

Commentary by Dr. Önder Özkalıpcı*

I congratulate the author for bringing this topic regarding the ethical dilemmas faced by NGOs when a perpetrator of torture requests a clinical evaluation to prove claims of persecution or being victim of torture. Such dilemmas may arise in the case of NGOs whose primary mission is to provide supportive documentation for asylum claims by victims of torture, in accordance with the Istanbul Protocol.

Questions related to these dilemmas may emerge in the daily practice of any rehabilitation centre for survivors of torture (RCTs). I will proceed to discuss the paper from the perspective of RCTs.

Firstly, I propose my support for the panel's position towards not contributing to the refoulement of anyone to a country that is unable to guarantee a person's physical or psychological integrity, regardless of whether that person is a perpetrator of torture. However, the first and second dilemmas present important challenges.

The duty of a RCT or a rehabilitation unit in an NGO is to provide healthcare. This point is reiterated in the conclusion of the paper, "*the organizations stance must be therapeutic, not judgmental.*"

Confusion seems to arise however, in situations where the provider fulfils forensic or medico-legal reports (MLRs) alongside rehabilitation. Within the centres expertise and remit, the healthcare and psychosocial support should be provided to everyone, without discrimination. Additionally, if the centre provides healthcare, providing MLRs should be

considered as part of the inherent therapeutic process.

In the case of persons seeking emergency services, providers do not, and should not, be requesting the person's criminal records. Therefore, when a patient is requesting treatment and a MLR for the problems acquired as a result of experiencing torture, services should not be rejected based on the possibility of the patient also being a perpetrator of torture.

In response to the question "*should a pro-bono NGO do a forensic assessment of a highly probable perpetrator that alleges to have been tortured him/herself to claim for international protection?*" the answer is very clear. The organization's obligation is to follow the ethical declarations of the World Medical Association (2018a; 2018b). These declarations outline that health support and care for those in need, should be provided without any discrimination and without regard to any discriminating factors based on identity, affiliation, or political opinion.

Being a pro bono organization does not change the ethical responsibilities of a RCT and the health professionals working there. All medical professionals working in hospital emergency clinics, prison medical units, army medical corps or a pro bono RCT, are all bound by WMA Hippocratic oath and international code of medical ethics (WMA, 2018). The RCT should be concerned only by the health of the patient.

In situations of pro bono organisations having limited resources for providing client services, staff may question where the resources are being directed. In particular, they may ask "with these limited resources and capacity, why do we support/serve an alleged perpetrator?" The answer is multifaceted.

Firstly, the health support is to be provided, without discrimination or regard to

*) MD, PhD. World Psychiatric Association and Journal of Forensic and Legal Medicine. Correspondence to ozkalipci@gmail.com

their identity, affiliation or political opinion, or crime record. Secondly, there should be scope within the RCT to conduct patient triage, whereby their capacity and limitations are considered. Vulnerable groups such as children or single mothers, should be prioritised. Additionally, the RCT could implement standards for medical screening or triage algorithm for psychiatric screening (TAPS). Ultimately, within the organisations scope and as a healthcare provide, they must provide healthcare to all – including, in the current context, the torture survivor who is also perpetrator.

To know whether the medical report produced by the healthcare provider will be used for an asylum application or for international protection by the patient, is outside the RCTs scope. Furthermore, the dilemma of what to do when a person is both torture survivor and perpetrator, is one of a legal nature.

It is pertinent to reiterate that the RCT would not be contributing to human rights violations, if they were to provide healthcare to a torture survivors and perpetrator. On the contrary, the RCT would be defending medical ethics and supporting colleagues such as Dr. Kuni who works for the treatment of torture survivors in conflict zones and in countries where torture is systematic (WMA, 2017a).

At this point, the response to the “second order dilemma” is clear. The center must provide support to patients with PTSD who have allegedly experienced torture.

I agree with the author’s conclusions regarding the second group of dilemmas. It is unnecessary to conduct “investigations” in the home country of the client for the purpose of determining whether he or she is a perpetrator or criminal. One scenario that may require contact with the country of origin is in the case of an RCT conducting an MLR. The RCT may request from the patient, any additional supporting documentation to their claims of

torture. Further, where originality or authenticity of the medical documents needs confirming, the RCT may follow this up.

