Documentation of torture victims. Implementation of medico-legal protocols

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Abstract

This article outlines the background for performing medical documentation in the context of a rehabilitation centre by reviewing literature and current practices. The article moreover delineates 6 ways of using medico-legal documentation in torture prevention: National legal proceedings; international legal proceedings; asylum cases; research, lobbying and advocacy activities. This article forms the basis for a Pilot Study performed at the Rehabilitation and Research Centre for Torture Victims in Copenhagen, which is described elsewhere.[1]

Key words: documentation, torture, Istanbul protocol, prevention of torture

Introduction

Documentation is believed to be a highly effective strategy for preventing torture and is applied in different variations by institutions ranging from the International Committee of the Red Cross (ICRC) to small local NGOs. By documenting abuse and maltreatment, facts can be presented to political leaders, prison wards and guards and others with power to change practice. Likewise, documentation is essential for persecuting perpetrators legally, another strategy believed to be highly preventive. Persecuting perpetrators of torture is also a way of offering redress and compensation and can thus play an important part in the rehabilitation of the individual and the torturestruck society.

As a way of streamlining and improving documentation methods, a group of experts within law, medicine, health care, psychology and social sciences created a manual, which has become the authoritative document on the subject: Istanbul Protocol – Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment.[2] However the Protocol is not widely applied.

There are many explanations for the lack of implementation. The volume and extent of the Protocol no doubt plays an important part, but another explanation may be that most approaches to victims of torture are rehabilitative in their scope. The rehabilitative and documentary strategies are seldom applied simultaneously. Documenting torture is not necessarily a logical consequence of rehabilitating torture victims – quite contrary, important ethical principles such as

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doctor-patient confidentiality and the therapeutic approach to victims inscribed in various ethical codes of health care personnel inhibit a combination of the two approaches. Moreover resources are often scarce and performing documentation represents an additional cost.

There are however many arguments for adding a medico-legal component to rehabilitation. Rehabilitation is important for the individual victim, the family and the torture-struck society, but in order to get to the root of the problem, torture must be prevented from occurring altogether. The primary source of information about a stealth phenomenon like torture is the individual victim in the rehabilitation process. The rehabilitation process is thus an important source of information for improving and developing preventive strategies.

The synergies between rehabilitation and documentation are noticeable as a large part of the information is essentially similar. This is especially true for the medical and psychological part of the Istanbul Protocol, but legal and practical information also typically surface during rehabilitation.[2] The victim for instance often describes the type of torture. Such information is recorded in the medical journal of each client, but inaccessible for other purposes due to the way it is collected, recorded and administered.

Where medico-legal documentation is gathered, it is rarely on the basis of the Istanbul Protocol, a likely reason being the high level of detail and the time required to perform a full examination. In a pilot study performed at the Rehabilitation and Research Centre for Torture Victims in Copenhagen (RCT) a full Istanbul-examination was estimated to take several hours if not combined with obtaining information for rehabilitation.[3] A similar study by the Archbishop's Human Rights Office (ODHAG) in Guatemala estimated as much as seven hours to perform a full examination according to the Istanbul Protocol.[4]

The experiences and strategies of other organizations in the field can provide lessons and ideas for the implementation. Medical and psychological methods of documentation will not be discussed in this report, since the aim is not to evaluate these methods but to assess how documentation can be implemented in a rehabilitation context.

Literature and current practices

It is widely agreed that the method of medico-legal documentation can be instrumental in fulfilling a range of *legal* obligations within the UN human rights system and the Geneva Conventions, including the UN Convention against Torture and it's Optional Protocol (OPCAT).[5] Notably, the principle of non-refoulement and the many principles to ensure the persecution of perpetrators can hardly be fulfilled without some sort of medico-legal documentation.

