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# Guidelines for the examination of survivors of torture

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**MEDICAL FOUNDATION**  
*for the Care of Victims of Torture*

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# Guidelines for the examination of survivors of torture

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# FOREWORD

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Advice on the documentation and assessment of the consequences of abuse and torture has long been needed to help doctors, particularly those with little or no experience of this arduous work, offer the most effective service they can to its victims. As a pathologist for forty years and patron of the Medical Foundation, I am very glad that these Guidelines are now in print to meet that need.

Much of the advice contained in this book concerns the provision of medical evidence to help substantiate (or evaluate) claims of ill-treatment and torture by those who are applying for asylum or sanctuary. In these circumstances a poor report can be worse than none. If a report is incorrect, badly presented or obviously biased, it will be counter-productive.

I have been involved in this work for a number of years, including missions for Amnesty International and I have examined many survivors of torture on behalf of the Medical Foundation. I have to say that I find these tasks much more arduous and upsetting than my usual profession of forensic pathology where I deal with criminal injuries and deaths. There is a cold-bloodedness and premeditation about the abuse of human rights that is even worse than the horrors of 'ordinary' homicide.

Perhaps child abuse comes nearer torture in its repugnance. Indeed, there is much in common between the medical examination of these two types of abuse. In child abuse, often the child is too young to describe what happened and the perpetrators have ready excuses of accident. Thus greater reliance has to be placed on objective findings rather than witnessed circumstances.

There is also a similarity between the medical examiner of abuse and the forensic pathologist. Both have to remain absolutely impartial and objective, avoiding any hint of bias, despite the highly emotive situation which quite naturally tends to colour the doctor's attitude. Evidence in a criminal court must remain strictly within what can be demonstrated and proven in order to be credible and useful. Similarly the reports written by a doctor looking at evidence of torture must be equally unshakeable. There are all too many critics who want to seize on any chance to discredit the allegations of maltreatment. It is not worth even the slightest exaggeration or over-interpretation of the physical findings.

These Guidelines are very timely and potentially valuable. The doctors at the Medical Foundation are to be congratulated on producing such a concise, but comprehensive document.

**Professor Bernard Knight CBE, MD, MRCP, FRCPath, DMJ, Barrister**

## SECTION 1

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# The physical after-effects of torture

**Duncan Forrest FRCS**

### **Introduction**

Torture is inflicted in many different ways, some of them characteristic of a particular country or culture, others universal. In some situations the torturers do not pay any attention to hiding their work and inflict injury indiscriminately, often leaving gross scarring, fractures and paralyses. In other countries, the torturers are anxious not to leave tell-tale sequelae which could be used as evidence in court and develop techniques which cause only transient bruising or physical disability. Psychological methods of torture may be just as damaging as physical yet leave no physical mark at all.

### **Natural history**

The appearance of recent bruising, oedema, abrasions and lacerations may give a good indication of the nature and date of the assault. Often bruising accompanied by petechial haemorrhages reproduces the shape or nature of the weapon used, such as an imprint of a hand on the face. Bruising caused by blows from a truncheon or stick may show parallel lines two or three centimetres apart ('tramlines')<sup>1</sup>. The appearance of lesions changes rapidly and eventually, usually within a few weeks, all signs disappear unless there has been a breach of the full thickness of the skin. There are some exceptions to this rule. In dark-skinned people, even superficial injury may result in permanent increase or decrease in pigmentation. Occasionally, injury which caused no breach in the skin may leave long-lasting subcutaneous fat necrosis or other changes in soft tissue or bone which can later be demonstrated by palpation, x-ray or other imaging techniques.

Abrasions, burns and full-thickness breaches of the skin initially become closed by a scab which falls off after about ten days. In partial skin destruction, the damaged skin at first looks pink but within a few weeks the skin has fully regenerated, including appendages such as hair, and has regained normal appearance. In the case of full-thickness loss, however, the skin is repaired by scar tissue which is at first pink and vascular but gradually fades and after about a year is pale and has reached its permanent appearance. The more recent an injury, the easier it is to date it by the appearance of the wound. After six months dating is usually impossible.

