Health Professionals in the Fight Against Torture

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Abstract

Medical and health professionals, especially working closely with lawyers, have a vital role to play in gathering information about torture, in documenting torture for legal purposes, in supporting and rehabilitating survivors, in preventing torture (including via providing training about helping torture survivors and documenting the evidence of torture), and in prosecuting perpetrators. Obtaining useful testimony from survivors of torture and other ill-treatment is a complex challenge: many survivors are reluctant or unable to talk about their trauma, and may even be re-traumatised by giving testimony, especially in court under cross-examination. Medical professionals have a crucial role to play in supporting survivors through this process and also in explaining the impact of trauma on victims' ability to provide coherent, consistent testimony. The article also explores the challenges of conducting effective, sensitive forensic examinations to gather evidence of torture. Finally, the impact of the Istanbul Protocol is discussed in relation to the importance of its standards in gathering and assessing evidence of torture.

1. Introduction

Prior to 1970, little was known about the sequelae of physical and psychological torture.[1] Following global outcry over the notorious torture practices of General Pinochet's military junta in Chile, interest increased in how medical expertise and research could assist in documenting torture, supporting victims,[2] and helping doctors in countries receiving Chilean refugees to set up rehabilitation initiatives for torture survivors. At the same time, Amnesty International launched an international campaign on prevention of torture and called for medical doctors to support the fight against torture by documenting mental and physical signs of torture and by developing treatment methodologies. Following this call, Amnesty medical groups were formed and the network of rehabilitation initiatives for torture victims around the world expanded.[3] In the past three decades, the network of health professionals working in the fight against torture has grown into a global movement: hundreds of rehabilitation centres – from Albania to Zimbabwe – now assist over 100,000 torture victims worldwide. Size, working methodology and services vary

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[1] For the purposes of this article, the term 'torture' should be understood to include torture and cruel, inhuman and degrading treatment or punishment.

[2] The terms 'torture victim' and 'torture survivor' will be used interchangeably in this article. While 'victim' is a recognised term in international human rights law, the technical term applied by health professionals is 'survivor'.

[3] Ole Vedel Rasmussen, 'Medical Aspects of Torture', (January 1990) *Danish Medical Bulletin* 37, Supplement 1, p.2.

greatly from centre to centre, according to the needs of the victims and the available resources. What unites them is the desire to combat torture and to provide health services and support to the best of their ability.[4]

While the main obligation and concern of health professionals is the care of their patients, the knowledge gathered through direct access to victims, and specific medical expertise in identifying physical and mental signs of torture, generates crucial insights. Rehabilitation centres provide support services, as well as providing general and medical documentation of the details of the torture and the specific context in which it occurred: this documentation is vital in designing effective strategies for preventing torture. This is essential because lack of information and relevant, accurate and reliable evidence is one of the major reasons that torture continues and impunity prevails. In a climate of impunity, crimes of torture can be safely committed without perpetrators risking arrest, prosecution or punishment. When torturers are not held responsible, there is a risk that torture will become a widespread, systematic crime.

Despite the fact that torture has been systematically prohibited under international law for over 60 years,[5] the International Rehabilitation Council for Torture Victims (IRCT) hears, on a daily basis, about acts of torture being committed around the world. From these reports, the IRCT extrapolates that torture is practiced on a widespread basis in more than half of all the countries in the world. However, detailed knowledge and objective data on the prevalence of torture is limited since torture mostly occurs behind closed doors and is often denied: its prevalence is frequently downplayed by state authorities. This limits access to evidence and increases the importance of alternative sources of information.

This article explores how rehabilitation of torture survivors and prevention of torture mutually reinforce each other, illustrating the vital contributions made by rehabilitation centres and health professionals in treating torture survivors, documenting their testimony and collecting crucial data. This information can support court cases, asylum procedures, institutional and legal reform, monitoring and advocacy campaigns to hold states accountable as regards their obligations under international law; a key method for achieving these outcomes involves sharing examples from the work of rehabilitation centres in different regions. The contribution of rehabilitation centres can be assessed by asking

(1) how are treatment and prevention interlinked, and in which ways do health professionals support these goals via sharing testimonies and gathering data?
(2) what is the particular value of medico-legal reporting of physical and psychological examinations in generating evidence of torture for use in legal proceedings and prevention campaigns?

2. Treatment and Prevention

There is no limit to the forms that torture can take. Methods of torture may be physical, psychological, or a combination of both. Common methods include body suspension, 'falanga',[6]

[4] For more information on rehabilitation centres and programmes, see the IRCT Global Directory: http://www.irct.org.

[5] Including in the Universal Declaration for Human Rights, the UN Convention against Torture, and the International Covenant for Civil and Political Rights.

[6] 'Falanga' is the beating of the soles of the feet.

electro-shocks, water-boarding, rape, solitary confinement, and sensory deprivation, to name a few. Torture survivors respond to, and recover from, torture in a variety of ways, depending on their individual environment and characteristics. The consequences of torture can be acute (e.g. bone fractures or haematoma), but may also include long-term physical and mental injuries, some of which may last a life-time. Studies show an increase in symptoms of mental illness, including depression and Post Traumatic Stress Disorders (PTSD), in survivors of torture.[7] However, torture impacts on families and communities, not just those who have been tortured. The aim of rehabilitation services is to enable individual survivors, their affected family members and their community to resume as full a life as possible and to restore their dignity. In order to meet the complex needs of survivors, rehabilitation centres use a variety of treatment approaches that take into account the individual's needs, as well as the cultural, social and political environment. Wherever possible, rehabilitation centres provide a holistic package of services which may include

(1) medical care (for both physical and mental health needs),
(2) physiotherapy,
(3) counselling and psychotherapy,
(4) legal services,
(5) practical help with basic needs (e.g. food, shelter, and language lessons), and
(6) further social care and integration (including in relation to living skills, education and employment training).

