

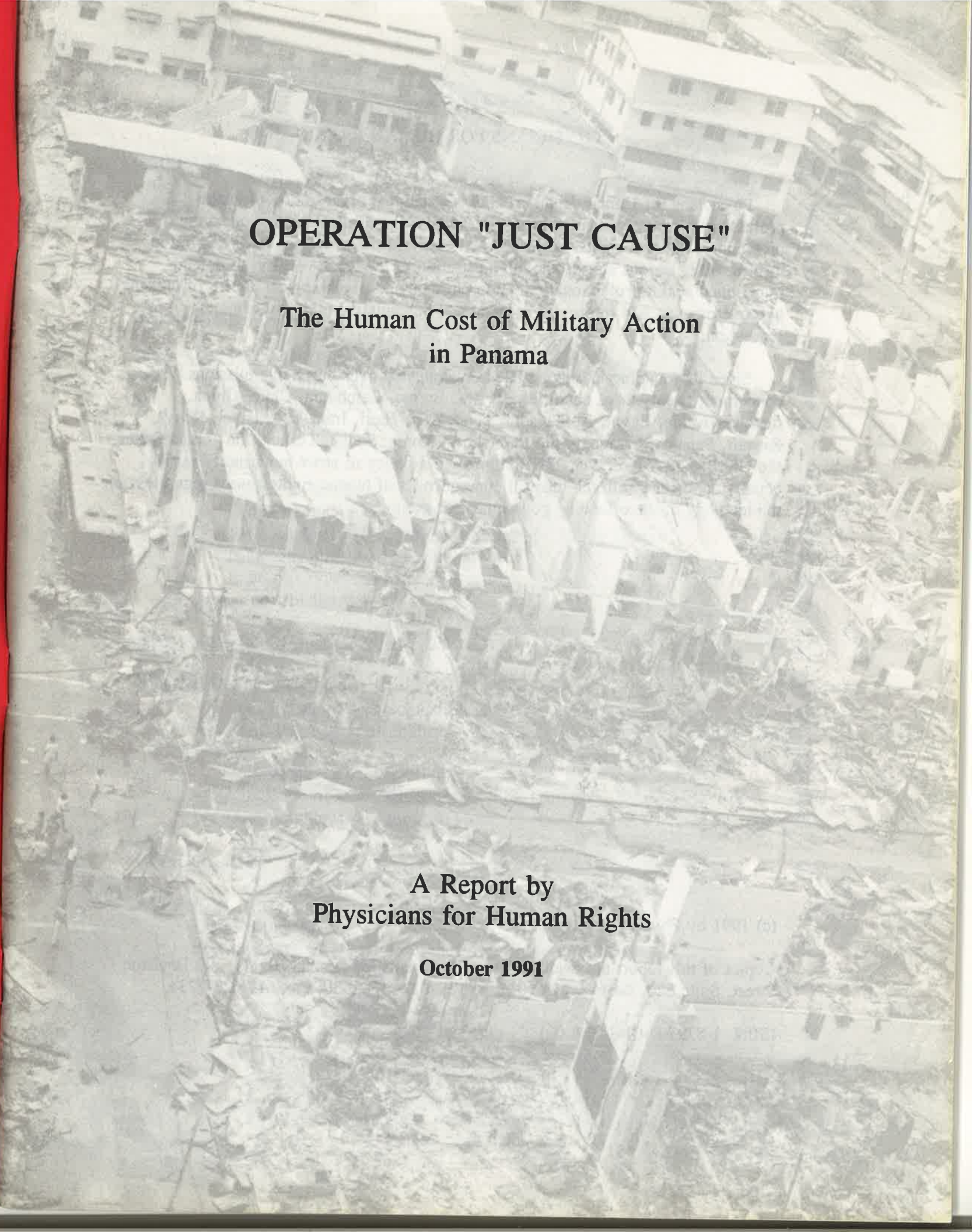
DISPLAY

OPERATION "JUST CAUSE"

The Human Cost of Military Action
in Panama

A Report by
Physicians for Human Rights

October 1991



OPERATION "JUST CAUSE"

**The Human Cost of Military Action
in Panama**

**A Report by
Physicians for Human Rights**

October 1991

PHYSICIANS FOR HUMAN RIGHTS

Physicians for Human Rights (PHR) is a national organization of health professionals whose goal is to bring the skills of the medical profession to the protection of human rights. PHR works to prevent the participation of doctors in torture, other serious abuses and administration of the death penalty; to defend imprisoned health professionals; to stop physical and psychological abuses of citizens by governments; and to provide medical and humanitarian aid to victims of repression.

Since its founding in 1986, PHR has conducted over thirty-five missions concerning twenty-three countries: Brazil, Burma, Cambodia, Chile, China, Czechoslovakia, Egypt, El Salvador, Guatemala, Haiti, Iran, Iraq, Israel, Kenya, Kuwait, Panama, Paraguay, the Republic of Korea, Sudan, Turkey, the United States, the USSR, and Yugoslavia. PHR adheres to a policy of strict impartiality and is equally concerned with the medical consequences of human rights abuses regardless of the ideology of the offending government or group.

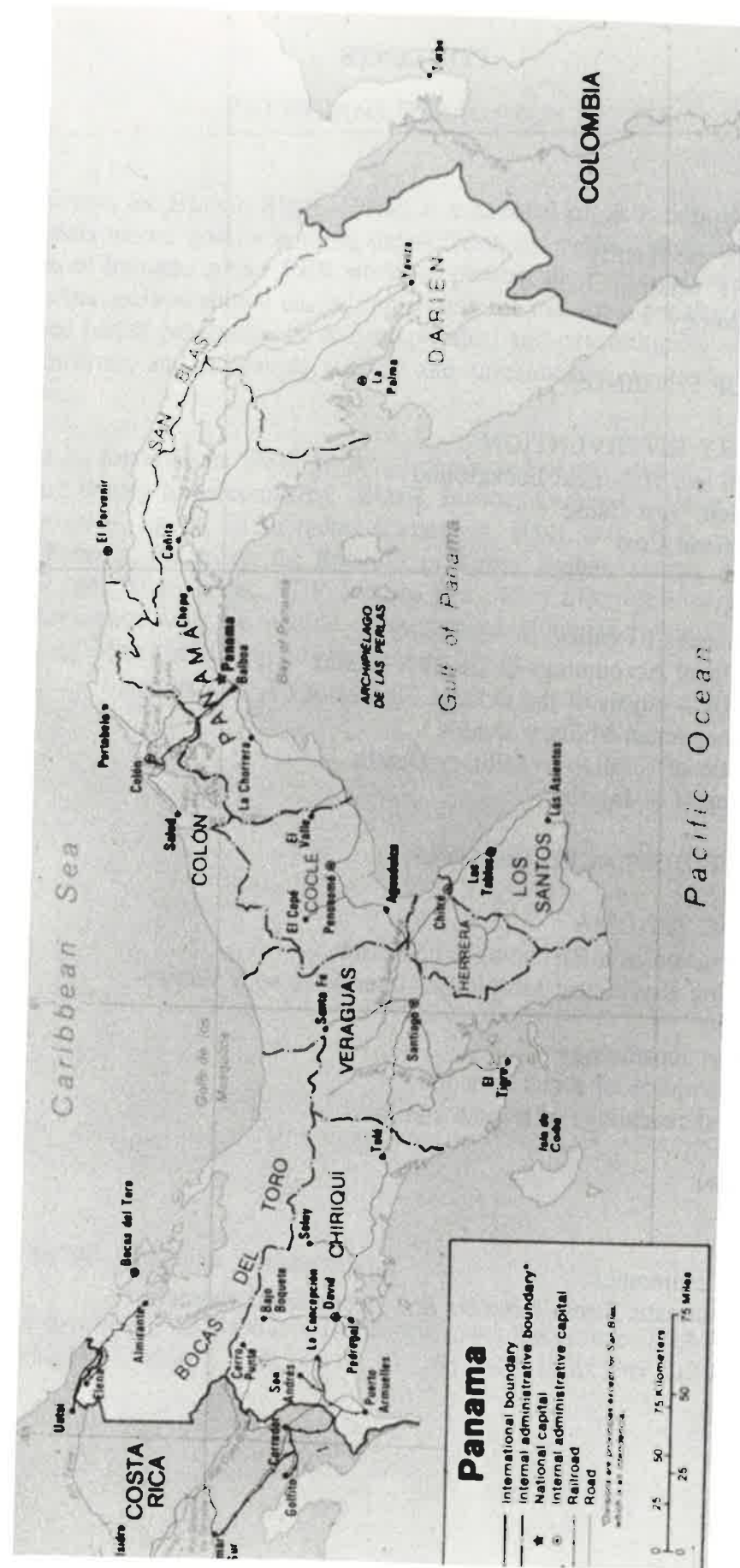
(c) 1991 by Physicians for Human Rights

Copies of this report are available from Physicians for Human Rights, 100 Boylston Street, Suite 620, Boston, MA 02116, Tel. 617/623-1930; Fax 617/623-7234.

ISBN 1-879707-01-2 (\$6.00)

CONTENTS

PREFACE	i
INTRODUCTION	1
Need for the Inquiry	1
The PHR Mission	2
Methodology	3
SUMMARY OF FINDINGS	4
THE MILITARY INTERVENTION	5
Political and Historical Background	5
Operation "Just Cause"	9
The Human Cost	12
CASUALTIES	16
Assessment of Deaths	16
Official Accountings of Civilian Deaths	16
PHR Analysis of the Official Figures of Civilian Deaths	18
Panamanian Military Deaths	23
Ratio of Civilian to Military Deaths	23
Assessment of Injuries	24
THE FATE OF DISPLACED PERSONS	27
PSYCHIATRIC TRAUMA	32
The Invasion as a Psychological Stressor	32
Assessing Psychiatric Morbidity: Interviews with Victims	35
Findings	37
Psychopathology	37
Disruption of social structure	39
Understandings of trauma and loss	40
CONCLUSION	45
APPENDIX	
Case Testimonies	
Post-traumatic Stress Disorder and Depressive Disorders	



PREFACE

In February 1990, Physicians for Human Rights (PHR) sent a team of three physicians to Panama to investigate the medical and psychological consequences of the U.S. invasion in December 1989. We did so because we believe that the American and world public has a right to know the human costs of the conflict.

Almost from its inception in 1986, PHR has sent medical teams into the field to investigate and report on the consequences of conflict in a variety of settings. In 1987, we reported on the effects of the use of massive quantities of tear gas in South Korea's major cities. In the same year, we investigated the use of indiscriminate force by General Noriega's forces against unarmed civilian demonstrators in Panama. In 1988, we sent a team to the West Bank and the Gaza Strip to chronicle the deliberate beatings and use of lethal ammunition by Israel's occupying forces. In that year, we also traveled to Turkey, where our team interviewed Kurdish victims of Iraqi use of poison gas. In 1989, we reported on Soviet use of chemical weapons against peaceful demonstrators in Tbilisi and on the violations of medical neutrality against hospital facilities and medical personnel in El Salvador's civil war. In 1990, in addition to the mission to Panama, we began to document the medically related violations of human rights in the Gulf Crisis beginning with the invasion and occupation of Kuwait. Finally in 1991, five additional missions examined the Gulf War consequences. PHR teams also assessed the effect on civilians of civil conflict in Burma and land mine injuries in Cambodia.

PHR joins with others in the human rights community in monitoring compliance with the Geneva Conventions and international human rights laws. PHR's special role is to bring medical, public health and psychiatric skills to the investigation of abuses and their consequences.

While others have called into question the legality of the invasion of Panama as well as the United States' compliance with the laws of war in conducting the invasion, we use our insights as medical professionals to examine the health-related consequences of the conflict. We recognize that even in situations where there is no clear-cut illegality, there may be serious or even catastrophic loss to civilians and needless suffering and cruelty to soldiers and prisoners of war.

Jonathan Fine, M.D.
Executive Director

ACKNOWLEDGEMENTS

This report was written by the delegation members and Eric Rosenthal, a student at Georgetown University Law Center and research assistant to Professor M. Gregg Bloche. Nancy Arnison of the PHR staff served as the principal editor. Barbara Ayotte, Jonathan Fine, Jack Geiger, and Susannah Sirkin, all of PHR; Hurst Hannum of the Fletcher School of Law and Diplomacy, Tufts University; and Nancy Heneson of Washington D.C. also contributed to the editing of this manuscript.

PHR is especially grateful to the Aaron Diamond, Ford, J. Roderick MacArthur, Joyce Mertz-Gilmore and Reebok foundations, the John Merck Fund, the Fund for Free Expression and the members of PHR -- too numerous to mention -- for financial support that made this report possible.

INTRODUCTION

Need for the Inquiry

In December 1989, the United States invaded Panama and ousted General Manuel Noriega. United States military officials immediately heralded the invasion as a surgical strike.¹ In January 1990 they announced official totals of 201 Panamanian deaths, 314 Panamanian military deaths and 23 U.S. military deaths.² Since the invasion, however, the accounting of Panamanian civilian deaths has been the subject of considerable dispute, with estimates ranging as high as 4,000 civilian dead.³ Similarly, the official number of Panamanian military deaths also has been disputed, with less than one sixth of the U.S. total confirmed by the Panamanian government.⁴

International humanitarian law sets standards that limit the use of force harmful to civilians during armed conflict. The rule of proportionality prohibits attacks against a military objective when injury to civilians is likely to be disproportionate to the anticipated military gain.⁵ Americas Watch analyzed the compliance of the United States with this and other principles of humanitarian law in its report issued in May 1990.⁶ As a medical human rights organization, Physicians for Human Rights does

¹Bennett, P., Robinson, W., U.S. steps up drive to gain control of Noriega. *The Boston Globe*, December 26, 1989, p. 1.

²The civilian toll was variously reported as 202 and 201. Omang, J., Priest, D. Accounting for Panama's dead: uncertainty and confusion. *Washington Post*, January 7, 1990, p. A23; United Press International. U.S. lowers estimate of civilian casualties to 202, plans to release 100 POWs. *Los Angeles Times*, January 13, 1990, p. A7.

³Clark, R. *Independent Commission of Inquiry on the U.S. Invasion of Panama*, New York: Commission of Inquiry, February 8, 1990, p. 4.

⁴Jehl, D. Panama's civilian toll put too low. *Los Angeles Times*, March 15, 1990, p. A20.

⁵Solf, W.A., Grandison, W.G. *International Humanitarian Law Applied in Armed Conflict*, *Journal of International Law and Economics*, 1975; Volume 10, p. 583.

