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The Medical Examiner and the Asylum Seeker

Janus Oomen

Abstract & Introduction

This paper discusses the medical constituent in the support of the asylum request. Medical reports in connection with asylum applications have become quite common in European resettlement countries. The medical professional approach links to issues of identity, solidarity, morality and the application of medical rights as put forward by the Istanbul Protocol 2002; paragraph 67 (Bruin et al. 2006). We reflect on the medical ethical duty to monitor and speak out as experienced by the Medical Examination Group of Amnesty International (Netherlands). The question is what roles medical practitioners could and should play in case asylum claims are rejected without appropriate medical evaluations. What are the medico-legal and ethical obligations? How should the reports be written in accordance with the Istanbul Protocol and by whom? Should the attending physicians be competent or are there to be specialised independent non-governmental medical examiners?

Preview of paper

First as a physician, since 1994, and later as a medical anthropologist, since 2004, I have participated in a volunteering medical professional approach with respect to the asylum procedure in the Netherlands. The interaction between human rights and medical issues have informed my views as researcher of the links between professional identity, solidarity, morality and the application of medical rights. Central in this paper is the search for verification of torture in the narratives of refugees. In addition to the personal interviews and examinations of victims, I witnessed the public and private events, that are the roles of state and asylum authorities, judges and solicitors, advocacies and scientists, and in particular the acting of medicine in support of refugees. This paper is an attempt for reviewing my interaction with the players.

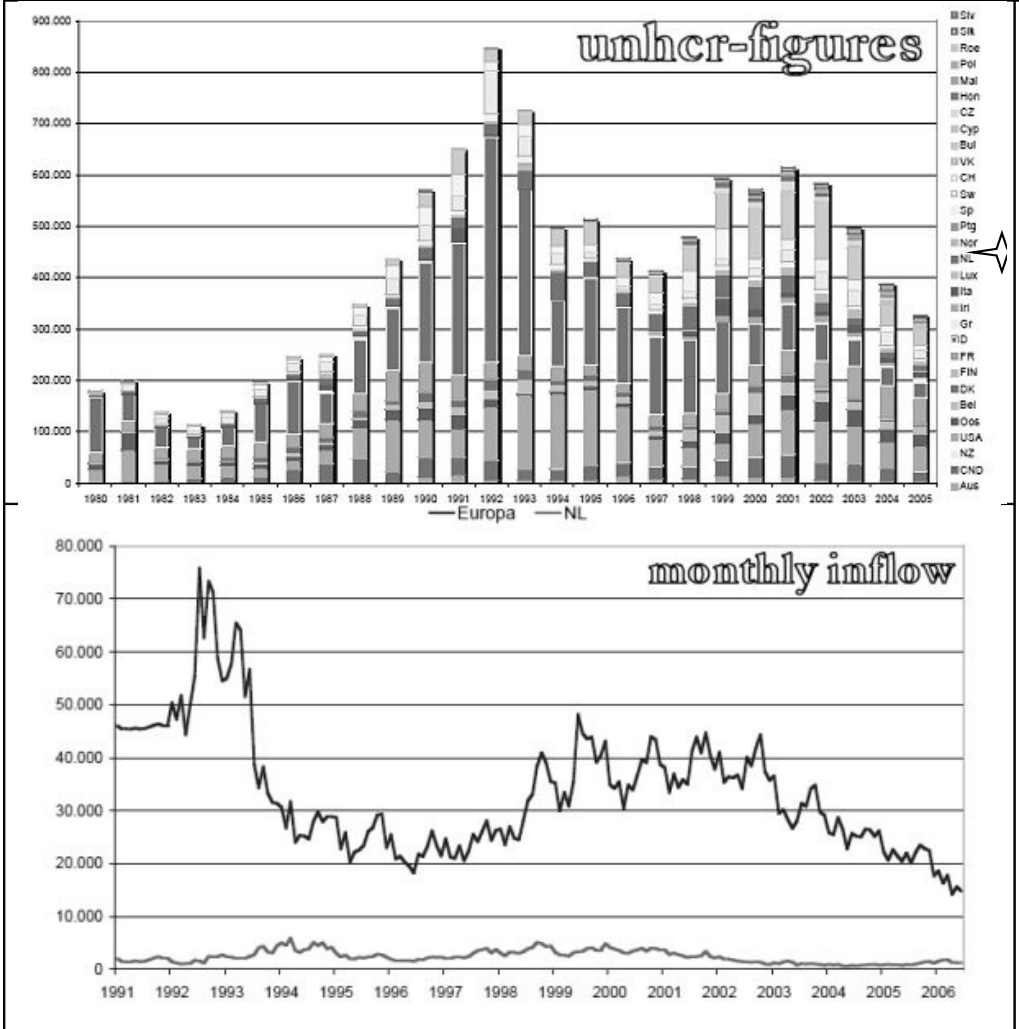
As one of approximately one hundred medical colleagues who cooperated with Amnesty International in the arena of asylum since 1977, this paper is my reflection on the burden of giving medical evidence on the consequences of torture. The particular turn of event, prompting the present review, is the fact that the Dutch asylum law is about to be revised in this very year 2010. The Dutch parliament has finalized a proposal to improve the asylum procedure by introducing a six-day preparatory period, specifically allowing for a medical examination (Bosman 2009: 601-612). The aim of the proposal is to confer on the asylum seeker an opportunity to declare the medical verification of the claim for protection. This, as will be amplified in the following paragraphs, is turning the previously inadmissible into a prospect of admissibility, and is, potentially, an important step in accord with the position on medical support, that advocacies, such as Amnesty International, have defended unremittingly.

