Commentary

Torture and Ill-Treatment Based on Sexual Identity: The Roles and Responsibilities of Health Professionals and their Institutions

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Amnesty International's (AI) recent report "Crimes of Hate, Conspiracy of Silence" examines the torture and ill-treatment of lesbian, gay, bisexual, and transgender (LGBT) people. The report documents widespread human rights abuses, ranging from loss of dignity to assault, rape, and murder. The report also reveals that both the state and society continue to sanction these human rights abuses through formal mechanisms, such as discriminatory laws, and through informal mechanisms, including stigma and prejudice. The disinterest or active hostility of the criminal justice system has allowed many of these abuses to be conducted with impunity.[1] This disturbing picture of abuses that goes against human decency should rouse health professionals—as well as citizens everywhere—to action. Health professionals should be particularly alarmed that health-care workers are implicated in these violations not

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only as passive bystanders but also as active perpetrators of human rights abuses against LGBT people. Health professionals and their institutions should therefore be prompted by the report to examine their roles and responsibilities regarding the health and human rights of LGBT populations.

In light of the AI Report, this commentary examines the challenges posed to both human rights activists and health professionals by recent work on sexual rights. Although it has been suggested that "the fields of health and rights are illuminated today by their commonalities," we argue below that relations between the human rights and health of LGBT persons remain problematic.[2]

Over the last decade, the complex linkages between health and human rights have received increasing attention. A three-part model of this relationship has been proposed.[3,4] The first relationship focuses on the positive and negative impacts on human rights of health policies, programs, and practices. Such policies and practices extend from large-scale public health programs to micro-level interactions between health-care providers and clients. For example, interventions to protect public health may include coercive measures, such as quarantine and isolation, both of which restrict individual rights. Individuals may also experience discrimination in health-care settings because of their gender, race, or sexuality.

The second relationship examines the link between violations of human rights and dignity and health. This ranges from the obvious short- and long-term impacts of rape, torture, and abuse to the adverse effects of violations of other rights. These include the right of access to information, for example, in relation to contraception, and the right to a safe and healthy work environment. The third relationship examines the links between promoting and protecting human rights and promoting and protecting health. In this regard, it has been suggested that "health and human rights are complementary approaches for defining and advancing human well-being."[5,6]

For many years, the invisibility of LGBT persons was reflected in the omission of sexual orientation from international and local human rights agendas.[7,8] Alice Miller has recently explored the ways in which sexual rights have been

constructed within human rights discourses.[9] She suggests that health contexts have been fertile ground for progressive formulations of the ways in which sexuality interacts with traditional human rights obligations. For instance, the first reference to sexual orientation in a general interpretation of a human rights treaty was in relation to the health obligations of states as part of the implementation of the International Covenant on Economic, Social and Cultural Rights.

Miller also notes that the health arena cannot be assumed to provide a safe harbor for sexuality and sexual rights. This is especially true for homosexuality given the historic role medicine and its related professions and institutions have played in oppressing nonheteronormative sexualities. Medicine continues to contribute to such oppression in many ways. Thus, while the progress of the sexual rights agenda within health is welcome, Miller offers two challenges to the use of health as a domain for human rights work: First, because health concerns do not cover rights in relation to "the full universe of sexuality," both health and sexual health need to be repositioned within a larger social justice framework and within efforts to transform civil society more broadly.[10] Second, establishing rights for the full range of sexualities must start by asserting sexuality as one of the core rights of all human beings and, therefore, as a right that should be fundamentally protected.

The latter issue raises an additional question in discussions of sexuality: Is there a global category of LGBT persons for whom rights can be claimed? Using such a category might suggest that such sexual identities are both universal and unchanging. Although human rights work requires the identification of a person as the subject of rights, social science research has suggested that sexual identities are socially constructed.[11,12] The AI report identifies worldwide patterns of abuse based on sexual orientation and gender identity. By documenting such experiences, the report makes global what have been perceived as local concerns and places LGBT issues firmly within international human rights discourse. We concur with this usage of the category "LGBT," but we also acknowledge that sexual identities are diverse and that generalizing across a wide

range of populations and settings creates difficulties. Our use of the term "LGBT" here is not intended to impose a particular construction of sexual identity but to serve simply as a convenient abbreviation. Nevertheless, we argue that despite the multiplicity of cultural constructions, prejudice toward nonheterosexuals is, with few exceptions, a universal phenomenon and therefore deserves wider analysis. Indeed, the AI report clearly shows that those expressing nonheterosexual sexualities share similar experiences of stigma, dehumanization, discrimination, ill-treatment, and torture across cultures and countries. By placing such violations within a global discourse on human rights, the report rightly rejects attempts to rationalize discrimination by claiming that diverse sexual identities are foreign to local cultures or religions.[13]

