

# Doctors in prison: documenting torture in detention

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## Introduction

The documentation of torture inside a prison raises a certain number of issues specific to the fact that those people interviewed are still in custody. Quite obviously, there will be pitfalls to avoid, and safeguards to ensure, that will not be present when documenting torture within the relative safety and calm of a centre for torture survivors. In a prison, the prisoners who have suffered ill-treatment and torture, are at least potentially still at risk in the sense that they are still in the custody of the authorities responsible for their suffering torture. They are not yet “torture survivors”, but indeed still “torture victims”, however much we may want to get away from the stigma of this term. This essential fact, the prisoners not yet being “home free”, as they may well be in a torture rehabilitation centre abroad or at least out of reach of the potential torturers, will condition the way doctors document ill-treatment and torture inside prisons and other places of custody.

When prisoners are seen outside prison, in a rehabilitation centre or similar situation for example, the documentation of torture will be a completely different story. Such centres will hopefully offer ideal conditions for medically examining torture survivors and documenting torture. These centres have trained medical staff, with the necessary medical and psychological skills and knowledge who can provide therapy. Most important, there may be few, if any, time limitations for interviews, and repetition of interviews according to need and desire will be the rule, not the exception. The doctor-patient relationship in a therapeutic centre will obviously be completely different from that between a prisoner in custody and, on the one hand, the local “prison doctor”, or, on the other hand, a visiting outside doctor.

## Doctors in prison: which doctors are we talking about?

The first point which must be addressed is exactly which type of doctor one is talking about in this paper, regarding the documentation of torture. A doctor in a prison can be the one who is part of the custodial system, paid by the authorities and thus seen by the prisoner as being “on the other side of the bars” by the prisoners. Such a doctor is perceived very differently, and is indeed in a totally different situation, from

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a doctor coming to the prison from the outside world, quite possibly even from an outside country.

As shall be discussed in more detail further on, the “prison system doctor” is in a situation of dual loyalties in the best of cases. As doctor of a prison system, s/he works within a system that demands loyalty and submission to certain constraints, while at the same time, s/he works with prisoners who are patients, and to whom the doctor owes loyalty as a physician within the “doctor-patient relationship”. The submission to constraints may be benign – concerning only obvious factors linked to security and to the fact that quite obviously prisoners lose many privileges and rights by the very fact that they are in custody.

However, as the issue is that of “documenting torture”, there may be very more complex and even dangerous situations to be considered. If torture exists in a given country (justifying the need for documentation in the first place), this means there is a system in place, or at least condoned, by a higher authority. The prison doctor, in the worst of cases, may be part and parcel of that coercive system, thus ending any discussion of documentation by the doctor. In a better case, torture may exist, but the prison system be outside of it, as is often the case when torture is practiced by the armed forces or security police, and not at all inside the prisons.

In the latter case, a prison doctor may well see the need to document the sequelae of torture, and thus may decide to take the risk of doing so. It should be obvious that such a doctor will nevertheless be putting him or herself at risk, as there may be very few mechanisms available to offer him or her any protection.

The other case is very different, that of a doctor coming in from the outside to docu-

ment torture inside prisons. The very fact that an outside medical expert is allowed into a prison already in a way guarantees the outside doctor’s physical “safety”. Otherwise it would be more simple just to refuse entry into the prison. This relative safety will allow the outside doctor to work, but s/he needs to be very specific about *how* the documentation will be done, so as not to put the prisoners interviewed in danger.

Thus, one has two completely different situations of doctors documenting torture. Paradoxically, what is often perceived as the most difficult part of documentation, i.e. objectively assessing signs and symptoms, is in fact the common ground that these two types of doctors have. Both can study and use the information given in the body of the “Istanbul Protocol” once they have decided to go ahead to interview and examine prisoners.