⁶Americas Watch, *The Laws of War and The Conduct of the Panama Invasion*, New York: Americas Watch, May 1990.

not pass judgment on U.S. compliance with humanitarian law in Panama nor do we judge the legality or wisdom of the invasion. Instead, we focus on the human toll experienced by Panamanians as a result of the invasion. Even a military intervention that is hailed as a "surgical strike" should be closely examined to determine the physical and psychological consequences for civilians. Well-informed public discussion must include an understanding of the numbers and types of civilian deaths and injuries and their proportional relationship to military casualties, the health-related consequences for civilians displaced by the combat, and the psychological effects of the invasion.

The PHR Mission

In February 1990, an investigative team conducted an inquiry for PHR into the medical and psychological consequences of the invasion for civilians. The PHR mission had three aims: to investigate the number of Panamanian deaths and the number and type of injuries resulting from the invasion and ensuing violence; to assess the psychological trauma experienced by those who suffered major personal losses (deceased loved ones, severe physical injuries, destroyed homes); and to evaluate the care and support provided to the displaced.⁷

The three-member team consisted of Jane G. Schaller, M.D., Professor and Chairman of the Department of Pediatrics at Tufts University School of Medicine and New England Medical Center;⁸ Paul Wise, M.D., a specialist in assessment of population mortality rates and Assistant Professor of Pediatrics at Harvard Medical School and Harvard School of Public Health; and Gregg Bloche, M.D., J.D., psychiatrist and Associate Professor of Law at Georgetown University Law Center.

⁷The inquiry was PHR's second in Panama. In 1987, as General Noriega took increasingly repressive measures against mounting internal opposition, Panamanian health professionals and human rights activists asked PHR to investigate the human toll of the regime's repressive acts. A PHR team visited Panama and conducted more than 50 interviews as well as physical examinations of victims of brutal treatment. Physicians for Human Rights, *Panama 1987: Health Consequences of Police and Military Actions*, Boston: Physicians for Human Rights, April 6, 1988.

⁸Dr. Schaller was also a member of the 1987 PHR delegation to Panama.

Methodology

Team members made two visits to Panama in February 1990, six weeks after the invasion. They visited hospitals, morgues and burial sites, reviewed emergency room logs, medical records, official lists of casualties, and lists provided by church and human rights groups. They conducted dozens of interviews with U.S. military and civilian authorities, Panamanian victims of the invasion and post-invasion violence, physicians, nurses, ambulance drivers, grave diggers, Red Cross representatives, relief workers, families, journalists, church workers, human rights activists and academic observers. They cross-checked lists and other information obtained from these sources. During the first visit they gathered information about the number of dead and injured and the situation of displaced persons. In late February Dr. Bloche returned to Panama to conduct psychiatric interviews with about two dozen people who had lost their homes or loved ones or suffered serious injuries in the invasion.

SUMMARY OF FINDINGS

1. At least 300 Panamanian civilians died due to the invasion, a toll approximately 100 higher than that reported by Panamanian authorities and U.S. military commanders.
2. The United States officially reported a total of 314 Panamanian military deaths, although only 50 Panamanian military bodies were found. Responding to PHR's findings, U.S. Southern Command officials acknowledged that the figure of 314 was derived from crude battlefield methods of counting casualties and that the figure of 50 represents a more accurate assessment of Panamanian military dead.⁹
3. The verifiable figures of 50 military deaths and at least 300 civilian deaths dramatically change the proportion of civilian to military casualties. The Pentagon's figures of 201 civilian and 314 military deaths would yield a ratio of two civilian deaths to three military deaths. PHR's figures, however, reveal a ratio of at least six civilian deaths to every one military death.
4. At least 3,000 Panamanian civilians received physical injuries sufficiently serious to require emergency treatment at hospitals or the U.S. military's field medical units during the invasion and its violent aftermath.
5. Relief efforts were inadequate to meet the basic needs of many civilians made homeless by the invasion. The United States took responsibility for support of no more than 3,000 of the estimated 15,000 displaced persons. Some of the displaced persons were without sufficient food or adequate shelter at the time of our visits to Panama.
6. The psychological trauma suffered by Panamanians who experienced combat and major personal losses was an important part of the invasion's human cost. This hidden cost of war has not been communicated in official and news media accounts of the invasion and its aftermath. Our findings of depression, post-traumatic stress and other psychological symptoms suggest that such suffering was widespread among the more than 15,000 who lost homes or loved ones or who suffered serious injuries.

These findings raise concern about the accuracy of the official death and casualty counts, the sufficiency of relief efforts, and the psychological toll borne by Panamanians.

⁹Jehl, D. Panama's troop toll cut: 314 to 50. *Los Angeles Times*, March 27, 1990, p. 13.

THE MILITARY INTERVENTION

Political and Historical Background

In the early morning hours of December 20, 1989, more than 24,000 U.S. airborne and ground troops, supported from the air by AC-130 Spectre gunships, Apache helicopters, and F-117A Stealth fighter-bombers, initiated an attack on Panama's armed forces.¹⁰ U.S. military objectives were to overwhelm the Panamanian Defense Forces (PDF) in urban areas, destroy their command structure, quickly capture General Manuel Noriega and prevent large-scale Panamanian resistance from taking hold.¹¹ As described by General Maxwell R. Thurman, Chief of the U.S. Southern Command, the action was designed "to be done in one fell swoop in the middle of the night in order to reduce casualties on both sides."¹²

The United States' decision to use military force in Panama followed a period of mounting frustration and unsuccessful attempts to remove General Manuel Noriega from command of the PDF.¹³ A former ally, Noriega's relationship with the United States soured in the late 1980s.¹⁴ Two federal grand juries indicted him in February 1988 on a number of charges, including shipping drugs from Colombia to the United States and laundering criminally acquired money in secret accounts at Panamanian banks.¹⁵ At that time, Panamanian President Eric Delvalle attempted to fire General Noriega but was himself dismissed by the Noriega-controlled National Assembly and

¹⁰Panama's armed military and paramilitary forces numbered approximately 12,000 troops. Kempe, F. *Divorcing the Dictator*. New York: G.P. Putnam & Sons, 1990, p. 13-15; Magnuson, E. Sowing dragon's teeth. *Time*, January 1, 1990, p. 24; Panama invasion. *Aviation Week and Space Technology*, January 1, 1990, Volume 132, No. 1, p. 30; Wilson, G. Invasion of Panama reflected General Thurman's gung-ho style. *Washington Post*, January 7, 1990, p. A1.

¹¹See *Washington Post*, *supra*, note 10.

¹²*Ibid.*

¹³Felton, J. Crisis gives Bush a lesson in the limits of power. *Congressional Quarterly Weekly (CQ)*, 5/13/89, p. 1131. These events also are chronicled extensively in Robinson, L. Dwindling options in Panama. *Foreign Affairs, 1989/1990 America and the World*, Volume 68, p. 187-198 and Dinges, J. *Our Man in Panama*. New York: Random House, 1990.

¹⁴See Dinges, *supra*, note 13, p. 276-298; Towell, P., Felton, J., Invasion, Noriega ouster wins support on Capitol Hill. *CQ*, 12/23/89, p. 3533-34.

¹⁵See Robinson, *supra*, note 13, p. 189.

had to flee the country.¹⁶ The United States responded by freezing Panamanian government assets, and placing monies owed for the use of the Panama Canal into an escrow account in the United States nominally controlled by President Delvalle.¹⁷

In March 1988, a nine-day general strike followed an attempted military coup against Noriega.¹⁸ Although Noriega survived the coup and suppressed the strike, he faced a worsening economic crisis.¹⁹ President Reagan toughened U.S. trade sanctions against Panama but stopped short of imposing a total embargo.²⁰ The United States also engaged in intense diplomatic efforts to negotiate Noriega's resignation and exile.²¹ Neither the economic nor diplomatic pressure induced him to depart.²²

During the spring and summer of 1988, discussion began in public and in private about the possibility of more direct U.S. involvement in efforts to remove Noriega. The Reagan administration considered various overt and covert military options and approved a covert plan to support Noriega's overthrow.²³ The Senate Intelligence Committee, however, opposed it on the grounds that it might violate the ban on U.S. government participation in political assassinations.²⁴

U.S. action against Noriega escalated at the time of Panamanian elections scheduled for May 1989. One week before the elections, *U.S. News and World Report* reported on U.S. undercover support for the opposition candidacy of

¹⁶See Dinges, *supra*, note 13, p. 296.

¹⁷See Dinges, *supra*, note 13, p. 297-301.

¹⁸*Ibid.* at p. 298; Pitt, D., Noriega appears to be prevailing in general strike. *New York Times*, March 31, 1988, p. A1.

¹⁹See Robinson, *supra*, note 13, p. 194.

²⁰See *CQ*, *supra*, note 14, p. 3534.

²¹See Dinges, *supra*, note 13, p. 300.

²²*Ibid.*

²³*Ibid.* at p. 302.

²⁴*Ibid.*

Guillermo Endara.²⁵ When a straw count by the Catholic Church showed that Endara was winning by a margin of three to one, Noriega nullified the election.²⁶ Hundreds of opposition supporters were arrested, and the world press carried photographs of Noriega's paramilitary "Dignity Battalions" beating vice-presidential candidate Guillermo "Billy" Ford.²⁷

The Bush administration responded to the nullification of the election by recalling its ambassador and evacuating U.S. citizens in Panama to military bases.²⁸ The United States airlifted an additional 1,881 troops to reinforce the 10,000 already stationed near the Panama Canal.²⁹ President Bush declared his support for the Organization of American States (OAS) regional initiatives against Panama but at the same time he declared that the United States was prepared to "carry out its obligations and assert and enforce its [Panama Canal] treaty rights."³⁰ The OAS sent a delegation to Panama to negotiate a peaceful "transfer of power" but by late summer declared that it had failed to produce results.³¹

On October 3, 1989, members of the PDF attempted another coup. The United States had at least two days advance warning of this attempt and was widely criticized for declining to take supportive action.³² Shortly thereafter, Secretary of State James A. Baker III, addressing a Senate panel, defended the right of the United States administration to take military action against Noriega but stated "If you're going to

²⁵See Robinson, *supra*, note 13, p. 196, citing Robbins, C. Taking Aim at Noriega, *U.S. News and World Report (USN & WR)*, Volume 106, No. 17, May 1, 1989, p. 40.

²⁶See Dinges, *supra*, note 13, p. 304.

²⁷*Ibid.*, Bush, G. Presidential address. *CQ*, 12/23/89, p. 3534.

²⁸Presidential news conference. *CQ*, 5/13/89, p. 1150.

²⁹See *CQ*, *supra*, note 13, p. 1131.

³⁰*Ibid.*

³¹Felton, J. OAS ministers admit failure in effort to oust Noriega. *CQ*, 8/26/89, p. 2223.

³²Towell, P. Abortive coup spurs debate over how much help. *CQ* 10/14/89, pp. 2723-2726. Senator David L. Boren, Chairman of the Senate Intelligence Committee, said that it was "wrong... to stand by ... and allow these people to fail." Towell, P. Failed coup against Noriega stirs Hill frustrations. *CQ*, 10/7/89, p. 2660. CIA Director William Webster declared the need to clarify the U.S. executive order banning political assassinations so that U.S. officials can "go right up to the edge of [their] authority and not worry if they or their agency is going to get into trouble." Towell, P., Administration seeks leeway in helping future coups. *CQ*, 10/21/89, p. 2812.

risk American lives, it's the President's view that you do so on your own timetable."³³

Two former top officials, Elliott Abrams, Assistant Secretary of State for Inter-American Affairs during the Reagan administration, and Admiral William J. Crowe Jr., Chairman of the Joint Chiefs of Staff until shortly before the attempted coup, aired conflicting perspectives on the use of force. In an op-ed article in the *New York Times*, Abrams attributed Noriega's survival to the failure of the United States to use "raw power" to topple him.³⁴ The use of force had been under discussion since 1988, according to Abrams, and had been rejected due to "adamant pressure" from Admiral Crowe.³⁵ In a letter to the editor later that month, Crowe retorted that "Mr. Abrams' proposals during the various mini-crises involving Panama were both naive in their formulation and reckless in their casual commitment of our military men and women."³⁶

Nevertheless, the balance was swinging toward the use of force. Three days before the coup attempt, General Frederick Woerner, U.S. Army Commander in Panama, had been removed from his command and replaced by General Maxwell R. Thurman, who rejected General Woerner's contingency plans for military action and developed his own plan for a massive attack.³⁷ Thurman's plan was approved as a contingency operation by General Colin Powell, the newly appointed chairman of the Joint Chiefs of Staff.³⁸ In the weeks that followed, the United States began to ship tanks and Apache attack helicopters to American bases in Panama.³⁹

³³See *CQ*, 10/7/89, *supra*, note 32, p. 2660.

³⁴Abrams, E. Noriega respects power. Use it. *New York Times*, October 5, 1989, op-ed page.

³⁵*Ibid.*

³⁶Crowe, Jr., William J., Elliott Abrams remains reckless on Panama. *New York Times*, Letters to the Editor, October 16, 1989.

³⁷See Kempe, *supra*, note 10, p. 11 and *Washington Post*, *supra*, note 10.

³⁸*Ibid.*

³⁹See Dinges, *supra*, note 13, p. 305.

Operation "Just Cause"

Events escalated rapidly in mid-December 1989. On Friday, December 15, the Noriega-controlled National Assembly of Representatives declared that Panama was "in a state of war while the aggression [by the United States] lasts."⁴⁰ The Assembly elevated Noriega to the position of "Maximum Leader" and charged him with the responsibility of confronting U.S. aggression.⁴¹ The following evening, a car carrying four unarmed U.S. servicemen made a wrong turn near PDF headquarters in Panama City and was stopped at a roadblock. Panamanian soldiers fired at the car as its occupants began to drive it away. Marine Lieutenant Robert Paz, a passenger, was shot dead.⁴²

The United States invaded in the early morning hours of December 20, 1989. In his Presidential Address on that day, President Bush said that the United States had acted to protect the lives of Americans in Panama who were in "imminent danger" due to Noriega's "declaration of war" and the subsequent Paz incident. Bush also justified the military action in larger terms, stating that "the goals of the United States have been to safeguard the lives of Americans, to defend democracy in Panama, to combat drug trafficking, and to protect the integrity of the Panama Canal treaty."⁴³

Noriega eluded U.S. forces for four days until he was located on December 24 at the Vatican Embassy in Panama City, where he later surrendered to U.S. forces.⁴⁴

⁴⁰See Dinges, *supra*, note 13, p. 306.