### **Factors which affect the nature of the scar.**

Sometimes, for a variety of reasons the scar remains unstable and may continue to itch and scab-over intermittently for years.

- In some cases, most often in Africans or after burns or other irritating forms of injury, the scar becomes hypertrophic. Keloids are sometimes established as soon as six weeks after injury.
- Shrinkage of the scar varies, influenced particularly by the supervention of sepsis and the time taken for the wound to heal. A deep wound which has been grossly infected will become puckered and sink below the general skin surface.
- Blows which would, when aimed at a well-padded area of the body, cause transient bruising, will often, if falling on a bony point such as the shin, cause a full-thickness wound, leaving a permanent scar.
- A blow from a blunt implement on a bony point may leave a sharply-defined wound which looks incised, but when fresh its margins will show some degree of contusion. However, the resulting scar will be indistinguishable from one caused by a sharp weapon.
- A blow which has left 'tramline' bruising may occasionally, if severe, result in 'tramline' scarring.
- A superficial injury which would not leave a permanent scar may, if it becomes infected become full-thickness, be delayed in healing and eventually form a permanent scar.

## **'Innocent' scars**

While examining an alleged torture victim it is essential to keep in mind the possibility that a scar may be 'innocent'.

- Most scars which result from work, sport or natural accidents are found in the most exposed parts of the body such as the hands or over bony points such as the scalp, eyebrows, knees or shins.
- Stretch marks are common in dark skinned subjects, even the young, athletic and slim. They most often occur around the shoulder girdle, buttocks, hips and lower back. They run in roughly parallel wavy lines of fairly uniform length and width and are usually bilaterally symmetrical.
- Acne which has become infected may leave scars on the back as well as the face which are very numerous, puckered and in random distribution. Infected insect bites may leave scars anywhere on the skin, but especially on exposed surfaces.
- Tribal markings are often deeply incised and are usually in parallel lines, bilaterally symmetrical on the face, trunk or arms.
- Traditional healing as practised in many countries may leave scars by scarification with knives or razor blades or burning. It may be applied over a tender spot or on the chest or abdomen where the seat of disease is thought to reside and so there are usually a number of similar scars in a circumscribed area.
- In some West African countries, skin is pinched up and then cut across with a razor blade to produce three or four short fine, parallel scars, usually in groups. This is used to introduce healing drugs or for counter-irritation of painful areas. (There is evidence that it may also be used in torture, see page 8.)
- *Girpma*, a traditional remedy used by Kurds to 'purify the blood' in infants, leaves a series of vertical parallel linear scars on the back close to the spine.
- Certain Islamic fundamental sects ritually flog themselves with whips or chains. They may show gross parallel linear scarring on the scalp and back.
- Vaccination scars, often multiple and puckered, are found on the forearm, thigh and buttock as well as the more usual

deltoid area. BCG scars are single, usually on the deltoid but sometimes on the back of the elbow or buttock. These scars are usually depressed but may become keloid.

- Operation scars are usually recognisable and the organ targeted obvious, though some surgical procedures may be bizarre and the subject may not know what was done to him\*.

### Scars from torture

Documentation is assisted if the subject is able to describe accurately the type of implement used, his posture at the time, whether he was restrained or was able to protect himself by adopting a fetal posture or holding the arms in front of the face, whether there was bleeding and a raw wound at the end of the session, whether the wounds became infected and how long they took to heal. If he was blindfolded at the time or became dazed or unconscious, he will probably not be able to give a precise description and if they are on the back he may not know of their existence.

- Scars resulting from **beating or whipping** are often found on the back or buttocks, where they tend to be fine and linear, parallel or criss-cross. They will also be seen over bony points where they tend to be circular. If the victim's hands were free, he will often use his arms to protect the face, and scars will be found on the backs of the forearms and hands rather than the face. The type of implement used influences the nature of the scar. Truncheons and thick sticks (such as Indian *lathis*) usually leave no permanent scar unless very violent when they leave wide linear scars or 'tramlines'<sup>1</sup> on soft parts and circular scars over bony points, whereas thin canes such as rattans or whips made of leather, fan belts or electric cables are more likely to leave scars, usually sharply demarcated, fine and linear. Belts with metal buckles such as the Zairean *cordelette* leave a mixture of fine linear scars and circular or ragged, often keloid, scars where the skin has been ripped by the buckle or metal bosses. Rifle butts often leave ragged, puckered scars over bony points.