AI's examination of torture and ill-treatment based on sexual identity focuses largely, though not exclusively, on the adverse health consequences of human rights violations, which is the second relationship of the previously described framework.[14] In this commentary, we try to broaden that discussion by exploring other dimensions of the relationship between the health and human rights of LGBT persons. In doing so, we suggest that the roles and responsibilities of health-care providers need to be developed as part of a comprehensive approach to public health that requires "explicit and concrete efforts to promote and protect human rights and dignity."[15] For purposes of this discussion, we use the terms "homophobia" (negative attitudes toward gay men and lesbians), "heterosexism" (the negation of nonheterosexual forms of sexuality, affection, or relationships) and "sexual prejudice" (negative attitudes based on sexual orientation, whether bisexual, homosexual, or heterosexual).[16] While such terms have emerged from academic discourse in the West, we use them here to refer to phenomena that, as the AI report shows, are by no means restricted only to that part of the world.

LGBT Human Rights and Health

The torture and ill-treatment of LGBT persons has obvious effects on their health, even though formal assessments of these impacts are seldom conducted. However,

these gross abuses form only the "tip of the iceberg" regarding the effects of sexual prejudice on health. The evidence presented by AI should therefore draw our attention to a range of less obvious, but often more insidious and pervasive, human rights violations and their effects on health. Health-care providers must recognize that a social environment that condones prejudice against LGBT people and promotes their social isolation can be detrimental to their physical and mental health.[17,18] "In the case of gays," one South African Constitutional Court judge declared, ". . . scarring comes . . . from invisibility. It is the tainting of desire, it is the attribution of perversity and shame to spontaneous bodily affection, it is the prohibition of the expression of love, it is the denial of full moral citizenship in society because you are what you are. . . ."[19] Challenging such a pathogenic environment should be a priority for health professionals.

The impacts of health policies, programs, and practices on the human rights of LGBT persons also deserve consideration. These policies cannot be viewed in isolation of the institutions that create them and the health-care providers who implement them. Medicine, as an institution, is closely involved in maintaining social consensus and control by regulating the boundaries of social normality.[20,21] Health-care providers continuously reaffirm these boundaries in their daily work, even when such restrictions are not sanctioned by law. In terms of sexuality, this regulation has virtually always favored the heteronormative, thereby privileging heterosexuals while pathologizing (or treating as ill) those of other orientations.[22,23] Through this process, heterosexuality is constructed as normal and "good for society," while other sexualities are labeled as deviant and are seen as a threat to societal stability.

Such institutionalized homophobia and heterosexism within health care may contribute directly to the ill-health of LGBT populations. The use, and threatened use, of forced psychiatric hospitalization against LGBT persons in Russia and the Ukraine, as described in the AI report, are blatant examples of this.[24] Such repression has also been justified on public health grounds as a means of preventing the spread of disease.[25] These examples and others demonstrate that when health-care providers act in the interests of the state

rather than of their patients, they may be infringing on their patients' rights, colluding in the enforcement of unjust and inhumane laws, and helping to uphold discriminatory social systems.[26-30] Not surprisingly, LGBT persons may be afraid to reveal their sexual orientation to a health-care provider, fearing breach of confidence, abuse, or reprisal.[31]

Although the American Diagnostic and Statistical Manual (DSM-IV) declassified homosexuality as a mental disorder in 1973 (and other classification systems have since followed suit), some areas of sexual identity remain pathologized.[32] For example, the DSM-IV still includes gender-identity disorder, which it defines as atypical or nonconforming modes of gender expression.[33] Medicine has also come under attack regarding sexual reassignment and cosmetic genital surgery for infants born with ambiguous genitalia. Advocates for intersexed individuals claim that cosmetic genital surgeries are akin to genital mutilation and that they violate human rights. Recently, the Constitutional Court of Colombia advanced this cause by severely restricting the use of such procedures for infants.[34] The Court recognized that intersexed people are a minority group who enjoy constitutional protection against discrimination and that every person has a right to define his or her own sexual identity.[35]

Viewing homosexuality as an illness may also lead to the promotion and use of treatments to "reverse" sexual orientation, even though science has discredited such "reparative" or "conversion" therapies, and despite the condemnation of such therapies as a violation of human rights.[36-40] In some cases, these therapies are used coercively and with the complicity of the state. For example, during apartheid, health professionals within the South African military used these therapies on homosexual military personnel without their informed consent.[41] (See Box 1.) However, "conversion" therapies persist even in democracies and despite the declassification of homosexuality as a mental disorder. This is illustrated by the recent widely publicized U.S. report claiming that "highly motivated" gay men and lesbians "can become heterosexual."[42] While not state complicit or coercive, such practices are still social in origin in that they seek to eliminate so-called deviant sexualities from society. States have an important role to play in addressing such

