The asylum request and the medical evidence

JANUS OOMEN

Asylum has become a paramount test for our cultural accessibility. Once upon a time the word itself defined finding refuge for the innocent victim, while at present, in our home-country, the discourse is prejudiced towards the disproof of the claim, the denial of the evidence and the procedural eviction, if needs be, by the criminalization of the applicants. As a reprieve, medical reports are common in appealing rejected asylum applications in all the European countries that receive high numbers of refugees. Physicians have the potential to support asylum requests when there is physical or psychological evidence of harm or torture that attests to a person’s necessity to resettle in a new country. The medical approach to assessing asylum cases 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). This protocol (1999) is a United Nations manual on the documentation of torture and all conduct that causes the need for asylum:

‘... In such cases [all doctors] have an ethical duty to take prompt action as failure to take an immediate stand makes protest at a later stage more difficult ... Doctors and professional associations should support colleagues who take such action on the basis of reasonable evidence.’

Certain physicians who participate in immigration and refugee procedures compose a community in support of individuals who are seeking asylum. While not all physicians work in teams or as a community literally, the collective moral obligation forms a new community – and an increase in the number of physicians who support asylum-seekers gives more power and form to this community. This paper draws from my experience in Amnesty International’s Medical Examination Group (MEG). The question posed here is: What are the potential roles medical practitioners play in asylum claims that have been rejected without appropriate medical evaluations?
Background

My interest in the role of medical evidence in asylum requests comes from my work as a physician and as a medical anthropologist. I am one among approximately one hundred medical colleagues who have cooperated with Amnesty International with respect to asylum-seekers since 1977. From 1994 onwards, I have volunteered medical services to those who seek asylum in the Netherlands. I primarily discuss the process of verifying torture in the narratives that refugees provide in their asylum applications to the immigration authorities, to Amnesty International (AI), and to medical examiners. In addition to the personal interviews with and examinations I have done on victims, I also witnessed public and private interactions among state employees, asylum authorities, judges, solicitors, immigration advocates, and scientists.

A demonstration of the role that medical evidence in asylum procedures has is timely and relevant as of this writing precisely because Dutch asylum law is undergoing revisions. Beginning July 1, 2010, the Dutch parliament has formalized a proposal to improve the asylum procedure by introducing a six-day preparatory period, in order to specifically allow a sufficient amount of time to perform a medical examination (Bosman, 2009, p. 601-612). The aim of this new law is not to confer on the asylum seeker an opportunity to declare the medical verification of their claim of torture. Medical examination (MediFirst and we will see later what is performed under that title) intends merely to check the fact that the asylum-seeker is in a suitable condition, mentally and physically, to be interviewed. This new legislation appears to admit the mistakes of the past and intends to support the position immigration advocates have long taken – that a medical assessment should be a required part of the asylum application procedure. I will reinforce this position that physicians play a crucial role in the verification of torture to validate asylum claims by reviewing the admissibility of medical examination and the role Amnesty International has played in supporting the use of medical reports.

Asylum context

Making claims for asylum in any European country is a complicated and lengthy process. In most European countries, reaching a final decision can take years of uncertainty, and chances for success are slim. The number of asylum cases that are completed following ‘proper procedure’, out of the
overall total requests, is on average as low as 5% (Hatton 2009, p. 187). Until the request is granted, asylum-seekers in the meantime have minimal legal rights and are unable to participate in society as productive workers and members of their new communities. Wilson and Drozdek (2004) described refugees as a traumatized population who are war and torture victims that confront numerous adversities, and are then subjected to stressful and degrading asylum trials, which leads to ‘broken spirits’.

According to the United Nations High Commissioner of Refugees (UNHCR, 2005), the political conditions surrounding asylum in Western countries affect a population of more than 20 million. The UNHCR graphs are impressive by virtue of the magnitude of the European refugee situation and the countries involved. I will not try to reproduce the stacks that represent the rise and fall of monthly calculations at international levels, because they cannot quantify the suffering and vulnerability of disjoined persons confronted by the rules of rejection. Refugees are driven out of their countries and flee their cultures because they are threatened: ‘Most observers would agree that wars and violence, political oppression and human rights abuses of various sorts lie at the root’ (Hatton, 2009, p. 197). The ‘push’ is victimization by physical and mental violence, torture and rape. The ‘pull’ factors are the expectations that European countries will offer protection. Asylum-seekers face the modern equivalent of the purgatory (Nazarova, 2002, p. 1339).