⁴¹*Ibid.*

⁴²There are various accounts of this incident. Some report that the American servicemen tried to run the roadblock. See, e.g., Kempe, *supra*, note 10, p. 9. Others state that they merely sped away. See, e.g., Dinges, *supra*, note 13, p. 306.

⁴³See *CQ*, *supra*, note 27, p. 3534.

⁴⁴See Kempe, *supra*, note 10, p. 25 and Dinges, *supra*, note 13, p. 310.

Noriega had been warned about the attack, either by Cuban intelligence or by the arrival of C-141 transport planes on the U.S. military airstrip at the rate of one every ten minutes the day before.⁴⁵ Residents of El Chorrillo, the poor community of densely packed tenements in Panama City surrounding Noriega's headquarters, were less fortunate. Although U.S. Armed Forces radio and television stations directed residents to leave dangerous areas, the English language broadcasts were lost on many of the citizens. It wasn't until nearly dawn that loudspeakers affixed to the tanks rolling through El Chorrillo carried the message to evacuate.⁴⁶

⁴⁵See Kempe, *supra*, note 10, p. 13; *Washington Post*, *supra*, note 10; Goldman, F. What price Panama? A visit to a barrio destroyed by U.S. forces. *Harper's Magazine*, September 1990, p. 73.

⁴⁶See Goldman, *supra*, note 45, p. 73.



Chorrillo residents make desperate efforts to save buildings.

The Human Cost

American military strategy in Panama put a premium on preventing heavy U.S. casualties by avoiding a bloody shoot-out with the PDF.⁴⁷ The large-scale use of sophisticated weaponry was meant to deter Panamanian resistance by presenting an overwhelming superiority of firepower. Military operations occurred in areas densely populated by Panamanian civilians. U.S. troops simultaneously struck multiple targets, many of which were located in and around Panama City, including Torrijos International Airport and the Bridge of the Americas.⁴⁸ The U.S. military's plan also attacked targets in Colón, a city strategically located on the northwestern entrance to the Panama Canal.⁴⁹

The primary target was Noriega's headquarters, the Comandancia in El Chorrillo.⁵⁰ Armored personnel carriers rolled into El Chorrillo after the Comandancia had been submitted to a barrage from U.S. AC-130 Spectre aircraft and mortar fire.⁵¹

Troops that moved into El Chorrillo had received training in low intensity warfare and urban conflict. The 82nd Airborne Division had practiced "simulated assaults on Panama."⁵² U.S. Army Rangers, specialists in fighting behind enemy lines, had field experience from the U.S. attack on Grenada.⁵³ Military police and infantry

⁴⁷See *Washington Post*, *supra*, note 10.

⁴⁸See *Time*, *supra*, note 10, p. 25; *Washington Post*, *supra*, note 10.

⁴⁹See *Time*, *supra*, note 10, p. 25; *Washington Post*, *supra*, note 10.

⁵⁰*Ibid.*; Goldman, *supra*, note 45, pp. 71-78.

⁵¹See Kempe, *supra*, note 10, p. 15. In reference to the attack on the Comandancia, General Thurman said that he instructed Lt. General Carl Stiner, Task Force Commander, to employ the "minimum use of power required." *The Washington Post* reported that Thurman "forbade Stiner from using such indirect fire as mortars and artillery or conducting aerial bombing or strafing without an officer of the rank of lieutenant colonel or above ordering it." See *Washington Post*, *supra*, note 10. See also *Aviation Week and Space Technology*, *supra*, note 10, p. 30 reporting that according to a U.S. army official, new imaging systems installed in helicopters were supposed to reduce civilian casualties caused by shooting from the air.

⁵²Panama: training ground for future conflict. *Jane's Defence Weekly*, January 13, 1990, p. 61.

⁵³Goose, Stephen D., *The warriors and their weapons. Low Intensity Warfare: Counterinsurgency, Proinsurgency and Antiterrorism in the Eighties*, Klare & Kornblugh, eds., New York: Pantheon Books, 1985, p. 86.

had received MOUT (Military Operations in Urban Terrain) training.⁵⁴ One Army commander said "Urban fighting is something we would rather not have to do. . .It's difficult and dangerous and there are more possibilities of civilian casualties. We'd much rather have a marked objective out in the battlefield."⁵⁵



Apartment in Colón hit by U.S. helicopter fire.

⁵⁴See *Time*, *supra*, note 10, p. 24.

⁵⁵*Ibid.*

The logic and legality of Operation "Just Cause", the installation of Guillermo Endara as president of Panama, and the capture of Noriega and his return to the United States to face criminal charges have been the subjects of public debate in the United States and abroad.⁵⁶ But in the immediate wake of the invasion, its human cost, especially to Panamanian civilians, received less attention.⁵⁷ One day after the invasion, before official U.S. casualty estimates were publicly available,⁵⁸ President Bush concluded that the loss of life had been "worth it."⁵⁹

Contributing to the lack of public discussion about Panamanian casualties was the absence of reliable information about combat in urban areas. The press was denied access to combat zones during the first crucial hours of fighting. Although the U.S. Army activated a "press pool" of fourteen reporters⁶⁰, the camera crews and reporters in the pool were not allowed to witness the initial period of combat.⁶¹ Instead, the Army provided journalists with its own previously filmed and edited camera footage. A larger contingent of 300 reporters was finally allowed in on Friday, December 22, but they were kept inside Howard Air Force Base for the next 12 hours because of continued combat in the area.⁶²

⁵⁶On December 29, 1990, the U.N. General Assembly voted 75 to 20 to "strongly deplore" the invasion and called for the immediate withdrawal of U.S. troops. Schwartz, E. UN Assembly condemns invasion. *Washington Post*, December 30, 1989, p. A17; See also *Americas Watch*, *supra*, note 6; National Lawyers Guild, *Report from Panama: Guild Delegation Finds No "Just Cause" for U.S. Invasion*, Vol. XIV, March/April 1990, No. 2; and *CQ*, *supra*, note 14, p. 3532.

⁵⁷In the immediate aftermath of the invasion, Pentagon press releases provided very specific estimates of military casualties, but they referred to civilian casualties vaguely as "collateral damage" without providing specific figures. Daniel, L. Commentary on Today's News. *United Press International (UPI) Wire Services*, December 31, 1989.

⁵⁸*UPI Wire Services*, December 21, 1989.

⁵⁹*Ibid.*

⁶⁰Merida, K. The Panama press pool fiasco: The military let journalists do everything except cover the news. *The Washington Post*, January 7, 1990, p. B2.

⁶¹*Ibid.*

⁶²"The press arrived just in time to discover that the military operation was not nearly as close to completion as the Pentagon suggested. Indeed, the first briefing for the horde of reporters had to be scrubbed when Panamanian forces mounted a fierce assault not far from the supposedly secure site where the news conference was to be held. Several soldiers and Panamanian civilians were killed or wounded." Robinson, W. Journalists Constrained by Pentagon. Coverage of intervention suffered. *The Boston Globe*, December 25, 1989, p. 3.

Reports of the number of civilians killed in Operation "Just Cause" have varied widely. On December 27, the United States Army released one of the first estimates of 250 corpses indicating that 20 could have been soldiers.⁶³ By early January, the civilian estimate had been reduced to 220.⁶⁴

On December 29, Panamanian authorities estimated the civilian casualty toll at 400 dead and 2,000 wounded.⁶⁵ Reports by former U.S. Attorney General Ramsey Clark and others alleged that thousands of civilians had been killed in the invasion and in the large fire that destroyed the neighborhood of El Chorrillo.⁶⁶ As of January 1990, the official U.S. estimate finally settled on figures of 201 Panamanian civilians killed, 314 Panamanian soldiers killed⁶⁷ and twenty-three American soldiers killed.⁶⁸

U.S. officials have portrayed Operation "Just Cause" as a surgical strike. According to Secretary of Defense Richard Cheney, "This has been the most surgical military operation of its size ever conducted."⁶⁹ However, Admiral David Chandler, a senior official of the Southern Command in Panama, cautioned that "surgical strike" is a "terrible term. . . [It] implies to the political decision makers. . . that all one has to do is go in and surgically remove the wart. . . Noriega, perhaps, or the Ayatollah. . . [But] how do you take him out without taking out Mrs. Noriega or the next-door neighbor?"⁷⁰

⁶³Eisner, P. More GIs around Noriega, *Newsday*, December 28, 1989, p. 5.

⁶⁴U.S. forces still hold 351 prisoners in Panama. *Reuters*, January 11, 1990; Mackay, R. Pentagon releases figures on civilians killed in Panama. *UPI Wire Services*, January 10, 1990.

⁶⁵Rohter, L. Residents say force loyal to Noriega set fire to neighborhood in reprisal. *New York Times*, December 29, 1989, p. A12.

⁶⁶See Clark, *supra*, note 3.

⁶⁷See *Los Angeles Times*, *supra*, note 2. The civilian toll was variously reported as 201 and 202.

⁶⁸See *Washington Post*, *supra*, note 2.

⁶⁹See *Boston Globe*, *supra*, note 1.

⁷⁰Interview with PHR, February 1990.

CASUALTIES

Assessment of Deaths

Official Accounting of Civilian Deaths

Both the United States and Panamanian governments adopted the civilian death figures reported by the Panamanian Legal Medicine Institute, or Instituto de Medicina Legal (IML). IML is under the jurisdiction of the Panamanian Attorney General's office and is charged with the medical investigation, including autopsies, of suspicious deaths or cases of interest to law enforcement agencies. During the war, IML was officially responsible for investigating invasion-related deaths (civilian and military) for the Panamanian government. Dr. Roger Montero was the director of the IML prior to and during the military action.



Cadaver photos on the office wall of Dr. Roger Montero, Director of Panamanian Legal Medicine Institute

IML staff reported to the PHR delegation that during the invasion and in the days immediately following, standard forensic procedures and provisions for autopsies proved inadequate. The staff gave as reasons for the failure, the large number of bodies at the morgues and the difficulty of moving about Panama City during the period of military conflict and ensuing civil violence. Few autopsies were conducted. Primary efforts of IML staff focused on creating individual files for all bodies of persons that they identified as having died from traumatic causes and that had been brought to the two municipal morgues at Santo Tomás Hospital and Social Security Hospital in Panama City. Each file contained an identification number; a photograph of the body; identifying information including clothing, jewelry, gender, apparent age, and whenever possible, name and military or civilian status; and the apparent cause and place of death.

U.S. military personnel collected some of the Panamanian dead. These bodies were taken to the U.S. Southern Command's Albrook and Howard military installations for processing and storage. When the number of bodies exceeded storage capacity at these facilities, the Army buried Panamanian dead in a common grave.⁷¹ The grave was located in the U.S.-controlled Corozal cemetery, directly adjacent to a large, well-traveled highway. By the time of the PHR delegation's visit, bodies had been exhumed from this grave and reinterred at the Jardín de Paz, a burial site in Panama City under Panamanian authority. Prior to reburial, each body was given an identification number and photographed by IML personnel.⁷² The IML, the U.S. military, and individuals who witnessed the transfer of corpses from the Corozal burial site to Jardín de Paz reported that 27 Panamanian dead had been buried at the Corozal cemetery.

The PHR team inspected the excavation site at the Corozal cemetery and found it to measure approximately 120 feet long by 20 feet wide. Although the size of the grave site alone cannot confirm the number of bodies buried there, these dimensions are not inconsistent with the burial of 27 bodies. Given the use of entry ramps and heavy machinery during excavation, the actual size of the trench used for burial was likely to have been approximately 100 by 10 feet. If one assumes approximately 3.5 feet by 8 feet per body, space for approximately 36 bodies would have been available. It is possible of course that bodies were piled together or the trench dug much larger than necessary. The depth of the burial trench is not known. Thus it would have been possible to bury more than or fewer than 27 bodies at the site. Nonetheless, the figure 27 is consistent with the size of the trench and that figure was given by three different sources noted above.

⁷¹PHR interview with Admiral David Chandler, U.S. Southern Command, February 1990.

⁷²PHR interview with Dr. Roger Montero, IML Director, February 1990.

The official IML tabulation of deaths associated with the invasion included all non-U.S. citizens dying from traumatic causes in areas of combat during the period December 20, 1989 through January 15, 1990. The IML made no distinction between deaths directly attributable to military engagements and those associated with widespread civil street violence that followed. Classification of dead as military was based on the presence of a Panamanian Defense Forces uniform, identification tags, or information provided by inquiring family members. The IML classified all other deaths as civilian.

The IML tabulation of the dead listed 143 known civilians, 50 known military, 27 unidentified, 13 burned beyond recognition, and 18 under investigation. (This tabulation included the 27 bodies transferred from the Corozal cemetery to the Jardin de Paz). All but the known military were ultimately listed as civilian dead. The resulting total of 201 civilian deaths was the figure also adopted by the U.S. Southern Command and has been quoted widely. The IML also listed 61 individuals reported by family members as "missing" at the time of the delegation's visit.

PHR Analysis of the Official Figures of Civilian Deaths

The PHR team found that the U.S. and Panamanian official figure of 201 significantly underestimated the number of Panamanian civilian dead. The team received reliable reports, as set forth below, of approximately 100 additional civilian deaths resulting from the invasion and ensuing violence that were not included in the official count.

Hospital-based data

Hospital-based data represented an important source of information for the team. According to church and human rights workers and medical personnel, hospital emergency rooms were the primary sites to which the injured and dead were transported. Panama City's two municipal morgues are located at the two largest public hospitals in the city, Santo Tomás and Social Security. Other hospitals have only holding morgues.

Dead and wounded began arriving at hospital emergency units on December 20, soon after the fighting began. Testimony of physicians and other staff portrayed a chaotic situation in which usual hospital procedures were overwhelmed. The two municipal morgues soon became depositories of large numbers of bodies, which quickly exceeded a total refrigerated storage capacity of approximately 50. In both facilities morgue personnel were forced to place two or three bodies in each of the refrigerated drawers, with additional bodies lined up on the floor of adjacent autopsy

rooms. The logs and testimony of the morgue officials generally were consistent with the numbers on the official IML list.

Much concern voiced by human rights groups regarding the accuracy of mortality figures centered on the reported use of common graves during the first few days of fighting. The PHR delegation confirmed by physical observation the use of common graves at three sites: the Jardin de Paz cemetery in Panama City, the U.S.- controlled Corozal cemetery in the former Canal Zone, and the Monte Esperanza cemetery outside Colón. The PHR team followed up, but was unable to corroborate, allegations that thousands of bodies were buried in mass graves.