Many rehabilitation centres provide treatment to survivors in a challenging environment, such as during on-going conflict, in countries where torture is systematically committed, or in systems with weak public health services and limited numbers of available and qualified health professionals. Centres may be part of well-equipped university hospitals or have medical wards to provide specialised treatment for hundreds of patients per year, or they may work at grassroots level and manage with limited space and staff. Some rehabilitation centres offer individual treatment sessions; others include the families or the entire community, or focus on specific groups of victims, such as asylum seekers, children or prisoners. This huge diversity of socio-political and cultural contexts means that designing a standard rehabilitation programme is neither possible nor desirable.

The positive impact of rehabilitation efforts are often far-reaching and go beyond the impact on the individual to affect communities and society at large. Torture is a political act, and the rehabilitation of torture survivors is, thus, often also perceived as political. Therefore, rehabilitation centres play a key role in promoting democracy, co-existence, and respect for human rights by their mere existence. In some cases, rehabilitated torture survivors take up roles in the fight against torture themselves. For instance, former torture victims in Kenya founded the anti-torture initiative Mwatiko Mahteso to provide support to torture survivors and their families; the organisation also publishes a journal, *The Survivor*, to advocate against torture.[8]

[7] Abigail Alexander, Stacie Blake and Michael Bernstein, (2007) *TORTURE* 17, p.1 onwards. However, a systematic review of available data shows a large variance in these figures: Z Steel, T Chey, D Silove, C Marnane, RA Bryant, M van Ommersen, 'Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement; a systematic review and meta-analysis' (5 August) *Journal of the American Medical Association* 302(5), pp.537-49.

[8] http://www.mahteso.org. Last accessed 20 August 2009.

Rehabilitation of survivors can be positively reinforced by torture prevention efforts. Often survivors seek both treatment and social interventions. In order to heal, they need recognition of the wrong-doing, for the perpetrators to be held accountable, and guarantees of non-repetition. Torture victims are often marginalised. Giving public testimony, and receiving recognition from the authorities, and also society, of the violations committed against them can have a healing effect. Impunity has a detrimental effect on the healing process of torture survivors. If atrocities are not acknowledged, and if justice is not served (i.e. if perpetrators go free and there is no guarantee of non-repetition), then the trauma is more likely to persist.[9] Research conducted on the positive effect of justice has shown that, for many survivors, the pursuit of justice, redress, and official recognition of harm done helps to restore individuals' morale and is as important as physical and mental rehabilitation. A damaged belief in a just and secure world can often only be regained after obtaining legal redress.[10]

In turn, torture survivors and health professionals can play a crucial role in fighting impunity and preventing torture. Rehabilitation centres keep records for each patient; testimonies given by torture survivors are an invaluable source of knowledge about types of torture, those who perpetrate it, the contexts in which it occurs and other relevant details. Testimonies can indicate where and when the risk of torture is greatest: for example, at the very outset of deprivation of liberty by law enforcement officials. This, in turn, can direct preventive efforts, including via training for personnel who handle detainees at the very beginning of their detention.

Increasingly, medical organisations have echoed the obligation of health professionals to denounce and document torture,[11] recognising that torture does not only cause severe physical and mental injuries, but is a crime absolutely prohibited under international law. However, documenting torture is not necessarily a logical consequence of the rehabilitation process. The primary obligation of doctors (and other health staff) is to promote the well-being of their patients. They are bound by medical ethics, and medical ethical codes, that may be at odds with documenting and denouncing instances of torture. For instance, doctors must respect patient autonomy and confidentiality, and no information may be passed on without the informed consent of the patient. Documentation of torture (and pursuit of justice and redress) must never compromise the best interests of the patient: the patient's wishes should be respected at all times. The fundamental principle here is that patients are the best judge of their own interests. The principle role of the doctor is to help the patient, including by helping them to understand the role and relevance of documentation, even if the patient does not, at the time of treatment, want information on their case used outside medical consultations. Providing treatment and rehabilitation services to survivors, at the same time as gathering data and collecting stories to denounce torture, can involve a delicate balancing[12] act as doctors must combine their

[9] Knut Rauchfuss and Bianca Schmolze, 'Justice heals: The impact of impunity and the fights against it on the recovery of severe human rights violations' survivors', (2008) *TORTURE* 18, p.38 onwards.

[10] Rauchfuss and Schmolze, p.44. See fn.9.

[11] The World Medical Association Council Resolution on Prohibition of Physician Participation in Torture, adopted by the World Medical Association 182nd Council Session, Tel Aviv, May 2009.

[12] Medical investigations of torture should be carried out in conformity with the following 10 principles: (1) Access: a victim should have prompt access to a doctor; (2) Independence: the examining doctor should be independent of authorities; (3) Confidentiality: the examination should take place in a private room; (4) Informed consent: the subject should give consent to the examination after getting detailed information on the purpose and possible outcomes of the medical examination; (5) Access to medical records: the doctor should have access to all medical records, including previous medical records; (6) Full examination: the doctor should do a full medical examination; (7) Report: the doctor should promptly prepare an accurate written report; (8) Confidentiality of the report: the report should not be made available except with the consent of the victim; (9) Second examination: a second

therapeutic role with an investigative[13] one while never losing sight of their principal responsibility: promoting the well-being of the patient.

