.R.* v. *Poland*, Application No. 27617/04 (2011), para. 159.
[39] Ibid., para. 153.
[40] See ECHR, *V.C.* v. *Slovakia*, Application No. 18968/07 (2011).
[41] A/67/227, para. 28; A/HRC/7/3, para. 38.
[42] A/64/272, para. 55.
[43] See Open Society Foundations, *Against Her Will: Forced and Coerced Sterilization of Women Worldwide* (2011).
[44] See Committee on the Elimination of Discrimination against Women, general recommendation No. 19, para. 22; Human Rights Committee, general comment No. 28, paras. 11, 20.
[45] A/HRC/7/3, paras. 38, 39.
[46] Ibid., para. 69.
[47] Communication No. 1153/2003 (2005), para. 6.3.
[48] ECHR, Application No. 57375/08 (2012), para. 76.
[49] See CAT/C/PER/CO/4, para. 23.

concern about the denial of or conditional access to post-abortion care.[50] often for the impermissible purposes of punishment or to elicit confession.[51] The Human Rights Committee explicitly stated that breaches of article 7 of the International Covenant on Civil and Political Rights include forced abortion, as well as denial of access to safe abortions to women who have become pregnant as a result of rape[52] and raised concerns about obstacles to abortion where it is legal.

C. Denial of pain treatment

51. In 2012, WHO estimated that 5.5 billion people live in countries with low or no access to controlled medicines and have no or insufficient access to treatment for moderate to severe pain.[53] Despite the repeated reminders made by the Commission on Narcotic Drugs to States of their obligations,[54] 83 per cent of the world population has either no or inadequate access to treatment for moderate to severe pain. Tens of millions of people, including around 5.5 million terminal cancer patients and 1 million end-stage HIV/AIDS patients, suffer from moderate to severe pain each year without treatment.[55]

52. Many countries fail to make adequate arrangements for the supply of these medications.[56] Low- and middle-income countries account for 6 per cent of morphine use worldwide while having about half of all cancer patients and 95 per cent of all new HIV infections.[57] Thirty-two countries in Africa have almost no morphine available at all.[58] In the United States, over a third of patients are not adequately treated for pain.[59] In France, a study found that doctors underestimated pain in over half of their AIDS patients.[60] In India, more than half of the country's regional cancer centres do not have morphine or doctors trained in using it. This is despite the fact that 70 per cent or more of their patients have advanced cancer and are likely to require pain treatment.[61]

53. Although relatively inexpensive and highly effective medications such as morphine and other narcotic drugs have proven essential "for the relief of pain and suffering"[62], these types of medications are virtually unavailable in more than 150 countries.[63] Obstacles that unnecessarily impede access to morphine and adversely affect its availability include overly restrictive drug control regulations[64] and, more frequently, misinterpretation of otherwise appropriate regulations;[65] deficiency in drug supply management; inadequate infrastructure;[66] lack of prioritization of palliative care[67]; ingrained prejudices about using

[50] See CAT/C/CR/32/5, para. 7 (m); A/66/254, para. 30.
[51] CAT/C/CR/32/5, para. 7 (m).
[52] General comment No. 28, para. 11; see also CCPR/CO.70/ARG, para. 14.
[53] WHO, "Access to Controlled Medicines Programme", briefing note (2012), p. 1.
[54] Resolutions 53/4 (2010) and 54/6 (2011).
[55] WHO, "Access", p. 1.
[56] See HRW, *"Please Do Not Make Us Suffer Any More...": Access to Pain Treatment as a Human Right* (2009).
[57] Open Society Foundations, "Palliative care as a human right", Public Health Fact Sheet, 2012.
[58] Ibid.
[59] Ibid.
[60] Ibid.
[61] HRW, *Unbearable Pain: India's Obligation to Ensure Palliative Care* (2009), p. 3.
[62] Single Convention on Narcotic Drugs, 1961, preamble.
[63] Joseph Amon and Diederik Lohman, "Denial of pain treatment and the prohibition of torture, cruel, inhuman or degrading treatment or punishment", *INTERIGHTS Bulletin*, vol. 16, No. 4 (2011), p. 172.
[64] See HRW, *"Please Do Not Make Us Suffer"*.
[65] E/INCB/1999/1, p. 7.
[66] A/65/255, para. 40.

opioids for medical purposes;[68] and the absence of pain management policies or guidelines for practitioners.[69]

Applicability of torture and ill-treatment framework

54. Generally, denial of pain treatment involves acts of omission rather than commission,[70] and results from neglect and poor Government policies, rather than from an intention to inflict suffering. However, not every case where a person suffers from severe pain but has no access to appropriate treatment will constitute cruel, inhuman, or degrading treatment or punishment. This will only be the case when the suffering is severe and meets the minimum threshold under the prohibition against torture and ill-treatment; when the State is, or should be, aware of the suffering, including when no appropriate treatment was offered; and when the Government failed to take all reasonable steps[71] to protect individuals' physical and mental integrity.[72]

55. Ensuring the availability and accessibility of medications included in the WHO Model List of Essential Medicines is not just a reasonable step but a legal obligation under the Single Convention on Narcotic Drugs, 1961. When the failure of States to take positive steps, or to refrain from interfering with health-care services, condemns patients to unnecessary suffering from pain, States not only fall foul of the right to health but may also violate an affirmative obligation under the prohibition of torture and ill-treatment (A/HRC/10/44 and Corr.1, para. 72).

56. In a statement issued jointly with the Special Rapporteur on the right to health, the Special Rapporteur on the question of torture reaffirmed that the failure to ensure access to controlled medicines for the relief of pain and suffering threatens fundamental rights to health and to protection against cruel, inhuman and degrading treatment. Governments must guarantee essential medicines – which include, among others, opioid analgesics – as part of their minimum core obligations under the right to health, and take measures to protect people under their jurisdiction from inhuman and degrading treatment.[73]

D. Persons with psychosocial disabilities

57. Under article 1 of the Convention on the Rights of Persons with Disabilities, persons with disabilities include those who have long-term intellectual or sensory impairments, which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. These are individuals who have been either neglected or detained in psychiatric and social care institutions, psychiatric wards, prayer

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[67] Palliative care is an approach that seeks to improve the quality of life of patients diagnosed with life-threatening illnesses, through prevention and relief of suffering. WHO Definition of Palliative Care (see www.who.int/cancer/palliative/definition/en/).

[68] E/INCB/1999/1, p. 7.

[69] HRW, *"Please Do Not Make Us Suffer"*, p. 2.

[70] Amon and Lohman, "Denial", p. 172.

[71] See for example ECHR, *Osman* v. *United Kingdom*, Application No. 23452/94 (1998), paras. 115-122; Committee on Economic, Social and Cultural Rights, general comment No. 14.

[72] Amon and Lohman, "Denial", p. 172.

[73] Joint letter to the Chairperson of the fifty-second session of the Commission on Narcotic Drugs, 2008, p. 4.

camps, secular and religious-based therapeutic boarding schools, boot camps, private residential treatment centres or traditional healing centres.[74]

58. In 2008 the mandate made significant strides in the development of norms for the abolition of forced psychiatric interventions on the basis of disability alone as a form of torture and ill-treatment (see A/63/175). The Convention on the Rights of Persons with Disabilities also provides authoritative guidance on the rights of persons with disabilities and prohibits involuntary treatment and involuntary confinement on the grounds of disability, superseding earlier standards such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991 Principles).

59. Severe abuses, such as neglect, mental and physical abuse and sexual violence, continue to be committed against people with psychosocial disabilities and people with intellectual disabilities in health-care settings.[75]

60. There are several areas in which the Special Rapporteur would like to suggest steps beyond what has already been proposed by the mandate in its efforts to promote the Convention on the Rights of Persons with Disabilities as the new normative paradigm and call for measures to combat impunity.

1. A new normative paradigm

61. Numerous calls by the mandate to review the anti-torture framework in relation to persons with disabilities[76] remain to be addressed. It is therefore necessary to reaffirm that the Convention on the Rights of Persons with Disabilities offers the most comprehensive set of standards on the rights of persons with disabilities, inter alia, in the context of health care, where choices by people with disabilities are often overridden based on their supposed "best interests", and where serious violations and discrimination against persons with disabilities may be masked as "good intentions" of health professionals (A/63/175, para. 49).

62. It is necessary to highlight additional measures needed to prevent torture and ill-treatment against people with disabilities, by synthesizing standards and coordinating actions in line with the Convention on the Rights of Persons with Disabilities.[77]

2. Absolute ban on restraints and seclusion

63. The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63/175, paras. 55-56). The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time

[74] See HRW, "*Like a Death Sentence*": *Abuses against Persons with Mental Disabilities in Ghana* (2012).

