

The role of the doctor in ICRC visits to prisoners

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1. Introduction

The ICRC visits prisoners all over the world, whether they are prisoners of war in camps or political detainees held in prisons or police stations. In 1990, ICRC delegates visited more than 84,000 prisoners in about 40 countries.¹ These visits are made by teams of delegates, the number of whom varies depending on the number of prisoners to be seen. Each team is made up of Swiss delegates specially trained to carry out such visits, including at least one doctor.

Doctors who become medical delegates are therefore delegates of the ICRC in the fullest sense. They must have had a minimum of three years' clinical experience and undertake an initial engagement of one year. Before they join a delegation they receive specific training on the activities of the ICRC and on the work done by delegates in places of detention. Once they have been trained and acquired some experience, medical delegates may be engaged for missions of shorter duration.

The ICRC doctor has two distinct roles within the team of delegates making visits:

- He is responsible for *assessing the state of health* of the prisoners, also every aspect of life in detention that impinges on health (food, hygiene, medical care, etc.). This role is that of an expert adviser, not of a doctor providing treatment.

¹ There may be two or more contexts to a conflict in one and the same country: in Afghanistan, for example, the ICRC visits prisoners in the hands of the government authorities in Kabul and elsewhere; ICRC delegates also visit those held by the Mujaheddin, on Afghan soil, but do so from a delegation based in Pakistan.

- Where there are *allegations of ill-treatment*, the doctor is responsible for obtaining the medical data required to establish a file on the subject, so that the ICRC can call on the competent authorities to put an end to such practices. As a medical adviser from outside, the ICRC doctor also has a role to play among the victims themselves, who can trust him.

2. Assessment of prisoners' state of health

The assessment made by the ICRC doctor covers the prisoners' state of health and the various systems existing within the place of detention to ensure their survival: food, hygiene, medical care, etc. He (or she) must therefore examine the various aspects of life in captivity. In order to obtain all the information he needs, he talks not only with the prisoners but also with the medical staff in the place of detention.

If nutrition is unsatisfactory, the ICRC doctor takes care to make a representative selection of prisoners. He must note objective signs of malnutrition, such as loss of weight, symptoms of deficiencies and lack of vitamins (beriberi, pellagra, xerophthalmia, scurvy, etc.), any or all of which provide proof that the diet is not adequate. However, the absence of any such signs does not mean that the rations supplied by the authorities are sufficient, since prisoners' relatives might be bringing food that compensates for the inadequacy of the official rations.

The ICRC doctor must make a detailed analysis of the food provided to prisoners, in order to determine whether there are deficiencies. This implies not only analysing the meals supplied on the day of the visit but also examining other non-medical features, such as the budget for purchasing food, the way in which foodstuffs are stored, whether or not prisoners' relatives bring them food, etc. These various factors, plus the doctor's professional medical report, enable the team to have an overall view of the situation. In no case, except in life-threatening conditions, does the ICRC take the place of the authorities in providing food to the prisoners; but it does attempt to discover the cause of the inadequacy (insufficient funds, food being diverted for consumption elsewhere, incompetence, etc.), in order to propose a solution and thus help the authorities to meet their responsibilities.

If sanitation² in the widest sense is unsatisfactory, with adverse effects on the health of those in detention, it is the ICRC doctor who, after he has made his assessment, must decide what measures are necessary. If need be, he will call on the help of specialists in water supplies and environmental sanitation.

Sanitation is a very extensive subject, covering the study of such matters as:

- *water supplies*, in sufficient quantity and quality for the prisoners, as a vital necessity for health;
- *elimination of waste water and solid wastes*, to avoid the possibility of contamination, disease and even epidemics;
- *vectors* (ectoparasites, rodents, insects, etc.), the presence of which can cause the spread of various diseases (malaria, bubonic plague, rickettsiosis, etc.);
- *general living conditions* in the place of detention, density of occupation of quarters, ventilation, cleanliness (the influence of the latter on health goes without saying).

The *medical system* for providing health care to the prisoners within the place of detention is also studied by the ICRC doctor, with special attention to its actual functioning. This means that he inspects the installations (infirmary/sick bay, consulting room, etc.) and talks with the medical staff, whose opinions and, at times, grievances are very useful for understanding how the system works and why it may break down (minimal pay of medical staff resulting in absenteeism, insufficient funds made available for medicines, system sabotaged by the prisoners, lack of transport for taking patients to hospital, feeling of insecurity among care staff, etc.).

The ICRC doctor also listens to the prisoners' account of the medical facilities. He hears some of them in private, away from the influence of the authorities, naturally, but also away from that of their group, which, among political prisoners especially, may impair the objectivity of the information.