The professional *ethical codes* for physicians and health care personnel[6] have more ambiguous implications for medico-legal documentation. On the one hand, the ethical codes are in line with the UN human rights in stipulating that all must be done to prevent torture and relieve the consequences, but on the other hand some of the most fundamental principles of the doctor-patient relationship – confidentiality, therapeutic focus etc. – do not adjust easily to medico-legal documentation. With documentation, the doctor's role changes from being purely therapeutic to becoming more investigative since the doctor has to judge whether the patient's story is legitimate, a concern which is irrelevant for treatment and rehabilitation. There are circumstances where documentation is detrimental to treatment or the doc-

tor has to choose between the two. Should the doctor then prioritize documentation and thus possibly help prevent torture in the long run or should the doctor focus on treating fewer victims thoroughly? The doctor should always act according to the best interest of the patient, but the dilemma is significant. Documentation must thus never compromise the best interest of the patient. Likewise, the principle of anonymity, which cannot be compromised by the doctor, requires careful consideration when performing medico-legal documentation.

In practice, a wide range of factors affects medico-legal documentation. The *aim* of the investigation for one (i.e. gathering evidence for a trial or screening large prison populations) largely determines the process since the level of detail and resources per victim varies accordingly.[7] Also security issues affect the process. In countries where torture victims are mainly refugees who have fled the country where the torture occurred, security measures play a small role although measures are in place to make the clients feel safe. In countries where torture occurs security issues play a dominant role for many NGOs since both the investigative team and the alleged victims risks violent repercussions from authorities attempting to silence accusations of torture and abuse. The proximity to perpetrators affects both the victim, who might be afraid or nervous and the investigator who has to rely on the goodwill of the authorities. Applying the security measures listed in the Istanbul Protocol and in the ICRC guidelines involves securing access to all prisoners, always speaking to prisoners in private, the ability to conduct follow-up visits and to record the identity of the alleged victim.[8] Securing these measures can be both costly and impossible, but if they're not in place, the victim may be better off not being documented.

A number of practical issues, such as the *time* and *resources* available and the *composition of the investigation team and their level of expertise* also affect implementation. The time available for medico-legal documentation basically sets the limits. At well-equipped centres a client may undergo a thorough rehabilitation process lasting up to one year, involving a wide range of doctors, psychologist, nurses, physiotherapist and social workers. However the time spent on one client equals time away from a new one, and time is thus still an issue at a comparatively well-resourced establishment.

For many organizations such as the ICRC and the Committee for the Prevention of Torture (CPT), which are involved in prison visits, the time spent on each inmate or client has to be carefully measured against seeing as many as possible. To cope with this problem some organizations, such as the International Rehabilitation Council for Torture Victims (IRCT), propose a screening methodology whereby a large prison population can be screened.

In addition to identifying victims for further investigation, this method renders a large data set, which allows the investigative team to speak for the entire population.[9] Similarly, the resources available affect the documentation process. A well-resourced team will for instance be able to photograph and videotape injuries and store data in an advanced data-system, while a team with fewer resources will have to rely on descriptions of injuries. Similarly, the type of experts available and their professional skill and experience with torture affects the investigation.

There are also several different methods for collecting data. The interview is the core of the documentation process and all observers emphasize the need to adopt an open questioning technique which allows the al-

leged victim to describe events in his/her own words, without suggesting answers.[10] The interview can take the form of a narrative/story, where the victim tells anything that comes to mind. The narrative can be an important element in assessing the credibility of the victim and guiding the interview.[11] The use of questionnaires is debated, since they tend to oversimplify, but it is widely recognized that the investigator needs some sort of checklist or questionnaire to lead the investigation.[12] Photographs and videotaping is recommended by all observers as a good way of documenting injuries. Self-reporting methods where the main source of data is the alleged victim's own report are generally discarded due to low credibility, while data of a more general nature (country reports, crime and health statistics) are recommended by some observers as a way of contextualizing the individual case.