[75] In November 2012, the Inter-American Commission on Human Rights approved precautionary measures to protect 300 individuals in Guatemala City's psychiatric facility, where unspeakable forms of abuses were documented.

[76] See A/58/120; A/63/175, para. 41.

[77] See for example Organization of American States, Committee for the Elimination of all Forms of Discrimination against Persons with Disabilities, resolution CEDDIS/RES.1 (I-E/11) (2011), annex.

may constitute torture and ill-treatment.[78] It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedures.

3. Domestic legislation allowing forced interventions

64. The mandate continues to receive reports of the systematic use of forced interventions worldwide. Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment.[79] Forced interventions, often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged "best interest" of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras. 38, 40, 41). Concern for the autonomy and dignity of persons with disabilities leads the Special Rapporteur to urge revision of domestic legislation allowing for forced interventions.

4. Fully respecting each person's legal capacity is a first step in the prevention of torture and ill-treatment

65. Millions of people with disabilities are stripped of their legal capacity worldwide, due to stigma and discrimination, through judicial declaration of incompetency or merely by a doctor's decision that the person "lacks capacity" to make a decision. Deprived of legal capacity, people are assigned a guardian or other substitute decision maker, whose consent will be deemed sufficient to justify forced treatment (E/CN.4/2005/51, para. 79).

66. As earlier stated by the mandate, criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent should be clarified in the law, and no distinction between persons with or without disabilities should be made.[80] Only in a life-threatening emergency in which there is no disagreement regarding absence of legal capacity may a health-care provider proceed without informed consent to perform a life-saving procedure.[81] From this perspective, several of the 1991 Principles may require reconsideration as running counter to the provisions of the Convention on the Rights of Persons with Disabilities (A/63/175, para. 44).

5. Involuntary commitment in psychiatric institutions

67. In many countries where mental health policies and laws do exist, they focus on confinement of people with mental disabilities in psychiatric institutions but fail to effectively safeguard their human rights.[82]

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[78] See CAT/C/CAN/CO/6, para. 19 (d); ECHR, *Bures* v. *Czech Republic*, Application No. 37679/08 (2012), para. 132.

[79] A/63/175, paras. 44, 47, 61, 63; Human Rights Committee, communication No. 110/1981, *Viana Acosta* v. *Uruguay*, paras. 2.7, 14, 15.

[80] See also A/64/272, para. 74.

[81] Ibid., para. 12.

[82] WHO, "Mental health legislation and human rights – denied citizens: including the excluded", p. 1.

68. Involuntary commitment to psychiatric institutions has been well documented.[83] There are well-documented examples of people living their whole lives in such psychiatric or social care institutions.[84] The Committee on the Rights of Persons with Disabilities has been very explicit in calling for the prohibition of disability-based detention, i.e. civil commitment and compulsory institutionalization or confinement based on disability.[85] It establishes that community living, with support, is no longer a favourable policy development but an internationally recognized right.[86] The Convention radically departs from this approach by forbidding deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory. Article 14, paragraph 1 (b), of the Convention unambiguously states that "the existence of a disability shall in no case justify a deprivation of liberty". Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. This must include the repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness (A/HRC/10/48, paras. 48, 49).

69. Deprivation of liberty on grounds of mental illness is unjustified if its basis is discrimination or prejudice against persons with disabilities. Under the European Convention on Human Rights, mental disorder must be of a certain severity in order to justify detention.[87] The Special Rapporteur believes that the severity of the mental illness is not by itself sufficient to justify detention; the State must also show that detention is necessary to protect the safety of the person or of others. Except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of "unsound mind".[88] As detention in a psychiatric context may lead to non-consensual psychiatric treatment,[89] the mandate has stated that deprivation of liberty that is based on the grounds of a disability and that inflicts severe pain or suffering could fall under the scope of the Convention against Torture (A/63/175, para. 65). In making such an assessment, factors such as fear and anxiety produced by indefinite detention, the infliction of forced medication or electroshock, the use of restraints and seclusion, the segregation from family and community, etc., should be taken into account.[90]

70. Moreover, the effects of institutionalization of individuals who do not meet appropriate admission criteria, as is the case in most institutions which are off the monitoring radar and lack appropriate admission oversight,[91] raise particular questions under prohibition of torture and ill-treatment. Inappropriate or unnecessary non-consensual

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[83] See Thomas Hammarberg, "Inhuman treatment of persons with disabilities in institutions", Human Rights Comment (2010).

[84] See Dorottya Karsay and Oliver Lewis, "Disability, torture and ill-treatment: taking stock and ending abuses", *The International Journal of Human Rights*, vol. 16, No. 6 (2012), pp. 816-830.

[85] See also CRPD/C/HUN/CO/1, paras. 27-28.

[86] See CRPD/C/CHN/CO/1 and Corr.1, paras. 92-93.

[87] See Peter Bartlett, "A mental disorder of a kind or degree warranting confinement: examining justifications for psychiatric detention, *The International Journal of Human Rights*, vol. 16, No. 6 (2012), pp. 831-844.

[88] See ECHR, *Winterwerp* v. *The Netherlands*, Application No. 6301/73 (1979) and ECHR, *E* v. *Norway*, Application No. 11701/85 (1990).

[89] See Bartlett, "A mental disorder".

[90] Stop Torture in Healthcare, "Torture and ill-treatment of people with disabilities in healthcare settings", Campaign Briefing, 2012.

[91] See CAT/C/JPN/CO/1, para. 26.

institutionalization of individuals may amount to torture or ill-treatment as use of force beyond that which is strictly necessary.[92]

E. Marginalized groups

1. Persons living with HIV/AIDS

71. Numerous reports have documented mistreatment of or denial of treatment to people living with HIV/AIDS by health providers.[93] They are reportedly turned away from hospitals, summarily discharged, denied access to medical services unless they consent to sterilization,[94] and provided poor quality care that is both dehumanizing and damaging to their already fragile health status.[95] Forced or compulsory HIV testing is also a common abuse that may constitute degrading treatment if it is "done on a discriminatory basis without respecting consent and necessity requirements" (A/HRC/10/44 and Corr.1, para. 65). Unauthorized disclosure of HIV status to sexual partners, family members, employers and other health workers is a frequent abuse against people living with HIV that may lead to physical violence.

2. Persons who use drugs

72. People who use drugs are a highly stigmatized and criminalized population whose experience of health-care is often one of humiliation, punishment and cruelty. Drug users living with HIV are often denied emergency medical treatment.[96] In some cases the laws specifically single out the status of a drug user as a stand-alone basis for depriving someone of custody or other parental rights. Use of drug registries – where people who use drugs are identified and listed by police and health-care workers, and their civil rights curtailed – are violations of patient confidentiality[97] that lead to further ill-treatment by health providers.

73. A particular form of ill-treatment and possibly torture of drug users is the denial of opiate substitution treatment, including as a way of eliciting criminal confessions through inducing painful withdrawal symptoms (A/HRC/10/44 and Corr.1, para. 57). The denial of methadone treatment in custodial settings has been declared to be a violation of the right to be free from torture and ill-treatment in certain circumstances (ibid., para. 71). Similar reasoning should apply to the non-custodial context, particularly in instances where Governments impose a complete ban on substitution treatment and harm reduction measures.[98] The common practice of withholding anti-retroviral treatment from HIV-positive people who use drugs, on the assumption that they will not be capable of adhering to treatment, amounts to cruel and inhuman treatment, given the physical and psychological suffering as the disease progresses; it also constitutes abusive treatment based on unjustified discrimination solely related to health status.

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[92] ECHR, *Mouisel* v. *France*, Application No. 67263/01 (2002), para. 48; see also Nell Monroe, "Define acceptable: how can we ensure that treatment for mental disorder in detention is consistent with the UN Convention on the Rights of Persons with Disabilities?", *The International Journal of Human Rights*, vol. 16, No. 6 (2012).

[93] Campaign to Stop Torture in Health Care, "Torture and ill-treatment in health settings: a failure of accountability", *Interights Bulletin*, vol. 16, No. 4 (2011), p. 162.

[94] Open Society Foundations, *Against Her Will* (footnote 43 above).

[95] See HRW, *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight against HIV/AIDS* (2006).

[96] Ibid., p. 44.

[97] A/65/255, para. 20.

[98] See HRW, *Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation* (2004).

74. By denying effective drug treatment, State drug policies intentionally subject a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence, in complete disregard of the chronic nature of dependency and of the scientific evidence pointing to the ineffectiveness of punitive measures.