Granting asylum is a legal decision, and MLRs provided by RCTs help asylum authorities make that decision. A MLR supporting an allegation of being victim to torture reflects a parameter to vulnerability, thereby assisting the asylum authorities to make their decision (European Asylum Support Office, n.d.).

The role of the RCTs is to provide psychosocial support and healthcare and where necessary, provide a report on the existing medical and psychological situation of the patient. According to the Istanbul Protocol, the health professional should provide within their report, a conclusion on the consistency of torture allegations as well as physical and psychological findings.

In situations where a RCT has both legal and treatment programs, or in our case, a multidisciplinary team, the relation between the two should be clarified. The rehabilitation team of the client can liaise with the legal team, in addition to providing the medical report. However, the rehabilitation team should never share information that could harm their client. With regards to information-sharing between the rehabilitation and legal team, prior consent to do so should be gained from the client first.

Human rights defenders and legal branches of human rights organizations have mandate to locate and expose perpetrators, however, for RCTs it is not the main mandate. In some instances their MLR s or human rights violence data on some countries or regions can be shared with the legal team. Along similar argumentation, legal organisations and legal experts have the choice to defend a perpetrator or not, albeit, they too are bound by their professional ethical codes.

Providing healthcare and psychological support to a client does not protect them from

judicial process. Likewise, providing an MLR to a client of your centre does not protect them from judicial process. Each MLR of RCTs are not, and cannot be, accepted as a pass for immigration. It is the asylum authorities' responsibility to assess the content and scientific quality of the medical reports.

Furthermore, it is always advisable that when making appointments for patients, it be organised as such to ensure they do not encounter other persons from his or her country or region of origin. Subsidiary to this, such practice by the RCT will prevent instances or opportunities for alleged perpetrators of torture to misuse the rehabilitation premises and activities, as a way to gather information on patients. Our patients' business and activities outside of the RCT premise is not of our concern. Where a patient does misuse the premise in such manner, it gives due cause to terminate the rehabilitation support.

When a complainant of this conduct reports to the RCT, they can be reminded of the legal options available, such as intervention or support from a legal human rights organisations. Nevertheless, alleged perpetrator identity should be held strictly confidential, as well as all of the RCTs patients. In the dilemma of a perpetrator of torture, identified by a court decision, (not to mention the dubious court decisions made by national courts under dictatorships) who is also claiming to be a victim of torture, the RCT should proceed with providing medical support and on request, a MLR for asylum application.

The statement of WPA is clear "risk direct harm to third persons". It is very unlikely that the alleged perpetrator knows the code of a ticking bomb.

Health professionals are dealing with the health problems of human beings. Their interest should not be towards whether their client is criminal nor whether their client is

an alleged perpetrator or alleged member of a terrorist organization. For example, how can you judge health professionals working in places of detention? These professionals are obliged to provide healthcare to prisoners regardless of whether they are paedophiles, serial killers, rapists or terrorists. Does that mean they are accomplices of these crimes? Can you blame the medical team of Scheveningen Prison in the Hague which hosts war criminals of ICTY or ICC convictions? Such professionals are fulfilling their medical duty of providing medical support to these prisoners. Consider medical experts in war, they too should provide healthcare, even to an enemy soldier. It is health professionals' duty to provide healthcare and health professionals are protected by Geneva Conventions (WMA, 2016). "Whether civilian or combatant, the sick and wounded must receive promptly the care they need. No distinction shall be made between patients except those based upon clinical needs" (WMA, 2017b)

In response to your comment "*Inevitably, we are also concerned about the legal risks we may have to assume in protecting an alleged perpetrator, accused of potential human rights violations*" the answer to this is also clear. To reiterate, RCTs provide healthcare and we must concentrate on this mandate - providing healthcare can never be a crime.

Rejecting clients can only be acceptable in cases where the expert feels uncomfortable to treat the client of concern. Although, in such cases, the healthcare provider must provide another feasible option for treatment - "Give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care" (2018b) - provided that institution or clinic is qualified for the rehabilitation of torture survivors.

The RCTs and their health professionals should concentrate more on improving the

professional skills to differentiate false torture claims rather than the crime record of their clients.

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