The ICRC doctor always makes a point of examining a representative sample of prisoners to obtain an objective idea both of their state of health and of the quality of the medical treatment provided by the detaining authorities.

² Term that includes all matters connected with water supplies, sanitary engineering (drainage, sewerage, etc.) and hygiene.

The ICRC doctor takes care not to act as a substitute for the existing system but to make it function as it should.

The means used to achieve this aim will, of course, vary according to circumstances. Persuasion through dialogue with the local doctors may be all that is needed to settle some problems. In other cases, the ICRC will give aid in the form of medical supplies to a prison doctor who has none. In exceptional cases, the ICRC may request the release of prisoners who are seriously ill or badly wounded if it considers that this would be of benefit to them.

In assessing the various systems and the prisoners' general state of health, the purpose of the ICRC doctor is to obtain an objective view of the shortcomings and to identify the reasons for them. The ICRC, as an institution, is then able to put forward specific and practicable proposals for improvements to be made by the detaining authorities.

It does so through specific steps taken by the delegation and by giving the higher authorities an official written report on the visit. A problem that has been described in a report by the ICRC can no longer be ignored by the authorities, and the ICRC's proposals may start a process of improvement. The prospect of another visit by ICRC delegates in the fairly near future is a major factor in furthering this process.

3. Role of the ICRC doctor in the event of ill-treatment³

If the prisoners tell the delegates that they have been ill treated, the ICRC does its best to ascertain the facts and draw up a complete file, in order to notify the responsible authorities and ask them to terminate such practices. In such circumstances, the ICRC doctor has to examine the detainees and give a professional opinion on their state of health and on the possible relationship between any lesions he may find and the allegations made.

³ The term "ill-treatment" is the one currently used in the official documents of the ICRC. It refers in fact to cases of torture and of cruel, inhuman or degrading treatment, as defined or cited in various international conventions against torture. The use of the term is not due to prudery or timidity: it enables the ICRC to report on these matters without the risk of automatic rejection by the authorities (for example, if the word "torture" were used). The subsequent description of the facts leaves no doubt as to what is meant (*see below*).

The doctor examines each case individually and also attempts to discern ill-treatment as a collective phenomenon that must be understood and discussed with the authorities in its entirety. The two approaches, individual and general, are impossible to separate.

The ICRC doctor must also inform, reassure and advise the victims of ill-treatment, since he is a “neutral doctor”, sometimes the only doctor whom the victims trust. Very often he is able to relieve their minds simply by explaining the after-effects of torture and the possibilities of therapy available once the prisoners have been released.

(a) How the ICRC combats torture worldwide

The ICRC itself has not adopted any definition of torture. Its role is not to prove the existence of torture before a tribunal, but to take action to help victims so that torture is stopped. When the ICRC receives allegations of treatment that it considers equivalent to torture or to the category of treatment defined by the UN as cruel, inhuman or degrading, it compiles a special file that is submitted in confidence to the detaining authorities. The form of the file depends on the circumstances, the number of cases and the seriousness of the facts. Yet in every case the action taken is the same: *the ICRC calls on the authorities to take all necessary measures immediately to put a stop to such practices.*

Although the ICRC does not have its own definition of torture, its doctors refer to definitions that are universally accepted, such as:

- the definition adopted by the World Medical Association (WMA) in the “Tokyo Declaration” of 1975; and
- the definition contained in the 1984 UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment.

None of the existing definitions of torture gives details of the “grey area” represented by cruel, inhuman or degrading treatment. This raises questions particularly regarding conditions of detention. What degree of overcrowding constitutes degrading treatment? What is to be said of latrines shared by hundreds of prisoners in poor conditions of hygiene? Is the body-searching of detainees degrading? The ICRC doctors are able to refer to certain texts;

- the UN Standard Minimum Rules for the Treatment of Prisoners (1984);

— the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1989).

For the ICRC the Minimum Rules serve as a guideline, but not as an absolute criterion. Depending on the circumstances and the possibilities of the detaining country, the ICRC may demand more than the strict minimum set down in the Rules.

(b) Interviews with prisoners

The interview in private (“without witnesses”) between the ICRC doctor and the prisoner is the most important phase in this type of visit. During the interview, the doctor will, obviously, avoid anything that might seem like another “interrogation”. Here, tact at the outset, and a sympathetic hearing are the essential requirements.