3. Sex workers

75. A report on sex workers documented negative and obstructive attitudes on the part of medical workers, including denial of necessary health-care services.[99] Public health rationales have in some instances led to mandatory HIV testing and exposure of their HIV status, accompanied by punitive measures.[100] Breaches of privacy and confidentiality are a further indignity experienced by sex workers in health settings.[101] Most recently, the Committee against Torture noted "reports of alleged lack of privacy and humiliating circumstances amounting to degrading treatment during medical examinations".[102] The mandate has observed that acts aimed at humiliating the victim, regardless of whether severe pain has been inflicted, may constitute degrading treatment or punishment because of the incumbent mental suffering (E/CN.4/2006/6, para. 35).

4. Lesbian, gay, bisexual, transgender and intersex persons

76. The Pan American Health Organization (PAHO) has concluded that homophobic ill-treatment on the part of health professionals is unacceptable and should be proscribed and denounced.[103] There is an abundance of accounts and testimonies of persons being denied medical treatment, subjected to verbal abuse and public humiliation, psychiatric evaluation, a variety of forced procedures such as sterilization, State-sponsored forcible anal examinations for the prosecution of suspected homosexual activities, and invasive virginity examinations conducted by health-care providers,[104] hormone therapy and genital-normalizing surgeries under the guise of so called "reparative therapies".[105] These procedures are rarely medically necessary,[106] can cause scarring, loss of sexual sensation, pain, incontinence and lifelong depression and have also been criticized as being unscientific, potentially harmful and contributing to stigma (A/HRC/14/20, para. 23). The Committee on the Elimination of Discrimination against Women expressed concern about lesbian, bisexual, transgender and intersex women as "victims of abuses and mistreatment by health service providers" (A/HRC/19/41, para. 56).

77. Children who are born with atypical sex characteristics are often subject to irreversible sex assignment, involuntary sterilization, involuntary genital normalizing surgery, performed without their informed consent, or that of their parents, "in an attempt to

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[99] Campaign to Stop Torture in Health Care, "Torture", p. 163; see also A/64/272, para. 85.

[100] WHO and the Global Coalition on Women and AIDS, "Violence against sex workers and HIV prevention" (WHO, 2005), p. 2.

[101] Campaign to Stop Torture in Health Care, "Torture", p. 163.

[102] CAT/C/AUT/CO/4-5, para. 22.

[103] PAHO, " 'Cures' for an illness that does not exist" (2012), p. 3.

[104] See HRW, *In a Time of Torture: The Assault on Justice in Egypt's Crackdown on Homosexual Conduct* (2003).

[105] PAHO/WHO, " 'Therapies' to change sexual orientation lack medical justification and threaten health", news statement, 17 May 2012; and submission by Advocates for Informed Choice to the Special Rapporteur on the question of torture, 2012.

[106] PAHO/WHO, " 'Therapies'".

fix their sex",[107] leaving them with permanent, irreversible infertility and causing severe mental suffering.

78. In many countries transgender persons are required to undergo often unwanted sterilization surgeries as a prerequisite to enjoy legal recognition of their preferred gender. In Europe, 29 States require sterilization procedures to recognize the legal gender of transgender persons. In 11 States where there is no legislation regulating legal recognition of gender,[108] enforced sterilization is still practised. As at 2008, in the United States of America, 20 states required a transgender person to undergo "gender-confirming surgery" or "gender reassignment surgery" before being able to change their legal sex.[109] In Canada, only the province of Ontario does not enforce "transsexual surgery" in order to rectify the recorded sex on birth certificates.[110] Some domestic courts have found that not only does enforced surgery result in permanent sterility and irreversible changes to the body, and interfere in family and reproductive life, it also amounts to a severe and irreversible intrusion into a person's physical integrity. In 2012, the Swedish Administrative Court of Appeals ruled that a forced sterilization requirement to intrude into someone's physical integrity could not be seen as voluntary.[111] In 2011, the Constitutional Court in Germany ruled that the requirement of gender reassignment surgery violated the right to physical integrity and self-determination.[112] In 2009, the Austrian Administrative High Court also held that mandatory gender reassignment, as a condition for legal recognition of gender identity, was unlawful.[113] In 2009, the former Commissioner for Human Rights of the Council of Europe observed that "[the involuntary sterilization] requirements clearly run counter to the respect for the physical integrity of the person".[114]

79. The mandate has noted that "members of sexual minorities are disproportionately subjected to torture and other forms of ill-treatment because they fail to conform to socially constructed gender expectations. Indeed, discrimination on grounds of sexual orientation or gender identity may often contribute to the process of the dehumanization of the victim, which is often a necessary condition for torture and ill-treatment to take place."[115] "Medically worthless" practices of subjecting men suspected of homosexual conduct to non-consensual anal examinations to "prove" their homosexuality[116] have been condemned by the Committee against Torture, the Special Rapporteur on the question of torture and the Working Group on Arbitrary Detention, which have held that the practice contravenes the prohibition of torture and ill-treatment (A/HRC/19/41, para. 37).

5. Persons with disabilities

80. Persons with disabilities are particularly affected by forced medical interventions, and continue to be exposed to non-consensual medical practices (A/63/175, para. 40). In the case of children in health-care settings, an actual or perceived disability may diminish the

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[107] A/HRC/19/41, para. 57. .

[108] Commissioner for Human Rights of the Council of Europe, *Discrimination on Grounds of Sexual Orientation and Gender Identity in Europe* (2011), pp. 86-87.

[109] D. Spade, "Documenting gender", *Hastings Law Journal*, vol. 59, No. 1 (2008), pp. 830-831.

[110] *XY* v. *Ontario*, 2012 HRTO 726 (CanLII), judgement of 11 April 2012.

[111] Mål nr 1968-12, Kammarrätten i Stockholm, Avdelning 03, http://du2.pentagonvillan.se/images/stories/Kammarrttens_dom_-_121219.pdf, p. 4.

[112] Federal Constitutional Court, *1 BvR 3295/07*. Available from www.bundesverfassungsgericht.de/entscheidungen/rs20110111_1bvr329507.html.

[113] Administrative High Court, No. 2008/17/0054, judgement of 27 February 2009.

[114] "Human rights and gender identity", issue paper (2009), p. 19.

[115] A/56/156, para. 19. See also E/CN.4/2001/66/Add.2, para. 199.

[116] Working Group on Arbitrary Detention, opinion No. 25/2009 (2009), para. 29.

weight given to the child's views[117] in determining their best interests, or may be taken as the basis of substitution of determination and decision-making by parents, guardians, carers or public authorities.[118] Women living with disabilities, with psychiatric labels in particular, are at risk of multiple forms of discrimination and abuse in health-care settings. Forced sterilization of girls and women with disabilities has been widely documented.[119] National law in Spain, among other countries,[120] allows for the sterilization of minors who are found to have severe intellectual disabilities. The Egyptian Parliament failed to include a provision banning the use of sterilization as a "treatment" for mental illness in its patient protection law. In the United States, 15 states have laws that fail to protect women with disabilities from involuntary sterilization.[121]

V. Conclusions and recommendations

A. Significance of categorizing abuses in health-care settings as torture and ill-treatment

81. **The preceding examples of torture and ill-treatment in health-care settings likely represent a small fraction of this global problem. Such interventions always amount at least to inhuman and degrading treatment, often they arguably meet the criteria for torture, and they are always prohibited by international law.**

82. **The prohibition of torture is one of the few absolute and non-derogable human rights,[122] a matter of *jus cogens*,[123] a peremptory norm of customary international law. Examining abuses in health-care settings from a torture protection framework provides the opportunity to solidify an understanding of these violations and to highlight the positive obligations that States have to prevent, prosecute and redress such violations.**

83. **The right to an adequate standard of health care ("right to health") determines the States' obligations towards persons suffering from illness. In turn, the absolute and non-derogable nature of the right to protection from torture and ill-treatment establishes objective restrictions on certain therapies. In the context of health-related abuses, the focus on the prohibition of torture strengthens the call for accountability and strikes a proper balance between individual freedom and dignity and public health concerns. In that fashion, attention to the torture framework ensures that system inadequacies, lack of resources or services will not justify ill-treatment. Although resource constraints may justify only partial fulfilment of some aspects of the right to health, a State cannot justify its non-compliance with core obligations, such as the absolute prohibition of torture, under any circumstances.[124]**

84. **By reframing violence and abuses in health-care settings as prohibited ill-treatment, victims and advocates are afforded stronger legal protection and redress**

[117] Committee on the Rights of the Child, general comment No. 12 (2009), para. 21.

[118] See A/HRC/20/5, para. 53 (d); A/63/175, para. 59.

[119] See Independent Expert for the Secretary-General's Study on Violence against Children, *World Report on Violence against Children* (2009).

[120] Open Society Foundations, *Against Her Will* (footnote 43 above), p. 6, A/64/272, para. 71.

[121] Open Society Foundations, *Against Her Will*, p. 6.