Throughout the data collection process, the investigator should be aware that torture victims typically experience memory lapses and confusion.[13] The victim also risks retraumatization when describing the torture incidence and the investigator should carefully observe the victim to avoid this.[14] Cultural differences between the investigator and the victim can also affect the data collection, since they may be speaking within different regimes of truth and understanding.[15]

A victim may have a different perception of pain and suffering than the investigator and thus perceive some torture methods differently from the investigator. The investigator should also pay attention to him/herself and any interpreters involved. Counter transference, i.e. feelings of guilt, rage, sadness, helplessness or an exaggerated identification with the victim, can seriously affect both and impede the investigation.[16]

The medical and psychological components of the medico-legal investigation as well as the special character of sexual torture are thoroughly described in the Istanbul Protocol and other literature on the subject. The procedures resemble those applied in the rehabilitation process. There are however significant differences between examining for rehabilitative and documentary purposes. First of all, medico-legal documentation represents an alteration of focus: The physician is no longer only concerned with treatment but has to assess the degree of consistency between the allegations of torture and the objective findings. At the end of the process, the investigator has to put forward an interpretation thus assuming an entirely new and more judgmental role. Moreover, in documentation, injuries that have healed or are otherwise unimportant for the ongoing treatment (typically scars) are also important and should be thoroughly described and perhaps photographed.[17]

The *legal* component of documentation is generally new to the rehabilitation process. The aim of documenting for legal purposes is the same as in other criminal investigation, i.e. to seek to establish the course of events and gather evidence. The literature offers many opinions on what information is most important to obtain from the victim, the main point of disagreement being the level of detail. Some emphasize that every little detail is important since it can be corroborated with other evidence. Others are more concerned with recording key points such as the place and date of torture and recommend leaving the specific details for later. The aim of medico-legal documentation is to prove that an incident amounts to torture or ill-treatment. The investigator must seek to prove by facts that all elements in the definition of torture were present in the incident. Useful documentation thus mirrors the torture definition[18] and evolves around the questions:

– What was done?
– Who did it?
– Why was it done?
– Where was it done?[19]

The individual case is normally the basis of any useful documentation, but general reports about the situation in a country can also be valuable in identifying torture patterns. The combination of individual cases, general reports and if possible a compilation of similar cases all strengthens each case individually since many similar cases can support the individual complaint and point to a pattern of abuse. Documentation in the form of photographs of injuries, medical records, testimonies, prison records etc. should be sought as supporting evidence, since mere claims of being subjected to torture can seldom be proven conclusively. Accusations of torture tend to occur in contexts where emotions and allegiances are very strong, and the possibility of false accusations being put forward as well as true allegations being discarded should be acknowledged.[20]

Learning from others

Although medico-legal documentation is a relatively new strategy of prevention and few apply the Istanbul Protocol in it's entirety, there are a number of organizations that have obtained know-how and experience in the field. The organizations vary in size, aim, resources available and methods but there are common denominators in their work. Almost all of the NGOs use medico-legal data proactively for advocacy and lobbying purposes, but have had a more difficult time assisting victims in bringing perpetrators to trial due to the legal and political systems in their countries.

The ICRC and the CPT under the Council of Europe are examples of international organizations that have specialized in prison visits and been instrumental in developing methods of medico-legal documentation. Both organizations use the data obtained as a basis for entering into dialogue with the authorities and have found this to be an effective strategy of prevention. The experiences of these organizations are included in the Istanbul Protocol, but since they are prison visiting mechanisms and not rehabilitation centers, the implementation issues are generally different from those explored in this article.

Many organizations involved in the rehabilitation of torture victims, typically rehabilitation clinics and human rights organizations working at a grassroots level in violent societies, have experience with medico-legal documentation. The Centre for the Prevention and Rehabilitation of Torture Victims and their Families (CPTRT) in Honduras have developed "La Pesquisa", a screening system where the health status and story of all new prisoners are attempted to be recorded through visits. The data is used for lobbying, advocacy and research. The CPTRT has, for instance, studied police conduct on the basis of medico-legal documentation. The Asian Human Rights Commission (AHRC) in Sri Lanka as well as the Centre for Victims of Torture (CVICT) in Nepal have gained experience in applying medico-legal documentation for legal purposes. Both have succeeded in bringing cases of torture to court. Medico-legal documentation has played an important role although results have been mixed due to the lack of an efficient legal system in both countries.