Flowers and stones mark the graves at Jardin de Paz

The Jardin de Paz Cemetery

The primary burial site in Panama City for those on the IML list of deaths is the Jardin de Paz cemetery, a large, well-known burial site with ready access for visitation. According to witness testimony, international press photographs and IML grave plot charts, a trench of about six feet in depth held corpses enclosed in military issue body bags. The corpses were placed side by side with approximately one foot spacing. Initially, two rows were created, but subsequent burials necessitated a third row. The length of these rows is not known to the PHR team. There were apparently three series of burials at this grave site, the first occurring on December 22, 1989. Numerous witnesses were present, and the international press published photographs of this burial. Two subsequent burials took place; the last, on December 29, included the exhumed bodies from the U.S.- controlled Corozal cemetery. At the

time of the delegation's visit, this site remained unmarked except for small stones and flowers placed by family members of the deceased. The IML staff developed a grid map of the location and identification numbers of the deceased. According to IML officials and independently corroborated testimony of cemetery workers, 193 dead were buried at the Jardin de Paz site.

Record of Deaths in Colón

In Colón, a common grave in the Monte Esperanza cemetery held unclaimed bodies. The Panamanian Red Cross labeled these as civilians because of the absence of military attire. The Red Cross representatives and medical personnel at a Colón hospital said that this common burial became necessary when deaths during several days of fighting and looting overwhelmed refrigerated storage capacity at Colón's morgue (capacity not known to PHR team). These corpses were not photographed before burial. The medical director of the Panamanian Red Cross in Colón, Jorge Barnett, who supervised the collection of bodies, reported to PHR 62 civilian deaths in Colón (including 39 buried at the Monte Esperanza cemetery), 38 more than recorded for that area by the IML. Barnett informed the PHR team that he had



Monte Esperanza Cemetery

reported these figures to the U.S. military authorities in a January 17, 1990 memorandum, a copy of which he released to PHR. During an interview with the PHR physicians on February 6, Dr. Roger Montero, the Panamanian official responsible for determining civilian casualty figures, stated that he was not aware of the Colón deaths. Asked why these 38 had not been included in the official totals despite having been reported to the U.S. military, Admiral David Chandler, spokesman for the U.S. Southern Command, said that he knew nothing about these deaths but would look into the matter.⁷³ A subsequent response to PHR from the State Department's Office of Panamanian Affairs, dated March 6, 1990, stated that the majority of the Colón deaths resulted from causes such as traffic accidents and heart attacks, unrelated to the violence surrounding the invasion. Barnett, however, stated that all 62 Colón civilian deaths reported to the U.S. military resulted from wounds sustained between December 20 and 29, 1989. He indicated that 29 died of gunshot wounds, approximately 30 died from wounds inflicted by machetes and long knives (items reportedly commonly carried by looters), and three were crushed to death when a ship's cargo container fell on them during looting.

Other sources of Documented Deaths

In addition to the Colón dead recorded by the Red Cross, the PHR team received reports from Catholic clergy, staff at several hospitals, and human rights workers of approximately 60 Panama City civilian dead whose names did not appear on the official lists.

The Catholic clergy's list, based on hospital, IML, and testimonial sources, reported 261 deaths: 184 identified and 30 unidentified in the Panama City area, and 27 identified and 20 unidentified from Colón. The human rights groups' lists contained 211 cases: 179 identified and 32 unidentified, from all areas. PHR's cross-checking of the church and human rights groups' lists against the IML tabulations was possible only for identified individuals. This process revealed 43 identified civilian deaths that did not appear on the IML list. In addition, hospital officials reported 16 deaths of hospitalized patients whose wounds were inflicted during the period of the fighting and whose names were not included on the IML list of dead.⁷⁴ Comparisons between the identified names on the various mortality lists revealed that the official IML list documented fewer civilian deaths than any other tabulation. The delegation also received eyewitness accounts from church workers of 16 cremations that were unlikely to have been known to IML officials. These

⁷³See Chandler interview, *supra*, note 71.

⁷⁴It should be noted that the IML reported some 61 individuals "missing" at the time of the delegation's visit.

cremations reportedly occurred in the impoverished El Chorrillo neighborhood adjacent to Noriega's Panama City headquarters. As it was not possible to corroborate those eyewitness accounts, the team did not add those cremation figures to the civilian death toll.

Thus, the PHR delegation found that there were approximately 100 additional verifiable civilian deaths in Colón and Panama City not represented on official lists. An attempt to reconcile the data from these different and overlapping sources revealed considerable internal consistency among and within the reports gathered by the team.

TABLE 1: PHR'S SUMMARY OF VERIFIABLE PANAMANIAN DEATHS

	<u>Military</u>	<u>Civilian</u>
	50	201 Official IML list 38 Colón Red Cross 43 Church, human rights lists 16 Hospital lists
Total	50	298

Of the known civilian dead, at least two were children and 16 were women. The two certain children are noted as "baby boy" followed by a surname. Since information regarding age was not systematically available, no accurate assessment of the actual number of children killed can be made. Fourteen of the women were listed as homemakers. The remaining two were killed at their places of employment; one was a baggage supervisor at the international airport and the other, a receptionist at a Panama City Hotel.

Official efforts by the Panamanian government and U.S. military authorities to determine the invasion-related civilian death toll appear to have been inadequate. In interviews with the PHR team, IML authorities acknowledged that they did not follow up on allegations that uncounted bodies were interred in mass graves other than at the two official burial sites in Panama City and Colón. The PHR team found no evidence that Panamanian authorities interviewed hospital staff, church workers, or others who might have had information about deaths not included in the official count. U.S. officials indicated that they considered counting the civilian dead to be a Panamanian responsibility and therefore did not make independent efforts to determine the toll.⁷⁵

Panamanian Military Deaths

The U.S. Southern Command stated that Panamanian military deaths totaled 314. According to Southern Command officials, this total was based on field reports by U.S. military personnel of observed, but not confirmed, "enemy kills," supplemented by the number of body bags requested by U.S. personnel and analysis of transportation needed for those killed in battle.

IML, on the other hand, documented that only 50 known Panamanian military bodies were found. Under the official IML classification system, all those who were not identifiable as military were labeled as civilians; therefore it is possible that some of the listed civilians were actually military or combatants in civilian clothing. It is also possible that some military personnel were among the 40 unidentified and burned bodies listed by the IML.

Nevertheless, even allowing for such potential additions to the IML count, the discrepancy between the Southern Command figure of 314 and the IML figure of 50 confirmed military deaths is substantial and raises questions about the accuracy of official accounting methods. When presented with PHR's findings, U.S. officials acknowledged that their official count of 314 military dead was based on "soft" battlefield reports and that the figure of 50 is more accurate.⁷⁶

Ratio of Civilian to Military Deaths

The official U.S. figures of Panamanian deaths (201 civilian and 314 military) reveal a ratio of approximately two civilian deaths to three military deaths. A revised

⁷⁵Interview with Ambassador Deane Hinton, February 1990.

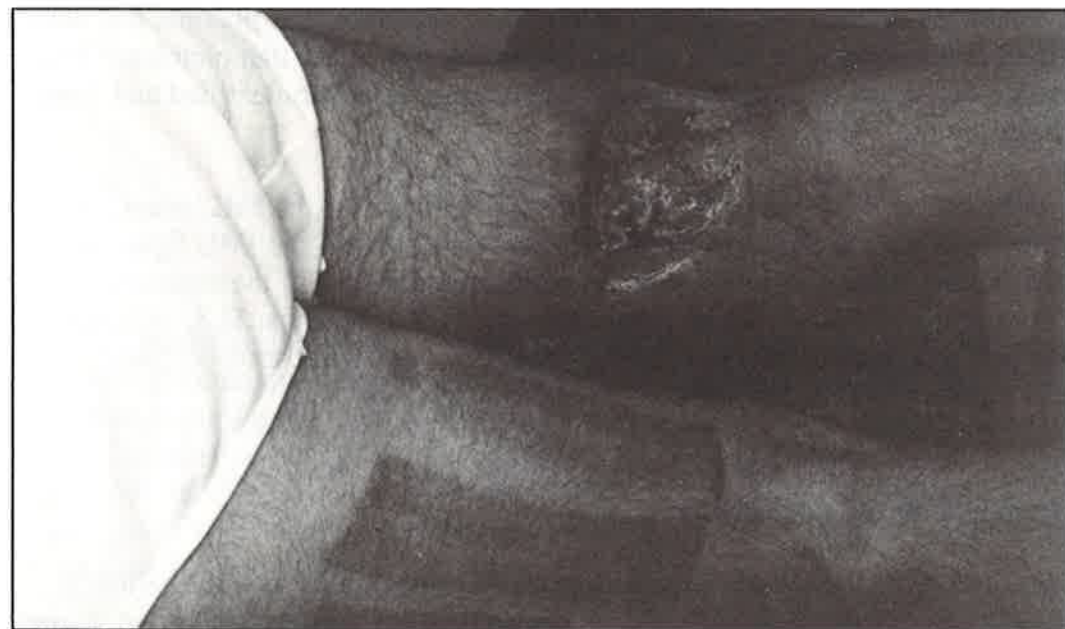
⁷⁶See *Los Angeles Times*, supra, note 9.

ratio that uses PHR's conservative findings of approximately 300 civilian and 50 Panamanian military deaths reveals approximately six civilian deaths to every one military death. According to these findings, approximately 85% of the Panamanian lives lost during the invasion and its violent aftermath were civilian.

Assessment of Injuries

Neither Panamanian nor U.S. authorities conducted a systematic accounting of the number of people injured during the invasion and its violent aftermath. The United States government estimated 1,508 injured Panamanians;⁷⁷ however, PHR's interviews with medical staff and examinations of records at five hospitals and several health clinics in Panama City revealed that at least 3,000 Panamanians sought hospital care for injuries sustained during the first week after the invasion (See Table 2).

The Santo Tomás Hospital treated the greatest number of injured, totaling 1,884. Most of these injuries were not life-threatening and were treated in the outpatient area set aside for emergency treatment of ambulatory wounded. Emergency room logs show that during the first two days of fighting the majority of serious injuries were due to gunfire, burns, and shrapnel. However, by the third day the predominant injuries were lacerations from glass and debris and from stabbings, although bullet wounds remained common. One hundred seventy-nine of the injured seen at Santo Tomas were hospitalized; the rest were treated and released.



Injured civilian
(photo courtesy of David Kiyanga)

⁷⁷Jehl, D. Panama's civilian toll put too low. *Los Angeles Times*, March 15, 1990, p. A20.

Emergency room logs indicate that the Social Security Hospital treated 412 injured during the first week of the invasion. The pattern of injuries was similar to that of Santo Tomás Hospital, with wounds from bullets and explosives occurring early on. Ninety-eight of the wounded were admitted to the hospital for treatment. At least two patients remained in the hospital at the time of the delegation's visit, some five weeks after admission.

The Children's Hospital reported treating 24 children with significant injuries. Four were admitted suffering from bullet or shrapnel wounds: a 5-year-old had been shot in the head; a 4-year-old had lost sight in one eye from grenade fragments; a youth of 14 had been shot in the leg; and a 13-year-old had received a bullet wound to the abdomen. The San Fernando Hospital, a large private facility in Panama City, treated approximately 175 injured patients and admitted 27 during the first week after the invasion. Gorgas Hospital treated 318 and admitted 49. Other health facilities reported treating a total of 200 injured patients.

The figure of 3,000 injured represents only those who presented to hospitals and clinics during the first week after the invasion for injuries related to the invasion and ensuing street violence. Given the difficulty of travel during that period and the reports that many injured people sought aid within their own families and communities, 3,000 is likely to represent only a partial count.



The injured Lee children (left to right): Jurisol Surani Lee, 6, lost vision in her right eye; Eleuterio Lee, Jr., 5, suffered head injuries and Johnny Lee, received stitches in his abdomen and head.



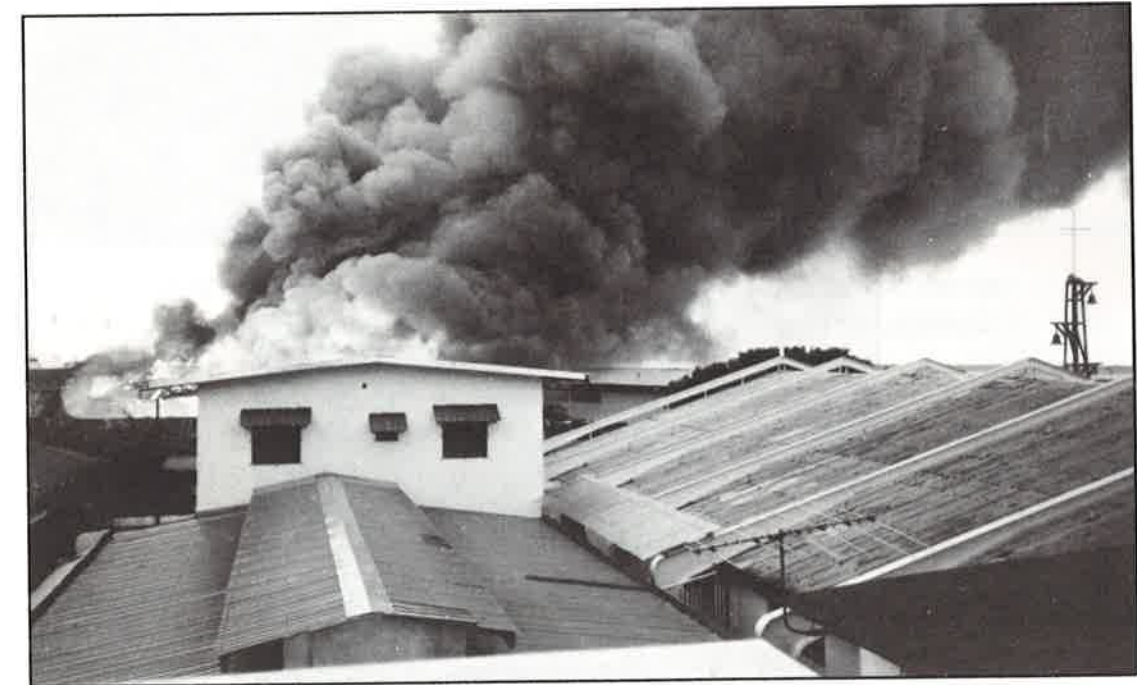
Injured civilian

TABLE 2: SUMMARY OF INJURED TREATED AT PANAMA HOSPITALS

<u>Hospital</u>	<u>Number Treated</u>	<u>Hospitalized</u>
Santo Tomás	1,884	179
Social Security	412	98
Gorgas	318	49
Children's	24	4
San Fernando	175	27
Other Health Facilities	200	0
TOTAL	3,013	357

THE FATE OF DISPLACED PERSONS

Approximately 15,000 Panamanians lost their homes due to the invasion and the associated violence, according to Panamanian government sources and private relief groups.⁷⁸ An unknown number also lost their livelihoods. The vast majority of those made homeless lived in El Chorrillo, an impoverished seaside neighborhood of wooden shanties hastily erected almost 100 years ago, during construction of the Panama Canal. Most of the displaced persons lost everything they owned.