[122] Convention against Torture, art. 2, para. 2, International Covenant on Civil and Political Rights, art. 7.

[123] See International Criminal Tribunal for the Former Yugoslavia, *Prosecutor* v. *Furundzija*, case No. IT-95- 17/1-T, judgement (1998).

[124] See Committee on Economic, Social and Cultural Rights, general comment No. 14.

for violations of human rights. In this respect, the recent general comment No. 3 (2012) of the Committee against Torture on the right to a remedy and reparation offers valuable guidance regarding proactive measures required to prevent forced interventions. Notably, the Committee considers that the duty to provide remedy and reparation extends to all acts of ill-treatment,[125] so that it is immaterial for this purpose whether abuses in health-care settings meet the criteria for torture per se. This framework opens new possibilities for holistic social processes that foster appreciation of the lived experiences of persons, including measures of satisfaction and guarantees of non-repetition, and the repeal of inconsistent legal provisions.

B. Recommendations

85. The Special Rapporteur calls upon all States to:

(a) Enforce the prohibition of torture in all health-care institutions, both public and private, by, inter alia, declaring that abuses committed in the context of health-care can amount to torture or cruel, inhuman or degrading treatment or punishment; regulating health-care practices with a view to preventing mistreatment under any pretext; and integrating the provisions of prevention of torture and ill-treatment into health-care policies;

(b) Promote accountability for torture and ill-treatment in health-care settings by identifying laws, policies and practices that lead to abuse; and enable national preventive mechanisms to systematically monitor, receive complaints and initiate prosecutions;

(c) Conduct prompt, impartial and thorough investigations into all allegations of torture and ill-treatment in health-care settings; where the evidence warrants it, prosecute and take action against perpetrators; and provide victims with effective remedy and redress, including measures of reparation, satisfaction and guarantees of non-repetition as well as restitution, compensation and rehabilitation;

(d) Provide appropriate human rights education and information to health-care personnel on the prohibition of torture and ill-treatment and the existence, extent, severity and consequences of various situations amounting to torture and cruel, inhuman or degrading treatment or punishment; and promote a culture of respect for human integrity and dignity, respect for diversity and the elimination of attitudes of pathologizaton and homophobia. Train doctors, judges, prosecutors and police on the standards regarding free and informed consent;

(e) Safeguard free and informed consent on an equal basis for all individuals without any exception, through legal framework and judicial and administrative mechanisms, including through policies and practices to protect against abuses. Any legal provisions to the contrary, such as provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must be revised. Adopt policies and protocols that uphold autonomy, self-determination and human dignity. Ensure that information on health is fully available, acceptable, accessible and of good quality; and that it is imparted and comprehended by means of supportive and protective measures such as a wide range of community-based services and supports (A/64/272, para. 93). Instances of treatment without informed consent should be investigated; redress to victims of such treatment should be provided;

[125] General comment No. 3, para. 1.

(f) Ensure special protection of minority and marginalized groups and individuals as a critical component of the obligation to prevent torture and ill-treatment[126] by, inter alia, investing in and offering marginalized individuals a wide range of voluntary supports that enable them to exercise their legal capacity and that fully respect their individual autonomy, will and preferences.

1. Denial of pain relief

86. **The Special Rapporteur calls upon all States to:**

(a) Adopt a human rights-based approach to drug control as a matter of priority to prevent the continuing violations of rights stemming from the current approaches to curtailing supply and demand (A/65/255, para. 48). Ensure that national drug control laws recognize the indispensible nature of narcotic and psychotropic drugs for the relief of pain and suffering; review national legislation and administrative procedures to guarantee adequate availability of those medicines for legitimate medical uses;

(b) Ensure full access to palliative care and overcome current regulatory, educational and attitudinal obstacles that restrict availability to essential palliative care medications, especially oral morphine. States should devise and implement policies that promote widespread understanding about the therapeutic usefulness of controlled substances and their rational use;

(c) Develop and integrate palliative care into the public health system by including it in all national health plans and policies, curricula and training programmes and developing the necessary standards, guidelines and clinical protocols.

2. Compulsory detention for medical reasons

87. **The Special Rapporteur calls upon all States to:**

(a) Close compulsory drug detention and "rehabilitation" centres without delay and implement voluntary, evidence-based and rights-based health and social services in the community. Undertake investigations to ensure that abuses, including torture or cruel, inhuman and degrading treatment, are not taking place in privately-run centres for the treatment of drug dependence;

(b) Cease support for the operation of existing drug detention centres or the creation of new centres. Any decision to provide funding should be made only following careful risk assessment. If provided, any such funds should be clearly time-limited and provided only on the conditions that the authorities (a) commit to a rapid process for closing drug detention centres and reallocating said resources to scaling up voluntary, community-based, evidence-based services for treatment of drug dependence; and (b) replace punitive approaches and compulsory elements to drug treatment with other, evidence-based efforts to prevent HIV and other drug-related harms. Such centres, while still operating as the authorities move to close them, are subject to fully independent monitoring;

(c) Establish an effective mechanism for monitoring dependence treatment practices and compliance with international norms;

[126] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 43 (a)-(f).

(d) Ensure that all harm-reduction measures and drug-dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations (A/65/255, para. 76).

3. Lesbian, gay, bisexual, transgender and intersex persons

88. **The Special Rapporteur calls upon all States to repeal any law allowing intrusive and irreversible treatments, including forced genital-normalizing surgery, involuntary sterilization, unethical experimentation, medical display, "reparative therapies" or "conversion therapies", when enforced or administered without the free and informed consent of the person concerned. He also calls upon them to outlaw forced or coerced sterilization in all circumstances and provide special protection to individuals belonging to marginalized groups.**

4. Persons with psychosocial disabilities

89. **The Special Rapporteur calls upon all States to:**

(a) Review the anti-torture framework in relation to persons with disabilities in line with the Convention on the Rights of Persons with Disabilities as authoritative guidance regarding their rights in the context of health-care;

(b) Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application. The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation;[127]

(c) Replace forced treatment and commitment by services in the community. Such services must meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned, with an emphasis on alternatives to the medical model of mental health, including peer support, awareness-raising and training of mental health-care and law enforcement personnel and others;

(d) Revise the legal provisions that allow detention on mental health grounds or in mental health facilities, and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned. Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished.

5. Reproductive rights

90. **The Special Rapporteur calls upon all States to ensure that women have access to emergency medical care, including post-abortion care, without fear of criminal penalties or reprisals. States whose domestic law authorizes abortions under various circumstances should ensure that services are effectively available without adverse consequences to the woman or the health professional.**

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[127] Convention on the Rights of Persons with Disabilities, art. 4, para. 2.

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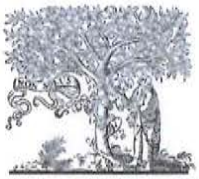

ELSEVIER

Journal of Pediatric urology

REVIEW ARTICLE

Evidence regarding cosmetic and medically unnecessary surgery on infants

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Abstract The *Journal of Pediatric Urology* has recently published several articles from the Annecy (France) Working Party on DSD. We question several of the presented findings and recommendations. In two key articles summarizing their review, the authors concluded that identified studies are not representative and suffer from methodological weaknesses, such that they "lack the necessary detail to base further recommendations". In a third article, the Working Party reported that the science supporting early surgery is "scanty", and that "no studies" support the belief that gender variant children require early genital surgery. Nevertheless, the Working Party warned that without long-term research, "if no effort is made, we will be left, in the next generation, to continue making the same judgment, based on 'experience' and 'expert opinion'". None of the studies cited in the articles support such assertions as we read them. We maintain that reviewed evidence suggests a moratorium on early surgical intervention is imperative for children with differences in sex development, and that the best ethical and scientific considerations require that gender surgery should be delayed until the child can consent. We further present evidence that UN and case law presently under way in the USA support such a moratorium.

The *Journal of Pediatric Urology* has recently published (vol. 8, no. 6) several articles from the Annecy (France) Working Party on DSD. We significantly question several of the findings and recommendations as presented.

The Working Party reviewed a selection of studies from 1974 to 2012 that purport to assess the validity of surgery for children with differences of sex development. Based on that review, the Working Party concluded that the selected studies suffer from methodological weaknesses and "lack the necessary detail to base further recommendations" on care for individual child patients [1,2]. The Working Party further reported that the science supporting early surgery is "scanty", that critical long-term studies are "scarce" and unlikely to emerge, and, most significantly, that "no

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studies" support the belief that gender variant children require early genital surgery for societally favored gender development [3]. Nevertheless, the Working Party warned that without long-term research, "if no effort is made, we will be left, in the next generation, to continue making the same judgment, based on 'experience' and 'expert opinion'" [2], leaving patients subjected to surgical decisions on a "case-by-case basis with individual surgeons relying on their own professional expertise and opinions" [3].