In questioning the victim about the ill-treatment he has received, the ICRC doctor must bear in mind that he is entering into a very personal sphere. This intrusion into a recent experience that the prisoner has tried — usually in vain — to forget may be traumatic. Some prisoners take the opportunity to “tell it all”, since they need to talk about their experience. The fact that they can talk to someone other than their fellow detainees may be beneficial in itself. Other victims are unable or unwilling to talk about their ill-treatment. In some cultures, where important matters are never discussed straight out during a first meeting, prisoners will obviously be most reluctant to speak about such an intimate subject.

Non-medical delegates who talk with these prisoners must take the utmost care not to invade their privacy. It is better to interrupt an interview than to cause distress. Here the other delegates can turn to the doctor in the team, who is, by training and by experience, more accustomed to this difficult type of interview.

After noting the allegations of ill-treatment, the ICRC doctor examines the prisoner. The examination takes place in private, ideally without an interpreter (provided that the ICRC doctor is fortunate enough to speak the language of the prisoner’s country). If an interpreter is needed, the prisoner himself *chooses* one.

The physical examination has three main aspects:

- First of all, it forms part of the normal relationship between a doctor and a patient. The prisoner moreover expects it, particularly if he has not been seen by the doctor in the place of detention, either for lack of time or because of negligence.

- Secondly, the ICRC doctor must see for himself exactly what physical consequences the torture has had. On the one hand, he must compare existing traces with the allegations made by the prisoner, but above all he must get a clear personal idea of the various methods used to produce visible after-effects (also psychological effects — see below).
- Finally, examination of the victim is essential for the ICRC doctor to provide him with the only immediate service possible: a tentative diagnosis of his condition and an estimate of future progress. Often the doctor is able to add some practical advice (for example, on physiotherapy that the prisoner can give to himself).

(c) The specific role of the ICRC doctor vis-à-vis victims of torture

Ideally, the ICRC doctor should examine every prisoner who has been tortured. Since this is impossible when the number of victims is very large, the doctor must choose a representative sample from the group, so as to obtain a general idea of the situation.

There are several reasons why the ICRC doctor ought to try to see every person who has been ill-treated:

- victims will usually discuss their problems more readily with a doctor than with the other ICRC delegates;
- victims need to be reassured as to their state of health;
- only the doctor in the visiting ICRC team is able, because of his expert knowledge, to provide professional evidence for the file on ill-treatment so that the ICRC can take the necessary steps to help the victims;
- the ICRC doctor can have a beneficial influence on prisoners suffering from psychological disorders as a result of ill-treatment, if he says the right thing at the right time;
- if medical staff are alleged to have taken part in torture, it is essential for the ICRC doctor himself to collect all the information so that he can take action.

The above points merit closer consideration.

- ***Victims will discuss their problems more readily with a doctor***

Experience shows that a victim's account of torture differs depending on whether it is given to a "lay" person (i.e., not a doctor)

or to someone from the medical profession. This is particularly true when the torture is of a sexual nature. It should be pointed out that this type of torture is universal. Such treatment is easier to describe to a doctor, since the victim feels less ill at ease as the “patient” speaking to “his/her own doctor” than in a non-medical context. The reluctance to report the torture suffered naturally varies according to the individual’s cultural and ethnic background. The sex of the doctor will play a role in some cultures: for example, a male doctor will not be allowed to talk to or examine women in some Muslim countries. On the other hand, experience has shown that the opposite is not always true (at least for the interview): many male prisoners are very willing to confide in a woman doctor, who thus acts as a sister or a mother.

Sometimes the account of sexual torture is accompanied by an appeal, explicit or tacit, from the victim. In some way the victim wants the doctor to take a professional attitude so that he can pluck up the courage to ask questions. Others prefer the doctor to lead the discussion.

Since torture is an assault on their most intimate selves it is completely understandable that victims should prefer to talk to someone who can reply to questions they cannot or dare not express.

Some want to be told that their injuries are not permanent; others simply need to tell their story to someone without feeling ashamed or embarrassed; many merely wish to be reassured that what they feel is “normal”.

- *The detainee needs to be reassured as to his state of health*

The physical injuries may range from superficial, apparently unimportant, scars to severe or disabling lesions. It is certainly not necessary to be a doctor to realize that circular scars at the base of both thumbs is probably due to the thumbs having been tied tightly with string for a long period, as usually reported by prisoners. Nor is it necessary to be an expert in medical law to know that multiple scars on the back are abnormal and are due, until the contrary is proved, to the whipping alleged by the detainee.

In both cases, however, the victims must be examined by the ICRC doctor. Even if the lesions are minor, there may be associated problems that should receive the doctor’s attention. In the first case described, that of the scarred thumbs, victims often complain of the absence of sensation below the compressed area.

