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Asylum requests by victims of torture who have fled to the Netherlands are often rejected. In these cases, the torture stories of the asylum seekers have failed to convince officials judging their asylum request. The author studied the cases of asylum seekers whose claims were first rejected, but then supported by Amnesty International, and eventually, after a court appeal, received residency. The author, therefore, concludes that the initial rejections are the result of the manner in which these asylum seekers were interrogated by civil servants of the immigration authority. These civil servants appear not to want to hear the details of torture, and their attitude colludes with a tendency in the asylum seekers to avoid discussing painful experiences.

Keywords: torture, narratives, asylum, Amnesty International, medical examination, Istanbul protocol

Introduction: the story is all

In this paper, the author reflects on his experience as one of the physicians in a medical examination group (M.E.G.) of Amnesty International (A.I.) in the Netherlands. The M.E.G. provides documents for asylum seekers, whose claim was rejected after a 'definite' hearing by the immigration authority. The aim is to show that the evidence of torture, in asylum procedures, depends on the manner of interrogation.

The torture site and circumstances are far removed from asylum hearing. The flight from executioners cannot be combined with delays to obtain the documents required by the asylum authority. To provide forensic proof of having been tortured is an extra burden. The story is all the torture victims have to support their request for asylum. '*Verification*', '*speaking out*' and '*hearing out*', during official interrogation, are crucial to the process of transforming trauma into asylum.

The medical examinations by Amnesty International in the Netherlands

A 40-year old refugee alleges that (s) he has been detained and tortured in the country of origin. Six months later, (s) he applies for asylum in the Netherlands. The Dutch Immigration and Naturalization Department (I.N.D.), who have decided that statements are unreliable, deny the request. The solicitor appeals to a State Court and requests, through A.I., a medical examination to be conducted. A dossier is created by Amnesty refugee experts, collecting queries on the I.N.D. decision and presenting, in support of the refugee's allegation of torture, a medical document by a physician (M.E.G.). The appeal succeeds in court and the I.N.D. revises the negative decision.

The above example describes a common occurrence in the Dutch asylum procedure since the mid 1970s. In actual practice, the process described here takes 2 to 15 years. Since the 1970s, A.I. trains and operates a medical group of approximately 40 Dutch physicians, volunteering to study dossiers and clients (numbering in the thousands; in recent years up to 100 annually) because torture was not taken into account in the negative decisions taken by the I.N.D.

Why was the asylum narrative not believed during the first hearing? Why was no medical expertise requested by the I.N.D.? In a formal asylum procedure, the allegation of torture should be met from a medical point of view, and by instructions that stipulate that medical evidence be sought. This should occur on demand, followed by an examination by an experienced physician who can independently document findings pertinent to human rights. In that perspective, the medical findings would then be part and parcel of the government decision on the asylum request.

Without doubt, if tortured, the claimant has a genuine reason for asylum and has to be accepted as a refugee. By definition, the country of origin is either the perpetrator or unable to vouchsafe against torture. States, of which the Netherlands is one, are bound by Covenants to offer a non-refoulment guarantee: no one is extradited to a place where the torture took place or can occur again. There is also no doubt what torture is (Istanbul protocol, 2001). What is missing in the current standards of human rights is the right to a proper procedure of verification: on this issue *human rights acts are rights which do not act.*

In the Dutch setting, since the 1970s, I.N.D. law officials expect that the asylum seeker will produce evidence of having been tortured *'at the earliest opportunity'*. The narrative has to be presented in one decisive hearing, within 48 hours of the entry date of the asylum request. At this point, the Dutch asylum instruction (Dutch Aliens Act, 2002) sharply diverges from the above stated medical view because: 'on the basis of medical examination, *no firm pronouncements* can be made as to the cause of complaints or scars'. So instructed, the official, hearing the asylum request, is interdicted to rely on medical expertise for just that purpose. In actual practice, even in case of the affiliated asylum medical services having details of the torture, the asylum official takes no heed of the medical source as a means of verification. Extraordinary as it may appear, in view of (inter)national expectations, where on indication and demand, medical expertise pro/contra allegations is a self-evident feature, the *'firm pronouncements cannot be made'* clause is the crux of the Dutch Aliens Act. In assessing trauma, the asylum decision relies solely on the individual, personal observation of the hearing official only.