The Bangladesh Rehabilitation Centre for Torture Victims (BRCT) has developed a distinct system of medico-legal documentation where a proactive effort of identifying victims is coupled with a follow-up of treatment and/or legal action, enabling the

NGO to work towards rehabilitation and prevention simultaneously. The BRCT has developed a comprehensive database system of news clippings and data about torture incidences and the rehabilitation process. The aim is to use the database for research on the phenomenon of torture, prevention strategies and the rehabilitation process. The BRCT documentation system is rather new and the use of the data has not been developed fully.

The ODHAG in Guatemala has taken a different approach to medico-legal documentation launching a pilot study and attempting to be as true as possible to the Istanbul Protocol. The ODHAG study is thus quite similar to that of the Rehabilitation and Research Centre for Torture Victims in Copenhagen in aiming at investigating how the Istanbul Protocol can be implemented by a rehabilitation centre.

However there are important variations due to the context: The ODHAG study involved prison visits and was potentially dangerous for both the investigator (the documentation was conducted by one person alone, a psychologist) and the inmates. As a safety precaution the prison authorities were not informed about the true purpose of the visits. Six individuals and one group were documented, thus demonstrating that group documentation can also be a way of obtaining information though this type of information hardly meets the requirements for evidence presented in legal proceedings.

The documentation process was not optimal since access to prisoners was restricted. The investigator for instance had to interview prisoners through bars and could not always inspect injuries thoroughly. An important achievement of the ODHAG study was the use of data obtained in the study of a case at the Inter-American Court for Human Rights (IACHR). ODHAG has furthermore used the data to substantiate a shadow report on Guatemala to the UN Committee Against Torture in May 2006.[21]

Possible use of data

Traditionally medico-legal documentation was developed as a way of gathering evidence to persecute perpetrators, but the review of literature on the subject and current practices have revealed several other ways to use medico-legal documentation.

National legal proceedings: Medico-legal documentation is a way of gathering evidence of torture. The methods are applied in various forms in court cases around the world and many organizations pursue this strategy although it is often difficult due to malfunctioning legal systems and authorities that hamper investigations, often violently. In many countries a fair trial can be rare, but thorough medico-legal documentation generally strengthens the victims position since it becomes more difficult to disregard the complaint. In Denmark and other countries where torture victims are primarily refugees, the main obstacle for assisting victims in persecuting their perpetrators is not a malfunctioning legal system, but the fact that the crime was committed several years ago in a country far away. A case can only be pursued if both the victim and the alleged perpetrator are residents in Denmark, which is rare. Furthermore, the far-away crime scene and the time passed makes it extremely difficult to investigate the allegation and often the authorities in the country are not helpful in investigating allegations against their own police/military.

International legal proceedings: International Criminal Tribunals such as the International Criminal Court (ICC) and the Tribunals established in former-Yugoslavia (ICTY) and Rwanda (ICTR) as well as International Human Rights Courts such

as the IACHR and the European Court for Human Rights (ECHR) are likely outlets for medico-legal documentation.[22] As a rule of thumb, national legal procedures should be exhausted as the international options are reserved for those cases that cannot or will not be pursued nationally. Also, it is generally more complicated taking a case through the international system. Not many rehabilitation centers have been involved in this type of activity, with the notable exception of ODHAG in Guatemala, who has provided medico-legal documentation in one case at the IACHR. Medico-legal documentation has however been presented as evidence in several cases at the international level.[23]

Asylum cases: Medico-legal documentation can be instrumental in investigating asylum cases, where the asylum seeker alleges torture as a reason for being granted asylum. Previous subjection to torture does indicate that the person has been persecuted by the authorities and thus faces an increased risk of torture upon return if the regime has not changed. Asylum cases represent special challenges for conducting medico-legal investigations, since there is often suspicion that the asylum seeker has exaggerated or invented the allegations of torture with the aim of obtaining asylum.