\*The masculine pronoun has been used throughout for ease of reading.

- **Beating on the soles of the feet** (*falaka, falanga*) is used throughout the Middle East, India and Sri Lanka. It causes immediate gross swelling and exquisite pain on walking, but, although late signs have been reported from Denmark<sup>2</sup> and Turkey<sup>3</sup>, we have seldom been able to confirm this, either on clinical examination or imaging with x-ray or Technetium scan. There may be deep tenderness on the ball and heel, but only occasionally thickening of the plantar fascia or deformity of the metatarsals or digits due to old fractures, or damage to the toenails. We have only rarely seen ‘smashing’ of the ball of the foot or excessive dorsiflexion of the great toe as described by Rasmussen<sup>4</sup>, and Skylv<sup>5</sup> and it is important to emphasise that such gross findings are the exception rather than the rule. Many subjects, however, complain of pain on walking moderate distances for several years afterwards and characteristically suffer burning pain running up the legs in bed after a strenuous day.
- **Kicks** usually produce more or less circular scars over the kneecaps, shins and ankles. Kicks to the trunk do not usually cause skin lesions except over bony points but may leave evidence of fractured ribs or ossified sub-periosteal haematoma. There may be a history of haematuria immediately after, or of ruptured liver or spleen which had required a laparotomy.
- **Electrical burns** seldom leave permanent scars, but occasionally there are fine white linear or puckered circular scars or groups of red, punctate marks. They may be grouped round a target area such as the nipples, lips or ear lobes. Scars on the genitalia (a frequent site of electrical torture) are rare because the skin of the penis or vulva does not scar easily (but the nearby pubic skin is very easily scarred). Scars on the penis must be distinguished from scars of circumcision. If the history is of electricity having been passed through clips applied to the skin, there is more likelihood of scarring.
- **Cigarette burns** leave circular scars which depend for their severity on the length of time the lighted cigarette has been in contact with the skin. If it has simply been touched to the skin, there may be little or no permanent scar, or be indistinguishable from acne or insect bites, but if contact has been prolonged and the cigarette has been actually stubbed out on the skin, then there is often a deep, puckered circular scar with a thin, silvery surface, sometimes with a central papilla.

The victim may be able to describe the manner in which the cigarette was applied. Deliberately inflicted cigarette burns are often applied to a part of the body which was accessible to the interrogator, e.g. on the front of the thigh or back of the forearm or hand if the victim was seated. The fact that they are often distributed in a regular pattern such as a line or rosette, makes them one of the few types of scar which can categorically be stated to have been deliberately inflicted (though they have to be distinguished from innocent causes such as vaccination or ritual scars).

- **Stab Wounds.** Stabbing with a knife characteristically leaves a fairly clean one to two cm linear scar. A bayonet, which has one sharp edge and one blunt one, may leave a slightly teardrop-shaped scar, sharply pointed at one end and rounded at the other. There may occasionally be evidence of underlying muscle or nerve injury. Indian police carry a long, stout bamboo stick (*lathi*) which sometimes has its metal tip sharpened to a point and used to prod the victim. It leaves a 1cm circular scar rather like a cigarette burn.
- **Razor Cuts.** In West Africa these have reportedly been used for torture as well as innocently for treatment (see page 5). They may be used as a means for the prisoner to be identified in future arrests or simply as a painful torture. Chilli paste or other irritant is sometimes rubbed into the wounds to add to the pain and to impress upon the victim that he is being given 'bad medicine' or poison.
- **Finger and toe nails** are often crushed or removed with pliers, or pins or splinters pushed under them. The end result is a thickened and distorted nail, not easy to distinguish from innocent trauma or infection.

### **Postural Injury**

Neurological damage may be due to a penetrating wound, suspension or compression. The neurological picture can often be explained by the described torture. There is often also a psychosomatic element. There may be pain, sensory change, weakness, wasting, or loss of deep reflexes. It should be possible to distinguish cord, root, or peripheral nerve damage.