Fire swept through El Chorrillo. (photo courtesy of Fr. Artetas, Fatima Church)

Shortly before midnight on December 19, U.S. helicopter gunships, artillery, and ground forces began pummeling the PDF's command center in El Chorrillo. Within minutes of the first shooting fires started in some adjacent residences, according to several eyewitnesses. Others reported seeing members of Noriega's paramilitary "Dignity Battalions" deliberately setting fire to homes during the early morning hours. Residents fled during the night amid automatic weapon fire and burning buildings.

They streamed toward the Fatima church where by late morning 10,000 people were crowded inside, according to Fatima's priests. Flames approached the church while workers doused its outer walls with water. The church was the last structure left standing in a burnt-out area of many square blocks along the sea.

⁷⁸See also Goldman, *supra*, note 45, p. 72.

Before dusk on December 20, thousands began walking from El Chorrillo to Balboa high school in the nearby former Canal Zone, where the U.S. military hastily made plans to house them. The U.S. Agency for International Development (AID) assumed responsibility for people from El Chorrillo who were housed at Balboa.⁷⁹ During the first several days at this overcrowded facility, many slept outside without tents. Several displaced persons interviewed said that food supplies were inadequate. Conditions became more difficult with the coming of rains, and many left Balboa to stay with family members or to seek shelter in other public buildings.



Masonry wall of Fatima Church where the fire was stopped.

⁷⁹Telephone conference with Barry Heyman, Assistant Director, Office of Foreign Disaster Assistance (OFDA), Washington D.C., February 1990 and Alejandro James, an OFDA regional disaster expert in Panama, February 1990.



U.S. Albrook Air Force Base: 506 cubicles became the homes for approximately 2,200 of the 15,000 displaced Panamanians.

On January 15, the approximately 3,000 people who remained at Balboa were moved to the U.S. Albrook Air Force Base, where AID continued to provide for their support. At Albrook approximately 2,200 people lived in 506 wood-framed, 3 x 3 meter cloth cubicles inside a vast aircraft hangar. Excluding hall space and a common area outside the hangar, the population density was approximately one person per two square meters. Another 700 lived in similarly cramped conditions in several dozen large tents outside the hangar. Residents received two meals per day, one paid for by AID and the other by private donations, according to Dr. Manuel Pereira, a camp physician. Conditions in Albrook appeared generally sanitary during two visits by the PHR physicians but, according to an American Red Cross source who inspected the camp in late January, defecation in passageways had been a problem.

According to one U.S. official, AID declined to take full responsibility for any of the displaced who were not part of the Albrook group, on the grounds that their needs were being met by "private groups or other donors."⁸⁰

In Panama City, approximately 1,000 displaced persons were camped in public buildings.⁸¹ AID provided cots and blankets to some of these facilities and supplied

⁸⁰See Heyman interview, *supra*, note 79, February 1990.

⁸¹Telephone conference with Teresita Arias, coordinator of relief activities for displaced persons in Panama City, February 1990.

meals to the Fatima church.⁸² One PHR team member visited four of the facilities and reported that conditions appeared filthy at three of them--the Salvador and Venezuela schools and the Junta Comunal hall. At least one of these, the Venezuela school, lacked showers, and the hallways smelled of urine and excrement.

Residents of several facilities complained of insufficient food. At Junta Comunal, where about 200 were encamped, residents said that during the first several weeks after the invasion, they received weekly deliveries of rice, beans, sugar, and cooking oil from the Episcopal Church, supplemented by occasional contributions from the Salvation Army. The church deliveries then dropped off to one every ten days. On the day a PHR team member visited, February 27, residents reported that no food deliveries had been received for 15 days. Several residents complained that they did not have enough to eat and were losing weight. Others said that they lacked access to medical care because they could not pay for transportation.



Tents set up at U.S. Albrook Air Force Base for displaced Panamanians.

⁸²Telephone conference with James, *supra*, note 80.

Some displaced persons lived in El Chorrillo with family members whose homes were not destroyed. They, too, complained of insufficient food. Members of one extended family, who said that their children were going without breakfast, stated that they did not have money to pay for the 25-cent subsidized breakfasts offered by the nearby Fatima church.

Queried about complaints of insufficient food for displaced persons outside Albrook, a United States government representative replied, "If they were inside the [Albrook] camp, they wouldn't have that problem." But he stated that no one would be permitted to come to Albrook at that time. "They should have thought about that [food] two months ago," he said, "before they left Balboa."⁸³

Office of Foreign Disaster Assistance (OFDA) representative Alejandro James stated that AID did not provide relief assistance to refugees in Colón because OFDA "didn't find any refugees there."⁸⁴ However, on February 4, the PHR team visited Colón and saw several partially and totally destroyed multifamily dwellings. Local residents led them to a gymnasium where several dozen people were encamped. Those interviewed and Colón representatives of the human rights group Coordinadora Popular de Derechos Humanos en Panama (COPODEHUPA) said that their homes had been destroyed during the invasion. They complained that they did not have enough food. In addition, representatives of the local churches and COPODEHUPA told the team members that other displaced people were living with family members or in common areas within multifamily homes.

⁸³*Ibid.*

⁸⁴*Ibid.*

PSYCHIATRIC TRAUMA

The Invasion as a Psychological Stressor

Many Panamanian civilians caught directly in the path of invasion-related violence experienced psychosocial stress of catastrophic proportions.⁸⁵ More than 15,000 people lost their homes, social networks, friends or family members. In El Chorrillo thousands of civilians endured a night and day of mass terror, commencing with a midnight artillery bombardment and followed by automatic weapon fire and an inferno



Children at the Albrook Air Force Base.

⁸⁵American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, third edition, revised (DSM-III-R)*, Washington, D.C.: American Psychiatric Press, 1987. The *DSM-III-R* uses the term "catastrophic" to characterize the severity of experiences such as natural disasters and internment in concentration camps. For more on stressors likely to have mass psychiatric sequelae, see R. Bolin. Disaster characteristics and psychosocial impacts. In: *Disasters and Mental Health: Contemporary Perspectives and Innovations in Services to Disaster Victims*, B.J. Sowder and M. Lystad, eds. Washington, D.C.: American Psychiatric Press, 1986, pp. 11-35.

that forced many to flee their homes.⁸⁶ They saw the dead and injured in the streets, with bodies charred and mutilated.⁸⁷ The bombardment struck at midnight with little or no warning. Even those who heard the U.S. forces' warning announcements had only seconds or minutes notice.

In El Chorrillo, the proportion of the population affected was very high, forcing mass relocation to makeshift living arrangements.⁸⁸ Poverty, unemployment and a lack of sufficient Panamanian or U.S. funds to rebuild destroyed homes left those displaced from El Chorrillo with slim prospects for reconstituting a self-reliant community in the near future.⁸⁹

For El Chorrillo's victims, the belief that human carelessness, callousness, or worse is to blame for the disaster may contribute to the psychological stress.⁹⁰ The articulated objects of blame are many: the American invaders, Noriega, the failure of either side to provide adequate warning to civilians, and the failure of the Panamanian and/or U.S. governments to provide sufficient aid or compensation to civilian victims in the invasion's aftermath.⁹¹

⁸⁶The mass terror in El Chorrillo is well-documented in a report by the priest from the local parish--the Church of Our Lady of Fatima. Artetas, J. Statement of the events occurring near the parish from December 20 to December 27, 1989 [unpublished]. Several other heavily populated areas, including Colon and San Miguelitos, also endured artillery and automatic weapons fire but not with the destructive effect and mass terror that ensued in El Chorrillo.

⁸⁷Terror (intense fear evoked by the power, immediacy and unexpectedness of a destructive force) and horror (especially shock and revulsion at the sight of the dead or severely injured) have been closely linked with subsequent psychiatric symptoms. Lifton, R.J. and Olson, E. The human meaning of total disaster: The Buffalo Creek experience. *Psychiatry* 39 (1): 1-18, 1976.

⁸⁸The proportion of affected to unaffected people in a community, termed the "impact ratio" by some researchers, also correlates well with the subsequent incidence of psychological sequelae. See Bolin, *supra*, note 85. Disaster that destroys a community severs its victims from their physical and interpersonal environment. Erikson, K.T. *Everything in Its Path: Destruction of Community in the Buffalo Creek Flood*. New York: Simon and Schuster, 1976; Miller, J.A., Turner, J.G., and Kimbal, E. Big Thompson flood victims: one year later. In *Family Relations* 30 (1): 111-116, 1981.

⁸⁹The resulting dependence on outsiders and loss of control over one's fate increases a disaster victim's vulnerability to psychological problems. See Bolin, *supra*, note 85.

⁹⁰See Lifton and Olson, *supra*, note 88.

⁹¹PHR interviews with Panamanians, February 1990.



El Chorrillo shortly after the invasion.



El Chorrillo after bulldozers cleared the wreckage.

Assessing Psychiatric Morbidity: Interviews with Victims

Panamanians rarely seek psychiatric consultation, except in cases of chronic psychosis.⁹² Particularly among the poor, characteristic responses to mental health problems range from stoic endurance to reliance on family members and the church. Hospital records are thus of little use in assessing the invasion's impact on Panamanians' mental health.

Due to constraints of time and resources, the PHR team could not conduct the type of epidemiological study needed to produce statistically valid information on the psychological impact of the invasion upon the entire Panamanian population.⁹³ Instead, the team focused on interviews with "primary victims" -- those who actually suffered personal losses (as opposed to "secondary victims," who viewed the disaster but did not lose loved ones or property or suffer personal injuries).⁹⁴

Psychiatrist Gregg Bloche conducted interviews with two dozen Panamanians who had lost loved ones or homes and personal possessions, or suffered serious physical injuries. The interviews had a dual aim: to detect psychiatric symptomatology for diagnostic purposes,⁹⁵ and to elicit each interviewee's subjective experience of invasion-related trauma and loss.

⁹²Interviews with Ovidio de Leon, M.D., Chief of Psychiatry at Santo Tomas Hospital in Panama City, February 1990.

⁹³We are grateful to Susan Solomon, Ph.D., of the Center for Mental Health Studies of Emergencies at the National Institute of Mental Health, for advising us about potential epidemiologic research approaches and sharing with us some of the evaluative instruments employed to study the psychological impact of natural and manmade disasters.

⁹⁴See Bolin, *supra*, note 85.

⁹⁵Affective and anxiety disorders, including major depression and post-traumatic stress disorder, are the most common psychiatric syndromes seen in disaster victims. Victims may also be at increased risk for organic mental disorders (resulting from head trauma, malnutrition, or stress-related substance abuse) and psychosomatic symptoms.

Dr. Bloche conducted the diagnostic part of each interview⁹⁶ along the lines of an initial evaluation that would take place in a clinic or psychiatric emergency room. He first invited interviewees to talk about troublesome psychological symptoms and their experiences of trauma and loss. He then asked follow-up questions to fill out and clarify interviewees' accounts of their symptoms, assess their mental status, and learn pertinent aspects of their psychiatric and social histories.

Dr. Bloche elicited accounts of experiences of trauma and loss through open-ended questions about what the interviewees had seen and felt, their reactions, and their attitudes toward the various actors (e.g., PDF and American forces, Noriega, the U.S. government, family members, friends, and relief workers).⁹⁷

The 24 interviews generally lasted from 45 to 90 minutes.⁹⁸ They were conducted in a variety of settings, including cubicles at Albrook, medical clinics, and private homes. Privacy was maintained except for the presence of an interpreter and the occasional presence of several interviewees' children. The team told the interviewees at the outset that information that they provided might be used in published materials. They were given the option of requesting that their names not be made public.

Interviewees included displaced people living at Albrook, injured people still receiving hospital treatment, displaced individuals living with friends or relatives in or near El Chorrillo, Colón, and Chelibré (a small town on the highway between Panama City and Colón) and people in Panama City who remained in their own homes. Some at Albrook were randomly approached while others were identified with the assistance of clinical personnel. Staff at two Panama City hospitals,⁹⁹ as well

⁹⁶Diagnoses interviewing was conducted in accordance with the criteria for classification of psychiatric disorders specified in *DSM-III-R*. We considered augmenting the interviews with one or more standardized psychiatric rating scales, including the Self-Report Symptom Inventory-Revised (SCL-90-R), the Hamilton Rating Scale for Depression (HAMD), the Beck Depression Inventory (BDI), and the Structured Clinical Interview for DSM-III-R/Non-patient Version (SCID-NP). See MacKinnon, R.A. and Yudofsky, S.C. *The Psychiatric Evaluation in Clinical Practice*. Philadelphia: Lippincott, 1986, pp. 165-187. However, concerns about interpreting subjects' responses across cultures, the difficulty of translating structured interviews and self-reporting instruments accurately into Panamanian Spanish, and unwieldiness of administration led us to opt against use of any such instruments. We are grateful for the advice of Robert L. Spitzer, M.D., chair of the APA working group that drafted the *DSM-III-R*, who advised us against the use of standardized rating scales for these reasons.

⁹⁷Several interviewees had organic impairments that precluded this line of inquiry.

⁹⁸Four were shorter -- three with severely organically ill patients and one with a senior Panamanian government official who had to end the session after 30 minutes to make another appointment. A few ran longer than two hours.

⁹⁹Santo Tomás Hospital and the Social Security Hospital.

as church-related relief groups in El Chorrillo and Colón, assisted in identifying others. Of those interviewed, five had lost their spouses, three had lost sons, one his father, and another his brother. Six had lost less immediate relatives or friends with whom they had been very close, and nine had sustained serious injuries. At least eight had lost their homes. Twenty-one were from Panama City, one was from Colón, and two were from Chelibré.