Taken together, these articles represent candid and unequivocal statements from some of the world's best-known practitioners of surgery on gender variant children. They conclude, without qualification, that current surgical practices on children with differences of sex development lack sufficient scientific support. The implication of these findings is that the research that was in existence when early surgical intervention had started to become the standard of care could not reasonably have been interpreted as clear scientific validation of such surgery, and that representations in studies once heralded as that validation, particularly those from the Johns Hopkins University Hospital [4–6], were wrong. As early as 1965, the theory that sex neutrality in newborns provided a basis for early gender surgery on children had been directly, scientifically challenged, along with a recommendation for "extensive clinical reappraisal" [40]. Remarkably, these latter findings were not seriously examined again until the end of the 20th century [7–9]. To say the least, then, the Working Party's review was needed long ago. Indeed, the U.S. National Institute of Health (NIH) reported in 2006 that there is a "crisis of clinical management" for children with atypical genitals precisely because "there are insufficient data to guide the clinician and family in sex assignment" and "optimal application of surgery and its timing remain unclear" [10].

In this light, we must register our strong disagreement with the Party's assertions that scientific uncertainty precludes detailed recommendations for present and future clinicians. On the contrary, the Party's review of evidence resoundingly supports one recommendation – that any medically unnecessary cosmetic surgery should be delayed until the patient can consent to all of the risks involved. This is the only scientifically sound and ethical way to ensure that the surgery coincides with each child's gender identity and interests in how his or her body might appear. Indeed, in 2006, when the NIH declined to support a moratorium on early surgery, it did so with the assumption that new research would produce findings that could guide clinicians [10]. At that time, it was already nearly a decade after a clinical call for a moratorium on early surgery was first made [7]. (The first call for a moratorium on cosmetic infant surgery for ambiguous genitalia was in a 1998 print publication, the *Journal of Clinical Ethics* [7]. That same year, at an invitational presentation to the American Academy of Pediatrics, Section on Urology, a direct appeal was made to cease such surgery as the procedure lacked validation [8]. The following year, in 1999, a conference was specifically called for Dallas, Texas (USA) to reappraise the issue of pediatric gender assignment and reassignment and how to manage infant ambiguous genitalia [11]. At that conference the American Academy of Pediatrics Section on Urology and the Society for Fetal Urology were said to have formed committees that were to work on developing a registry of how such cases were managed and study long-term outcomes [11].) We maintain that a moratorium on early surgical intervention is imperative for children with differences of sex development, and that the best ethical and scientific considerations require that any gender surgery should be delayed until each child can consent to it.

The Working Party has indicated that "most" former patients who have been surveyed also favored early cosmetic surgery. None of the studies cited in the articles support such assertions, even as a statistical matter. For example, Wisniewski et al. reported that a minority of respondents to their survey gave the most common response to the question of the time for surgery as "during infancy" [12]. A majority of patients gave a wide array of responses on questions of surgical timing or declined to respond at all. We doubt if an option of "never" was offered to respondents in connection with the disclosure that doing so would have allowed full retention of erotic sensitivity. (We think it necessary that all questionnaires are included with any survey study so the meanings of the presented findings can be properly evaluated. If that is not done then at least each potential answer should be provided with the exact wording of the question evaluated.) Similarly, Warne et al. based their findings on a 53% participation rate to a mailed survey, attributing the substantial lack of response to possible patient dissatisfaction with surgery or poor questionnaire design [13]. Fagerholm et al. based their review on another mailed survey that also recorded a 53% response rate. Many of their respondents had their first surgery from age four to their late teens. The authors reported that their respondents "prefer" early surgery despite finding a risk of impaired sensitivity in all genital surgery. They further found that 23% of patients were dissatisfied with their surgical outcomes [14]. Given the thousands of patients who have not been surveyed, we think the negative responses and lack of patient participation in these surveys speaks volumes about the clinical significance of their findings.

Most notably, of the four studies cited by the authors as favoring early surgery, the significant work of Nordenström et al. made no such sweeping claim [15]. On the contrary, nearly all the patients assessed by that study said that genital sensitivity was negatively affected by surgery. The authors' findings grew out of a project that had earlier concluded that the surveyed patients were less than satisfied with genital function and appearance "whether operated or not" [16]. Nordenström et al. thus concluded that gender identity and quality of life considerations were likely as important to patients as mere surgical outcome statistics [15]. The authors expressly recommended that surgery should be "restrictive", and warned that their data demonstrated that clinicians' perceptions of surgical outcomes differed significantly from patients' perspectives on their own bodies. These findings cast substantial doubt on the ability of physicians to fully represent patients' wishes without patient input and, thus, weigh against early surgical intervention.

The characterization of these and other studies as favoring early surgery is not only at odds with the Working Party's overall findings, but also with several of the Party members' own studies, which are not given equal space in the Working Party's reports. For example, Houk and Lee have reviewed cases of highly virilized 46 XX, CAH children

raised as males without surgery, reporting that many of these patients are satisfied as males [17]. Acknowledging that the Chicago Consensus Statement was based on tentative findings and the weakest form of scientific evidence, Hoch and Lee urged "bold" reconsideration of presumptively feminizing the studied children, instead recommending to parents that their children could be raised as males, with full disclosure of the risk of gender dysphoria and physical injuries from early surgical feminization. While this proposal had been made before (with counseling for all involved) [18], Hoch and Lee noted that traditional standards of care during past decades had rigidly excluded such alternatives. Today, the authors explained, "the proposal for less invasive surgery also aligns well with the message heard from patient advocate groups that propose limited surgery until the patient is old enough to consent. The recent Consensus Statement makes it clear that all gender reassignments must be patient initiated" [17,19].

Similarly, Sarah Creighton's works have repeatedly concluded that evidence shows high risk involved in making such surgical decisions for a child without the child's consent. In 2001 she wrote, "Adult patients are unhappy and feel mutilated and damaged by surgery performed on them as young children, however worthy the clinician's motives" [20]. In 2006 she wrote, "Early infant vaginoplasty may be justified if there were good evidence it produced better long-term anatomical, cosmetic and functional outcomes than later delayed surgery. However, this does not seem to be the case.... Many adult intersex people with first-hand experience of infant genital surgery vehemently condemn this approach" [21]. Along with Christine Minto, Creighton wrote, "Most vaginal surgery can be deferred until after adolescence unless haematocolpos is a risk... Children with mild clitoromegaly should have surgery deferred until they are old enough to be involved in the decision" [22]. Creighton and Minto further expressed their feelings with an editorial in the *British Medical Journal* entitled "Most vaginal surgery in childhood should be deferred" [23]. And with Lih-Mei Liao and others, Creighton wrote that "asymptomatic adult women with CAIS" are increasingly choosing not to remove their gonads when given the choice, in light of "very limited evidence based on which clinicians can advise ... [about] gonadectomy" [24].

We have serious doubts that clinicians will be open to these concerns and adjust their practices in light of the evidence without strong formal leadership urging them to do so. In 2010, the Endocrine Society wrote, "There are no randomized controlled studies of either the best age or the best methods for feminizing surgery", "there are no data comparing psychosexual health in girls and women who have undergone early and late surgery" and "[t]here is no evidence at this time that either early surgery or late surgery better preserves sexual function" [25]. And yet, on the very pages it documented this lack of evidence, the Society continued, "We suggest that for severely virilized females, clitoral and perineal reconstruction be considered in infancy" and that vaginoplasty "should be simultaneously done at an early age". The Society not only recommended early surgery but also advocated studying only early surgery. That recommendation is not evidence-based medicine [26] but is, rather, the purposeful favor of one practice, in the hope of gathering data that will support that practice, without any reasonable basis for believing that such data will emerge.

It is undeniably appropriate that the Working Party now questions the role that physicians may play in encouraging patients to choose surgery. The Working Party has advised that clinicians should be open to the fact that patients might prefer to sacrifice sexual sensitivity in order to "look normal" [2]. For males with micropenis, the Working Party has asked whether clinicians should encourage patients to transition to female [2]. These are the very problems that clinicians struggled with generations ago before surgery became "preemptive". But from the patients' perspectives, the questions of whether they should receive deference in regard to their own surgeries are transparently bypassed by performing such surgery on very young children. It should be obvious that the questions the Working Party now raises are meaningful to patients who have been given a chance to grow up and become sexual beings with a gender identity, so that they have the needed perspective about how they wish their genitals to be in ways that suit them for the rest of their lives.