I will focus on the medical aspects in the verification of torture to validate the claim for asylum – reconsidering as it was until now in the Dutch situation. For backgrond the asylum context is first detailed and illustrated by a few graphs. I review the admissibility of medical examination and the role of Amnesty International. Next, the findings and results are discussed and the structural problems experienced in the medical examination of torture victims are analyzed. I argue what the performance of medical examinations should contain and apply the arguments to the proposed revisions in the asylum procedure.

Asylum context

Claims for asylum in any European country generate a process of complicated and lengthy procedures. In most European countries to complete the judgment will take years of uncertainty and a slim prospect of success. The asylum recognition rate at completion is at present, on the average, as low as 5% (Hatton 2009: 187). Until the request is granted asylum seekers have minimal legal rights and are unable to participate in the host society. Wilson & Drozdek (2004) described the traumatized population, war and torture victims submerged in cyclus of adversities and now subjected to the asylum trial, as

'broken spirits'. Acording to the reports of the United Nations High Commissioner of Refugees (UNHCR 2005), the political conditions surrounding the issue of asylum in Western countries affect a population of more than 20 million. The following graphs give an impression of the magnitude and dynamics in numbers and countries involved.



Stacks represent annual (1980-2005) and monthly refugee migration shared by European, countries. The Dutch share since 1991 show an average in claims processed monthly. (Grütters 2006)

What drives refugees from ‘countries of origin’ towards ‘countries of asylum’? “Most observers would agree that wars and violence, political oppression and human rights abuses of various sorts lie at the root” (Hatton 2009: 197). The push is victimization by cultures of physical and mental violence, torture and rape. The pulling forces are the

expectations towards cultures of protection. At work behind the request is individual violation as the single most pathological agent. From a normative viewpoint, an asylum claim is to be assessed purely with regards to 'genuine narratives' of suffering, but critics argue that 'situational forces', political, economic considerations influence the assessment in order to deter potential asylum seekers via low recognition rates (Neumayer 2005: 43). As a result we see that torture is an agency generating a discourse on the medical rights within the safe boundaries of Western states. The role of the medical professional is based on the individual narrative of the asylum seeker. Requesting asylum is not considered a medical situation, but a condition constructed by governmental institutes, attitudes and developments. For this paper the perspective in the Dutch context is taken as reference in my qualitative description of the skirmish of the (in)admissible examplified by certificates, appraisals, rejections, and appeals.

Under local law, executed by the immigration and naturalization department (IND) all refugees, requesting asylum, are met by being segregated in a closed camp, tested during two formal hearings, and, on verbal testimony and interpretation only, a decision is struck within 48 hours. Within a margin of two days the asylum seeker has to present evidence of his or her traumatization and of future endangerment in the country of origin. On the average 55% of claims are rejected forthwith and claimants are expelled from the camp as illegals, and exhorted to return immediately to their country or face detention as criminal non-citizens. The rate of removing the rejected in the Netherlands is high compared to other countries in the E.U. (Amnesty International 2008: 11). After the first 48-hour elimination in the 'AC-procedure', the remainder of claimants, on the average 45% of the initial cohort, face a trajectory of several years of re-assessments and appeals, in the attempt to produce a narrative to convince the authority of their need for protection. In the Dutch asylum procedure the burden of torture narratives is met by a mind set on keeping the boundaries closed by "the disadvantages of the doubt" (Amnesty Internation 1990).