Vascular damage may result from compression, direct violence or nutritional defect. A history of acute swelling, colour change or sensory loss after trauma followed by wasting may give a lead. Diminution or loss of peripheral pulses may be detected.

Almost all torture victims complain of persistent pain and stiffness of the neck, back, hips and knees. This could be due to repeated direct trauma to the spine, to desperate attempts at avoidance during torture, or adverse prison conditions in a cramped, damp cell. Characteristically there is tenderness over the cervical and lower thoracic or upper lumbar spines and muscles, and pain on movement in the neck, flexion of the back and all movements of the hips and knees. Physical examination may show loss of normal contour and x-rays of the cervical and thoracolumbar spine may reveal pathology such as ankylosing spondylitis, spondylolisthesis or narrowing of a disc space.

'Palestinian hanging' in which the whole body weight is supported behind the back by the extended and internally rotated shoulder joints, often results in some degree of permanent damage to the shoulder girdle. Most victims faint after a few minutes, so do not know how long they have been suspended, probably only for a few minutes at a time, but often repeatedly. At first, the muscles around the shoulder protect the joint, but when they become fatigued, the whole weight of the body falls on the capsule and ligaments of the joint. Only a very muscular man can prevent this damage by holding the arms straight and close into the back. Physical signs are painful limitation of all shoulder movements, with the joint often completely frozen. Sometimes there is recurrent dislocation.

Abduction of the hips (*cheera*, tearing). In India, a wooden bedframe, the *manja* or *charpoi*, is used to restrain the victim or he may be sat on the floor with a man behind him pulling the head back by the hair and a knee in his back. The legs are then forcibly abducted to 180° repeatedly or held for half an hour or more. The victim sometimes describes a tearing sound followed by the appearance of gross haematomas in the groins where the adductors have been avulsed from their origins. The long-term result is pain and tenderness in the muscles round the hip joints, especially the adductors, and pain on walking or running.

The *Ghotna* is a thick wooden pole, about four feet long and four inches in diameter, used in India as a pestle for grinding corn

and spices. *Ghotnas* are kept in many police stations, (or there may be similar specially-made implements of wood, metal or stone), and used in several ways for torture:

- As a weapon to beat the subject.
- Placed between the thighs and the knees then tied tightly together with ropes or cloths. This may lead to vascular damage.
- The *ghotna* may be placed in the popliteal fossa and the knees forcibly flexed over it.
- With the subject lying supine, the *ghotna* is placed on the thighs, two or more men stand on it as it is rolled down the thighs.

This causes gross destruction of muscle, sometimes resulting in early death from renal failure due to crush injury<sup>6,7</sup> or later with permanent disability but no outward signs apart from abnormal tenderness in the muscles which have been traumatised. If the *ghotna* is rolled over bony points such as the iliac crest or shins, the skin may be rubbed off, leaving extensive scarring.

Suspension by one or both arms can lead to permanent lesions of the lower roots of the brachial plexus or pathology in the shoulder or elbow joints. In countries, such as India where the torturers attempt to avoid permanent scarring, they often use soft cloth such as a turban or wrap ropes in soft material before suspending the victim.

### **Internal Injury**

Blows to the head by a heavy weapon such as a rifle butt may produce a traumatic cataract or retinal detachment, ruptured eardrum, often followed by otitis media, fractured nasal bones and anosmia, loss or loosening of teeth, lacerations of the tongue or mucosa of the cheeks. If there has been a history of concussion, especially if repeated, there may be evidence of epilepsy, loss of short-term memory, confusion or dementia. These sequelae warrant specialist investigation but can seldom be proved to have been caused by deliberate violence, though their existence may fit in with details of the history.

Imprisonment in complete darkness or exposure to bright lights or the sun often leads to long-standing photophobia and lachrimation, though there is seldom any demonstrable pathology.

Repeated ducking under water to the point of drowning, *submarino*, may lead to permanent lung pathology such as emphysema, though the causative relationship would be difficult to prove.