Box 1: Testimony on the Use of Conversion Therapy on Gay Personnel in the South African Military during the Apartheid Era

Clive, a South African man, was a conscript in the South African military from 1973 to 1974. He then immigrated to Holland, where he became involved in the anti-apartheid struggle. He is now a professional businessman in South Africa. All the names used in the following paraphrased interview are pseudonyms. *

I turned 18 in the army. About then I realized that the experiences with other boys were now clearly my orientation. And this was now difficult in the army in a very anti-gay sort of environment and I spoke to the army doctor. He suggested that I go and talk to Dr. Stoch [a military psychiatrist]. And I thought I was going to see this chap and I'd get tips on how to cope with it all.

When I saw Dr. Stoch, he proceeded to admit me [to hospital]. He made me tell my parents in his office. I think my parents were very traumatized by that. They agreed that I should stay there because he offered this therapy which he wasn't very specific about, which would help me overcome the problem. By then, I was actually convinced that it was a problem to be gay.

He told me roughly the mechanics of it. That you're going to get hooked up to something that resembles a massage device. So well, I thought, what the hell, try it. I was there for I think four to five weeks and I had to come back once or twice a month. And these sessions would last for about an hour. He'd show you pictures from boy magazines and [you'd] tell him what you thought. And while you were talking the electric stuff and the sensation on your arms would start and then it would become very painful. And then when you kind of reached the maximum point and then you'd say "No, no, no, I couldn't stand it any more" then he would say, "Now you must think about your girlfriend."

I found the therapy itself terribly painful, very disorientating. It made me completely depressed. and confused. [But] It didn't change me. I'd go off and carry on anyway. I suppose I was ... terrified of authority you just simply did what you were told. Because if you didn't co-operate, there was always that unstated threat that you would be dispatched to Greefswald [a military work camp]. One's got to look at it from the point of view of seeing very young boys, who are scared of authority this thing being held up to them as their only alternative against another alternative. And that kind of blackmail of unstated authority, blackmail in the sense of you'd better go along with this.

* The aVersion Project (AM2757), Gay and Lesbian Archives, Department of Historical Papers, University of the Witwatersrand Libraries, South Africa.

practices as their human rights obligations involve not only respecting and protecting rights, but also fulfilling rights. In this instance, such obligations may involve governments putting in place the mechanisms to ensure an open and diverse society in which the diversity of sexual identities is accepted.[43] In its recommendations, the AI report uses strong language to condemn interventions to change sexual orientation, calling them "cruel, inhuman, or degrading treatment which could amount to torture [and] should be prohibited in all circumstances."[44] It urges medical associations to affirm that homosexuality is not a medical disorder and to condemn and prohibit their members from participating in any nonconsensual treatment aimed at "curing" or "treating" homosexuality. We would add that governments need to act on their obligations to respect, protect, and fulfill human rights.

Institutionalized heterosexism has also led to the marginalization and neglect of LGBT health issues. This has resulted in inadequate attention to their health concerns, biased provision of resources, lack of knowledge of and insensitivity to the cultural concerns of LGBT people, and denial of access to services.[45] Additionally, LGBT health workers who might otherwise promote LGBT health may experience homophobia from colleagues and superiors.[46,47] Too often in addressing LGBT health, health-care providers have further stigmatized LGBT populations, which also contributes to their abuse.

Finally, health research that stigmatizes LGBT people may contribute to discrimination and abuse. For example, the association of HIV/AIDS with gay men in the United States has been used a pretext for unjustified violations of LGBT rights, such as segregating HIV-positive prisoners and dismissing HIV-positive health-care workers, as part of "public health" efforts to curb the epidemic.[48] Recently, attempts to establish the biological etiology of homosexuality have been renewed.[49] Advocates of this research suggest that scientific evidence of the innate nature of homosexuality will promote social acceptance and human rights for LGBT people. But researchers must heed critiques showing that biological arguments for other socially constructed categories, such as race and ethnicity, are fraught with contra-

dictions and have not led to tolerance.[50] Moreover, these efforts may further pathologize homosexuality by continuing to place LGBT populations under medical scrutiny.

