

John Yudkin's rebuke<sup>1</sup> of the Israeli Medical Association's (IMA's) silence over medical participation in torture is timely. In March, the UN Human Rights Council passed a resolution,<sup>2</sup> that, in revisiting the role and responsibility of medical and other health personnel in torture and other cruel, inhuman, or degrading treatment, reminds the profession that torture is more than an ethical issue.

Freedom from torture is a non-derogable right that must be protected under all circumstances, including in times of international or internal conflict or disturbance and state of emergency. Furthermore, acts of torture can constitute crimes against humanity, and everyone has a duty to report torture to relevant judicial authorities.

However, the IMA might consider criticism from the UK an example of the pot calling the kettle black, given that the British Medical Association (BMA) has yet to break its Trappist silence over the violation by the British government of an equally binding international human right—the right to the highest attainable standard of health of refused asylum seekers.<sup>3</sup> Although torture involving doctors is the very antithesis of ethical medical practice, de-facto collusion over the denial of someone's health rights amounts to a disavowal of ethical medical practice.

Had the BMA acknowledged the fact of the violation 3 years ago, it would have transformed the received wisdom base on which the profession's response has been debated—to the extent that the Department of Health might have been discouraged from successfully appealing the Judicial Review that provided the all too brief respite from the ban on access to free secondary care.<sup>4</sup>

I had a role in the development of General Comment 14 of the International Covenant on Economic, Social, and Cultural Rights.

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## Sri Lanka: the aftermath

About 171 000 internally displaced people fled the conflict zone in northern Sri Lanka during April, 2009.<sup>1</sup> Several reports were published in *The Lancet* on this humanitarian issue,<sup>2–5</sup> most of which were based on media reports controlled by either side involved in the conflict.

We experienced the situation on the ground among internally displaced people in Sri Lanka while working in a field clinic in a camp for internally displaced people in May, 2009, as members of a voluntary health-care team.

The biggest problem in the camp was overcrowding, which led to disease, as did the poor sanitation facilities. Clinically, most patients had upper respiratory tract infections. They had walked for long distances in tough weather conditions and some had suffered near drowning. Diarrhoeal diseases were the second most frequent condition, and hepatitis A and varicella zoster were other common infectious diseases. Scabies, tinea, and painful dental caries were also prevalent. Tuberculosis could have constituted an important health problem among patients with chronic cough, since there were several treatment defaulters. Growth retardation was a common problem in infants and children owing to months or years of malnutrition.

We witnessed only a few acute injuries, but there were many condi-

tions associated with old injuries of the war. Nerve damage due to shrapnel, numbness, pain, scarring, contractures, misaligned fractures, retained shrapnel, and psychological disturbances were common among internally displaced people. Although they had received acute management, their chronic ailments were never attended to.

Patients with type 2 diabetes, hypertension, ischaemic heart disease, epilepsy, bronchial asthma, and psychiatric disorders had been without medication or follow-up for weeks to months, and most had lost their medical records. Some patients had received numerous drug regimens from different hospitals since they have been shifted to various places where the availability of drugs differed. Some patients presented with problems such as seizures, acute severe asthma, and features of hyperglycaemia. Restarting and titrating drugs for chronic conditions was a time-consuming and resource-consuming activity.

The field health centre consisted of an outpatient department, emergency treatment unit, minor surgery room, and maternal and child care units. About 14 doctors, together with pharmacists and other health-care workers, were covering the camp population of about 52 000. Things were not well organised in this newly established health centre, which comprised a large tent whose sides were half-covered with plastic sheets. The whole health centre was crowded with patients from the early morning onwards. Proper admission and recording procedures were impossible. However, thanks to the efforts of the administrators and all health-care workers, we saw an improvement in these aspects during our stay in the camp.

We declare that we have no conflicts of interest.

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The printed journal includes an image merely for illustration

- 1 UNHCR. UNHCR sends emergency team as first group of civilians returns to Sri Lanka's north. <http://www.unhcr.lk/news/releases/2009/01May09.htm> (accessed May 18, 2009).
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- 5 Anon. Sri Lanka's twin humanitarian crises. *Lancet* 2009; **373**: 1667–68.

Sri Lanka's brutal, three-decade-long war has come to an end. Although very timely, your May 16 World Report<sup>1</sup> contains some points that are biased and incorrect, and will certainly tarnish the image of Sri Lanka.

First, the main reason for the military operations continuing during the country's biggest festival was to rescue the innocent civilians kept as hostages. This is a legitimate right of the Government of Sri Lanka.<sup>2</sup>

The long time taken by the Sri Lankan army to rescue just a 3 km<sup>2</sup> area is itself strong evidence of the respect that the army had for the lives of civilians. Heavy artillery and air attacks would have finished the job in a matter of a few hours.

I agree that there are deficiencies in the facilities provided for displaced people for obvious reasons. But these deficiencies are no worse than what the world witnessed, for example, after hurricane Katrina in New Orleans in 2005.<sup>3</sup> This is the biggest ever hostage-rescuing mission in the world, and Sri Lanka is a developing country trying hard to thrive amid terrorism. What we need at this hour is help and positive encouragement.

I declare that I have no conflicts of interest.

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- 1 Anon. Sri Lanka's twin humanitarian crises. *Lancet* 2009; **373**: 1667–68.
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What is still lacking in the aftermath of the Sri Lankan conflict<sup>1</sup> is any information on the three missing doctors T Sathiyamoorthy, T Varatharajah, and V Shanmugarajah, who served the affected population and provided eye-witness accounts to international media. As we write this letter, we do not know their fate. It is widely reported that they were detained by the Sri Lankan forces.<sup>2,3</sup> We are still waiting for answers.

We declare that we have no conflicts of interest.

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## Fire-related deaths in India: how accurate are the estimates?

Prachi Sanghavi and colleagues (April 11, p 1282)<sup>1</sup> estimate that there were 163 000 fire-related deaths in India in 2001. However, they do not adequately discuss the limitations of the Survey of Causes of Death (SCD) for rural areas, where 73% of the population lives. Sampling units for the SCD are villages with a health centre; hence these units are not a true representation of the mortality patterns of rural India. Moreover, the SCD suffers from misclassification of causes of death, high proportions of unclassifiable deaths, and lack of systematic quality assurance.<sup>2</sup> Sanghavi and colleagues base the absolute number of fire-related deaths on the Sample Registration System,

but do not take into account age, gender, and state-specific undercounts.<sup>3</sup>

Similarly, Sanghavi and colleagues' use of "nature of injury" codes from the International Classification of Diseases indicates the poor quality of coding in the Medically Certified Causes of Deaths system used in urban hospitals.

The intent behind fire-related deaths could not be determined from the SCD despite the use of external cause codes, so fire-related suicide rates from Tamil Nadu were used.<sup>4</sup> However, this extrapolation of suicide data from a rural area of a southern state to the entirety of India is unlikely to result in accurate estimates, since large differences exist in cause-specific death rates in various regions.

In view of these limitations, the absolute number of fire-related deaths estimated by Sanghavi and colleagues might not reflect the true burden. Existing research needs to be supplemented by nationally representative studies such as the Million Death Study;<sup>5</sup> estimates of burn injury from this study are due this year.

We declare that we have no conflicts of interest.

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