3. Testimonies

Owing to the traumatising nature of torture, it is often difficult for survivors to share the unspeakable with others, even friends and family:[14] as such, many survivors have a barrier to disclosure as a consequence of psychological distress. Traumatised persons often learn to avoid thinking about the traumatic events in order to minimise the associated fear and other negative emotional reactions.[15] An unwillingness to discuss traumatic events is a normal general response to trauma. This reticence is well-documented in cases of domestic violence, sexual assault that does not constitute torture and also serious accidents. A key element in the rehabilitation of torture survivors involves building a trusting therapeutic relationship that enables survivors to express their experience of torture either verbally, usually via telling their story, or nonverbally, perhaps using drawing or drama. This enables rehabilitation professionals to target interventions effectively in order to address survivors' needs and to help them rebuild their lives.

For some survivors of torture, this may be the first time they have been given a chance to tell of their experiences and this telling, or testimony, can have a positive therapeutic effect in itself. However, it is the health professionals' responsibility to manage this process with sensitivity, to allow sufficient time for survivors to dictate the pace of their telling, and to use their understanding of the key issues of torture, and the survivors' socio-cultural context, to inform their work as facilitators of such tellings. While sharing their story may be empowering for some survivors, it can also be a highly traumatising experience. Wherever possible, there should be time to provide parallel, continuous and follow-up support after such therapeutic work.

Torture survivors' testimonies can greatly contribute to prevention efforts. Testimonies may be crucial in investigations and court cases relating to criminal, or disciplinary charges against perpetrators, and also to reparation claims. However, for the vast majority of victims, going to court is, to say the least, an extremely unpleasant experience. Confronting the perpetrator, having to expose intimate details of humiliation or suffering to an audience, and being challenged during cross-examination can make the most determined person flinch. Facilities should be made available to survivors in the courtroom, such as a screen so that the survivor can be protected from the view of the perpetrator or, if possible, the opportunity to give testimony via video-link so that it is not necessary for the survivor to be in the courtroom with the defendant. For example, when asylum-seekers were giving evidence to an independent commission on asylum, the witnesses agreed to talk about details of trauma only when such facilities were guaranteed. Outside the courtroom, legal professionals should show sensitivity in terms of the manner in which, and place where, they discuss the case with the victim. Psychological support should be provided (where needed) before, during and after the trial in order to enable victims to cope with

examination by an independent physician should be permitted if requested; and (10) Ethical duties: the primary duty of a physician is to promote the well-being of a patient. See Jose Quiroga, and James M. Jaranson, 'Politically-motivated torture and its survivors: A desk study review of the literature', (2006) *TORTURE* 16(2-3).

[13] For more details on medico-legal reporting, see Section 5.

[14] Rauchfuss and Schmolze, p.41. See fn.9.

[15] Jane Herlihy and Stuart Turner, 'Should discrepant accounts given by asylum seekers be taken as proof or deceit?', (2006) *TORTURE* 16, p.85. For a discussion of the sampling methods, see the full text of the article at http://www.irct.org/library/torture-journal/back-issues/volume-16,-no.-2,-2006.aspx. Last accessed 15 January 2009.

the experience of the court hearings without being re-traumatised or further humiliated. Research on victims' experiences of the criminal justice system indicates that many victims find cross-examination to be an aggressive and humiliating process that also causes them to relive the trauma.[16] Support during this process is often provided by independent health professionals from rehabilitation centres, though some courts have specialised witness protection and care units in place.

In the 2006 Atenco Case in Mexico, 3000 police officers carried out an operation with the alleged purpose of re-establishing law and order in San Salvador, Atenco. More than 200 persons were taken into custody and transferred to the Santiaguito Prison. Almost all these detainees raised allegations of torture and ill-treatment, including with the Inter-American Court of Human Rights. The local rehabilitation centre, Collective against Torture and Impunity (CCTI), offered crisis intervention, medical care or psychotherapy to more than 60 victims and in 2007, for the first time in Mexico, helped the victims to present a collective law suit. According to CCTI, many of the victims from Atenco would not have presented their case in court if they had not received psychological support and treatment.

It must be noted that testimony provided by traumatised persons may be incomplete or contradictory. However, inconsistency does not necessarily indicate that a statement is false. Individuals who give inconsistent testimony have not necessarily forgotten the event (or the details of it) but, as discussed above, may try to avoid speaking about certain aspects of their experience due to the overwhelming emotions that recalling the trauma raises. In a study of 39 Kosovan and Bosnian refugees living in Britain who were interviewed on two separate occasions about both traumatic and non-traumatic events, all participants changed some responses between the first and the second interview. Participants with high levels of PTSD symptoms and other forms of psychological distress were more inconsistent when there was a longer delay between the interviews.[17] In the eyes of the court, inconsistencies in testimony can be misconstrued or perceived as representing lies. This can cast doubts on a victim's account and decrease its credibility: a core element for assessing evidence in legal proceedings.[18] Often, this leads to victim testimony being devalued and has an impact on the likelihood of a successful outcome to the case. If judges, prosecutors and lawyers are not trained to be sensitive to these issues, they may base their assessment on incorrect assumptions about how memory works, especially when trauma is involved and, thus, draw inappropriate conclusions.[19] To avoid misconceptions, psychological examination reports can support or supplement witness accounts by providing a specialised assessment of the mental state of the witness and correlating the allegations and findings.[20] For instance, such reports can help if they pin-point when a survivor is unable to speak coherently about his/her experiences. On this basis, it is possible to establish that certain areas of apparent inconsistency should not be allowed to undermine the testimony as a whole.