Abdominal palpation very commonly reveals epigastric tenderness, indicating a stress ulcer. Peptic ulcers may also be caused by the forced ingestion of noxious substances. Swallowing of caustic or acid may result in oesophageal stricture. Abdominal surgical scars may confirm a history of splenectomy or nephrectomy following trauma. Loin or suprapubic tenderness may be present if there is urinary abnormality.

Hernia or hydrocele may or may not be post-traumatic. The vas may be palpably disrupted. A testis that is smaller than its fellow, especially if normal sensation is reduced, is very suggestive of past trauma. Many male victims believe themselves to be impotent or sterile. This may be the result of actual trauma or by psychological conditioning by the torturers who often threaten to destroy the victim's manhood by blows or electric shocks.

Penile trauma leaves scarring on the skin only if there has been gross violence, though the underlying corpora may be fractured, leaving palpable thickening. Hesitancy or dribbling micturition may indicate a urethral stricture. A meatal stenosis is visible and a stricture of the anterior urethra may be palpable. These may result from insertion of foreign objects with or without electrical shocks and be followed by chronic infection. Such urinary trauma requires full specialist investigation.

Rape or other sexual abuse may leave scars in the vulval or perianal skin, though, because the skin in this area usually heals quickly, they may be difficult to find. Colposcopy or proctoscopy are likely to be unnaturally painful and emotionally damaging and therefore unacceptable without general anaesthetic, and digital examination is usually unproductive. Only if there has been extreme violence will there be thickened scarring or stricture. The distinction between trauma and 'natural' anal fissure or haemorrhoid is impossible to make. These latter may have been induced by constipation as the result of prison conditions and continue to cause pain or bleeding long afterwards.

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## SECTION 2

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# Guide to writing medical reports on survivors of torture

**Edited by Duncan Forrest FRCS**

### **The role of the medical expert**

- 1 Although examination of patients is essentially the same whether they are seen for medico-legal purposes or have simply come for advice in a normal consultation, there are differences in the way patients are referred and seen. Though medico-legal reports are basically the same, asylum reports are different in some respects. The following guidelines describe these differences and highlight points which the doctor preparing a medical report on an asylum applicant should bear in mind.
- 2 Cases referred for medical examination are selected by solicitors who consider that there may be medical evidence of torture to support an asylum application. The solicitor who represents the asylum applicant's interests instructs the doctor who is, therefore, in the position of an expert witness. The doctor is asked to prepare a medical report outlining what, *if any*, injuries have been suffered as a result of torture, the role of other pre-existing or coincidental factors, and some form of prognosis. The role of the expert witness, as defined by the court, is to give objective, impartial advice based upon his clinical and professional experience.
- 3 The doctor should be aware that the solicitor is instructed to represent the asylum applicant's best interests and will be concerned to present such evidence as will assist him in advancing his client's case. The solicitor is under no obligation to inform the doctor of any facts that he knows which are

adverse to his client's case. The doctor must not assume that the solicitor has related all the material facts. The onus is upon the doctor to discover and report upon any material features which he considers relevant, even if they may be adverse to the case of the party instructing him. The solicitor does, of course, run the risk of his medical expert having no credibility at all if that expert has not taken into account material features relating to the asylum applicant's history.

- 4 The medical report should be factual, detailed and carefully worded. It is important to be aware how easily medical evidence and jargon can be challenged and the doctor should avoid making assertions that could not be defended in court. Since the report will be read mainly by non-medical officials, abstruse medical terms should be avoided, or if they must be used, they should be defined. Descriptive terms, such as *falaka*, should also be defined.
- 5 The examination should ideally be done by a doctor with knowledge of the prison conditions and torture methods in use in the particular region, and their common after-effects.
- 6 All relevant sources of information, e.g. Political Asylum Questionnaire, solicitors' deposition, caseworker's report, findings by other doctors, which are available should be perused before proceeding to the medical examination. A list of these sources should be recorded in the report so that the reader will be able to judge how the report relates to them.