Findings

Psychopathology

The interview data suggest that depression and post-traumatic stress disorder (PTSD)¹⁰⁰ are common among Panamanians who personally experienced violence and loss.¹⁰¹

Of the ten interviewees who had lost immediate relatives (spouses, sons, a father, and a brother¹⁰²) six suffered from major depression¹⁰³ as defined by

¹⁰⁰In addition, virtually all of those interviewed also reported anxiety, dysphoria, or somatic symptoms consistent with the diagnosis of Adjustment Disorder, a category that embraces a range of maladaptive reactions to stress. However, uncertainty about how the *DSM-III-R* criteria for the "maladaptive nature" of symptoms should be applied to these interviewees casts doubt on whether they qualify for this diagnosis. The *DSM-III-R* requires that the "maladaptive nature of the reaction" be established by either impairment in occupational or social functioning or "symptoms that are in excess of a normal and expectable reaction to the stressor(s)." The former was not possible to assess for these interviewees, almost all of whom lost their jobs and/or were separated from their prior social and family networks due to invasion-related devastation. The latter criterion was impossible to apply meaningfully without a valid standard for the "normal and expectable reaction" to the extraordinary stresses these interviewees experienced. The fact that virtually all of those interviewed reported significant anxiety, dysphoria, or somatic complaints suggests that these symptoms were a "normal and expectable reaction." Yet to therefore withhold the diagnosis of Adjustment Disorder from these interviewees would be to dismiss the clinical significance of their reactions because of the extraordinary intensity of the precipitating stressor. Surely this turns the purpose of psychiatric diagnosis on its head.

¹⁰¹The line between psychiatric symptomatology traceable to invasion-related violence and to economic depression and state terror during the Noriega years is less than clear. The chronic stress of life under the Noriega regime before the invasion had its own adverse mental health consequences. De Leon, O.A. Community intervention during an economic disaster (unpublished 1989 paper by chief of psychiatry at Santo Tomás Hospital reporting on mental health consequences of the economic depression in Panama that followed U.S. imposition of financial sanctions in 1988).

¹⁰²Two of these also suffered serious physical injuries and five were left homeless.

¹⁰³A seventh, who lost his father (a PDF member) in the U.S. assault on the Comandancia, described sadness with loss of appetite, insomnia, auditory hallucinations, and other symptoms sufficient for the diagnosis of a major depressive episode, but he also reported a history of manic depression.

diagnostic criteria in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, third edition, revised (DSM-III-R)* (see Appendix). Of the five who had lost their spouses, four suffered from major depression,¹⁰⁴ as defined by DSM-III-R diagnostic criteria. Two of these, widows living in cubicles at Albrook and cut off from their pre-invasion social networks, were severely depressed, with occasional suicidal ideation, reported weight loss of thirty pounds since the invasion, and a continuing lack of appetite. Both said they spent most of each day lying in bed in a state of despair, unmotivated to seek out food or to care for their children. Each had come to the camp clinic with medical complaints -- one sought treatment for asthma and the other for insomnia and loss of appetite -- but neither had received drugs or other treatment for depression.

Two of the 10 who had lost immediate relatives suffered from Post-traumatic Stress Disorder (PTSD), as defined by DSM-III-R diagnostic criteria (see Appendix). Another two reported distressing PTSD symptoms but did not clearly qualify for the diagnosis. All four reported increased irritability and persistent, painfully intrusive memories of violent and grotesque scenes that they had witnessed. Three out of four described recurrent, painful dreams about their dead loved ones or about horrible experiences on the night of the invasion. One recounted a series of dreams about her deceased husband. In one recurring dream, he lies dead in a street but calls to her; in another he is dancing with her. Deceased loved ones appeared frequently, both dead and alive, in the others' dreams. Of the five who had lost their spouses, one met the criteria for the diagnosis of PTSD. Another did not qualify for the diagnosis but reported frequently recurring memories of the sight of her husband's body in the street, his broken bones protruding through his skin, and his mangled genitals exposed to public view.

Six interviewees had lost people close to them who were not immediate relatives (a nephew, boyfriends, in-laws, military comrades).¹⁰⁵ Of these, two suffered from major depression,¹⁰⁶ two had symptoms of dysthymic disorder¹⁰⁷ and two qualified for the diagnosis of PTSD.

¹⁰⁴One of these also sustained serious (and permanently disabling) physical injuries, and four were left homeless.

¹⁰⁵Two of these also sustained serious physical injuries. No one was left homeless.

¹⁰⁶A third also met *DSM-III-R* criteria for major depression but reported having a history of bipolar disorder.

¹⁰⁷Dysthymic disorder is a less severe form of depression. These two failed to qualify for the *DSM-III-R* diagnosis only because they had not experienced these symptoms for two years, the minimum requirement of duration for the diagnosis.

Of the nine who had sustained serious physical injuries¹⁰⁸, two had major depression and six more had dysthymic symptoms. Five qualified for the diagnosis of PTSD. Another reported some distressing PTSD symptoms but did not qualify for this diagnosis.

Of the eight who lost their homes¹⁰⁹ five met criteria for major depression and the remaining three had dysthymic symptoms. Three also met diagnostic criteria for PTSD, while two others showed PTSD symptoms that were distressing but not sufficient to qualify for this diagnosis.

Disruption of social structure

The thousands who lost their homes to the inferno in El Chorrillo experienced not only physical devastation but also the breakdown of their social system. El Chorrillo was a self-contained community, held together by networks of extended family and longtime neighbors, active church and social service organizations, and an array of locally based economic activities.¹¹⁰ The inferno shredded many of these social bonds just as it destroyed the physical structure of the community.



El Chorrillo

¹⁰⁸Four of these also lost immediate relatives or other people close to them. In addition, five (including two who lost people close to them) were left homeless.

¹⁰⁹Five of these also lost immediate relatives and five sustained serious physical injuries (two suffered serious physical injuries and the loss of immediate relatives).

¹¹⁰Interviews with O.A. De Leon, Chief of Psychiatry at Santo Tomás Hospital, in Panama City, February 1990.

The mass severing of individuals from their prior social context can be an extremely damaging and continuing source of stress,¹¹¹ with the capacity to greatly prolong the time needed for psychological recovery.¹¹² The nearly 3,000 displaced persons housed in numbered cubicles and tents at the Albrook camp live severed from their prior points of social reference. When the support of the familiar was most needed, it was a mere memory.

Loss of community was less complete for the approximately 1,000 displaced persons who took residence in public buildings. Interviews with several leaders of the displaced revealed that people gathered at each site tended to know each other from before the invasion. Extended families and groups of neighbors stayed together in these places to a much greater extent than they did at Albrook.

Understandings of trauma and loss

Painful ambivalence about the U.S. invasion and its consequences came across in most of the interviews with victims. Against a backdrop of relief over the removal of General Noriega, interviewees who suffered devastating personal losses faced the need to deal with private sadness and anger. Many seemed to have difficulty doing so. Most invoked divine explanations as they grappled with moral confusion about the invasion that brought both their freedom from Noriega and deaths, injury and loss of home. For some, particularly those from El Chorrillo and other impoverished communities, fatalistic acceptance of loss as part of an incomprehensible, divine plan engendered at least a surface equanimity. For others, resentment and bitterness were more visible. Amid sadness and despair, some interviewees expressed hope. The hopes and plans for the future seemed consistently motivated not by Panama's political transformation but by feelings of commitment and love for surviving spouses, children, close relatives, and friends.

Ambivalence

Ambivalence about the invasion cut across class lines. Ms. A., a woman of aristocratic background who opposed the Noriega regime, lost her son-in-law when U.S. troops fired on his car. Her daughter was in the front passenger's seat but survived by ducking beneath the dashboard. Immediately after the invasion, Ms. A. was appointed to a senior government position. In a 45-minute interview, she voiced muted support for the U.S. action:

¹¹¹See Erikson, *supra*, note 88.

¹¹²Rangell, L. Discussion of the Buffalo Creek disaster: The course of psychic trauma. *American Journal of Psychiatry*; 133:313-316, 1976.

Through 21 years, we were opposed to Torrijos and Noriega. . . . We never thought violence was the correct way because we know that the social cost of a military encounter would be very great for a small country. . . . If the country, in general terms, has gained, the cost for each of us is very great. . . . I asked myself, in the design of God -- two people in the same danger -- one died and the other didn't. . . . He left my daughter alive.

Ms. E., a lifetime resident of El Chorrillo, was crippled by a fracture that destroyed part of her right leg when she leapt from a balcony to escape flames. Moments before, her 27-year-old son was cut down in a crossfire between U.S. troops and members of a Dignity Battalion. She now lives with her sister in a shanty a block away from the burnt-out zone:

The strength I give myself is that my son gave his life for a change, but I don't see things changing. . . . The only change I see is that Noriega is under arrest. . . . Now I can't work. . . . Why, if they wanted to take Noriega, why didn't they just look for him? Why did so many people get killed? . . . I don't know the meaning of this invasion, because things are worse now. When Noriega was here, we had a home, we had a job and we had food. Now, Noriega isn't here and we have nothing. So, what is the change? [Father Artetas said that the dead] are in another world, with the Lord -- they are in a better life. . . . That day, I wanted to stand up and say, "who did my son give his life to -- God or to his country?"

Anger and blame

Fatalistic acceptance of loss superficially soothed the pain of ambivalence for some. Mr. J., an elderly Colón shantytown resident who lost his wife when an errant rocket hit their apartment and exploded while she was preparing dinner, insisted that he felt no anger:

I ask my own self why it happened. That was my wife's destiny. There is nothing more. . . . I feel a little bit happy because they [the Americans] gave us freedom. I feel free. . . . I don't feel angry. . . . That was her destiny. I can't think about it any other way.

In most of the interviews, however, anger was palpable. The objects of anger and blame varied. Noriega was the most common focus of wrath, but anger also was directed at an array of others, including American soldiers and political leaders, members of the Dignity Battalions, relief workers, the people of El Chorrillo, and God. A few blamed themselves for failing to take steps that might, in retrospect, have saved the lives of loved ones.

Anger at Noriega was much more common than anger at the invading Americans. "If Noriega had not brought the country to this, it wouldn't have happened," said Ms. G., a woman in her late twenties whose husband, a civilian, was shot dead outside their home in El Chorrillo. Ms. C., a widow in her late thirties who had lost her

husband, a PDF soldier, during the U.S. assault on the Comandancia said she neither believed that the Americans had done wrong nor saw her husband as a hero. "Sometimes, yes, I wonder why this man died. The one that's alive [Noriega] -- it's his fault. . . . I really don't know, but I blame Noriega."

Integrating their anger and their faith, a few interviewees found moral lessons in Noriega's culpability. For Ms. I., another new widow in her late thirties, blind materialism was the invasion's moral subject. "The invasion," she said, "was a way to show us that we must not attach ourselves to things, because this man [Noriega] who attached himself to things is responsible for many deaths. . . . Because he didn't want to give up power, he sacrificed a whole section of the city to his wickedness."

But the lone PDF soldier interviewed had a different reason for his anger at Noriega. Asked why he deserted his unit, the elite Battalion 2000, when ordered on December 21 to take up arms as a guerrilla inside Panama City, Mr. J., a 22-year-old paratrooper, explained, "The dictator Noriega. . . . wasn't paying us much money."

Three of the people interviewed voiced anger at Americans, but with bitter intensity. Mr. A., a medic in his mid-twenties who served as a civilian with Battalion 2000, sustained permanently disabling leg injuries when he leapt from a bridge to escape American fire. He spent a night beneath the bridge, bleeding heavily and applying tourniquets, before he was found by American troops and taken to a hospital. He criticized the Noriega regime for warning PDF officers of the invasion in time for them to escape, leaving common soldiers to die at their posts. But the United States was the object of his most bitter feeling:

In the name of democracy, you don't care who dies and who gets destroyed. . . . I'm talking about your leaders. . . . You send young people to kill people to kill others. . . . If they wanted to do it, they could have taken Noriega without killing anyone. . . . George Bush wanted the total destruction of Panama.

Mr. F., a retired civil servant in his mid-fifties who years ago served in the PDF and who lost both a son and a brother in the invasion, expressed similar rage: "I believe that they came here to massacre people, thinking the whole people were in favor of Noriega." Glaring angrily, he told the interviewer, "I feel like killing a gringo."

For some, particularly women, anger seemed more diffuse -- less politically charged. Ms. B., whose husband died in a crossfire in El Chorrillo, described unremitting angry feelings:

I don't know who to be angry with, and I get angry at my daughters. Then I realize it's not their fault. . . . If [only] God could have stopped this from happening. . . . He was a good husband and a good father. Why did God take him? . . . Oh, God, you took my husband! . . . Oh, God, you took my house!

She also spoke bitterly of the burning of houses by Dignity Battalions and of shortages of clothing, soap, toothpaste, and other toiletries at the Albrook camp.

Dilemmas of dependence

For those who lost their homes and livelihoods, ambivalent feelings about being dependent upon others for basic needs complicated their ambivalence about the invasion itself. Interviewees expressed varying mixtures of gratitude, resentment, and fear, along with hope that someday they will again be able to provide for themselves and their families.

Several interviewees told of having been rescued from life-threatening situations by American troops, and more expressed thankfulness for American protection. Fear of the Dignity Battalions and even the imagined return of Noriega seemed pervasive. But among the displaced, gratitude for U.S. and Panamanian relief efforts seemed muted by resentment as well as frustration over their perceived insufficiency. "I still feel young -- I am only 60," said an Albrook resident who suffered permanently disabling leg injuries when she jumped from her burning apartment. "I hate to sit down and have people give things to me."

Her 60-year-old husband, who was badly burned in the fire and had not yet returned to his job as a painter, more poignantly expressed his problems with dependence:

My most painful memory [is] having lost everything we had. . . . We struggled very much to have what we have. . . . and we lost it in minutes. . . . This is going into the third month that I have no money from my job. . . . If I sit and think about it all day -- I lost my T.V. and I lost my furniture and everything. . . .

His voice faded, then he spoke of the preoccupation of many displaced persons with deficiencies in relief efforts and recovery of their material losses:

I cannot be like that -- like the others. . . . They say they want to get back everything. . . . I think I have to get well and get out and start again like a man. If anything is given to me, great, but I want to feel well again to start struggling again. I have a piece of land in Arraijan. I paid \$20 to have it measured. I planted fruit trees. I haven't paid for all this land, and I am thinking with this new government I might lose everything I worked for.

He then reflected on his wife's injuries and his inability to help her:

I can get well, but she might remain a cripple. She says she would rather die than be like that. . . . I take her walking so she can forget her thoughts and for her legs to strengthen up. I tell her, if I can go out in the sunshine, I can take you walking from

early in the morning to afternoon, but I can't -- sometimes the doctors have seen me outdoors and told me I shouldn't be [because of his burns]. She needs special shoes costing \$40 to \$50. I can't afford them.

Myriad pitfalls mar the path to self-sufficiency. Mr. D., a 27-year-old bus driver, sustained multiple bullet wounds while driving a car two days after the invasion. Fearful that looters would destroy his bus and thus his livelihood, he had gone out to move his bus to a safer place. He was shot on the way home. A bullet that penetrated a lung almost killed him. Another bullet removed part of an ankle.