More than two decades ago, Suzanne Kessler recruited a large random population of young adults to objectively test that very hypothesis [27]. On the question of surgical reduction of a clitoris between 1.0 and 2.5 cm in length, 93% of women would not have wanted their parents to agree to surgery unless the condition were life-threatening, even if it resulted in loss of orgasm or pleasurable sensitivity. And when given a choice as to when they might have wanted such surgery done, almost half would have wanted to be able to make their own decisions. Most of the women would not have wanted vaginal surgery even if the condition made them uncomfortable or limited their ability to have intercourse. Males were asked the comparable question of whether they would have wanted surgery for hypospadias. A third of the males would not have wanted the surgery even if it kept them from standing up to urinate, and three-quarters would not have wanted the surgery if it meant the loss of pleasurable sensitivity. Almost none of the men would have wanted sex reassignment for micropenis or other reason if it meant loss of orgasm or reduction in pleasurable sensitivity [27]. Today, the Working Party [1,2], like the Chicago Consensus before it [19], has finally questioned much clitoral reduction surgery and feminization of males with micropenis — not because patients with atypical sex development were asked — but because injuries to untold numbers of patients proved it was unnecessary and harmful, at the patients' expense.

The knowing continuation of unproven surgery on children in the search for evidence is experimentation, and should not be done in unmonitored, uncontrolled clinical practice. Indeed, the continuation of early surgical intervention on children without their consent has only increased the uncertainty surrounding the current standards of care, not the reverse. As a result, objective scientific research cannot continue in this field without a moratorium on early surgery, precisely because favoritism for early surgery seems to have closed many clinician-researchers' minds to the scientific possibility — indeed, the reality — that children with differences in sex

development can thrive without surgery. Decades ago, although unpublished, one well-known Harvard dissertation documented the health and stability of such individuals unaltered by surgery [28]. This was even at a time dominated by dogmatic and archaic notions of gender and sexuality. The Working Party's findings now make abundantly clear that the model of surgery-in-a-state-of-uncertainty is not reliable, particularly for cosmetic surgery for which no evidence of medical need exists, as cosmetic surgery is an imperfect mix of art and science. As Schober, another Working Party member, has written, a "reliable, successful genitoplasty procedure that can be performed early in childhood for either feminization or masculinization has not yet been developed" [29].

The priority of research, therefore, should be a commitment to delay surgery and determine how patient participation in surgical decisions can be incorporated into practice. The Working Party has recommended a multidisciplinary registry of surgeries [30], along with a systematic recording of long-term outcomes of treatment from birth to adulthood [2]. They have, however, recommended that these steps be taken prospectively and without a moratorium in place. A registry already exists in Europe, has already been proposed for the USA, and should be available everywhere surgery is performed [31]. But we cannot support the notion that early surgeries continue in the midst of systematic documentation while we await evaluation of long-term outcomes. Too many patients will be negatively affected in the interim. Even if all practitioners were to commit today to delay all surgery until each patient consents, we would have more than enough patients who have undergone early surgery to follow prospectively, while practitioners focus their energy on documenting patient histories that have been lost to follow-up. Several participants in the Working Party already have more than enough cases from their own practices that they could review and register, if not publish. The combined results would rapidly displace any claim of lack of data in securing the best evidentiary bases to medical practice relative to infant cosmetic surgery.

In the past, legal authorities have been slow to take a stance in this field. That is now changing. The Colombian Constitutional Court – the first in the world to require the consent of many young children to genital cosmetic surgery [32] – has requested a consult with one of us (MD) with regard to future management of intersex identity [33]. The German Ethics Council has proposed increased legal controls of genital and gonadal surgery for all children [34]. The UN "Special Rapporteur for Torture and Other Cruel, Inhuman, Degrading Treatment" has called for all nations to reform laws in order to prevent medically unnecessary and nonconsensual genital surgery [35]. Most recently, the Parliamentary Assembly of the Council of Europe has called on all Member States to take measures regarding "early childhood medical interventions in the case of intersexual children" to "ensure that no-one is subjected to unnecessary medical or surgical treatment that is cosmetic rather than vital for health during infancy or childhood" [36].

Perhaps most significantly, in recently filed litigation in the USA, a federal court has already held that nonconsensual genital and gonadal surgery may violate the constitutional rights of affected children [37]. The facts of that case [38] are compelling:

> "Despite the fact that M.C.'s condition did not threaten his health, the defendant doctors planned and decided to perform a 'feminizing-genitoplasty' on the sixteen-month-old M.C. During this surgery, [the surgeon, Dr. X] cut off M.C.'s phallus to reduce it to the size of a clitoris, removed one of M.C.'s testicles, excised all testicular tissue from M.C.'s second gonad, and constructed labia for M.C. The surgery eliminated M.C.'s potential to procreate as a male and caused a significant and permanent impairment of sexual function....
>
> The defendant doctors knew that sex assignment surgeries on infants with conditions like M.C.'s pose a significant risk of imposing a gender that is ultimately rejected by the patient. Indeed, one of the doctor defendants who performed the surgery on M.C. had previously published an article in a medical journal wherein he recognized that 'carrying out a feminizing-genitoplasty on an infant who might eventually identify herself as a boy would be catastrophic.'
>
> Since a young age, M.C. has shown strong signs of developing a male gender. He is currently living as a boy ... Defendants' decision to perform irreversible, invasive, and painful sex assignment surgery was unnecessary to M.C.'s medical well-being."

M.C.'s legal case is the first of its kind, but is likely not to be the last. Nevertheless, physicians with knowledge of the lack of sufficient evidence to justify early surgical intervention can avoid harm to patients – and thus avoid litigation or sanctions – by allowing patients to decide, on their own, if they wish gender surgery or not.

The Working Party's findings are, therefore, important to read in detail precisely because they document that there is no evidentiary basis to continue early sex assignment and genital surgery. The inescapable conclusion of those findings is that a moratorium on such surgery is overdue as both a scientific and medical matter. Patients' human rights must be seen as compatible with the best ethical considerations for medical practice [7,9,39]. We continue to support the clinical guidelines for medical management of differences in sex development in children, as presented in 1997 [18]. We urge, in the absence of imminent dangers to patients' lives or health, that gender variant conditions must be managed with the least invasive means available and respect for each patient's autonomy.

Conflict of interest

None.

Funding

None.

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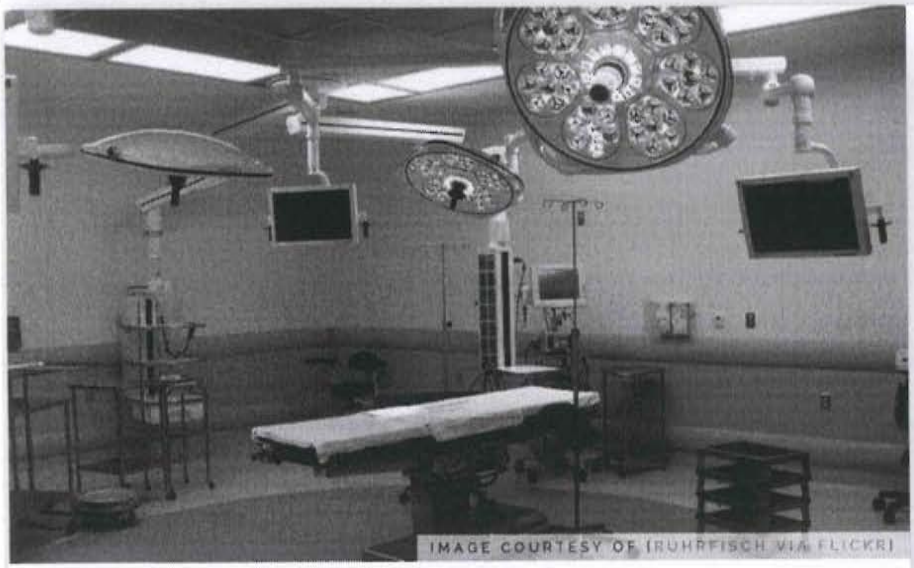

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HEALTH & SCIENCE

Infant Intersex Surgery: Genital Mutilation in the U.S.?

By Jennifer Polish | July 30, 2015

While many people from the United States often concern themselves with "female genital mutilation" in other countries, very little mainstream media sources focus on the nonconsensual surgeries on infants' genitals that are frequently performed in hospitals in the United States. Approximately one out of every 1,200 births in the U.S. is an intersex child, and doctors generally treat these infants with genital surgeries.

What is the purpose of these genital surgeries, and why do intersex people and advocates often call these surgeries genital mutilation?

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WHAT DOES IT MEAN TO HAVE INTERSEX TRAITS?

Before discussing surgeries, it is first necessary to define what is meant by "intersex."