The ICRC doctor must examine the patient's hands to be able to reassure him. Most of the time the effect is temporary anaesthesia due to damage to the sensory nerve, and this will very gradually recover its function as long as the nerve sheath has not been destroyed.

In the second case, the doctor must take note of the lesions and see whether any treatment can be suggested to the patient. After a physical examination, the victim can be informed of his condition and told of the probable future progress of the lesions.

These two cases were chosen because they are relatively frequent occurrences, for which non-medical delegates often think that the doctor's opinion does not appear necessary. Yet experience has shown that victims of such ill-treatment have been reassured simply by having the professional opinion of a "neutral" doctor.

When torture is related directly or indirectly to the reproductive organs, victims very frequently ask questions such as "Will I still be able to have children?" or "Will I be able to have intercourse with my wife?".

Such questions will arise more or less easily, depending on the extent of the cultural barrier between prisoners and delegates. In every case, the ICRC doctor is the one best placed to answer them, as the only person possessing both theoretical and clinical experience.

- *Only the doctor can provide expert testimony in support of the file on ill-treatment*

Naturally, there are many cases of physical torture where medical expertise is patently justified. Disability due to badly healed fractures (pseudarthrosis, for example), shrunken scars, specific lesions of organs, residual paresis or paralysis, are the most frequent physical after-effects of torture.

In such cases, the doctor's role is to make an objective professional evaluation of the after-effects. Subsequently, the ICRC will take the necessary action, depending on the severity of the cases. It will request, for example, that the victims be hospitalized or given special treatment or that they be provided with prostheses, etc. These moves in favour of individuals supplement the ICRC's more general approaches to the authorities designed to put a stop to the phenomenon of torture.

For a victim disabled by torture, the meeting with an ICRC doctor is the means by which he will perhaps be supplied with a prosthesis or receive suitable medical treatment, and this is what counts most for

him, irrespective of other steps taken by the ICRC, the benefits of which he will see only later and indirectly.

This brings us to the compilation of a professional medical report on torture. The ICRC is not a body that carries out inquiries as such, and it acts only in the direct interests of the victims. This means that it does not seek to “prove”, to provide evidence that torture exists. Nevertheless, it is indispensable for the ICRC to have a well-documented file if it is to be able to take action with the relevant authorities at a later stage. Experience has shown that the description of lesions observed must use precise and recognized terminology. This is particularly true when the authority to whom the file is to be submitted is “sceptical”.

When the ICRC reports allegations of ill-treatment to the authorities, it is vital that the victims’ account be accompanied by a precise and irrefutable description of the lesions noted by the ICRC doctor, a description that will stand up against any contrary medical report produced by the detaining authority. However, the ICRC’s description, though rigorously accurate, must not be esoteric, since it must be comprehensible to a non-medical reader.

A file may take one of a number of forms. It may report on several individual cases, the medical opinion taking the form of a clinical description of each case, with documentation of the lesions noted, the patient’s functional disabilities and their probable cause.

In some cases, the ICRC doctor analyses a series of cases without giving details of individual victims. This applies, for example, when he is documenting types of ill-treatment inflicted on a group of detainees.

The ICRC medical delegates, therefore, though not trained in medical law, must be conversant with the precise and specific terminology applied to torture. They alone, as doctors, are qualified to decide what is “compatible” or not with the detainees’ allegations.

It should not be assumed that the ICRC acts only in cases of torture where there are compatible physical lesions. Very often it takes action when there are no lesions to be seen, either because the torture has left no trace or because the period of time since it took place is long enough for all traces to have disappeared.

- *The ICRC doctor may have a beneficial influence on prisoners suffering from psychological disturbances*

The mental and emotional injuries resulting from torture are often

much worse than the visible lesions. Experts do not yet all agree on what in fact constitutes a “torture syndrome”.

With this type of victim too, the ICRC doctor has a role to play. Obviously, in most cases, torture victims will be suffering from both physical and psychological traumata. The two categories of symptoms are indissociable, and the distinction should in fact be dropped. Every type of “physical” torture has psychological repercussions; similarly, “psychological” torture has physical results on the victims.

A common denominator of all forms of torture appears to be the extreme stress and anxiety it arouses in the victims. A table of “psychological after-effects” has thus been compiled. On the other hand, the physical after-effects of various forms of physical torture differ greatly depending on their nature and intensity.

In the context of psychological after-effects of torture, the role of the ICRC doctor is clearly very difficult. Obviously, in the space of a single visit it is impossible to consider giving “treatment” as such. Nevertheless, by examining each victim separately, he will be able to give the advice most appropriate for that particular person and from time to time even to reassure the victim that his feelings in relation to his psychological sufferings are no more than a normal reaction to extreme psychological assault.