[16] It must be recognised that many cases based solely on testimony never come to be heard in court. Moreover, there is a generally low success rate for cases of all types that are based on uncorroborated victim accounts. Failure to persuade prosecutors to prosecute a case, and failure to bring a successful case, can also have a traumatic impact on victims. Accurate and timely documentation is thus of paramount importance for bringing cases to trial, as well as winning them.

[17] Herlihy and Turner, 85. See fn.15.

[18] Herlihy and Turner, p.83. See fn.15.

[19] Jane Herlihy quotes a study of members of the Swedish migration board: 39% believed that inconsistencies in testimony are an indication of lying (21% endorsed it as a rule of thumb, 18% as the most important factor). Herlihy and Turner, p.83. See fn.15.

[20] Medico-legal reporting will be addressed in greater detail in Section 5.

For example, the health professional is in a position to explain to the court how and why a victim might become confused about the sequence of traumatic events. Thus, it is crucial that legal and health professionals work together, not only with regard to documenting evidence, but also with regard to understanding each other's ethics codes in order to facilitate the process of effective prosecution of perpetrators of torture.

In addition to their value in court proceedings, testimonies recounting the experiences of torture survivors can also be used in advocating for policy change and in awareness-raising. Personal testimonies are compelling and are a key way to engage the public in the fight against torture: people are more inclined to support causes that are 'personalised'. Hearing or reading about such accounts may also encourage other survivors to come forward and document their own suffering. Regardless of what form they take, testimonies permit a broader group of people to bear witness to crimes against humanity and create documentary evidence that can become part of historical memory.

4. General Data

Reliable statistical reports and official data on torture rarely exist. The conditions permitting collection of data, let alone scientifically designed research studies on the incidence of torture, are difficult to achieve in most countries where torture is a serious problem. Consequently, many human rights organisations are operating in an environment starved of empirical data.[21] Rehabilitation centres are well-placed to gather information on all aspects of torture through direct contact with both survivors of torture and their relatives. Even in cases where patients prefer not to share their stories publicly, anonymised data from patient records can provide information about the number of cases and the demographic details of the victims. This can help specific target groups to be identified, then analysed and statistically evaluated to gain an insight into the scope and use of torture in a particular region or country, including in relation to particular groups.

Information gathering must, however, be accomplished with great care. Pressure is often placed on legal and health professionals to dismiss actions in torture-related cases: centres that operate in countries where torture is widespread and/or used systematically are familiar with the difficulties (and even dangers) that this brings. Survivors and their families are often reluctant to take action for fear of retribution and harassment. Exposing themselves by denouncing torture may lead them to face threats, intimidation or pressure to cease their activities. There are numerous cases each year of staff at rehabilitation centres receiving threats – even death threats – to silence their voices.[22] Many countries lack both sufficient safeguards and effective laws offering protection to survivors, and health and legal professionals: where measures are in place, they are not always implemented in practice. In some environments, the security situation is so severe that no systematic case or information registration is carried out on paper or electronically with regard to allegations of torture. Moreover, many rehabilitation centres operate on a purely voluntary basis and with very limited financial resources. In such circumstances, the priority is providing direct assistance to patients to relieve immediate suffering and to help meet their basic

[21] Independent Medico-Legal Unit Kenya, Understanding Torture in Kenya: An Empirical Assessment, August 2007 Available at http://www.imlu.org/images/documents/imlu%20torture%20survey%20report-%20final.pdf. Last accessed 20 August 2009

[22] See Lamwaka in this volume.

needs. However, despite the personal risk, and constraints of lack of resources, the vast majority of rehabilitation centres do collect and disseminate data for prevention purposes. They compile reports for donors, authorities, and national and international bodies, including human rights monitoring mechanisms. Only with solid information can effective prevention campaigns be designed and governments be monitored and held accountable.

The Foundation for Integral Rehabilitation of Victims of Violence (PRIVA) in Ecuador has extensive experience in using data from rehabilitation for research and advocacy purposes. In 1998, together with other human rights organisations, PRIVA carried out an investigation based on interviews with 2405 prisoners in 12 prisons: this investigation revealed that 70% of the detainees had been subjected to torture. A similar investigation, carried out from 2001 to 2003, put this figure at 40%. This significant reduction can attributed to a range of causes. It is possible that monitoring (via the study) had a preventive effect, but there are many other possible explanations. A new database, established in 2009, will enable PRIVA to register all the inmates in one of Quito's prisons; the objective of this database is to monitor the prevalence of torture and violations of human rights and, thereby, to identify what types of targeted training for law enforcement staff are needed. For example, targeted training in prisons might involve exercises in how to apply control and restraint techniques in a human rights compliant way.

Rehabilitation centres have, on a number of occasions, used data gathered through their rehabilitation work to produce alternative reports to the Committee against Torture (CAT); these reports are often submitted on behalf of, or in collaboration with, other human rights organisations in order to increase their impact. For example, the Independent Medico-Legal Unit in Kenya presented an alternative report[23] to the CAT in November 2008. The report was developed in collaboration with 19 other organisations and has resulted in the establishment of a working group at the Ministry of Justice to follow up on the CAT's recommendations. In March 2009, the Medical Action Group in the Philippines submitted an alternative report to CAT at its 42nd session;[24] this report was the result of a collaborative effort involving 12 non-governmental organisations. This was part of a long-term effort to advocate for the full implementation of the UN Convention against Torture and other cruel, inhuman or degrading treatment or punishment (UNCAT)[25] in the Philippines. In June 2009, the Philippines saw the passage of an anti-torture bill at the Philippine Senate: this removed the last obstacle for the enactment of a law prohibiting torture in the Philippines, discussions on which were initiated in early August 2009.