As a compromise to criticism, the I.N.D. in 2001 qualified trauma as a strictly defined category (occurrence within 6 months before leaving the country of origin, and, consisting of violent death of close relatives, and/or substantial detention without penal cause, and/or been subjected to, or witnessed torture or rape). How verification of the allegation is to be done remains undefined. The instruction that medical evidence is beyond the scope of the official hearing stands as before. For emphasis: the I.N.D. has its own group of physicians (Bureau of Medical Advisors), of which the members are banned from offering expertise in the asylum request. These are the conditions that shape the A.I./M.E.G. interventions.

Results of intervention

The strategic part of this report is to answer solicitor's questions and offer expertise on the actual complaints and signs of torture. Vervaat (2000) and Oomen (2004) analysed both a random sample of the M.E.G. population and the role of one examiner, respectively. A majority of victims show scars consistent with their narratives. The history of torture and the presence of scars had been communicated during the official I.N.D. hearing, with few exceptions. Of equal importance is the fact that a majority of clients are still mentally traumatized – in the M.E.G. examination – to the extent that, according to Dutch standards, psychiatric treatment is indicated. With few

exceptions, the torture in the narrative meets the requirements of human rights conventions, assessing the alleged torture as the main cause of distress. The exceptions have in common cultural factors, which, combining with mental or physical dysfunction, prevented the victim from fully disclosing the trauma during the I.N.D. hearing. Such exceptions are illustrated by the following case histories.

A 30-year-old female had been abducted, raped and beaten by two perpetrators unknown to her in her country of origin. She was unable to admit the details to her relatives due to overwhelming feelings of guilt and shame. Therefore, she made up a story of harassment by state officials. Her family helped her to escape to her husband, who had at the time obtained asylum in the Netherlands. During the first hearing, she kept the rape secret, fearing that her husband, now her only support, would disown her. After the negative decision, she discussed the rape with her Refugee Council contact and was advised to disclose the traumatic details in a second procedure. Unfortunately, as a result of the well-intended interference, her husband became aware of the rape and did in fact disown her.

In the asylum appeal, the court ruled that she should have disclosed the actual trauma and, having failed to do so, the decision remained negative. The solicitor put the problem to A.I. to obtain a statement that the client had been mentally unable to disclose the specifics of what necessitated her asylum request at the first opportunity. The M.E.G. complied for humanitarian reasons, notwithstanding the fact that the trauma did not qualify as a state-condoned mistreatment according to (inter)national asylum law.

In another case a married couple was involved: the husband had been tortured and had gone into hiding. The police persecuted the wife to find out where her husband was hidden. While in advanced pregnancy of her fourth child, she was assaulted and lost consciousness. She was admitted to hospital where a dead premature child was removed by caesarean section. In her asylum hearing, afraid of the consequences if her husband learned the facts, she disclosed less than the full story and received a negative decision, due to contradictions in her narrative. In the medical examination, however, she cooperated fully and in the due process of appeal she received a positive decision. However, once the story became known, her husband left her and his three children.

In many instances, combined cultural–physical–individual mental incapacities, caused by the traumatic events, considerably restrained the potential of a medical examination's ability to fit the narrative to the solicitor's queries. Triangulation with previous information by attending physicians, relatives, contacts (such as the solicitor and the Refugee Council), proved indispensable. In comparable cases, the time lapse between first hearing and medical examination had the advantage that acculturation and the course of illness contributed to clarify the cause of traumatization. The outcomes of the M.E.G. medical observations over several decades are quantifiable. Quantification shows relevant factors to be (1) the year of asylum request, age and gender; (2) country of origin; (3) type of allegations; (4) time lapse since the trauma; (5) physician findings (scars, handicaps) in relation to the allegations; and (6) the medical diagnosis. Averages should be interpreted with caution for a number of reasons, as the author discovered during his own examinations of 50 clients during 1994–2006. Important features to define the population are: 73% had put all procedures possible behind them at the time of the M.E.G. examination. From this group, 60% are known to have received the asylum status originally withheld from them in the follow up to the M.E.G. examination. Also from this group, 28% were still awaiting new procedures, while 6% were postponing appeal due to a florid psychiatric disorder, and another 6% had irrevocable negative decisions. The time lapse, between the trauma

and asylum, averaged 46 months in the M.E.G. follow up evaluation. Between asylum request and medical examination, this time lapse averaged 24 months.