Some victims may be less troubled than others by such phenomena as a false sense of guilt, nightmares, difficulties in concentrating, loss of memory, emotional problems, loss of self-esteem and self-confidence: all these are merely normal reactions to extreme aggression, which is *not* normal. This is something only a doctor outside the system is able to tell them.

- ***If it is alleged that medical staff have taken part in torture, then the ICRC doctor himself must carry out an investigation.***

The participation of doctors in torture is very widespread in the world of today. Recent studies even claim that it is universal, since torturers require “medical advice” to carry out their work.

It is likewise true that persons in white coats sometimes take part in torture sessions, passing themselves off to the victims as doctors, occasionally playing the role of the “good man” in the well-known alternation of “good man” and “bad man”, used as a technique of psychological destabilization.

Whatever the facts of the matter, the part played by medical staff in torture must be substantiated by objective proof. The ICRC doctor must if possible establish the facts exactly and be satisfied that the

persons concerned are really doctors, by asking pertinent questions. Experience shows that it is relatively easy to discover whether someone in a white coat is indeed a doctor or an impostor.

Once the ICRC doctor has made a report on doctors taking part in torture, he may if appropriate refer the case to the local medical association. Conversely, when he is approached by doctors whom the detaining authorities wish to force to take part in torture, it is his duty to take steps to support and protect them.

(d) Physical examination of the patient in the event of torture

At times, circumstances dictate the ICRC doctor's working conditions. If he has to see 2,000 detainees in five days, it is obvious that he will not be able to examine each of them personally.

Yet he must do his utmost to assign priorities and give the time required to the severest cases, whether solely medical or related to torture.

If circumstances do allow thorough individual examinations, which is most often the case, the doctor proceeds methodically and meticulously.

It is desirable for him to have a diagram of the body, so that his documentation will be comprehensible to other readers. However, such a diagram is never a substitute for a description of lesions, using a precise vocabulary. The diagram is chiefly useful for noting and siting the lesions, which are then easy to find later. The way in which the doctor makes his examination is not important as long as it is logical. The following systematic approach is given as an example:

- classification of lesions by anatomical area (e.g., head and neck; face; thorax; shoulders; back (upper and lower); abdomen; legs (left and right, distinguishing the three levels of thigh, knee and lower leg); arms (*ditto*); hands; feet; sexual organs).

Under each area, the lesions noted must be classified in accordance with a number of criteria:

- age of lesions
- type of lesion (abrasion, cut, laceration, contusion, burn, etc.)
- additional lesions noted (e.g., atrophy, ankylosis, specific neurological defect, etc.)
- suspected internal lesions.

Finally, the medical report (which will not necessarily take the form of the final document subsequently submitted to the authorities) must make a statement on the compatibility of the lesions with the allegations made by the detainee.

The examination itself will be conducted according to circumstances, and each doctor proceeds according to his own customary methods. The one indispensable condition is not to forget anything, since in most cases it will not be possible to see the patient again for a long time.

The doctor should note which is the detainee's dominant hand, if possible without his knowledge, as it might prove useful information should the detainee be suspected of having inflicted the lesions himself.

When the ICRC doctor is making an expert report on lesions resulting from torture, he must not omit mention of all visible scars that the patient himself states are not due to torture. The inclusion of such statements enhances the authenticity of the final report.

It is useful, in our experience, to make a brief test of the mental faculties of all patients who are examined individually. This test should include at least the following features:

- orientation in time (date? day? year?)
- orientation in space (name of prison? which floor?)
- awareness of outside events (national news? family events?)
- simple mathematical calculations
- abstract reasoning.

This very limited mental test will enable the ICRC doctor to obtain an idea of his patient's mental state and, if necessary, check on it again during the next visit.

4. Conclusion

Summary: In the medical field, as elsewhere, the ICRC does not attempt to take the place of the detaining authority.

With regard to medical care, the ICRC doctor provides no treatment and cannot replace the doctor in the place of the detention. The work of the ICRC doctor is to make an overall evaluation of the situation, especially concerning diet and sanitation. He must analyse conditions in order to discover the reasons for any shortcomings. His

purpose is to co-operate with the local authorities to find specific and practicable solutions to the problems he has noted. With respect to ill-treatment, he must not only carry out a general survey of the phenomenon but must bring what solace he can to the victims he meets. This is done through personal contact, however brief, the "doctor-patient" relationship being a special occasion during which the doctor is able to provide information and advice and often to reassure the victim.

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