Asylum requests are most compelling when there has been an individual violation done to the person. An asylum claim is to be assessed purely with regards to ‘genuine narratives’ of suffering, but critics argue that ‘situational forces’, such as political and economic considerations, often skew decisions to decrease the number of requests in order to deter other potential asylum-seekers (Neumayer, 2005, p. 43). As a result we see that evidence of torture becomes even more important in deciding cases and focuses on the medical rights within Western countries. A medical professional plays a role in asylum in the singular instance that the asylum seeker requests an ‘Istanbul protocol’-examination. From a ‘forensic’ perspective, assessing asylum is not considered to be a part of any physician’s responsibility. Instead, asylum decisions are left to governmental entities.

Under Dutch law, as stipulated by the immigration and naturalization department (IND), all refugees who request asylum are first sent to a reception centre – an enclosed camp, outside which they are illegal – and then interrogated during two formal hearings, whereby on the basis of their verbal testimonies, a first decision is delivered on ‘genuinity’. Then, the genuine asylum seeker has only six days to present evidence attesting to his or her traumatisation and to future endangerment if forced to return to where
he or she is from. Within the funnel-shaped path, on average 55% of claims are rejected forthwith and applicants are expelled from the centre as ‘illegal immigrants’ to enforce their return to their home country or else face detention. The rate of removing the rejected in the Netherlands is high compared to other countries in the European Union. (Amnesty International, 2008, p. 11). After the first round of rejections, the remainder of claimants – 45% of the initial cohort – faces a trajectory of several years of re-assessments and appeals, during which each refugee attempts to produce a narrative that will convince immigration authorities of their need for protection. The ambivalence on the offer of asylum is amplified by a plethora of advocacies and stubborn supportive institutions, principled solicitors appealing each step until the highest court of state. A twenty to forty thousand backlog of unsolved cases forces the government to arrange for a ‘general pardon’ approximately every ten years. In between we read almost daily stories in the newspapers exhorting the immigration ministry to revoke negative decisions on harrowing cases. In that concept of asylum, torture narratives are in principle meant to be unsuccessful since the refugees’ stories are deniable and the scars are unrecognized or forensically unverifiable (Amnesty International, 1990).

The impact of medical reports on asylum cases

From an ethical point of view, the immediacy and finality of asylum decisions is further aggravated by the fact that the rejected claimant is offered no opportunity to ask for, and is not provided with, medical or psychological support. Prior to the 2010 legislation, the Dutch immigration authority (Vreemdelingen circulaire, 2000: C14/4.4.2, Bosman, 2009) has stipulated that: ‘On the basis of medical examination no firm pronouncements can be made as to the cause of complaints or scars.’ In other words, the immigration authorities have disregarded medical professional opinions on asylum claims in the Netherlands as an unauthorized intervention. I refer to this above statement as the ‘inadmissibility-provision’ and regard it as one of the ‘situational forces’ that restricts granting asylum.

The main focus of international and local immigration advocates has been on the lack of medical evidentiary support, and this campaign is 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 giving the evidence in the ways that are expected by the IND is difficult to meet, and torturers intentionally hide, eliminate, or deny any evidence of their actions against their victims. Forensic examiners have no access to the places where the offenses occurred and the people responsible for it and it is exactly the purpose of recognizing and interpreting delayed effects of torture for which the Istanbul protocol came into existence. Complaints, post-traumatic signs and scars due to torture are legally considered only if presented in medico-legal reports – making it crucial to include medical examinations. Wilson and Drozdek (2004, p. 46) estimate that 10 to 30% of asylum-seekers have been tortured. As posited, torture as a pathological agent is difficult to verify, quantify or qualify. For this reason, the handling of the narrative given by asylum-seekers is an important part of the asylum procedure.

To quote Farmer (1997, p. 261) in his observations on suffering and structural violence: ‘The texture of dire affliction is in the gritty details of biography.’ The ability to conduct interviews with victims is a necessity for medical investigators to ultimately produce an evidentiary approximation of torture scars.