The Way Forward

Positive developments in LGBT health and human rights have undoubtedly been made in the past three decades. Most significantly, international human rights bodies, such as the United Nations Human Rights Committee, have affirmed that discrimination based on sexual orientation violates international human rights standards.[51] At least one international treaty has now been interpreted to include sexual orientation as grounds for nondiscrimination in health care and in the underlying determinants of health.[52] Within the health arena, a number of professional organizations have affirmed their opposition to discrimination based on sexual orientation or to the characterization of homosexuality as an illness.[53-56]

The body of LGBT health research is growing and gaining the attention of mainstream health journals. For example, the *American Journal of Public Health* recently published its first issue focusing on LGBT public health.[57] In the United States, the Institute of Medicine issued a report on lesbian health, and the Gay and Lesbian Medical Association has successfully lobbied to include LGBT concerns in the U.S. government's "Healthy People 2010" document, which sets health priorities for the next decade.[58,59] Furthermore, LGBT health-care consumers are increasingly demanding services that meet their needs, resulting in a number of innovative programs.[60-62] Incorporating LGBT health into medical education curricula may be one way to change health-care providers' attitudes toward LGBT persons.[63-67] Other strategies, such as using the Internet to facilitate referrals to gay-and-lesbian-sensitive health-care providers, are also being explored.[68] Nevertheless, many areas of concern still exist and much work must be done to place LGBT health and human rights firmly on the health agenda. The first step is for organizations of health professionals to affirm LGBT rights as human rights. This does not mean claiming new or special rights for LGBT populations but rather ensuring that they are guaranteed the civil,

political, social, economic, and cultural rights protected by international human rights instruments.[69] As the AI report cogently notes: "If we tolerate the denial of rights to any group, we undermine the whole protective framework of human rights by taking away its central plank—the equal rights and dignity of all human beings."[70]

The AI report specifies a range of measures, directed mainly at governments, to combat discrimination against LGBT populations. (See Box 2.) Governments' duty to take an active role in ensuring the well-being of LGBT people should include not only avoiding harm (ill-treatment and torture) but also promoting health and well-being, according to WHO's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[71] Governments must actively develop solutions to the discrimination and bias that plague LGBT health through interventions at all levels. This includes civil society; academic and training institutions; statutory health profession councils; health professional organizations; the criminal justice system; individual health-care providers; and consumers. Health-care professionals must be at the forefront of these efforts.

Addressing human rights from the prism of health carries both promise and risks.[72,73] While human rights and health concerns converge, they are not coterminous. First, some rights can be limited in the interest—or under the guise—of public health, as discussed earlier. Although such infringements on individual rights must be least restrictive and must be scrutinized for excessive breadth and arbitrariness, there is always potential for their abuse.[74-76] Second, not all rights have clear or immediate health implications. By putting sexuality-related rights claims only within a health context, human rights advocates may risk eclipsing aspects of sexual rights that do not have a health component (e.g., the right to freedom of association). By conflating sexuality claims in health, we risk health concerns being perceived as the only justification for sexuality-related human rights and, by extension, adverse health outcomes being used as a "litmus test" for human rights violations. This would distort the health concerns argument in human rights. Human rights are related to "the inherent dignity"

and "the equal and inalienable rights of all members of the human family," and their justification must therefore not be contingent only on their health implications.[77]

Nevertheless, human rights and health concerns are intertwined.[78] The increasing mobilization of LGBT populations worldwide and efforts by human rights organizations, such as Amnesty International, will hopefully lead to more powerful demands for access to rights within health care and beyond. Health-care professionals and their institutions must accept their moral and professional responsibility to work with these movements to advocate and support

Box 2: Recommendations to Governments for Preventing Torture and Ill-Treatment Based on Sexual Identity*

1. Repeal laws that could result in the discrimination, prosecution, and punishment of people solely for their sexual orientation or gender identity.

2. Condemn torture and ill-treatment, whoever the victim, and give clear indications that this will not be tolerated.

3. Provide safeguards to protect LGBT people in custody from torture or ill-treatment.

4. Prohibit forced medical treatment including nonconsensual treatments aimed at changing sexual orientation or gender identity.

5. End impunity by ensuring that all allegations of torture and ill-treatment are investigated and those responsible brought to justice.

6. Protect LGBT people, including children, against violence in the broader community, including domestic violence.

7. Protect refugees fleeing torture based on sexual identity.

8. Protect and support human rights defenders at risk because of their work on issues of gender and sexual identity.

9. Strengthen international protection for LGBT people through ratifying international human rights instruments and ensuring that UN and regional human rights bodies advance LGBT human rights issues.

10. Combat discrimination by ensuring legal protection against homophobic abuses, initiating antidiscrimination campaigns; and enforcing the rights that LGBT organizations and individuals have to freedom of association and assembly.

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measures to uphold human rights and to promote the health of LGBT persons.

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77. United Nations, Universal Declaration of Human Rights, adopted and proclaimed by the General Assembly, resolution 217 A (III) of 10 December 1948, available from www.un.org/Overview/rights.html.
78. See note 2.