These figures demonstrate how significant the delays are part of procedural process of waiting for asylum. The interval between trauma and medical documentation can extend to more than 15 years.

On the issue of probability that confirmation of the medical queries contribute to asylum in appeal: the evidence at a random point of observation is, that negative decisions are not reverted in less than 10%. In straightforward terms, I posit that 90% had been refused asylum wrongly and a medical examination, at the 'definite' hearing, would have contributed to the proper decision. In addition, no one in this population had been extradited, which as a 'collateral' consequence, contributed to an outcome justified by the course of events. However, the exact efficacy of the medical contribution remains hard to deduce, both due to the delays and also to the impossibility of connecting essentials of the trauma, findings of medical examination and the final outcome in the asylum process. The difficulty of obtaining an insight into the interaction between the medical examination and the consequences of asylum procedures is very much a part of the burden of giving evidence.

Who are these victims of torture?

More often than not, the clients were unarmed civilians caught in a local conflict, as bystanders and not as active participants. This was even more applicable with female and young examinees. They often had suffered protracted harassment by discrimination, arrest and detention. The loss of significant others was one recurring reason, either by violent or by natural causes, for leaving their country. These clients often had to pay bribes in order to leave their country of origin.

In many cases, the refugee was preoccupied with the care for a relative, who had preceded or followed them into asylum, and had obtained a refugee status independently, while the client was still awaiting appeals.

The trauma narrated by victims is a sequence of events, including extra judicial arrest, detention and severe physical abuse.

The clients were arrested without formal charge, solicitor or publicity. Relatives were not notified, but were informed through guards, parleying between the detained and the family. The arrest often took place with a team of persons, in the home environment; the arresting 'officials' were armed, and bystanders threatened, and sometimes killed. Persecutors did not identify themselves, but were described by the victims as belonging to the government of the country of origin.

The most severe physical abuse occurred in the early part of detention. When asked during the asylum procedure for the possible reasons why they had been chosen to be subjected to torture, the victims had difficulty in answering. They had contradictory comments such as: '*it was an unfortunate accident of the kind that happened to a lot of people at that time and setting*'. Mostly the clients emphasized that they had nothing to reveal or to let out, as a main cause of mental abuse.

For a majority of victims, a vital part of humiliation was of a sexual abusive nature, and this part is usually the hardest for examiners to force the client to speak about. The victims, both men and women, who are able to state that they had been raped, make clear that the sexual acts performed by their torturers were a gesture of ultimate contempt. Several victims referred to the physical torture as something from which they could recover, but to the sexually abusive experiences as being without repair, and for which they had no words.

Interactions with the I.N.D. The availability of documents is a major concern of the I.N.D., and with one exception, none of my clients had the documents expected from them. Most had never possessed any formal identification papers. In other instances the authority in the country of origin took what they did have during detention. As a rule, medical records or documentary proof of arrests or sentences were also unavailable. The exact date of birth, marriage and other 'Western' administrative milestones are unavailable in the cultures and countries of origin the clients fled from. This is a fact well known of course, but systematically kept out of sight in the asylum bureaucracy. A minority of clients admitted to obtaining false identification papers as part of the deal with the agents who organised travel, which had then been destroyed or retaken by these agents. In several instances, clients offered evidence of their identity later, for example by the help of relatives staying in the Netherlands. This form of verification was often not accepted by the I.N.D. in revision of negative decisions, because information should have been given at the one and only *'first opportunity'*.

The I.N.D. often ignores medical information that is both obvious and available.