As a consequence of the inadmissibility-provision, victims of torture have been frequently denied asylum in the Netherlands. Amnesty International (AI) has advocated for medical examinations in asylum procedures, 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 1970’s, AI aimed to demonstrate to the immigration authorities that they were wrong in disregarding medical expertise for the purpose of asylum verification, but in the end AI was unsuccessful. Of necessity, the Medical Examination Group during the past 30 years specialized in counteracting the inadmissibility-provision in cooperation with the asylum solicitors of the victims involved. As a result, AI 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 inadequate medical examinations. Traumatic events in the narratives of asylum-seekers were taken into account by the medical staff that routinely attended to the camp populations, but these records were not communi-
cated to the immigration officials that were deciding the claims. If torture had occurred, but the verbal testimony was unconvincing to the state official, the only way to prevent ‘refoulement’ (claim rejection and expulsion to the country of origin) is for the immigration solicitor to appeal to AI. In the majority of cases where the MEG has supported the claimant, the rejection has been shown to be unjustified, confirmed in court and the IND has changed decisions into some kind of asylum.

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

The above figures are the most recent evaluation for the period 2004-2008, on the impact during appeals over the same period, showing what little room there is for an advocacy to negotiate (Stolwijk, 2010).

The table informs on the complexities of the medical intervention. Due to the protracted procedure and constant changes in recognition policy, in many cases the result of medical support cannot be measured against any standard (Bruin et al., 2006). Still, we can conclude from the above evaluation that in approximately 75% or more, medical interventions of the type offered by the MEG help end the traumatic and protracted period of attempting to qualify for asylum.

**Argument in favour of medical intervention**

The following thought is offered by Wilson and Drozdek 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’ (2004, p. 672). Because asylum-seekers are non-citizens, the attending physicians play no role in asylum procedures; their sole function is to attend to the medical issues presented to them by patients without the tag of asylum-seeking. A Dutch minister for immigration articulated this position in the
following way: ‘[T]he 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’ (Wilson and Drozdek, 2004, p. 672). At
that level of administrative overrule, clinicians encounter a system within
which they have no currency and little power. The role of doctor and clinici-
anal advocate is altered by crossing over into the jurisdiction of immigration
law. Unfortunately, in particular for the asylum-seekers, the Dutch medical
professional accepts to be excluded ‘as a rule’.

Medical professionals, however, have the potential to greatly impact the
process at all stages. In the first stage, immediately after admitting asylum-
seekers to the procedure, a medical and psychological screening of the physi-
cal and mental condition of the person can determine if the asylum seeker
can speak, or if he or she is unable to present a coherent narrative to the
immigration authorities, or when ‘silences are becoming loud’ (Tankink,
2009). A second supportive step is that of an expert verification by a compe-
tent medical professional of torture claims. An examination of injuries at the
earliest opportunity will be more useful if a forensic approach in verification
is attempted, even if the site and perpetrators of the crime are inaccessible.

Another reason to conduct a medical examination immediately is to
place the focus of the trial from the beginning on the fact that the refugee
was tortured. Medical examinations are also important in the event that
during the hearing, the asylum seeker reports mistreatment in the country
of origin, the consequences of these allegations can be a part of the medi-
cal workup. In addition to the diagnostic and judicial consequences, the
medical observations can lead to necessary referrals and further necessary
treatment as in any other regular clinical interaction. Later on, if a nega-
tive decision is rendered, the appeal should include access to medical-legal-
psychological expertise as the normal course of action, common in all other
Dutch judicial procedures.