I am depressed because I have been deprived of part of my work and my foot. . . . I need an operation [to walk without pain] and the hospital won't do it without being paid since I haven't been paying Social Security. . . . The only way I can do it is to sell the bus.

Disabled interviewees feared for the futures of financially dependent loved ones. Mr. O., a 22-year-old factory worker, was shot in a crossfire between U.S. troops and a sniper on the PanAmerican Highway a day after the invasion. He sustained multiple fractures in his left leg, complicated by infection and loss of bone tissue that required a prolonged hospital stay. "How am I going to support my family being six months in the hospital?" he asked the interviewer. He said his most immediate fear was that his family's home would collapse unless he builds a supporting wall. "And afterwards -- I don't know . . . the fracture of my tibia and the loss of the structure of the bone. . . . How is my family going to do without me working?"

Yet children and other loved ones were also the focus of interviewees' most passionately expressed hopes. Ms. B., the young widow from El Chorrillo who had expressed anger at her daughters, God, the Dignity Battalions, and relief workers, admitted to the interviewer that she had thought about killing herself. At one point, she mulled over the possibility of swallowing a bottle of Motrin:

I feel so alone -- the other day I thought of taking some pills -- but then I looked at the girls. And I asked God to give me some strength. Because they don't have support from anybody except from me. . . . I wanted to live for my daughters.

Ms. G., the widow in her late twenties who is bitter toward Noriega, suffered leg fractures that put in doubt her ability to ever walk again. Asked about her hopes for the future, she replied, "Being able to walk, to see if I can get a job. . . to educate my children. . . so they can be somebody in life."

CONCLUSION

The U.S. military's description of Operation "Just Cause" as a "surgical strike" should not preclude the accurate and public accounting of the toll it claimed in injured and dead. This report has presented as accurately as possible an independent record of the direct human toll the invasion exacted from the Panamanian people.

Operation "Just Cause" demonstrated the validity of a premise of contemporary American military doctrine -- that the use of technologically sophisticated "invincible force" can hold U.S. casualties to low levels, thereby making it politically feasible to employ American military power.¹¹³ We are concerned about the high cost of acting upon this premise; the impact upon civilians in areas where overwhelming force is employed can be devastating. As Admiral David Chandler told PHR, the notion that such force can be used "surgically" amidst civilians is illusory. The imprecision of our destructive power and the surprises and passions of war make a high cost to civilians inevitable if combat occurs near populated areas.

We are also concerned about the inadequacy of official efforts to assess invasion-related casualties and to attend to the physical, psychological, and social needs of civilians made homeless or otherwise victimized. Rumors that thousands of civilians perished and were disposed of in clandestine ways thrive in a climate of suspicion nurtured by official failure to investigate them.¹¹⁴ In addition, the failure to meet the most basic needs of those made homeless reinforces a popular bitterness that is both distressing in itself and potentially dangerous for Panamanian society.

¹¹³Atkinson, R., Woodward, B. Gulf Turning Points; Strategy, Diplomacy; Prolonged Buildup reflects doctrine of invincible force, *Washington Post*, December 2, 1990, p. A1.

¹¹⁴Uhlig, M. In Panama Counting the Invasion Dead is a matter of dispute, *New York Times*, Section E, p. 2, October 28, 1990.

APPENDIX A

CASE TESTIMONIES

The Meneses Salas Family



Jose Isabel Salas: 67-year-old laborer

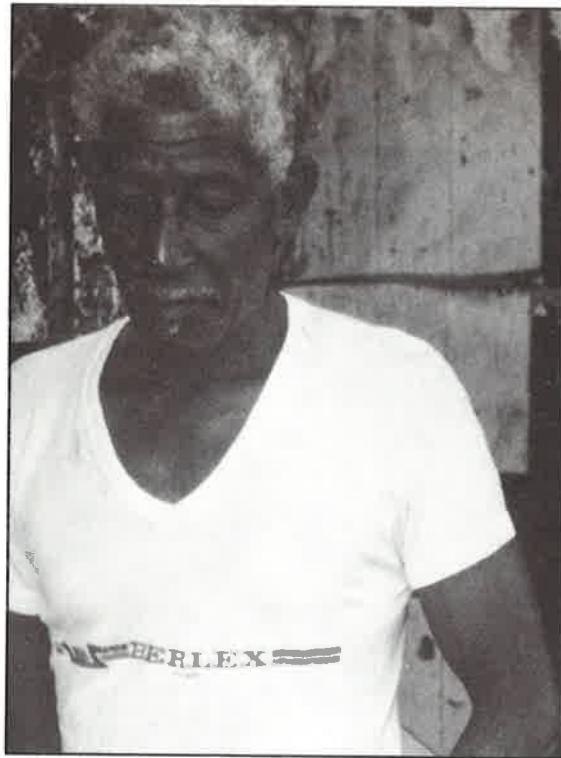
On December 22, 1989 at 10:00 A.M., Dionisia Meneses De Salas was home preparing dinner. With her were her husband, Jose Isabel Salas, 67; her daughter, Adilisa Alarcon Meneses, 20; her brother, Rufino Meneses; and her brother-in-law, Claudio Salas Meneses. At approximately 1:30 p.m., while she sat washing rice in the kitchen, a Cobra helicopter flew overhead, pursuing a sniper in a building two blocks away. Her husband witnessed the entire event:

It got in front of the 15th floor of another house. The helicopter went around and answered [the sniper's fire] back -- one of the rockets (projectiles) went in our house and got to her. It blew one of her legs away and part of our building as well. The shot hit the wall and bounced back to her legs She was immediately dead. I was there. Other people were wounded too.



Adilisa Alarcon Meneses

Mrs. Salas' daughter, Adilisa, 20, sat near her mother when the shell entered the home. Everything went dark. She then made her way to her mother and held up her head. She noticed blood coming from her mouth. She then realized that her mother's leg was missing and that "the insides of her were inside my hand." Adilisa received a laceration to her breast and was treated by American military medics.



Rufino Meneses

Rufino Meneses, sitting directly next to his sister, was knocked senseless by the explosion. When he got to his feet, he didn't realize what had happened, but soon became aware that Mrs. Salas had been killed. Rufino suffered facial and leg wounds in the explosion. He was initially treated by neighbors and was hospitalized for six days. The PHR team noted scars on his right cheek, his right arm and his left leg. As a result of his injuries, Mr. Meneses, a sailor at the Panama Canal, missed 37 days of work.

Claudio Meneses suffered multiple deep wounds on his lower back and legs. He was initially treated at Coco Solo Hospital, and then flown by helicopter to Gorgas Hospital. He stayed there until January 3, when he was transferred to Santo Tomás Hospital for six more days. During his time at Santo Tomás, somewhere between the third and fifth of January, there was shooting near the hospital and Mr. Meneses, in attempt to get out of bed, re-opened his stitches. He commented that there were many wounded in Santo Tomás Hospital; extra cots had to be used to handle the overflow.

As a result of the attack, the Salas home, wooden with a cement foundation, burned to the ground. The family lost everything. The family members were split up, living with various relatives.

The Lee Family



The Lee Family of Colón: Luisa Alicia, 23 and her husband, Eleuterio Lee, 28 and their four children: Juvisol, 6; Eleuterio, Jr., 5; Johnny Noe Lee, 3; and Isaac, 2 months.

On December 22, 1989, at approximately 3:00 p.m., the Lee residence was hit by a projectile fired from a Cobra helicopter circling a building two blocks away. Luisa Alicia Corpas de Lee, her husband Eleuterio Lee, and their four children (Juvisol, age 6; Eleuterio, Jr., age 5; Johnny, age 3; and Isaac, age 2 months) were all at home. Mr. Lee was in the kitchen while the mother and the three eldest children sat at a table. The baby was nearby in the living room. When the projectile hit, the room was shattered and the ceiling partially collapsed. Mrs. Lee was thrown on top of her children and she realized that they were covered with blood. At first she panicked, believing one of her children to be cut in two and the rest dead. She then heard her husband, who was not injured, calling to her.

Mrs. Lee got to her feet, gathered the children, and with the help of Mr. Lee, made her way toward the door. Despite the damage to the room, the iron bar-lock on the door remained

intact and the keys had been lost in the explosion. While Mr. Lee struggled with the door, it became apparent that Mrs. Lee had suffered injuries to her legs and was now losing her ability to walk. Mrs. Lee also noticed that her baby's face was covered with blood.

The door was eventually opened. Mr. Lee took the children to the hospital in a neighbor's car. Mrs. Lee, unable to walk, was left on the stairs of the burning house. She was eventually rescued by neighbors who took her to a Red Cross station.

Later, at the Amador Guerrero Hospital, Mrs. Lee received 36 stitches in her arms and legs resulting in multiple scars. The children, initially taken to Coco Solo Hospital, were later airlifted to Gorgas Hospital and then to a children's hospital in Panama City. Jurisol had lost vision in her left eye. Eleuterio, Jr. suffered head injuries and, after receiving a CT scan, was diagnosed as suffering from "intercerebral hemorrhag[ing]." He had difficulties with speech and motor functions in one arm and leg. Jurisol and Eleuterio Jr. were hospitalized for fifteen days. Johnny suffered superficial abdominal and head wounds, both of which required stitches. Isaac, the baby, suffered only minor burns on his face and body.

Since the attack, the family has been staying with Mrs. Lee's mother. The Lee home was destroyed by the shell and the consequent fire. The remains were looted by "neighbors." Mr. Lee, an unemployed accountant and truck driver prior to the attack, had his truck destroyed and looted. At the time of PHR's visit, the family was currently receiving a weekly food parcel from the Panamanian government intended to feed six people. The parcel included one can of milk, five pounds of rice, one can of tomato paste, two cans of vegetables, and two cans of Spam.

The Jaramillo Family



Mr. and Mrs. Jaramillo and their daughter

Mr. Jaramillo, 25, a shoemaker, resided in a housing complex on Eighth Street between Centrale and Melendez Streets in Colón. The wooden complex had a central hall and a number of adjoining apartments. It housed fifteen families, or approximately sixty people. Mr. Jaramillo lived there with his wife, Martina, 30, and their baby, 2.

On December 23, 1989, at approximately 4:00 a.m., approximately 40 American troops, in two groups, surrounded the complex. The troops reportedly were searching house-to-house for Noriega. The Jaramillos and the other families were forced to leave their apartment and lie on the floor in the common kitchen during the search.

Encountering a locked door, the soldiers shot it open, setting the building on fire. The families were evacuated without being allowed to salvage any personal items. The complex, as well as the neighboring building, was completely destroyed.

The Jaramillos moved in with relatives. Like many others whose homes were destroyed in the fighting, at least five of the families from the Eighth Street complex had to take refuge in Colón Arena. They were not considered victims of the invasion and had been unsuccessful in obtaining compensation from the government.

APPENDIX B

POST-TRAUMATIC STRESS DISORDER
and
DEPRESSIVE DISORDERS

Excerpts reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders, third edition, revised*. Copyright 1987 American Psychiatric Association.

Please refer to the Diagnostic and Statistical Manual for full descriptions of these and other diagnoses.

ANXIETY DISORDERS

309.89 Post-traumatic Stress Disorder

The essential feature of this disorder is the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience (i.e., outside the range of such common experiences as simple bereavement, chronic illness, business losses, and marital conflict). The stressor producing this syndrome would be markedly distressing to almost anyone, and is usually experienced with intense fear, terror, and helplessness. The characteristic symptoms involve re-experiencing the traumatic event, avoidance of stimuli associated with the event or numbing of general responsiveness, and increased arousal. The diagnosis is not made if the disturbance lasts less than one month.

The most common traumata involve either a serious threat to one's life or physical integrity; a serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence. In some cases, the trauma may be learning about a serious threat or harm to a close friend or relative, e.g., that one's child has been kidnapped, tortured, or killed.

The trauma may be experienced alone (e.g., rape or assault) or in the company of groups of people (e.g., military combat). Stressors producing this disorder include natural disasters (e.g., floods, earthquakes), accidental disasters (e.g., car accidents with serious physical injury, airplane crashes, large fires, collapse of physical structures), or deliberately caused disasters (e.g., bombing, torture, death camps). Some stressors frequently produce the disorder (e.g., torture), and others produce it

only occasionally (e.g., natural disasters or car accidents). Sometimes there is a concomitant physical component of the trauma, which may even involve direct damage to the central nervous system (e.g., malnutrition, head injury). The disorder is apparently more severe and longer lasting when the stressor is of human design.

* * *

The traumatic event can be reexperienced in a variety of ways. Commonly the person has recurrent and intrusive recollections of the event or recurrent distressing dreams during which the event is reexperienced. In rare instances there are dissociative states, lasting from a few seconds to several hours, or even days, during which components of the event are relived, and the person behaves as though experiencing the event at that moment. There is often intense psychological distress when the person is exposed to events that resemble an aspect of the traumatic event or that symbolize the traumatic event, such as anniversaries of the event.

In addition to the reexperiencing of the trauma, there is persistent avoidance of stimuli associated with it, or a numbing of general responsiveness that was not present before the trauma. The person commonly makes deliberate efforts to avoid thoughts or feelings about the traumatic event and about activities or situations that arouse recollections of it. This avoidance of reminders of the trauma may include psychogenic amnesia for an important aspect of the traumatic event.

Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia", usually begins soon after the traumatic event. A person may complain of feeling detached or estranged from other people, that he or she has lost the ability to become interested in previously enjoyed activities, or that the ability to feel emotions of any type, especially those associated with intimacy, tenderness, and sexuality, is markedly decreased.

Persistent symptoms of increased arousal that were not present before the trauma include difficulty falling or staying asleep (recurrent nightmares during which the traumatic event is relived are sometimes accompanied by middle or terminal sleep disturbance), hypervigilance, and exaggerated startle response. Some complain of difficulty in concentrating or in completing tasks. Many report changes in aggression. In mild cases this may take the form of irritability with fears of losing control. In more severe forms, particularly in cases in which the survivor has actually committed acts of violence (as in war veterans), the fear is conscious and pervasive, and the reduced capacity for modulation may express itself in unpredictable explosions of aggressive behavior or an inability to express angry feelings.

Symptoms characteristic of Post-traumatic Stress Disorder, or physiologic reactivity, are often intensified or precipitated when the person is exposed to situations or activities that resemble or symbolize the original trauma (e.g., cold snowy weather or

uniformed guards for survivors of death camps in cold climates; hot, humid weather for veterans of the South Pacific).

Age-specific features. Occasionally, a child may be mute or refuse to discuss the trauma, but this should not be confused with inability to remember what occurred. In younger children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Young children do not have the sense that they are reliving the past; reliving the trauma occurs in action, through repetitive play.