Medical constituent

From an ethical point of view, the immediacy and finality of asylum decisions is further aggravated by the fact that the rejected claimant was offered no opportunity to ask for, and was not provided with medical or psychological support. For many years the Dutch immigration authority (Vreemdelingen circulaire 2000: C14/4.4.2; Bosman 2009) stipulated that ..'on the basis of medical examination no firm pronouncements can be made as to the cause of complaints or scars' .. . This stipulation I will refer to as the *inadmissibility-provision* and deal with as one of the 'situational forces' created to restrict asylum. Even in the further verification of the asylum claim, until today, this basic statement disregards medical professional support of the asylum claim in the Netherlands as an unauthorized intervention. The medical-legal attempts to contradict and act against the lack of medical evidentiary support has been the focus of opposition of many international and local advocacies, best summarized in this proposal to the European Parliament in 2009 (COM 554/4, Stolwijk 2010):

> "The applicant must be entitled to request a medical examination in order to support his/her statements relating to past persecution or serious harm. It is also specified that the applicant must be given a reasonable time limit to submit a medical certificate to the determining authority".

Because the IND decides on verbal testimony only, without medical substantiation, there is no proper assessment of torture, whether physical, mental or sexual – because, as we will see, giving the evidence in the ways that are expected is hard, and torturers provide no documents to victims of their deeds. Complaints, post-traumatic signs and scars due to torture are legally considered only if evidenced by medico-legal expertise, but an opportunity for that purpose was not made available in the Dutch law.

Wilson & Drozdek (2004: 46) estimate that between 10 and 30% of asylum seekers have been tortured. The estimate of a 20% torture incidence defined by the expert medical institutions is an informed guess. As a pathological agent torture is difficult to verify, quantify or qualify. To quote Farmer (1997: 261) in his observations on suffering and structural violence: "The texture of dire affliction is in the gritty details of biography".

The access to, and direct interviews of the victims is what the medical investigators need as the least of the requirements for an assessment that will ultimately inform an epidemiological approximation. Since 1977 Amnesty International in the Netherlands provided rejected asylum seekers and their solicitors with an opportunity to supplement their testimonies during appeals and that effort will be discussed in the following summary from my own experiences, during participation in the group of medical examiners since 1994.

As a consequence of the *inadmissibility-provision*, victims of torture have frequentely been denied asylum in the Netherlands, even if it is difficult to state an exact figure of wrong decisions. Importantly, a standard of medical evidence to investigate allegations of torture has been adopted internationally; the Istanbul protocol since 1999. In the previous 30 years the local branch of Amnesty International in the Netherlands (AI) has advocated the medical examinations and has organized, trained and supervised volunteering medical professionals into an independent professional service to intervene when an asylum seeker, who has a strong cause, is denied refugee status (Stolwijk 2010). Initially, in the late '70's, the motivation was to demonstrate the asylum authority that they were wrong in discarding medical expertise for the purpose of asylum verification. As the Medical Examination Group (MEG) during 30 years specialized in counteracting the *inadmissability-provision,* in cooperation with the asylum solicitors of the victims involved, they became the only effective institution, to the point of being included in the instructions of the IND for consideration in appeals. What did not happen however was the intended change of the asylum procedure being responsible for adequate medical examinations. Traumatic events in the narratives of asylum seekers were taken into account by the medical services, routinely attending the camp populations, but not communicated to the immigration officials deciding on the claim. A Bureau of Medical Advisers (BMA) to the immigration authority was even instructed to consider the medical aspect of the asylum claim as out of bounds. If torture had occurred, but the verbal testimony had not convinced the official deciding on the asylum claim, the only

remaining prevention of refoulement (claim rejection and expulsion to the country of origin) was for the solicitor to to appeal to Amnesty International.

In the majority of cases when the MEG has supported the claimant, the rejection has been shown te be unjustified in court and changed into one or other form of asylum. The most recent evaluation on the period 2004-2008, on the impact during appeals over the period 2004-2008, shows (Stolwijk 2010):

	2004	2005	2006	2007	2008	Total	[%]
Reports provided	32	34	25	38	35	164	100
Reports not considered	2	1	2	2	0	7	4
Asylum granted	16	20	14	22	12	84	51
Pardon intervening	9	4	6	1	1	21	13
No asylum granted	2	5	1	5	4	17	10
Unknown / out of sight	2	2	1	0	0	5	3
Still under appeal	1	2	1	8	19	32	20

The table does not demonstrate the complexities of the medical intervention though. Due to the protracted procedure and changes in recognition policy, in many cases the result of medical support cannot be measured against a standard of evidence such as the Istanbul Protocol (Bruin et al. 2006). Still, we can conclude from the above evaluation that in approximately 75% or more medical intervention of the type offered by the MEG helps to provide the solution that ends the traumatic and protracted period of qualifying for asylum for the rejected refugees involved.