### **The prison doctor**

Doctors working inside prisons confronted with the issue of torture can be in two very different scenarios. In the first case, the detainees or prisoners (the difference depends on whether they have been sentenced or not) have been tortured *before* arrival in the prison. This means torture has occurred either upon their arrest, or during the interrogation procedures, or in a different place of custody, very often a “secret one”. In the first case scenario, torture does not occur in the prison where the doctor actually works as a doctor. The second scenario will be the case where torture actually occurs inside the prison where the doctor is working as a prison doctor. This second scenario will of course put the doctor in a much more complicated situation.

Prison doctors will often not have the trust of the prisoners in their care, all the more so if the prisoners have been tortured

by the very authorities the prison system represents. Such prisoners will more often than not see the prison doctor as part of the coercive system. This will be all the more so if other doctors have actually been present or participated in coercive torture sessions. The fact that doctors may have participated in the system of repression will result in prison doctors being assimilated into the general repressive regime. In other contexts, where torture is exclusively practiced by a non-custodial body such as the police, prisoners may acknowledge that once they are in a prison the prison staff, including doctors, is not involved in harassing them nor continuing the repression. In such cases, the prison doctors may be seen with at least some degree of sympathy, and prisoners may put some trust in them.

Documenting torture is a very difficult matter with prisoners still in custody. They are still vulnerable, and often extremely so.

For a prison doctor the most important factor in documenting torture will be obtaining the trust of the prisoners, without which any objective documentation will be impossible. However, even if good communication is somehow achieved between prisoners who have been tortured and a prison doctor with integrity who wants to document torture, there are other problems to consider.

The main purpose of seeking documentation of torture would surely be to draw up a file of information to be submitted to some higher authority, in the endeavor of putting a stop to the taking place of torture. This very fact, obtaining data and putting it down on paper or otherwise, will already introduce several risk factors which any doctor must assess before actually going ahead with documentation.

Documentation of torture in a country where torture takes place may well put both documenter and documentees at risk. There

may be a risk for the doctor who is seen as collecting information which might be used to incriminate perpetrators of torture or their superiors who have authorized its use. A prison doctor must consequently be very aware of the possible risk s/he may be taking. Even more important, the risk to the prisoners, whose trust s/he must obtain, and who will provide information on torture, needs also to be assessed.

Documenting torture should never become an absolute objective in itself. The principle to constantly keep in mind is "primum non nocere", one of the four main principles of medical ethics, i.e. that of non-maleficence. Even in the general interest of combating torture, apart from protecting themselves, doctors have to be absolutely sure that there will be no reprisals on those persons whom they speak to and who will have give not only their testimonies, but also their trust, within the medical consultation. Unless the prison doctor is certain s/he can guarantee the safety of any prisoner interviewed, documentation should not be pursued.

When documenting torture in such a situation, there will be pitfalls to be avoided. These concern the working methodology and actual documentation procedures.

One major issue that may seem obvious to medical staff working in rehabilitation centre for victims of torture, but may not be self-evident to run-of-the-mill prison doctors, is that prisoners who have been tortured should never be *forced to* "relive" their torture experience by having to tell their stories to interviewers, i.e. forced to undergo "retraumatization" during the documentation of torture. Well-meaning prison doctors, having been trained in the signs and symptoms of torture, may be all too eager to "get documentation" ... The risk of opening a prisoner's "Pandora's Box" of retraumatiza-

tion is very real. What is meant by the term Pandora's box, is a whole "collection" of thoughts and memories, many terrible, and all traumatic, involving the personal torture history of each prisoner. These recollections can be varied according to contexts and situations, and of course individual vulnerabilities. A prisoner may finally have achieved "locking up" such memories, flashbacks, nightmares, and other traumatic experiences, so to say in a "box" which is still ever-present, but closed. As in the legend of Pandora, the opening of that box will release demons and devils, and all the coping mechanisms the prisoner may have painfully put together are rent asunder by the well-meaning good intentions of the person eager to get documentation ...

#### **Establishing trust between the prison doctor and the prisoner**

This key issue of trust will be a crucial issue in most contexts. Prison doctors almost always work for a prison administration, under the responsibility of the Interior or Justice Ministries. It is very rare to have the prison medical service entirely independent from the prison administration. This is the case in a mere handful of countries, mainly in Europe, where the prison doctors work for the Ministry of Health, and are "on loan", so to say, to the prisons.