The sharing of rehabilitation experiences, case stories, and data between organisations and institutions, as well as the press and media, can contribute significantly to general awareness-raising initiatives and can also be used to put pressure on authorities, and other relevant stakeholders, to take preventive action. This can form the basis for evidence-based, targeted, constructive advocacy and lobbying. Each year on 26 June (the UN International Day for the support of Victims of Torture), rehabilitation centres join a global campaign to demonstrate

[23] Independent Medico-Legal Unit, Torture and Related Violations in Kenya: Alternative Report to the United National Committee Against Torture, 15 October 2008. Available at http://www2.ohchr.org/english/bodies/cat/docs/ngos/IMLU_Kenya_CAT41.pdf. Last accessed 20 August 2009.

[24] Joint Civil Society report on torture and other cruel, inhuman or degrading treatment or punishment in the Philippines [Presented to the UN Committee against Torture], March 2009. Available at http://www2.ohchr.org/english/bodies/cat/docs/ngos/JCS_Philippines42.pdf. Last accessed 20 August 2009.

[25] The UNCAT is the treaty that establishes the CAT. UNCAT, adopted by the UN General Assembly, UN Doc. A/Res/39/46, 10 December 1984, entered into force 26 June 1987.

against torture.[26] The process of persuading decision makers at all levels to change practices that encourage torture, and to establish adequate safeguards, is facilitated if it can be proven that the problem is real and severe, and if the shortcomings of institutions, and the need for remedial action, can be demonstrated.

In-depth knowledge about the effects of torture – physical, psychological and social – can help identify training gaps and needs. Rehabilitation centres provide different kinds of training to support the proper implementation of state obligations with regard to setting up effective legal and administrative mechanisms to prevent torture,[27] and with regard to the ongoing education of relevant staff (such as law enforcement personnel and health professionals in prisons) on detecting torture.[28] In many countries, trainees are not aware of the possible health consequences of torture (including the particular consequences commonly associated with particular types of torture) or of the ways in which physical and psychological medical evidence of torture can be established. Experience of the impact of this lack of awareness in Sri Lanka led to training of local police officers being changed to include sessions from medical professionals on torture prevention. Anecdotal feedback indicates that the knowledge gained by police officers is now enabling them to recognise signs of torture even if a significant amount of time has elapsed since the torture occurred, and that this has had an important preventive impact.

5. Forensic Examinations and Prevention

In addition to supporting victims and collecting general data, health professionals can provide medical forensic documentation, based on physical and psychological examinations, that can be critical for prevention purposes. Standardised medico-legal reporting, in particular the use of the so-called Istanbul Protocol (the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment),[29] which was endorsed by the UN 10 years ago,[30] has increasingly provided the basis for gathering solid evidence in torture cases.

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[26] See http://www.irct.org/about-us/what-we-do/awareness-raising/26-june---un-day-against-torture.aspx. Last accessed 15 January 2010.

[27] UNCAT, Article 2(1). See fn.25.

[28] UNCAT, Article 10(1). See fn.25.

[29] The Istanbul Protocol is published by the Office of the High Commissioner for Human Rights in its Professional Training Series. The Protocol is available in Arabic, Chinese, English, French, Russian and Spanish at http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf. Last accessed 20 August 2009. See also www.ohchr.org/english/about/publications/training.htm: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

[30] The Istanbul Protocol was drafted, as part of an initiative set up by the Human Rights Foundation of Turkey and Physicians for Human Rights USA, by more than 75 experts in law, health and human rights during three years and involved more than 40 organisations. The comprehensive work to develop the manual was concluded at a meeting in Istanbul in March 1999 and the Protocol was submitted to the UN High Commissioner for Human Rights on 9 August 1999. Subsequently, the Istanbul Principles (the core part of the Protocol) were endorsed by the former UN Human Rights Commission and the UN General Assembly, and also by several regional bodies, including the African Commission on Human and Peoples' Rights and the European Commission. Other institutions and organisations have reiterated the UN and other bodies' recommendations in their reports, statements, and comments, including the Advisory Council of Jurists and the Asia Pacific Forum of National Human Rights Institutions (see Pasha in this volume). Claudio Grossmann, Chairman of the UN Committee against Torture, argues that the Istanbul Protocol has developed into an enforceable legal instrument, setting forth obligations that States must incorporate into their domestic legislation and which international supervisory organs must apply in their decision-making. For more information, see http://www.irct.org/the-istanbul-protocol/background---purpose.aspx. Last accessed 19

As discussed above, it can be difficult to prove that a person has been tortured, as torture mostly takes place in secrecy or hidden from scrutiny. The torture may have taken place many years ago, and documentary or physical evidence may therefore have disappeared. Wounds may have healed or the particular method used may be one that leaves no visible marks. Many torture methods are designed specifically so as to inflict maximum pain while leaving minimum physical traces. It therefore takes specialised knowledge and skills, and knowledge of appropriate medical and legal procedures, to investigate and document cases of torture and to bring these to court. In addition to the fact that obstacles to obtaining legal redress for torture survivors are numerous, many cases do not lead to justice for torture survivors primarily because physical injuries have not been appropriately documented by doctors and/or used effectively by lawyers in legal proceedings. For example, the CPT visit reports refer to cases of people with recent injuries, documented by the forensic medical members of CPT delegations, but either entirely undocumented or scantily documented in official records. Forensic documentation of alleged torture based on physical and psychological examination of the victim may be decisive in proving cases of torture.