Medical argument

The following thought is offered by Wilson & Drozdek (2004: 672) for reflection. A health professional must have complete clinical independence in deciding upon the diagnosis of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate, but professionally, in the asylum debate as shown in the above, the doctor is entering a zone where the usual conceptions of human rights and obligations to others do not seem to apply. Asylum seekers in immigration detention are

officially unauthorized noncitizens and the medical examination to verify their claim was an unauthorized intervention.

To substantiate the argument, a minister for immigration is quoted by Wilson & Drozdek (2004: 672): "…the state has the sovereign right to determine which non-citizens can enter the country, those that can remain, and the conditions under which any may be removed… While deterrence is not a primary purpose of detention, it is an important incidental factor". At that level of administrative overrule, the naive and well-intentioned clinician encounters a system within which not only those they advocate for, but they themselves have no currency and little power. The role of doctor and clinical advocate is altered by crossing over into the jurisdiction of immigration law. The social contract, as we usually experience it, does not operate here. As a consequence, our words have no power. How can we overcome this crisis by an effort of imagination?

What kind of support is indicated? In the first stage, immediately after admitting asylum seekers to the procedure, medical and psychological screening on the physical and mental conditon is significant to assess if asylum seekers can speak out or are unable to present a coherent narrative to the immigration authorities (Tankink 2009). A second supportive step is that of an expert verification of claimed torture by a competent medical professional, offered to all as early as possible for several reasons. An examination of hurts and injuries at the earliest opportunity will be more consequential if a forensic approach in verification is attempted, even if the site and perpetrators of the crime are unavailable in the asylum context. Another reason is that both the victim, in speaking out about, and the official, in hearing and deciding on the asylum claim, are made aware from the beginning of the paramount reason for requesting asylum: the fact that torture has occurred and that it is the main argument for seeking protection. Lastly: if during the decisive hearing on the claim the asylum seeker indicates that mistreatment in the country of origin has occurred, the consequences thereof should be part of the medical workup. In addition to the diagnostic and judicial consequences, the medical observations indicate referral and follow up in the regular medical circuit. Further on, if the decision on the

claim is negative, the appeal should include access to medical and/or psychological expertise too as the normal course of justice common to all Dutch judicial procedure.

Medical support is required in all stages of surviving torture, by linking safety and revalidation, balancing the restoration of mental and physical health, getting over grief and mourning, and finally connecting with life again (Pederson 2009: 33). Paramount however is, that the pathological agency is recognized and handled with empathy, skilled by understanding exactly what the suffering is about. Forensic approaches are rarely applicable. The perceived irrationality of torture is often paramount in the ineptitude in expressing and observing traumatization during asylum interrogation. Difficulties are, that the victimization has a paralyzing effect in speaking out on why and how and by whom the subject has been tortured. Narratives often contain apparent contradictions or inconsistencies emphasizing the lack of perceived meaning or the forceful attempt to silence, forget and deny the abuse: “I have no words”; “I do not want the hurt reopened”; “I can only live on by forgetting what occurred”; “*Then*, I had no means to defend myself, but *now* I can resist having to tell about what happened”. The making explicit of mental and physical scars under those conditions is hard, as I have experienced during many interviews and also by researching the effect of photography on the documentation of torture (Park & Oomen 2010). The full story frequently needs considerations, which are rarely understood by the asylum authority. One example is that the intention of the tortured for leaving their country of origin is complicated by more reasons than the risk of refoulement and re-exposure to torture. One compelling reason is the pledge to stay as far away as possible from the torture scene and circumstance, because the escape has been made possible and has succeeded due to a combination of expulsion, bribery and conspiracy between the victimized, the assisting and the persecuting parties. All concerned have heavily invested and all are at risk of being re-exposed when the victims return home to the torturers. The medical problems asylum seekers face are related to personal, community, and cultural losses, multiple separations and unrequited needs for parental or family support and care, distressing familial conflicts and psychiatric disturbances, long-lasting uncertainty in acquiring residency in the new country and

starting up a normal life, minimal facilities and common violence in reception centers, limitations to education and freedom of movement, social marginalization and discrimination (Amnesty International 2008). In this context of complexities the problem of truthfinding for asylum claims is not over with medical certification.

As Fassin & d'Halluin (2005: 598) argued, it is in the attitude of concealment favorable to all types of subsequent denial that the medical certificate assumes increasing importance in societies in which the victims of political violence are supposed to be accepted and protected.

Note: Janus Oomen is a physician (MD 1968, PhD 1974, MA 2004) specialized in internal medicine. He is as a medical anthropologist since 2004 guest-researcher in the medical anthropology and sociology unit of the University of Amsterdam. This article is the work of Janus Oomen and does not represent Amnesty International in the Netherlands; any errors contained here are the author's alone.

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