This situation, as has been mentioned, means that prisoners see the prison doctor as "part of the system", and prison doctors do have to "split" their loyalties between the prison service and the patient. This can turn out to be a major dilemma. In countries where torture takes place, it may be difficult or quite impossible for a doctor to act freely and start to investigate and document cases of torture. In the ICRC experience, prison doctors in countries that torture most often prefer to "look the other way" when prison-

ers have complaints or symptoms that could possibly be related to torture.

In some countries torture may not only be present, but actually rampant, and evidence of it readily available. For example, there may be medical articles which describe cases of renal insufficiency secondary to massive beatings or crush-syndrome. Prison doctors in such countries will however be extremely reluctant even to consider talking about such cases, let alone go out on a limb and document even the obvious ... In a country that tortures, such doctors will have legitimate concerns or fears for their lives or that of their families, and one can understand their reluctance.

From the prisoners' point of view, they may be reluctant to talk about their torture experience to the prison doctor for two different reasons. First of all, as has been said, it is the overall context of the situation in the country. The fear not only for themselves but also for their families. This will often make prisoners hesitant to consult the prison doctor about any sequelae of torture. Rightly or wrongly, they will fear reprisals for "having complained" about it. Second, torture by its very nature is a subject that prisoners do not broach easily. It involves the infliction not only of pain and suffering, but also of humiliating and degrading practices, which prisoners understandably will have great difficulties speaking about.

Even in the case of prisoners having visible scars of brutal torture on their bodies, they will often be very reluctant to saying anything about it out of fear of reprisals. Informed consent should be a "sine qua non" condition for using any of the information about torture provided by prisoners during interviews. A prison doctor may need to keep any information s/he has gathered "in secret", until the overall situation changes and only then bring it out when there is no

longer any risk either to doctor or prisoners.

### **The case of visits by an outside doctor to document torture**

The main aim of visits to prisoners by outside bodies, such as the Council of Europe CPT, the UN Special Rapporteur on Torture, or the International Committee of the Red Cross, is to document torture. However, it should not be forgotten that there are other issues concerning prisoners that also will need to be part of the overall approach to violations of human rights or of International humanitarian law. Prison conditions for example, may be unsatisfactory, but not be part and parcel of an actual system of torture.

When torture is the issue, the aim is to obtain concrete information about methods and circumstances of torture and about the effects and durable sequelae of torture on the persons who have suffered it. This will allow outside bodies or governments to exert influence upon the perpetrators, the ultimate aim being to put a stop to the practice of torture.

Doctors coming from the outside who document torture will normally not start with the handicap of mistrust that confronts even the most well-meaning prison doctor. The outside doctor will have to know exactly what his/her terms of reference are, and then only accept to interview prisoners if it is certain within reasonable doubt that no one will suffer reprisals or punishments for having spoken out. It is essential that any prisoner interviewed is seen *in private* by the interviewing doctor. In private means not only without the presence of custodial staff, but also without any other presence, particularly of fellow inmates.

It is only through the safeguard of having interviews in private that prisoners may

decide it is safe for them speak freely and divulge information about torture. Prisoners may also, very understandably, desire privacy for personal reasons, as torture can raise a series of very intimate matters that prisoners may want to keep private. In all cases the interviewing doctor should explain the doctor-patient relationship and tell the prisoner that anything said or found upon medical examination will not be divulged without the prisoner's informed consent.

### **General considerations about the "torture interview"**

The way to document torture will vary considerably according to the person having been subjected to torture. An interview with a political activist or political prisoner will be very different from that with a simple farmer caught up in a war situation, or from a very sensitive interview with a young woman having been tortured and raped by her oppressors. Documentation will also vary according to context, to the religious background of the victims, and according to what methods are used. The Istanbul protocol goes through the many forms torture may take, describing methods and sequelae in great detail. There are, however, general considerations concerning any interview with a victim or survivor of torture, which doctors, prison and outside, will need to consider at all times.

