

## Commentary by Dr. Juliet Cohen\*

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This paper poses the ethical question of whether or not an NGO should provide forensic documentation for suspected perpetrators of torture, if the person is seeking asylum and claims that they have themselves been tortured. The author illustrates the dilemma with three case examples- one who is a high-ranking officer held to be responsible for the actions of his troops now presenting with complex PTSD, the second was forced to join an armed group aged 18 and also has PTSD, while the third case is an informer, suffering nightmares but not PTSD.

The author asks themselves a series of questions about how these cases could affect both an individual staff member and the NGO as a whole. These questions are important considerations. It is good practice for an NGO to consider such issues and develop an organisational policy to provide guidance, rather than be in the position of responding to an individual who presents with an unexpected and urgent request.

The first point we are asked to consider is whether or not it matters if the person is definitely a perpetrator? Following on from this, should the NGO make this judgement or indeed seek out more information to elucidate this from the country of origin, when to

do so might endanger the person should they be returned?

In my opinion, this whole question is one for others to answer, not for the NGO providing reports for torture. If torture is wrong, then it is wrong absolutely, so it is wrong to torture *anyone*, and it is not for us as doctors to judge the victim's past deeds or decide their guilt. Many of us have treated patients who were rude, or unpleasant personalities, who told us they had cheated on their partner, or who lied to us, and still our duty is to provide them with the medical care they need. We do not have to like or admire them, but we do have an ethical obligation to provide healthcare. If a doctor thinks they should not examine a perpetrator, will they examine a person who has committed other crimes? How bad do the crimes have to be? If the issue is that the person has brought this on themselves, should a doctor treat a smoker with lung cancer? It is better not to set foot on this ethical "slippery slope" at all.

The authors ask if seeking information from the client's home country is part of our duty to correlate information for consistency, and if we should do this, if it might mean putting them in danger by alerting people in the home country to their whereabouts. Firstly, this seems to overstep the boundary from being a doctor documenting torture to an investigator, and this is not our role. To be generally informed about patterns of torture in a person's country of origin is important, in order to compare an account and clinical findings with such information, as advised in the Istanbul Protocol. But it is usually only necessary to consider information generally available to all and not particularised. Even if information is so scarce that a doctor felt it imperative to contact an NGO in the country of origin, it is surely possible to do so without giving any details that might identify the person involved. And we have an ethical obli-

\*) MA, MBBS, DipRACOG, MRCGP, FFFLM.  
Head of Doctors at Freedom from Torture.  
Correspondence to: jcohen@freedomfromtorture.org

gation to maintain confidentiality for our patients which would mean we cannot reveal any specifically identifiable information.

The next area in question is about future risk assessment and harm to others - what if we help this person gain asylum and this enables them to commit further human rights violations? Again, this seems to put the doctor into the role of judge and invites them to stray far from their duty of care. One might just as well argue that by identifying and documenting their torture, they may be enabled to seek treatment for their PTSD which may well in turn reduce the risk of their committing future acts of violence. PTSD is associated not only with fearfulness but with anger and aggression. Therapy may assist the person to reflect on their past actions and choose to act differently in future. How do we know that treatment may not therefore reduce the risk of further crimes?

The authors ask if helping a perpetrator gain protection may hinder victims' access to justice. This appears to be a further legal area rather than one of medical ethics. The existence of an extradition treaty with the country of origin should not be an ethical consideration in whether or not we treat a patient. And as the authors themselves point out, in fact the person is unlikely to be granted asylum if they are a perpetrator since exclusion regulations will be applied. If the person has themselves been tortured to confess their past actions then this evidence is surely inadmissible - again, it is not the doctor's role to be the judge in this area.

A more difficult question is about the extent to which suspicions that the person may be a perpetrator should be included in the report. We have a duty to the Court to include in the report all relevant information. Being a past perpetrator seems likely to affect the assessment of potential causes for the current psychological condition, as all past traumatic, or

otherwise significant, experiences will be relevant here. If a person reveals they are a perpetrator then this should be included. They may, as in the second case, have been forced into a situation they could not escape, or suffered earlier traumatic experiences which impacted them. The doctor's duty is to record all of this and give their opinion on the relative contribution of all known factors on their current condition. The doctor also has an ethical duty to inform their patient with whom they will be sharing the information given to them.

A further question posed is about a person who reveals themselves to be actively involved in torture currently- is there still a duty to provide a report for them? I would answer yes, nothing is significantly different about this case: If there is evidence that they have been tortured in the past this should be reported, as well as the current factors affecting them. Further questioning might reveal for example that they are only currently active because their family is detained and under threat of harm- again, it is not the doctor's role to be the judge here. And further, if there is evidence of current serious harm being inflicted that can be prevented by breaking patient confidentiality, then the doctor has an ethical duty to do this.

The authors conclude by proposing specific criteria:

1. Rejecting potential clients where there is conclusive evidence that they might be active perpetrators

Conclusive evidence would be rare to see in such a case and there is no solution proposed for the fuzzy grey area of suspicion that is more often found in real life. I think if we hold onto the principle that all torture is wrong, and must be reported upon, then the answer to this question is clear.

2. Rejecting potential clients that are claimed by a national or international court for human rights violations

This criterion presupposes their guilt, which again is not the role of the doctor. Indeed, even if they were already found guilty, they may still be suffering the effects of torture and the doctor has a duty to document and report this.

3. Not contributing to the refolement of anyone

This criterion is effectively countered by the proposals above, to deny documentation of some cases, which would then effectively be contributing to the likelihood of their refolement.

The important dilemmas posed in this paper can in my opinion be effectively answered by keeping the general ethical principles of medical practice firmly in mind: *autonomy, beneficence, non-maleficence and justice*.

In these case examples, and in the question of documenting torture for perpetrators more generally, these principles can be employed as follows:

*Autonomy*- respecting the autonomy of the individual includes respecting their confidentiality and not seeking to be an investigator, prosecutor or judge.

*Beneficence*- requires the doctor to act for the patient's benefit and therefore to document their torture and assess its impact upon them and their treatment needs, and to enable them to access rehabilitation as a torture victim.

*Non-maleficence* means that the doctor must not put the patient into harm's way, such as refolement where there is a risk of their being tortured again.

*Justice*- means the patient must be treated fairly, the same as other patients and not dis-

criminated against, regardless of whether we hold a personal antipathy to them. It should also be kept in mind that, just as there is a duty to report torture where it occurs, there is also a duty to consider the possibility of someone fabricating torture to escape justice, and the expert doctor is best placed to consider this and report on it.

It must be acknowledged that situations are not always clear-cut and that other considerations must sometimes be included in ethical decision-making. An example would be if a patient who is a possible perpetrator needs to attend the NGO premises and this poses a potential risk to others who could be survivors of torture inflicted by that person and traumatised by seeing their persecutor. There is an ethical duty to prevent harm to others where possible, therefore, it is in the best interests of all if potential perpetrators are examined off-site where this risk is much less likely, or at a time when no other victims might be present.

A further consideration must be made for the staff involved. In the UK, doctors who have a moral or religious opposition to a woman's right to termination of pregnancy can excuse themselves from involvement in her care provided they refer her on to another doctor who does not hold such views. A doctor who feels that they will not be able to provide an objective and impartial medical report for someone who is or may be a perpetrator, should excuse themselves from this duty, but they are ethically obliged to refer the person on to someone who will be able to do so.

In summary, ethical practice dictates that we should treat all patients equally, according to their healthcare needs, and leave the determination of guilt or innocence to others.