## **History**

- 1 Before the history is taken, an explanation of the reason for the consultation should be given to the applicant, stating that it is on behalf of the solicitor who has briefed the doctor as a medical expert. The doctor should also explain that this is a medico-legal examination and say how the session will be conducted.
- 2 As is normal medical practice a full medical history should be taken, including relevant family and social history and previous medical and psychiatric history before proceeding to the clinical examination. The history may reveal much more about a patient's medical situation than does the physical examination.

- 3 It is important, as far as possible, to avoid asking leading questions, where the form of words or even the tone of voice may suggest a certain answer. Nevertheless, it is impossible to learn everything important without steering the conversation at some stage. The applicant may be inhibited by a number of factors: he may consider some facts not worth mentioning because they are taken for granted in his culture; he may have forgotten details; some items may be part of a cultural taboo; some symptoms may not seem relevant to him, for instance, hyperventilation.
- 4 As is common in any medical consultation, the patient may be unable to give a detailed account at a first interview. For this reason it is sometimes valuable to build up a history over more than one session. The applicant may have been blindfolded, confused, partially or completely unconscious during or after torture. Some time may have elapsed since the events, and there may be psychological sequelae. It is normal behaviour for an interviewee to be nervous, unsure and confused. It is most unusual for an applicant to recall in exact detail all dates and aspects of repeated detentions. He may be reluctant to disclose details which he fears may implicate relatives back home.
- 5 The applicant may be in a highly complex emotional state. This may make giving a history a severe ordeal for the subject who relives experiences which are often extremely distressing. For this and other reasons, it may be wise not to stick too rigidly to the convention of taking the history before the examination, but to elicit some aspects of the history while the physical examination is taking place.
- 6 Details of detentions include:
  - **Prison conditions:** Poor prison conditions are noted, including any withholding of food and drink or forcing contaminated food or drink; withholding toilet and washing facilities; withholding or provision of medical treatment; confinement in total darkness with intermittent exposure to bright light, in extreme heat or cold, in small or unacceptably crowded cells, or where the floor is wet, infested or covered in excrement.
  - **Psychological torture:** Testimony is recorded of details such as solitary confinement; sensory deprivation; mock executions; provocations, insults and threats during torture;

enforced witnessing of the torture, rape or execution of family members or others.

- **Physical torture:** Information is recorded on the frequency, timing and duration of any torture sessions, number and profession of assailants, e.g. police, soldiers, security guards or prison officers, and whether a doctor was involved.
- 7 The record of the torture itself includes:
- **Type of weapons used**, parts of the body attacked, posture, physical restraints, suspension and the use of blindfolds, hoods or 'Apollo' helmets, etc.
  - **The immediate effects:** whether the applicant could see his assailants and the weapons they used; whether he became confused or disorientated or partially or completely unconscious; whether he used protective devices such as hyperventilation; whether he could walk unaided at the end of the torture session.
  - **The after-effects:** the presence of bruising, bleeding, open wounds or other injuries immediately after abuse, the length of time taken for healing; other physical symptoms such as vomiting, internal pain, dizziness or disturbance of sight or hearing; whether or not any medical assistance was offered at once or after release and the presence or absence of permanent after-effects, physical or mental.
  - **The applicant's emotional reaction** during and after torture and any religious or doctrinal beliefs that helped him to survive.
- 8 The history should be checked against other documents such as the PAQ. Discrepancies of fact are noted and explanations sought from the applicant. Dates or other details which clash with other documents should not be mentioned.
- 9 Suspicion may arise that the story is fabricated or embellished. It is often possible to explore this possibility by asking more detailed questions, especially about the way in which specific weapons were used and the immediate effects such as bruising, cuts, blisters etc. and how long the wounds took to heal. The answers to such questioning could not have been previously rehearsed and can be assessed in relation to long-term evidence such as scarring or loss of function.

- 10 It is important to try to distinguish between the applicant who is embellishing his story with each retelling, and the one who genuinely recalls more details each time.
- 11 If the true history cannot be satisfactorily established, if there is lingering doubt about credibility, or if the patient has difficulty in speaking about his experiences, a caseworker may be asked to interview the applicant. Details can then be discussed with the caseworker or solicitor before the report is written.