The Survivor Project defines intersex as:

> *The word that describes those of us who, without voluntary medical interventions, possess bodies that doctors can't neatly classify as male or female. This includes people who have chromosomal sex other than XX (female) or XY (male), or primary or secondary sex characteristics that defy the medical definitions of male and female. Somehow, doctors [react negatively] when a newborn baby is found to be intersexed, and often mutilate her or his genitals to conform them to the doctors' idea of what a normal baby should look like, even though intersex conditions usually do not threaten the health of the infant. Parents are often not given enough information or support to make an informed decision regarding their babies' care.*

Put another way, Inter/Act, a youth group for youth with intersex conditions, explains being intersex as:

> *An umbrella term describing people born with variations of internal and/or external sex anatomy resulting in bodies that can't be classified as the typical male or female. We're usually taught that sex is merely black and white, "male" or "female," but that's simply not true. There are a lot of awesome gray areas in the middle that could make someone intersex.*

What It's Like To Be Intersex

People with intersex traits are sometimes included in the LGBTQI acronym, but it is important to point out that being intersex does not necessarily mean that someone will not be straight. As a volunteer contributor to *Everyone is Gay!* and someone with intersex traits, Claudia of everyoneisgay.com writes of the debate regarding intersex inclusion and exclusion in queer circles:

> *People have questioned whether intersex issues really "fit" into the LGBT acronym or not. The LGBT acronym represents those with sexual orientations and gender identities outside the normative party line. And intersex isn't a sexual orientation or a gender identity–it's a bodily way of being. (Things can get a bit tricky here–some intersex people might identify their gender identity as "intersex," and we need to allow intersex people–like all people–the room to identify however is authentic. Strictly speaking, however, intersex is about biology.)...Although intersex is about bodies, intersex people are fighting to be accepted, respected, and protected for being perceived as outside the norm. Since issues of bodily diversity are also often tied up in misunderstandings about how sex, gender, and sexual orientation fit together–hence, why so many people still advocate for "fixing" intersex people to make us "normal,"...including intersex people in LGBT issues makes a lot of sense...Many intersex people support adding the "I" and the LGBTQIA*

> *have been hesitant to support this inclusion because they with the queer community. This stems (at least in part) from the perception that intersex people have to be L, G, B, or T in addition to being intersex for inclusion to make sense. But this doesn't have to be the case.*

WHAT IS INTERSEX GENITAL MUTILATION?

Since the 1950s, when infants with intersex characteristics are born in the United States, doctors have chosen with overwhelming frequency to ignore the principles of informed consent and patient-centered models, instead choosing to follow concealment-centered models of care.

Doctors practicing concealment-centered models of care on intersex infants believe that genital "[r]econstruction to create normal functioning genitalia… performed using many different techniques" is a necessary part of giving infants with intersex traits a certain quality of life. To doctors who perform these surgeries,

"the most important factors in the sex assignment of intersexed children are achieving a "normal" appearance of the genitalia in the assigned sex, and sexual function. If a male's phallus is deemed unlikely to be able to "perform" adequately, then re-assignment as a female may become the preferred medical choice. But appearance and sexual function is not the only factor used in sex assignment – many laboratory tests are also done to determine the child's genetics and potential for fertility."

Before performing these surgeries, doctors evaluate certain standards before determining whether their surgical intervention will be aimed toward creating more male external genitalia or more female external genitalia. Some of these standards include the ability to ensure that children who will be raised as young boys can urinate while standing, and that children who will be raised as young girls will not have testes. Doctors make these determinations in order to allow children to grow up with genitalia considered typical for their gender.

This model of care encourages doctors to

> *Carry out largely unregulated and controversial surgeries that aim to make an infant's genitals and reproductive organs more normal but can often have unintended consequences, according to intersex adults, advocates and some doctors…A long and gut-wrenching list of damaging side effects—painful scarring, reduced sexual sensitivity, torn genital tissue, removal of natural hormones and possible sterilization—combined with the chance of assigning children a gender they don't feel comfortable with has left many calling for the surgeries to be heavily restricted.*

Because one of the standards that doctors use to provide these surgeries is the potential for an infant to eventually have penetrative vaginal sex, many strenuously assert that surgeries on intersex infants is not about the health of the infant, but rather about their potential to successfully perform–both in genital appearance and in sexual activity–heterosexual sex.

Studies show that infants subjected to these surgeries, upon coming into adolescence and adulthood, are dissatisfied with the decisions and abuse inflicted on them by medical providers. Intersex advocates question both the legalities and the ethics of doctors who treat intersex infants with these surgeries. The website of Advocates for Informed Choice, an organization dedicated to the legal rights of those with intersex traits, explains:

> *The medical treatment of children born with intersex traits raises several legal and ethical issues. There are important questions about whether current medical practices meet legal standards for informed consent. Some parents of children born with intersex traits have reported feeling pressured to make quick decisions, often without complete information about the risks of surgery and the uncertainty of outcomes. Many parents feel that their child's emotional health is a major factor in their decisions, yet are not given access to specialists in children's mental health and development. Caring physicians may try to ease parents' fears by downplaying the risks, but parents who learn after the fact about the doubts surrounding elective genital surgery may be dissatisfied...Legal scholars and ethicists have also questioned the process for making surgical decisions on behalf of children with intersex traits. The ethical and clinical uncertainty that exists in this area raises important questions about whether the current model of decision-making is legally valid. Additional legal questions come up if surgical treatment may result in loss of fertility for the child. No U.S. court has ruled on these issues in a published opinion...Other legal issues that may arise for children with intersex traits include medical privacy rights, access to medical records, school accommodation, and bullying or teasing.Children with intersex traits who are in state custody, such as foster children, may have special legal needs."*

These special legal needs are often neglected in the United States, but Parliament of the European country of Malta has recently banned "normalization" surgeries on intersex infants. Maltese doctors are no longer permitted to perform medically unnecessary genital procedures on intersex babies. This ban is in keeping with a 2013 U.N. Special Rapporteur on Torture report, which acknowledges that intersexuality rarely poses a threat to a person's health, and therefore, performing irreversible "normalization" surgeries to "correct a problem" that doesn't medically exist is immensely harmful to intersex people.

WHAT IS BEING DONE?

Many intersex people who have been harmed by genital surgeries when they were infants become activists advocating against the future use of these irreversible, medically unnecessary procedures. By advocating for informed consent and patient-centered models of care, people with intersex traits are working to change the medical landscape to ensure that intersex genital mutilation is no longer the default response to intersexuality in infants born in the United States.

SOURCES

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Intersex Society of North America: Frequently Asked Questions

The Atlantic: Should We 'Fix' Intersex Children?

Jennifer Polish

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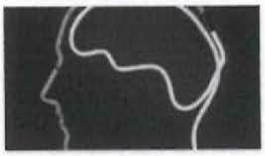

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Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

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COMMITTEE AGAINST TORTURE

CONSIDERATION OF REPORTS SUBMITTED BY STATES PARTIES UNDER ARTICLE 19 OF THE CONVENTION

Initial reports of States parties due in 1995

Addendum

UNITED STATES OF AMERICA*

[15 October 1999]

* The list of Annexes.

Article 4: Torture as a criminal offence

178. Throughout the United States, its territories and possessions, all acts constituting torture are criminal offences, punishable by appropriately severe penalties. Additionally, acts constituting attempts, "complicity", "participation" and conspiracy to torture are likewise criminal offences. No single federal statute specifically defines or prohibits torture or directly implements the central provisions of the Convention. Nonetheless, at the time of ratification, it was determined that existing state and federal law was sufficient to implement article 4, except to reach torture occurring outside United States jurisdiction, as discussed below under article 5.

179. Where acts constituting torture under the Convention are subject to federal jurisdiction, they fall within the scope of such criminal offences as assault, maiming, murder, manslaughter, attempt to commit murder or manslaughter, or rape. See 18 U.S.C. §§ 113, 114, 1111, 1113, 2031. Conspiracy to commit these crimes, and being an accessory after the fact, are also crimes. See 18 U.S.C. §§ 3, 371 and 1117. Where such acts are committed within the "special maritime and territorial jurisdiction" located within a state, federal law incorporates criminal defences as defined by state law. See 18 U.S.C. §§ 7, 13.

180. Conduct falling within the scope of the Convention will often constitute criminal violations of the federal civil rights statutes. For example, violations of 18 U.S.C. §§ 241 and 242 carry a maximum of 10 years in jail or, if the victim dies, the death penalty. Section 241 penalizes conspiracies to deprive an individual of "the free exercise or enjoyment of a right of privilege secured by the Constitution or laws of the United States". Section 242 addresses wilful deprivation of such rights "under color of law".