Research: The information collected for documentation can especially if it is systematically and meticulously registered be used for various research purposes. A database could for instance be used to identify individuals or groups for research projects, i.e. to identify clients who have been subjected to the same kind of torture or experienced similar sequelae. But such a database could also be used for research on its own. One possibility could be to conduct quantitative analysis on torture methods in various regions. Or it could be used to study the effect of medico-legal documentation on the prevention of torture. BRCT in Bangladesh has compiled medico-legal documentation and information about the rehabilitation process for almost two years now and is considering how the data can be used for research. The CPTRT has studied police conduct and torture patterns through medico-legal documentation.

Lobbying: These activities are another area where medico-legal documentation can be useful to substantiate communications with authorities and others with the ability to change the situation. The process of persuading authorities to change behavior is facilitated if they can be presented with documentation that the problem is indeed real and severe. In a Danish context, medico-legal documentation could for instance be presented at hearings in Parliamentary Committees about refugee and asylum matters. Internationally, ODHAG has as previously mentioned, used medico-legal documentation in a shadow report to the UN Committee against Torture (CAT) as well as in their national oriented lobbying activities. Also the AHRC and CPTRT are skilled in using this type of information for international and national lobbying. The CPTRT even succeeded in establishing a dialogue with the authorities, which enabled them to gain access to prisons on an almost regular basis. Medico-legal documentation can also be applied in urgent action appeals such as those of IRCT, where focus is on persuading authorities to intervene on behalf of an individual judged to be in imminent danger.

Advocacy: Advocacy efforts can be strengthened by medico-legal documentation. Mediastrategies typically focus on individual case stories, but also on statistics for instance the prevalence of different torture methods or where the torture took place could be relevant. Amnesty Interna-

tional typically publishes individual cases with a focus on the narrative. This has both an advocacy and a legal aim. At the BRCT, the AHRC and CPTRT the journalistic approach is part of the preventive and awareness-raising work in the society.

Summary

In the past decade the fight against impunity for perpetrators of torture has been significantly strengthened. One very important achievement has been the development of the Istanbul Protocol on medical documentation in 1999. A further achievement has been the establishment of international and national institutions responsible for the legal persecution of perpetrators of crimes such as genocide, crimes against humanity, war crimes and other serious crimes, including torture.

In this survey it was demonstrated that the aim of medical documentation and the context it is performed in essentially defines how it can and should be conducted, as well as how the medico-legal documentation is used for preventive purposes. The review of current practices in the field of medico-legal documentation revealed that very few organizations at NGO-level apply the Istanbul Protocol, and that few have a systematized approach to medico-legal documentation. The general explanation seems to be lack of time and resources. There are, however, notable exceptions. The BRCT in Bangladesh and ODHAG in Guatemala is among the most prominent. BRCT has more or less developed a distinct system of medico-legal documentation involving a proactive effort of identifying victims and a two-tiered process of treatment and documentation. ODHAG has, on the other hand, conducted a pilot study on the implementation of the Istanbul Protocol, quite similar in scope to that of RCT in Copenhagen, except for variations resulting primarily from the prison context and heightened security concerns. The results of the ODHAG project showed that the information was useful for both legal and advocacy activities, but that it was time-consuming. The CPTRT in Honduras, the AHRC in Sri Lanka & Hong Kong as well as the CVICT in Nepal, also have important experience in applying medico-legal documentation in practice. Finally we have delineated six different ways of using medico-legal documentation in torture prevention: National legal proceedings, international legal proceedings, asylum cases, research, lobbying and advocacy activities.

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