A man appeared aged beyond his 45 years due to diabetes and post traumatic brain lesions. His relatives stated that the head trauma had occurred in detention. At the time of his definite hearing he was clearly unfit to be interrogated, due to partial amnesia. Yet, he was interrogated by the I.N.D., with an interpreter. The transcript of his hearing is clearly that of a confused person. The interpreter repeatedly declared that he was unable to translate what had been said. Neither the report of the definite hearing, nor the negative decision mentioned these limitations. The I.N.D. document states: 'I often feel ill and should be taking medicine, but forget to do so. When I try to go out, I get lost and people have to take me back, holding my hand. If I leave this room, I know I will forget everything that has been said here.' However, the I.N.D. official ignored the amnesia due to the trauma disorder. In the negative decision no attention is paid to the effect of a medical condition during the hearing. The attending physicians did not intervene, neither during the hearing, nor following the negative decision.

This case was appealed and the negative decision reversed.

In another case, a young male stated during the I.N.D. hearing that he was in pain, due to an inflamed knee, and that he could not talk about what had happened in this condition. The treatment of his knee had been delayed because the attending surgeon did not want to perform a difficult operation on a patient without the prospect of obtaining asylum.

This case was also appealed and the client obtained asylum – after 15 years.

In a minority of cases, the client's conscious denial is a severe setback during both the *'decisive'* interrogation (I.N.D.) and the *'final'* appeal that includes the medical examination (Amnesty). For better or worse, sometimes clients decide that the only way to be able to enjoy life is *'not to think about it'*. This mind frame makes them unwilling to attend psychiatric treatment, even when in crisis their impulsivity and auto-aggression betrays severe inner turmoil. In the setting of the Amnesty examination they have to make a visible and painful effort to assist the medical examiner *'to get at the facts and events'*, from which, in their own minds, they are trying to escape. Of course, being enabled to do so is significant, both to the client, but also to the medical examiner and the evidence required. What does this mean in terms of the client's fate? In my retrospective study of the I.N.D. hearings, in comparison to later events, the client is allowed to state how the arrest and mistreatment took place, but no further questions are asked. No help is offered to relate a complete and detailed story. Clearly, for the

victims of torture, this lack of interest does not support or enable them to express the full story, in particular if the victim considers the information of a very private and sensitive nature. This is almost always the case after rape. In the I.N.D. verdicts, studied by the author personally, not once were particulars of torture independently verified by the I.N.D., through triangulation, or by any other means, and neither are the signs of torture observed by the hearing official, or argued in decisions. As a result, the author believes that the asylum hearing can be constructed as an attempt to deny the torture, as offered by the victim's narrative, has occurred. The trauma is transformed into *'a matter out of place in a proper hearing procedure'* and the burden of evidence is fully and squarely put onto the asylum seeker. The asylum hearing approach, which has been described as a common feature in the clients the author has examined, is founded on the prejudice that asylum seekers are economic intruders and adventurers of fortune, and therefore, the assessment of their trauma is an unjustified medicalisation of improbable allegations.

Discussion and conclusion

As both case examples and quantified/qualified results show, the verifiable account of trauma is made for the first time many months after the asylum hearing. This occurs during the A.I. medical examination, which follows a negative decision. This happens only by virtue of the fact that the solicitor is appealing to a state court and, in due process, wants to attach an independent medical examination. In Dutch law, the court cannot reverse I.N.D. decisions. It can only judge, on the basis of 'new' documents, including the medical report, that the I.N.D. did not follow their own instructions and did not investigate the medical aspect. If, after such a ruling, asylum claims are finally accepted by the I.N.D., the reasons behind the reversal of a negative decision remain undisclosed.

Disbelief is the key to the asylum procedure in the Netherlands. In respect to the verification of his or her allegations of being traumatized, the asylum seeker has to convince the authorities. Although the international community offers unequivocal support to medical expertise in the assessment of torture, the Dutch authorities want to avoid all interference by medical expertise. The disavowal of an independent medical examiner is institutionalized by the instruction that *no firm pronouncements can be made* on the basis of expertise as to the cause of post traumatic complaints and/or scars.

The extreme prejudice that neither scars, nor post traumatic stress disorder can *'tell'* about causality, has to be qualified as a denial. This denial, a part of official policy, creates a situation where it is only during the belated medical examination that an individual narrative of torture is voiced, and made significant in the claim for asylum.

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