The Istanbul Protocol is a unique guide that enables legal and medical professionals to methodically investigate, document and report cases of torture. The Protocol introduces common standards for the assessment of such cases, including methods to facilitate interviews with survivors, safeguards, diagnostic tests, and anatomical charts, as well as instructions for the interpretation and evaluation of findings, including information about how to correlate evidence to create a credible scientifically-based interpretation of testimony to support individual allegations of torture.[31] Physical and psychological examinations form the core of the documentation process. Both are necessary to reveal the full picture of the injury caused by the alleged torture. Often specialist examinations and laboratory tests, as well as previous medical reports from hospitals or general practitioners, are required as supplementary documentation.

The Istanbul Protocol provides guidelines for the medical evaluation itself,[32] but there is no standardised practice for managing interaction and collaboration between clinicians. A medical doctor (usually a general practitioner) will typically carry out the initial examination of the patient and, thereafter, request and coordinate further examinations by mental health experts or other specialist clinicians. To demonstrate that torture has taken place, doctors often have to obtain legal advice since, in many countries and under many international instruments, the definition of torture requires that acts of torture are performed by, or with the acquiescence of, an agent of the state and for a specific purpose (such as obtaining information or a confession).[33] The resulting expert opinions are consolidated in a draft medico-legal report that is circulated to all the professionals involved, or to key individuals acting as representatives, for their comments,

August 2009. See also IRCT, Shedding Light on a Dark Practice: Using the Istanbul Protocol to document torture, 2009, p.11. Available at http://www.irct.org/library/other-irct-key-publications.aspx. Last accessed 15 January 2010.

[31] It should be noted that, even for experienced and skilled health professionals, it can be difficult to categorically state that an injury could not have been caused in any other way than torture. In line with the Istanbul Protocol standards, medical doctors should impartially indicate the degree of consistency of the medical findings with the survivor's story of abuse. This may indicate a high probability that a particular abusive technique had been used on the victim.

[32] The Istanbul Protocol, Annex IV. See fn.29 and 30,

[33] Contrary to the UN definition of torture, the World Medical Association endorsed definition in the Declaration of Tokyo, often used as a point of departure for health professionals, does not specifically require the acquiescence of a state agent. The World Medical Association definition was adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975, and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005, and the 173rd Council Session, Divonne-les-Bains, France, May 2006.

especially concerning the conclusion of the report and the consistency of medical findings with the victim's testimony.

Before beginning any forensic examination, the medical doctor must explain his/her role to the patient and it make clear that medical confidentiality is not a usual part of his/her role, as it would be in a therapeutic context.[34] As discussed above, it is essential that the forensic examination of an alleged torture victim is conducted with sensitivity to avoid re-traumatising the patient.

> The examination starts as soon as I see the patient. How does he/she walk, sit down, use his hands, are any of his movements limited, what is his facial expression? Once the patient and most often the translator have settled in their seats, I introduce myself. I speak slowly for the sake of the translator, but also for the sake of the patient, some people can understand a bit of English and I want to include them as much as possible.
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> I explain with very simple words what my function is and what my limitations in terms of confidentiality are. Also I explain that I will take notes and maybe pictures or drawings and I go through who will have or can have access to these documents. I try to give the patient as much control as possible over the examination and I tell him that he is not obliged to answer my questions and that he can stop and have a break. In some circumstances but not all, the patient can also refuse any part of the examination.
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> I then ask the patient to tell me what happened in terms of torture and warn him that I might have to ask multiple questions in order for me to understand what he went through and to have a proper picture of the ordeal. And indeed, I need to know everything from the beginning (usually the arrest, and where it happened, at what time of the day, who was present, how did he get to the place of detention …) to the end: the release or escape from the detention place if the person is already out. And I need to know everything in between like the description of the cell, the type of food provided …, the minute depiction of the episode(s) of torture: where (in the cell, on the way to the toilet ...), how [the person was tortured] (beating, burning, electricity …), [how] often [torture was inflicted], by whom, for how long, were there any witnesses, any health professional[s] involved, how did the person get back to the cell (if the person gets back unconscious, is dragged by the guards, or can walk on his own, it gives me an idea of the severity of the torture). Were any injuries related to torture treated on site, and how?
>
> This part of the consultation can take hours, some people have several episodes of torture to tell, some are able to give a lot of details, and some are overwhelmed by the memories and find it very difficult to speak. Many people find disclosing sexual assault or humiliation particularly hard and some will simply not be able to mention it or even will deny it. Patience and respect of the person is paramount, reassurance as well that other people also unfortunately go through the same experiences.
> Once the patient has been through his story of torture, I have to ask another set of questions relating to their [*sic*] health state, medication taken, operations, previous accidents … . I need to know for instance if a scar is due to a fall as a child or if it is

[34] See Vincent Iacopino, Michele Heisler, Shervin Pishevar, and Robert H. Kirschner, 'Physician complicity in misrepresentation and omission of evidence of torture in post-detention medical examinations in Turkey', (1996) *Journal of the American Medical Association* 276, p.396.