181. It has long been recognized that these statutes apply to official misuse of authority and force. In the notorious Rodney King case, two officers of the Los Angeles Police Department were convicted of violating § 242 by beating Mr. King repeatedly with batons during an arrest. Each was sentenced to 30 months' imprisonment for criminal violations of the civil rights statutes. This case began as a local prosecution of the four police officers involved in the incident - they were acquitted of the charges after the defence convinced the jury that their conduct was not unreasonable under all the surrounding circumstances. The subsequent federal criminal prosecution was successful in convincing a federal jury that the principal actor used unreasonable force, and his supervising sergeant had permitted him to do so. See United States v. Koon, 518 U.S. 81 (1996).

182. Even where a specific act constituting torture is not within the scope of these federal statutes, or is outside the protections afforded by the Fourth, Fifth, Eighth and Fourteenth Amendments, it will be found in violation of state criminal law. Every state criminalizes deliberate acts of bodily injury as well as abuses of authority on the part of state agents, whether as common assault and battery, homicide, rape, etc., as well as conspiracies, attempts, complicity, solicitation, etc. Twenty-two states have "official oppression" statutes, many of which are patterned after the American Law Institute's Model Penal Code section 243.1, which provides that a person acting or purporting to act in an official capacity commits a crime if he or she knowingly subjects another to arrest, detention, search, seizure, ill-treatment, dispossession, assessment, lien or other infringement of personal or property rights or denies or impedes another in the exercise or enjoyment of any right, privilege, power or immunity. The Oregon

state penal code, for example, includes a specific crime of official misconduct. See also, Alaska Stat. 11.56.850 (1997) ("official misconduct"); Col. Crim. Code C.R.S. 18-8-403 (1996); Georgia OCGA 45-11-3 (1997); N. Dak. Cent. Code 12.1-14-01 (1997); Oreg. Stat. 163.205 (2) (1997); Tenn. Code Ann. 8-18-101 (1997).

Article 5: Jurisdiction

183. As a general matter, criminal jurisdiction under federal and state law is territorial. It encompasses crimes committed by any person within the territory of the United States (or relevant subordinate jurisdiction) regardless of the nationality or citizenship of the offender or victim.

184. In relatively few instances, the definition of "territory" has been specifically crafted to apply to acts taking place outside United States geographical territory. For example, certain provisions of the federal criminal code apply within the "special maritime and territorial jurisdiction of the United States" (18 U.S.C. § 7), which includes, inter alia, vessels registered in the United States, aircraft belonging to the United States, and "any place outside the jurisdiction of any nation with respect to an offence by or against a national of the United States". Federal law also defines the "special aircraft jurisdiction of the United States" to include extraterritorial offences against aircraft in specified instances. See 49 U.S.C. § 46501 (2).

185. For instance, United States criminal jurisdiction extends beyond the territory of the United States to the following conduct:

- criminal acts which occur on a vessel belonging to a United States individual or corporation located on the high seas. 18 U.S.C. § 7 (1).

- criminal acts which occur on an aircraft belonging to a United States individual or corporation flying over the high seas. 18 U.S.C. § 7 (5).

- criminal acts performed by or against a United States national outside the jurisdiction of any country. 18 U.S.C. § 7 (7).

- criminal acts which occur on any foreign vessel with a scheduled departure or arrival in the United States and the criminal act is performed by or against a United States national. 18 U.S.C. § 7 (8).

- criminal acts performed on an aircraft with its next scheduled destination or last place of departure in the United States, if it next lands in the United States. 49 U.S.C. § 46501 (2) (D) (i).

- criminal acts performed on an aircraft leased (without a crew) to a United States lessee with its principal place of business in the United States. 49 U.S.C. § 46501 (2) (E).

186. These provisions meet the obligation of the United States under article 5 to establish jurisdiction over acts of torture when committed "in any territory under its jurisdiction or on board a ship or aircraft registered in" the United States.

CHAPTER 113C—TORTURE

Sec.
2340. Definitions.
2340A. Torture.
2340B. Exclusive remedies.

AMENDMENTS

2002—Pub. L. 107–273, div. B, title IV, § 4002(c)(1), Nov. 2, 2002, 116 Stat. 1808, repealed Pub. L. 104–294, title VI, § 601(j)(1), Oct. 11, 1996, 110 Stat. 3501. See 1996 Amendment note below.

1996—Pub. L. 104–132, title III, § 303(c)(1), Apr. 24, 1996, 110 Stat. 1253, redesignated chapter 113B as 113C. Pub. L. 104–294, title VI, § 601(j)(1), Oct. 11, 1996, 110 Stat. 3501, which made identical amendment, was repealed by Pub. L. 107–273, div. B, title IV, § 4002(c)(1), Nov. 2, 2002, 116 Stat. 1808, effective Oct. 11, 1996.

§ 2340. Definitions

As used in this chapter—

(1) ''torture'' means an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control;

(2) ''severe mental pain or suffering'' means the prolonged mental harm caused by or resulting from—

(A) the intentional infliction or threatened infliction of severe physical pain or suffering;

(B) the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality;

(C) the threat of imminent death; or

(D) the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality; and

(3) ''United States'' means the several States of the United States, the District of Columbia, and the commonwealths, territories, and possessions of the United States.

(Added Pub. L. 103–236, title V, § 506(a), Apr. 30, 1994, 108 Stat. 463; amended Pub. L. 103–415, § 1(k), Oct. 25, 1994, 108 Stat. 4301; Pub. L. 103–429, § 2(2), Oct. 31, 1994, 108 Stat. 4377; Pub. L. 108–375, div. A, title X, § 1089, Oct. 28, 2004, 118 Stat. 2067.)

AMENDMENTS

2004—Par. (3). Pub. L. 108–375 amended par. (3) generally. Prior to amendment, par. (3) read as follows: ''''United States' includes all areas under the jurisdiction of the United States including any of the places described in sections 5 and 7 of this title and section 46501(2) of title 49.''

1994—Par. (1). Pub. L. 103–415 substituted ''within his custody'' for ''with custody''.

Par. (3). Pub. L. 103–429 substituted ''section 46501(2) of title 49'' for ''section 101(38) of the Federal Aviation Act of 1958 (49 U.S.C. App. 1301(38))''.

EFFECTIVE DATE

Section 506(c) of Pub. L. 103–236 provided that: ''The amendments made by this section [enacting this chapter] shall take effect on the later of—

''(1) the date of enactment of this Act [Apr. 30, 1994]; or

''(2) the date on which the United States has become a party to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.'' [Convention entered into Force with respect to United States Nov. 20, 1994, Treaty Doc. 100–20.]

§ 2340A. Torture

(a) OFFENSE.—Whoever outside the United States commits or attempts to commit torture shall be fined under this title or imprisoned not more than 20 years, or both, and if death results to any person from conduct prohibited by this subsection, shall be punished by death or imprisoned for any term of years or for life.

(b) JURISDICTION.—There is jurisdiction over the activity prohibited in subsection (a) if—

(1) the alleged offender is a national of the United States; or

(2) the alleged offender is present in the United States, irrespective of the nationality of the victim or alleged offender.

(c) CONSPIRACY.—A person who conspires to commit an offense under this section shall be subject to the same penalties (other than the penalty of death) as the penalties prescribed for the offense, the commission of which was the object of the conspiracy.

(Added Pub. L. 103–236, title V, § 506(a), Apr. 30, 1994, 108 Stat. 463; amended Pub. L. 103–322, title VI, § 60020, Sept. 13, 1994, 108 Stat. 1979; Pub. L. 107–56, title VIII, § 811(g), Oct. 26, 2001, 115 Stat. 381.)

AMENDMENTS

2001—Subsec. (c). Pub. L. 107–56 added subsec. (c).

1994—Subsec. (a). Pub. L. 103–322 inserted ''punished by death or'' before ''imprisoned for any term of years or for life''.

§ 2340B. Exclusive remedies

Nothing in this chapter shall be construed as precluding the application of State or local laws on the same subject, nor shall anything in this chapter be construed as creating any substantive or procedural right enforceable by law by any party in any civil proceeding.

(Added Pub. L. 103–236, title V, § 506(a), Apr. 30, 1994, 108 Stat. 464.)

CHAPTER 114—TRAFFICKING IN CONTRABAND CIGARETTES AND SMOKELESS TOBACCO

Sec.
2341. Definitions.
2342. Unlawful acts.
2343. Recordkeeping, reporting, and inspection.
2344. Penalties.
2345. Effect on State and local law.
2346. Enforcement and regulations.

AMENDMENTS

2006—Pub. L. 109–177, title I, § 121(g)(3), (4)(A), Mar. 9, 2006, 120 Stat. 224, substituted ''TRAFFICKING IN CONTRABAND CIGARETTES AND SMOKELESS TOBACCO'' for ''TRAFFICKING IN CONTRABAND CIGARETTES'' in chapter heading, added items 2343 and 2345, and struck out former items 2343 ''Recordkeeping and inspection'' and 2345 ''Effect on State law''.

Additional resources

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