### **Present condition**

- 1 The applicant is questioned and details recorded about his present general physical and psychological condition, especially in relation to the pre-detention state, and including changes in weight, appetite, energy and general well-being. Special emphasis is placed on physical symptoms attributed to detention, ill-treatment or torture. Symptoms suggestive of psychological stress, such as sleep disorder, nightmares, loss of concentration, hypervigilance, mood changes, panic attacks, asthma, hyperventilation or indigestion or susceptibility to external stimuli such as sudden noises or the sight of uniforms, should be recorded.
- 2 Many applicants will include complaints that the doctor may think irrelevant but should nevertheless be recorded. Applicants will often be socially isolated, uncertain of their future and grieving for lost or missing family members and so may focus on these concerns rather than on scars and physical pains.

### **Examination**

- 1 The examination should follow the usual routine, but with special emphasis on any abrasions or scars, bruises, lacerations, tenderness, abnormality or limitation of movement of joints and neurological changes such as weakness, sensory change or wasting.
- 2 Every scar and other lesion detected must be measured and recorded. It is sometimes helpful to illustrate scars, etc. on an outline diagram or photograph.
- 3 Throughout the interview and examination the applicant's emotional response and mental state should be observed closely.

Abnormalities often include loss of affect or garrulous or tearful behaviour, hyper-alertness, lack of concentration or heightened response to sudden movement, touching, noise or bright light. In this way, both an assessment of credibility and an estimate of the psychological after-effects of torture can be made. It is best simply to describe the mood and behaviour rather than to apply a psychiatric diagnostic label such as 'post-traumatic stress disorder'.

## **Interpretation**

- 1 In writing the report, the objective listing of positive findings under the heading 'On examination' should precede and be separate from the section of 'interpretation' in which the applicant's explanation and the examiner's interpretation is listed for each lesion.
- 2 The applicant may attribute some scars to childhood or other accidents. These should be detailed, together with the applicant's explanations. Distinguishing them from those scars which are attributed to torture shows that the subject is not trying to exaggerate his torture and thus adds to his credibility.
- 3 Scars which appear in patterns or in certain parts of the body may have been caused by tribal rituals, traditional remedies, stretch marks or disease. It is important to recognise these alternatives in order to make an informed assessment of possible causes other than torture.
- 4 Consistency and credibility are continuously assessed as the interview and examination proceed. In coming to a conclusion, the doctor must make a series of judgments, assessing the applicant's demeanour as well as the history and physical signs. Allowance may have to be made for psychological factors that disturb the subject's demeanour, for instance, if he has a flattened affect or is unable to maintain his concentration or his responses are illogical and he finds difficulty in giving a coherent account.
- 5 In only a few instances the 'scars speak', i.e. the physical traces could not have been caused in any way but by the torture described. In such cases, it is essential to state why the possibility of a natural explanation cannot be entertained.
- 6 Where scars are present they are almost always non-specific, with many possible causes. If other causes are a real possibility,

this may be stated and the likelihood assessed. (An example would be an applicant with scars on the shins who claims that he was repeatedly kicked by guards and denies ever having played contact sports such as football.) All the participants in the asylum process inevitably need to make some estimate of the applicant's credibility. The examining doctor is not excluded from this process of assessment, and is assisted by having all possible documents, especially those recording previous medical examinations, at his disposal.

- 7 Accurate dating of scars is virtually impossible unless they are very recent. Examination may be made many months or years after the alleged torture, and so it is not usually possible to state categorically whether or not the age of the scars coincides with the dates given in the history, except to say whether or not they are compatible.
- 8 In many cases, there are few or no physical signs, since only injuries which cause full thickness destruction of the skin leave scars. Bruises and abrasions nearly always disappear without trace, occasional exceptions being subcutaneous fat necrosis or, in deeply pigmented races, hyperpigmentation or depigmentation of an area of skin.
- 9 Abnormal psychological responses may indicate a state of severe stress. This is seldom referable specifically to torture, but if the account of nightmares, daytime flashbacks etc. includes details e.g. of pursuit, capture, beating or confinement which accurately re-enact events given in the history, this may lend support to the credibility of the history and the causal relationship of the torture to the present psychological state.
- 10 If the balance of the medical evidence does not support torture, or there is significant inconsistency, the doctor should state this in the report and consult with the solicitor. If the report does not appear to assist the claim, the solicitor will probably not submit it to the Home Office.
- 11 If any item of the evidence is equivocal or inconclusive but not contradictory, the report should state that it is compatible with the applicant's story and not in conflict with it.