> related to torture. I also need to know the different occupations of the patient; a shepherd might have more scars than an office worker.
>
> The time of the examination per se has come. Again, I try to demonstrate sensitivity, respect and patience. There is no need for the patient to be naked, one can examine one part of the body, then cover it and go to the next one. I explain each of my gestures and the purpose of any instrument I may use (like a hammer to test reflexes). The history of events has given me a canvass for my work. Ideally, if the circumstances and/or the patient allow, I will thoroughly examine the patient from head to toe. I will record my findings on a body diagram with measurements, description[s] … or take pictures with a scale. Once the examination is finished, I usually have to ask a few more questions to clarify some points and very importantly I also answer the questions of the patient.
>
> At that point, usually several hours have gone by, the consultation is finished, I watch the patient go and see if there are any changes compared with the way he came [in]. I always hope that the person has not suffered too much during this time with me. I will still have to spend hours on writing a report which eventually will be of use in court.[35]

In addition to producing medico-legal reports, health professionals in rehabilitation centres sometimes serve as expert witnesses in connection with the actual trial. However, the procedural rules on the admissibility of health professionals as expert witnesses differ from country to country. Sometimes the court will only call upon forensic experts employed by the national authorities and not accord expert status to independent medical personnel, leaving no room for independently collected evidence. This may be highly problematic in cases concerning torture in which, by definition, allegations are raised against public officials. For example, in some jurisdictions the forensic doctor providing expertise on alleged ill-treatment is based at the court and is in frequent close professional contact with prosecution and police officials; thus, the independence and impartiality of the doctor cannot be guaranteed, whereas, in other instances, cases are referred for expert opinion to university-based or other independent forensic units.

When appearing in court, the role of the health professional is, first and foremost, to serve the court or the investigative authority. The health professional is not on the side of the alleged victim or the perpetrator, but should give his/her opinion based on the facts gathered and on current research. For instance, health professionals may use the Istanbul Protocol to establish the degree of consistency required between the findings and the victim's account of the alleged torture.[36] It is also the role of health professionals to explain the limitations of documentation of torture to lay-people or professionals not specialised in the area of torture. Due to these difficulties, and the complexities of demonstrating that the abuse was inflicted by or at the instigation of an agent of the state and for a specific purpose (i.e. that it can be defined as torture under the relevant law), findings specific to torture are rare. However, it is crucial to understand that the absence of a finding of torture might not disprove the allegation.

One of the major advantages of the Istanbul Protocol is that it provides a framework for the collaboration between medical and legal professionals that recognises the different ethical allegiances of the two professions. Lawyers, judges and prosecutors must promote the rule of law and aim (i) to obtain relevant, accurate and reliable information, and (ii) to recover and

[35] Account of a forensic examination by Dr Muriel Volpellier, IRCT medical advisor.

[36] See Section 3 for a detailed discussion of the issue of inconsistency of victim testimony.

preserve evidence related to the alleged torture and determine how, when and where it occurred. While medical professionals have a duty to ensure clinical independence and produce medical records, their primary responsibility is to ensure that the best interest of their patients are upheld; this may not always involve the pursuit of legal redress on their behalf.[37]

At first sight, it may appear that it is mainly medical investigations and interviews that provide useful evidence for legal processes. However, although the findings of medical examinations, and the physical and psychological evidence of torture, support the legal process, interviews at the legal level can also provide findings that are of use in the medical sphere. Lawyers often have more frequent contact, particularly in interview, with the alleged victim than health professionals; they may also be in a better position to obtain information useful to health professionals. Interviews with lawyers often provide important opportunities for victims to expand their testimony and provide additional details. For instance, a doctor might document signs of blunt instrument trauma, but a lawyer might ascertain details of the exact weapon used (for example, 'It must have been made of rubber because it bent when he hit me.'). Investigation and documentation of torture is a multidisciplinary task: close collaboration between health and legal professionals is crucial to ensure compliance with the specific legal procedural requirements and also successful presentation and evaluation of evidence. For instance, a lawyer might identify ambiguities in a medical report so that these can be resolved before the report is submitted to the court.

A precedent court case – *Miguel Castro Castro v. Peru* at the Inter-American Court for Human Rights – demonstrated how successfully a team of lawyers and doctors can be in providing forensic documentation as crucial evidence in torture cases. In Peru, in May 1992, inmates at the Castro Prison in Lima were subjected to torturous acts during and after a massacre that led to the injury and death of both male and female prisoners. In June 2006, the court ruled that torture had occurred at the prison and awarded reparations to the 300 survivors and their relatives. Acknowledging the expert testimony of medical experts regarding the physical and psychological damages endured by the victims and their families, the Court ruled for a broad range of reparations, including medical and psychological rehabilitation for survivors.[38]

Other regional courts, including the European Court for Human Rights, also recognise the value of medical documentation and refer to the Istanbul Protocol as the key standard when scrutinising the evidence presented. In a recent case concerning a Turkish complainant, the Court rejected the entire body of state-produced physical evidence as unreliable, and based its decision on psychological evidence, collected in accordance with the Istanbul Protocol standards, that was submitted by the applicant.[39] The Inter-American Court of Human Rights has, on several occasions, made reference to the Istanbul Protocol in its case law, particularly in relation to means of redress and its implementation in the domestic torture investigation framework.[40]

The same applies to national courts, which, in several instances, have accepted medico-legal

[37] Shedding Light on a Dark Practice, p.69. See fn.30.

[38] *Miguel Castro-Castro Prison v. Peru,* Judgment of 25 November 2006, Inter-American Court of Human Rights. Available at http://www.corteidh.or.cr/docs/casos/articulos/seriec_160_ing.pdf. Last accessed 20 August 2009.

[39] *Salmanoğlu and Polattaş v. Turkey,* Application no 15828/03, Judgment on the Merits of 17 March 2009, European Court of Human Rights, para.85-95.