Diminished interest in significant activities and constriction of affect both may be difficult for children to report on themselves, and should be carefully evaluated by reports from parents, teachers, and other observers. A symptom of Post-traumatic Stress Disorder in children may be a marked change in orientation toward the future. This includes the sense of a foreshortened future, for example, a child may not expect to have a career or marriage. There may also be "omen formation", that is, belief in an ability to prophesy future untoward events.

Children may exhibit various physical symptoms, such as stomachaches and headaches, in addition to the specific symptoms of increased arousal noted above.

Associated features. Symptoms of depression and anxiety are common, and in some instances may be sufficiently severe to be diagnosed as an Anxiety or Depressive Disorder. Impulsive behavior can occur, such as suddenly changing place of residence, unexplained absences, or other changes in life-style. There may be symptoms of an Organic Mental Disorder, such as failing memory, difficulty in concentrating, emotional lability, headache and vertigo. In the case of a life-threatening trauma shared with others, survivors often describe painful guilt feelings about surviving when others did not, or about the things they had to do in order to survive.

Age at onset. The disorder can occur at any age, including during childhood.

Course and subtypes. Symptoms usually begin immediately or soon after the trauma. Reexperiencing symptoms may develop after a latency period of months or years following the trauma, though avoidance symptoms have usually been present during this period.

Impairment and complications. Impairment may be either mild or severe and affect nearly every aspect of life. Phobic avoidance of situations or activities resembling or symbolizing the original trauma may interfere with interpersonal relationships such as marriage or family life. Emotional lability, depression, and guilt may result in self-defeating behavior or suicidal actions. Psychoactive Substance Use Disorders are common complications.

Predisposing factors. Several studies indicate that preexisting psychopathological conditions predispose to the development of this disorder. However, the disorder can develop in people without any such preexisting conditions, particularly if the stressor is extreme.

Prevalence, sex ratio, and familial pattern. No information.

Differential diagnosis. If an Anxiety, Depressive, or Organic Mental Disorder develops following the trauma, these diagnoses should also be made.

In **Adjustment Disorder** the stressor is usually less severe and within the range of common experience; and the characteristic symptoms of Post-traumatic Stress Disorder, such as reexperiencing the trauma, are absent.

Diagnostic criteria for 309.89 Post-traumatic Stress Disorder

- A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.
- B. The traumatic event is persistently reexperienced in at least one of the following ways:
 1. recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
 2. recurrent distressing dreams of the event
 3. sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)
 4. intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. efforts to avoid thoughts or feelings associated with the trauma
2. efforts to avoid activities or situations that arouse recollections of the trauma
3. inability to recall an important aspect of the trauma (psychogenic amnesia)
4. markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)
5. feeling of detachment or estrangement from others
6. restricted range of affect, e.g., unable to have loving feelings
7. sense of a foreshortened future, e.g., does not expect to have a career, marriage, or children, or a long life

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

1. difficulty falling or staying asleep
2. irritability or outbursts of anger
3. difficulty concentrating
4. hypervigilance
5. exaggerated startle response
6. physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

E. Duration of the disturbance (symptoms in B, C, and D) of at least one month.

Specify delayed onset if the onset of symptoms was at least six months after the trauma.

* * *

MOOD DISORDERS

Terminology used in classification of Mood Disorders. A *mood syndrome* (depressive or manic) is a group of mood and associated symptoms that occur together for a minimal duration of time. For example, the Major Depressive Syndrome is defined as depressed mood or loss of interest, of at least two weeks' duration, accompanied by several associated symptoms, such as weight loss and difficulty concentrating. Mood syndromes can occur as part of a Mood Disorder, as part of a nonmood psychotic disorder (e.g., Schizoaffective Disorder), or as part of an Organic Mental Disorder (e.g., Organic Mood Disorder).

A *mood episode* (major depressive, manic or hypomanic) is a mood syndrome that is not due to a known organic factor and is not part of a nonmood psychotic disorder (e.g., Schizophrenia, Schizoaffective Disorder, or Delusional Disorder). For example, a Major Depressive Episode is a Major Depressive Syndrome (as defined above) in which it cannot be established that an organic factor initiated and maintained the disturbance and the presence of a nonmood psychotic disorder has been ruled out.

A *mood disorder* is determined by the pattern of mood episodes. For example, the diagnosis of Major Depression is made when there have been one or more Major Depressive Episodes without a history of a Manic or unequivocal Hypomanic Episode.

* * *

Diagnostic Criteria for Major Depressive Episode

Note: A "Major Depressive Syndrome" is defined as criterion A below.

A. At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure. (Do not include symptoms that are clearly due to a physical condition, mood-incongruent delusions or hallucinations, incoherence, or marked loosening of associations.)

1. depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others
2. markedly diminished interest or pleasure in all, or almost all, activities

most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time)

3. significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to make expected weight gains)
 4. insomnia or hypersomnia nearly every day
 5. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
 6. fatigue or loss of energy nearly every day
 7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
 8. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
 9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B. (1) It cannot be established that an organic factor initiated and maintained the disturbance
- (2) The disturbance is not a normal reaction to the death of a loved one (Uncomplicated Bereavement)
- Note: Morbid preoccupation with worthlessness, suicidal ideation, marked functional impairment or psychomotor retardation, or prolonged duration suggest bereavement complicated by Major Depression.
- C. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted).
- D. Not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.

* * *

DEPRESSIVE DISORDERS

296.2x Major Depression, Single Episode

296.3x Major Depression, Recurrent

The essential feature of Major Depression is one or more Major Depressive Episodes without a history of either a Manic Episode or an unequivocal Hypomanic Episode. Major Depression is subclassified in the fourth digit as either Single Episode or Recurrent. In addition, it is subclassified in the fifth digit to indicate the current state of the disturbance. If the criteria are currently met for a Major Depressive Episode, the severity of the episode is indicated as either mild, moderate, severe without psychotic features, or with psychotic features. If these criteria are not currently met, the fifth digit indicates whether the disturbance is in partial or full remission.

Course. Some people have only a single episode, with full return to premorbid functioning. However, it is estimated that over 50% of people who initially have Major Depression, Single Episode, will eventually have another Major Depressive Episode, the illness then meeting the criteria for Major Depression, Recurrent. People with Major Depression, Recurrent, are at greater risk of developing Bipolar Disorder than are those with a single episode of Major Depression. People with Major Depression superimposed on Dysthymia (often referred to as "double depression") are at greater risk for having a recurrence of a Major Depressive Episode than those who have only Major Depression.

The course of Major Depression, Recurrent, is variable. Some people have episodes separated by many years of normal functioning; others have clusters of episodes; and still others have increasingly frequent episodes as they grow older. Functioning usually returns to the premorbid level between episodes. In 20% to 35% of cases, however, there is a chronic course, with considerable residual symptomatic and social impairment. Some of these cases continue to meet the criteria for a Major Depressive Episode throughout the course of the disturbance (specified as *Chronic Type*); the others are coded as being in partial remission.

* * *

PHR PUBLICATION LIST - 1991

- Brazil** *The Search for Brazil's Disappeared: The Mass Grave at Dom Bosco Cemetery*, March 1991, 19 pp., \$3.00.
- Burma** *Forthcoming: Health and Human Rights in Burma (Myanmar): 1988 to the Present*
- Cambodia** *Land Mines in Cambodia: The Coward's War*, September 1991, 82 pp., \$7.00.
- Chile** *Sowing Fear: The Uses of Torture and Psychological Abuse in Chile*. October 1988, 116 pp., \$7.00.
- Czechoslovakia** *Medical Mission to Czechoslovakia*. July 1988, 35 pp., \$4.00.
- Egypt** *Forthcoming: A report on imprisonment and torture.*
- El Salvador** *El Salvador: Health Care Under Siege*. February 1990, 74 pp., \$6.00.
- Guatemala** *Guatemala: Getting Away With Murder*. August 1991, 115 pp., \$10.00.
- Haiti** *Forthcoming: Haiti since Duvalier: A study of the prisons*
- Iraq** *Winds of Death: Iraq's Use of Poison Gas Against Its Kurdish Population*. Report of a mission to Turkish Kurdistan. February 1989, 39 pp., \$6.00.
- Israel** *The Casualties of Conflict: Medical Care and Human Rights in the West Bank and Gaza Strip*. March 1988, 46 pp., \$6.00.
- Health Care in Detention: A Study of Israel's Treatment of Palestinians*. April 1990, 46 pp., \$6.00.
- Forthcoming: A report on PHR's forensic work in Israel and the Occupied Territories.*
- Forthcoming: A report on the effects of the curfew imposed on Palestinians during the Gulf War.*
- Kenya** *Kenya: Medicolegal Aspects of the Inquest into the Death of Peter Njenga Karanja*. October 1988, 14 pp., \$2.50.
- Kuwait** *Iraq-Occupied Kuwait: The Health Care Situation*, March 1991, 35 pp., \$6.00.
- Panama** *Panama 1987: Health Consequences of Police and Military Actions*. April 1988, 73 pp., \$6.00.
- Operation "Just Cause": The Human Cost of Military Action in Panama*, December 1990, 60 pp., \$6.00.
- Republic of Korea** *The Use of Tear Gas in the Republic of Korea: A Report by Health Professionals* July 1987, 16 pp., \$2.50.
- Tibet** *The Suppression of a People: Torture and Imprisonment in Tibet*, November 1989, 62 pp., \$6.00.
- U.S.A.** *Hidden from View: Human Rights Conditions in the Krome Detention Center*, April 1991, 81 pp., \$7.00.
- U.S.S.R.** *"Bloody Sunday": Trauma in Tbilisi*. Report on the April 9, 1989 events in Soviet Georgia and their aftermath. March 1990, 70 pp., \$6.00.
- Yugoslavia** *Yugoslavia: Mistreatment of Ethnic Albanians: A Case Study*, August 1991, 29 pp., \$3.00.
- Medical Testimony on Victims of Torture: A Physician's Guide to Political Asylum Cases**, October 1991, 55 pp., \$7.00.

PHYSICIANS FOR HUMAN RIGHTS

BOARD OF DIRECTORS

President: H. Jack Geiger, City University of New York Medical School
Vice President: Carola Eisenberg, Harvard Medical School

Judy Ann Bigby, Brigham & Women's Hosp.; Zenaido Camacho, Baylor College of Med.; Cesar Chelala, New York City; Richard Claude, U. of MD; Charles Clements, SatelLife, Boston; John Constable, Harvard Med. Sch.; Robert Cook-Deegan, Inst. of Medicine; Felton Earls, Harvard Sch. of Public Health; Paul Epstein, Cambridge Hosp.; John Hatch, U. of North Carolina; Howard Hu, Harvard Med. Sch.; Maria Judge, Fletcher School, Tufts U.; Robert Kirschner, Cook County Med. Exam. Off.; Robert Lawrence, The Rockefeller Foundation; Jennifer Leaning, Harvard Comm. Health Plan; Jonathan Mann, Harvard Sch. of Public Health; Gabriel Otterman, Children's Hospital, Boston; Irwin Redlener, Cornell U. Med. Ctr.; Randolph Reinhold, Tufts U. Sch. of Med.; Preston Reynolds, Johns Hopkins Hosp.; Stephen Robinson, City U. of New York Med. Sch.; Helen Rodriguez-Trias, Brookdale, CA; Linda Rosenstock, U. of Wash. Med. Sch.; Barry H. Rumack, U. of Colorado Med. Sch.; Jane Green Schaller, Tufts U. Sch. of Med.; M. Roy Schwarz, American Med. Assoc.; Jeanne Spurlock, American Psychiatric Assoc.; Kim Thorburn, U. of Hawaii Sch. of Med.; Philippe Villers, Concord, MA; Paul Wise, Harvard Med. Sch.

NATIONAL ADVISORY COMMITTEE

Herbert Abrams, Stanford U. Sch. of Med.; Mary Ellen Avery, Children's Hosp. Med. Ctr.; John Ball, American College of Physicians; Thomas Ballantine, Harvard Med. Sch.; Paul Beeson, U. of Wash., Emeritus; Robert Butler, Mt. Sinai Med. Ctr.; Christine Cassel, Pritzker Sch. of Med., U. of Chicago; Linda Clever, Pacific Presbyterian Med. Ctr., San Francisco; Robert Ebert, Harvard Med. Sch., Emeritus; John Edsall, Harvard U., Emeritus; William Foege, Carter Ctr. of Emory U.; Jerome Frank, Johns Hopkins U. Sch. of Med., Emeritus; Alfred Gellhorn, New York State Dept. of Health; Larry Gostin, American Society of Law and Med.; Lester Grinspoon, Harvard Med. Sch.; Lawrence Hartmann, American Psych. Assoc.; M. Alfred Haynes, Charles R. Drew Postgraduate Med. Sch.; Howard Hiatt, Harvard Med. Sch.; David Hodges, Harvard Med. Sch.; Edith Irby Jones, Past President, Nat. Med. Assoc.; Samuel Katz, Duke U. Med. Ctr.; Cynthia Krane, Beth Israel Hosp.; Joyce Lashof, Sch. of Public Health, U. of Calif., Berkeley; Philip Lee, Sch. of Med., U. of Calif., San Francisco; Robert J. Lifton, City U. of New York; John Mack, Harvard Med. Sch.; Roy Menninger, The Menninger Foundation; Carol Nadelson, Tufts U. Sch. of Med.; Aryeh Neier, Human Rights Watch; Jessica Neuwirth, Attorney, New York; Gilbert Omenn, Sch. of Public Health, U. of Wash.; Frank Oski, Johns Hopkins U. Sch. of Med.; Vivian Pinn-Wiggins, Howard U., College of Med.; Alvin Poussaint, Harvard Med. Sch.; Julius Richmond, Harvard Med. Sch.; Stanford Roman, Jr., M.D., New York; Steven Schroeder, Robert Wood Johnson Foundation; Cecil Sheps, Sch. of Med., U. of North Carolina, Emeritus; Aaron Shirley, M.D., Jackson, MS; Victor Sidel, Albert Einstein College of Med; Giorgio Solimano, Faculty of Medicine, Columbia U.; Eric Stover, Writer; Mervyn Susser, Sergievsky Ctr., Columbia U.; Harold Visotsky, Northwestern U. Med. Sch.; Bailus Walker, Jr., U. of Oklahoma; Levi Watkins, Johns Hopkins U. Sch. of Med.

STAFF

Jonathan E. Fine, M.D., Executive Director
Susannah Sirkin, Associate Director
Nancy Arison, Program Officer
Barbara Ayotte, Publications Assistant

ISBN 1-879707-01-2