## Opinion

- 1 The purpose of the medical report, commissioned by the applicant's solicitor, is to provide supporting evidence for the asylum application. The doctor is asked to give his opinion as to whether the available medical evidence supports the applicant's allegation of torture or other ill-treatment. It is no part of the doctor's function, however, to give an opinion as to whether asylum should or should not be granted.
- 2 The doctor's opinion is reached by taking into account the applicant's medical history, amplified by reference to as many other documents as are available, together with signs elicited by physical examination, with the interpretation of these signs by the applicant and the doctor. Reaching a definite diagnosis, just as in other clinical work, may be difficult or impossible. If no clear decision can be made, it may be helpful to order special investigations or call for a second opinion by a psychiatrist, neurologist, or other specialist.
- 3 It is essential to emphasise in the report that absence of scars does not vitiate a claim of torture unless the description given of the nature or severity of the injury is such that scarring or deformity would have been inevitable.
- 4 It can seldom be proved that the commonly-reported pains in the joints, neck and back, and the shoulder girdle damage thought to follow 'Palestinian hanging', are necessarily the result of torture. However, it can be stated that such symptoms and signs are most unusual in a young, healthy adult, that they could be explained by a history of serious physical abuse, or by specific forms of suspension such as 'Palestinian hanging' or that they could be accounted for by long incarceration in cramped, damp, cold conditions. Many elements are evaluated and summated, some of them positive, others negative or indeterminate, before a final opinion is reached.
- 5 In deciding on the wording of the report, the doctor should test and assess the validity of his views by considering whether he would be prepared to be cross-examined under oath as an expert witness.
- 6 In giving an opinion it is helpful, if relevant, to mention the factors which may have inhibited the applicant in giving a full and accurate history. Inconsistencies in a history should be

thoroughly checked and, if necessary, the solicitor consulted to correct any discrepancies in the history-taking. Any mistakes which had arisen through causes such as mis-translation can then be corrected. It is important to realise that a history with gaps or inconsistencies does not necessarily invalidate a claim that the applicant did indeed suffer ill-treatment.

- 7 An applicant who has given false evidence in other aspects of his asylum application may still have suffered the ill-treatment described. Untruthfulness does not rule out torture.
- 8 When histories are taken from several refugees from the same country or region, their accounts of torture are often very similar. This may be because police and prison guards have a limited and repetitive repertoire of torture methods. If appropriate, it is valuable to note in the report that the history is consistent with known techniques for that region (sometimes detailed in reports from independent bodies such as Amnesty International).
- 9 Some patients may have been receiving ongoing treatment for some time before a report is requested. In such cases, an extra heading, such as “Response to Ongoing Treatment”, may be included in the report, giving a description of the applicant’s progress and new details of history which have come to light in successive interviews. This may add greatly to the applicant’s credibility.
- 10 If, after a medical report has been submitted, new evidence arises which could affect the doctor’s opinion, the doctor may offer a re-examination and furnish a supplementary report.

## **The Medical Foundation for the Care of Victims of Torture**

- **provides survivors of torture in the UK with medical treatment, social assistance and psychotherapeutic support.**

Clients may be offered a combination of medical treatment, practical help and advice, counselling, individual psychotherapy, family or group therapy, child psychotherapy, physiotherapy and a range of complementary therapies. All this is achieved with the aid of a team of experienced interpreters.

- **documents evidence of torture**

Documentation of evidence of torture is principally used as part of a survivor of torture's asylum application. However, it also has a psychological benefit for the clients who, perhaps for the first time, are able to tell their stories to people who are willing to bear witness to their suffering.

- **provides training for health professionals in the UK and overseas in working with survivors of torture**

In the last few years the Medical Foundation has become increasingly involved in providing training, consultation and advice to fellow health and human rights workers in the UK and overseas.