Medical support is required during all stages of the asylum procedure
for torture victims. Clinicians can help torture victims feel safe and vali-
dated; facilitate improved mental and physical health; assist them in over-
coming grief and mourning; and connect them with feelings of normalcy
again: keeping them inside humanity (Pederson, 2009, p. 33). At heart,
what else is asylum about? Clinicians can assist in recognizing the problem
and help resolve it with empathy. In order to do so, physicians must receive
training to know how to adequately care for the victims of torture. The
perceived irrationality of torture often explains the ineptitude victims face
in expressing and observing traumatisation during asylum interrogations.
The meaning of torture is to exercise power at its worst and to have a para-
lyzing effect on victims, making it difficult for them to articulate why and how they were tortured, and who tortured them (Oomen, 2007). Torture narratives often contain contradictions or inconsistencies. Victims attempt to silence, forget and deny the abuse done to them, as a way of coping with trauma: ‘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 identification of explicit mental and physical scars under these kinds of interactions – where victims do not want to speak about the violence – is challenging, as I have experienced during many interviews, and in my attempts to incorporate photography in medical examinations (Park & Oomen, 2010). The full story is rarely heard and understood by the immigration authorities. One compelling reason is their own pledge to stay as far away as possible from the torture scene and the circumstances that led to their torture, because they have been able to escape – an achievement made possible through bribery and conspiracy between the victimized, the bystanders, the assisting and the persecuting parties. All those who helped and invested to enable a victim to escape and all that coping effort will be exposed and destroyed if and when the victims return home.

Although this paper has stated the need for medical support in verification during asylum procedures, I also recognize the limitations of physicians’ capabilities in assisting refugees. The medical problems asylum-seekers face are personal, communal and cultural. There are multiple separations and unrequited needs for parental or family support and care. Refugees also face distressing familial conflicts and the psychiatric burden of long-lasting uncertainty in acquiring residency in a new country. Asylum-seekers must start a new life with minimal facilities. Along the way, even genuine refugees experience petty or physical violence in reception centres, limitations on education, restricted movement, social marginalization and discrimination (Amnesty International, 2008). In this context, refugees’ difficulties with the asylum procedure do not end with medical certification. Still, one task is to first ensure a fair legal process for refugees seeking asylum. I have mentioned in this paper that legislative changes to Dutch law will allow medical evidence as an opportunity for clinicians to positively impact the asylum procedure. Because of the multiple challenges refugees face, and the fact that evidence of torture creates a strong argument in favour of granting asylum, the task of examining refugees and producing medical-legal reports is even more important for immigration advocates, asylum-seekers and empathic physicians. These reports are a conscious response to the political opposition to granting asylum and the low number of acceptance of asylum claims. As
Fassin and d’Halluin (2005, p. 598) argue, it is in the attitude of concealment favourable 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. Without medical support, the process of alienation becomes ever more sharp and pointed.

The ‘MediFirst’ check provision in the new law – that is access to a nurse and/or physician employed by the IND to guarantee the person’s suitability for a decisive hearing on his asylum request – suddenly provides a new insight in the labyrinth of concealment. If torture cannot be brought forward by the asylum-seeker, then ... at a later date, during appeals on the negative decision, the claim cannot be expressed anew: the decisive first hearing has been performed after medical certification, and another loophole is closed. The zigzag of procedural inadmissibility continues. Until immigration law is reformed for real, these medical certificates are the tool which physicians, as a community, must use to intervene on behalf of their patients. Without a community of committed physicians to perform medical examinations and write reports, however, the new legislation will have no impact – and it will be as if the law had never changed.

Acknowledgement
The author acknowledges with gratitude the help Rebekah Park has given in rewriting the paper. Marian Tankink and Paul Dallinga have shown me the new ways within the labyrinth. My interpretations do not represent Amnesty International in the Netherlands and any errors contained here are the author’s alone.

Note
Draft of this paper was presented by me in workshop 81, chaired by Annemiek Richters, during the 11th European Association of Social Anthropologists Biennial Conference: ‘Crisis and Imagination’ at Maynooth, Ireland, 26th August 2010.

References
Amnesty International, the Netherlands
1990 Het nadeel van de twijfel. Amsterdam.
Amnesty International, the Netherlands
Bosman, M.L.
Bruin, R., Reneman, M. & Bloemen, E. (Eds.).

Fassin, D. & d’Halluin, E.

Grütters, C.

Hatton, T.J.

Farmer, P.

Nazarova, I.

Neumayer, E.

Oomen, J.

Park, R. & Oomen, J.
2010 Context, evidence and attitude: The case for photography in medical examinations of asylum seekers in the Netherlands. Social Science & Medicine, 71(2), 228-235.

Pederson, C.E.
2009 Torture: Man’s inhumanities. Yankton: Erickson.

Stolwijk, M.

Tankink, M.

UNHCR

Vreemdelingenwet
2000 Kamerstukken 11 2008/09, 31 994, nr. 3.

Wilson, J.P. & Drozdek, B.