[40] *Gutiérrez-Soler v. Colombia*, Judgment of 12 September 2005, Inter-American Court of Human Rights 132, para. 100 and 109-110. See also *Tibi v. Ecuador*, Judgment of 7 September 2004, Inter-American Court of Human Rights 114, para. 252(m).

reports provided by rehabilitation centres and have cited the Istanbul Protocol in their legal analysis, thereby providing important precedents for future cases of a similar nature. In the Philippines, the use of the Istanbul Protocol, by the Medical Action Group in the case of the Manalo brothers, proved key in the first decision of the Supreme Court of the Philippines (October 24 2008) on the application of the *writ of ampar* (a remedy available to any person whose right to life, liberty, and security has been violated or is threatened with violation by an unlawful act or omission by public officials or employees, and by private individuals or entities).[41] In Egypt, the submission of forensic evidence by the El Nadim Centre in the case of Nasr Ahmed Abdallah (who died after being tortured in a police station in August 2007) resulted in the sentencing of one intelligence officer and three of his subordinates to seven years imprisonment. These sentences are viewed as an unprecedented success in the prosecution of torturers in Egypt. Despite this progress, on a global scale, much work remains to be done in national justice systems to ensure that the preconditions of legal procedure are such that medical evidence is admissible in courts and the quality of reports meets the standards of the Istanbul Protocol.

Effective medical documentation requires specialised expertise, skills and experience that, unfortunately, is not always available. Increasingly, efforts are being made to improve the capacity among relevant professions and, in the past few years, the IRCT alone has provided trainings on the Istanbul Protocol in over a dozen countries.[42] Some rehabilitation centres have specialised in medical documentation and have separate medico-legal units for documentation and rehabilitation work. Others, struggling with scarce resources, difficult working conditions, and a political climate that is unfriendly to human rights issues, deal with forensic reporting on a case-by-case basis. As specialised expertise is often also lacking in national forensic institutions, health experts at rehabilitation centres are often called upon by local groups or state commissions for human rights to document cases and elaborate on expert reports. In Uganda, the African Centre for Treatment and Rehabilitation of Torture Victims (ACTV)[43] works closely with the Uganda Human Rights Commission regarding the accurate documentation and submission of medical evidence relating to allegations of torture and other ill-treatment. Expert documentation is of particular importance in relation to the psychological effects of torture, as was illustrated in the case of *Iwolit Dismass-and-Attorney General*, in which the medical evidence proved to the tribunal that the complainant was suffering from post-traumatic stress disorder as a result of torture.[44]

In addition, many centres around the world provide training to health and legal professionals working (i) as general practitioners, (ii) in human rights institutions or (iii) in prisons; this, in turn, increases the effectiveness of reporting of acts of torture.
Through their experience with rehabilitation and documentation, including submission of independent medico-legal reports, rehabilitation centres can help generate important changes in official practices. The Turkish Government increasingly recognises the value of the Istanbul Protocol; for example, the Ministry of Health has endorsed new medical certificates, and requirements for official forensic reports have been changed in some provinces to accommodate

[41] *The Secretary of National Defense, the Chief of Staff, Armed Forces of the Philippines v. Raymond Manalo and Reynaldo Manalo*, GR No 180906, 7 October, 2008.

[42] See the IRCT website, dedicated to the investigation and prevention of torture, at http;//www.preventingtorture.org. Last accessed 20 August 2009.

[43] See Lamwaka in this volume.

[44] For more information, see the website of the Uganda Human Rights Commission: http://www.uhrc.ug. Last accessed 20 August 2009.

the Istanbul Protocol standards. Moreover, the Turkish Government (with the help of the Turkish Medical Association and the IRCT) is currently conducting a nationwide training programme on the Istanbul Protocol standards, reaching an impressive 4000 medical doctors, 1000 prosecutors and 500 judges.

6. Conclusion

Health professionals in rehabilitation centres share a common goal with legal experts and human rights activists: to eradicate torture and its effects, to fight against impunity, and to promote the prevention of torture. Beyond applying different treatment methodologies to help torture survivors, and their families and communities, health professionals use their expertise to provide the support, information and documentation needed in the joint drive to prevent torture in three key ways:

(1) Rehabilitation support is essential to individual survivors, and their families, in rebuilding their lives, and also to the justice system and human rights advocates fighting against torture.

(2) Specialised support helps survivors to give testimony about the torture they were subjected to and helps to protect them from being traumatised anew. This is crucial for judges, prosecutors and lawyers, who depend on credible witnesses being able to provide as full an account as possible of the alleged torture; if this is not possible, it is difficult to obtain sufficient information to successfully prosecute. It is therefore in the interest of the court, the investigating authorities, and lawyers that torture survivors receive appropriate treatment before, during, and after giving testimony. Human rights advocates can also benefit from obtaining comprehensive, reliable testimony from torture survivors as this can be used to promote policy change to prevent torture.

(3) Equally useful is the data collected on an on-going basis by rehabilitation centres. Facts and figures gathered on the demographics of torture survivors, the frequency with which torture of inflicted, and the types of torture used in specific places and circumstances strengthen the knowledge base that is necessary to monitor states and hold them accountable with regard to their international obligations. The Istanbul Protocol, the most powerful tool available for effectively documenting torture, has become an accepted standard for medico-legal reporting and providing evidence in legal proceedings. These guidelines provide legal and health professionals with a framework for working together to investigate and document torture and, thus, to gather detailed and comprehensive evidence.

The impact of the Istanbul Protocol is enhanced when legal and health professionals work closely together and understand each other's perspectives and ethics codes. Through taking a multi-disciplinary approach, professionals from different fields can reinforce each other's work and further efforts to effectively fight against torture.