– It cannot be repeated enough that *empathy*, real and not merely formal and institutional, is a paramount condition for anyone working with victims of torture. "Doing no harm" may mean, in some cases, putting down one's pen and paper and merely listening to the victim's story, in cases where direct and full attention is required and when it becomes obvious that the victim feels uncomfortable with what resembles an "interrogation"... Interviewers should never take the risk of enhancing the

injuries of torture by uncalled for assertiveness or aggressive interviewing. The persons interviewed should never feel they are being obliged to talk about their torture experience. It cannot be stressed often enough that a humane approach is even more important, from a humanitarian point of view, than actual documentation.

– It must be repeated that informed consent has to be obtained at the start of any interview for the documentation of torture. It would be unethical to obtain information about torture “at any price”, putting the prisoner at risk because he or she has confided in the prison doctor or outside doctor. The attitude “one cannot make an omelet without breaking some eggs” is absolutely not acceptable.

– Care should be taken to distinguish between the “veteran” political prisoner, who may be more “resistant” to torture and more willing to talk about it and answer specific questions, and the “bystanders” caught up in a situation they are in no way prepared for, and who are understandably more traumatized. More care may be necessary in interviews with the latter category, as they have been totally unprepared for the trauma of torture and its effects.

– Torture victims, as has been said, may have difficulties telling their stories. This may be for a number of reasons: cultural or religious taboos, feelings of guilt and/or shame, psychological defence mechanisms, impairment of memory, and not the least being fear and distrust regarding the visitors. The doctor will therefore need to guide the victim along (“guide” and not “direct”...) and determine which mechanism is in play so as to handle these difficulties. It is most important to have some knowledge about the context. Here the local prison doctor will have a distinct advantage over the expatriate doctor. It is even more important to *listen* to

the interviewee. This should not, however, lead to pre-conceived categorizations of torture. The doctor should approach torture and its consequences as a whole, and not reduce the information received to groupings of methods and medicalised symptoms.

– The outside doctor will have many other disadvantages compared to the local doctor, as the questions to ask will vary greatly from context to context. Chronology may not be in itself crucial to the issue at hand, as often it is difficult for a prisoner to determine the lapses of time. The description of what happened and how it was perceived and “what happened next” may be more relevant to the story. Here, local knowledge may often be a key factor in understanding exactly what happened.

– The actual structuring of the interview will depend greatly on the context and on the personal situation of each prisoner. Obviously, directed questions should be avoided (“Were you tortured when they arrested you?”) in favour of open, general questions (“When you were arrested, how did it go?”, “What happened then?”).

### **Gender issues and torture**

The issue of gender will have greater or lesser importance according to the context. In countries where men and women can exchange conversations without any hesitation, and where female doctors as well as male doctors work interchangeably with either gender, this should be less of a problem. This, of course, by no means rules out individual problems that may arise, as torture by its very nature is meant to humiliate and degrade those submitted to it. Furthermore, medical examinations may be simply out of the question, or at least very uncomfortable, when there is a gender difference between doctor and prisoner. This applies even more particularly to all forms of sexual torture, or

any torture targeting the genitals. Outside doctors will need to consider these gender sensitivities and take them into account at all times.

### **In conclusion**

The documentation of torture by doctors is not an easy task. Documentation of torture in prisons will be most relevant in countries where torture is actually used. There will therefore always be a certain risk to prisoners who are interviewed, and this should be very seriously considered before any documentation is carried out.

A local prison doctor will have experienced many difficulties that an outside doctor will not have, mainly in getting prisoners to trust him or her. Prison doctors are, sometimes rightly but very often wrongly, seen as part of the system of repression. It will be up to the doctor to obtain the merited trust of the prisoners s/he wishes to interview.

An outside doctor may not be at risk him/herself when documenting torture, but the risks for the prisoners will be the same, if not worse, if precautions are not taken to avoid reprisals. Specific modalities ensuring a proper “doctor-patient relationship” should be required before starting documentation, and private interviews with each prisoner should be guaranteed.