

Statement on access to relevant medical and other health records and relevant legal records for forensic medical evaluations of alleged torture and other cruel, inhuman or degrading treatment or punishment

International Forensic Expert Group*

Background

United Nations (UN) standards for forensic medical evaluations of alleged torture and ill-treatment are provided in the UN Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol).¹ The Istanbul Protocol standards are widely recognized by the UN, regional and national human rights bodies and are routinely applied in courts of law as part of the investigative procedures or scientific evidence.^{2,3}

Despite international recognition of Istanbul Protocol standards for the effective medical evaluation of alleged torture

or other ill-treatment, there have been a number of recent legal cases in which the access to information relevant to the discovery of medical evidence material to the case has been denied, limited, and/or filtered by legal experts and adjudicators on the basis of “national security” or other concerns.⁴

The purpose of this statement is to provide legal experts and adjudicators with an understanding of the need for access to all information, including complete medical and other health records, and relevant legal records, as a fundamental part of any forensic medical evaluation of allegations of torture and other cruel, inhuman or degrading treatment or punishment.

The opinions expressed in this statement are based on international standards and the experience of IFEG members in documenting the physical and psychological effects of torture and ill-treatment of thousands of detainees.

International standards for the medical evaluation of alleged torture and ill-treatment

The Istanbul Protocol provides international, legal standards on protection against torture and sets out specific guidelines on

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how effective legal and medical investigations into allegations of torture and ill-treatment should be conducted.

The Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol principles³) require that any investigation into such allegations must have not only the power, but also the obligation, to obtain all the information necessary to the inquiry. (Principle 3.a.). Moreover, the alleged victim and their legal representative must be provided access to any hearing and all information, and shall be entitled to present other evidence. (Principle 4). The standards require a complete, impartial medical assessment by qualified, independent medical experts, including a review of the complete medical and other health records as well as the relevant legal documents.

It is self-evident that in order to perform a full and impartial medical and legal assessment of any allegation of torture or other ill-treatment, access to the complete medical and other health records, as well as all the relevant legal documents is fundamental. By stating that all necessary and relevant information must be made available, the Istanbul Protocol Principles emphasize the obligation to gather as much factual information on the circumstances, events and consequences surrounding the alleged acts. Medical and other health records provide documentary evidence of the state of mental and physical health of the individual before and after, and in certain circumstances, during the alleged events, and are therefore of key evidential value.

Access to other information must also include relevant legal documents that pertain to the case, including any statements made by material witnesses, including relatives of the alleged victim, access to first

information reports, logs of any detaining authority showing dates of arrest or capture and the dates and to which authority any transfers were made; interrogation logs, internal investigations etc. The compilation of all this information is particularly important where the alleged victim is deceased and therefore unable to provide direct testimony. In the case of a deceased victim, if the body is retrieved, information on the circumstances of the retrieval and access to any post-mortem reports, where an autopsy has been, or can be conducted, is also essential. Any investigation into cases of suspected extra-legal, arbitrary or summary executions must be conducted according to the UN standard known as the Minnesota Protocol.⁴

Medical and other health records should be taken to include, amongst other things, all notes pertaining to an individual, whether in written or electronic format, compiled by any health professional including by physicians, psychiatrists, psychologists, nurses, medical orderlies, or any other health professionals, whether directly involved in the treatment, care or observation of an individual, or whether made by health professionals who have attended to, or assessed the individual for any other reason, including to serve the objectives and purpose of any third party. Medical and other health records also includes the results of any tests, medical imaging, screening and any other interventions whether preventive, curative or of any other nature, including photographic and video recordings. The complete medical and other health records must be made available following any treatment, care, observation, intervention or assessment for any purpose, whether these are done with or without the consent of the individual.

According to the Istanbul Protocol:

- Forensic medical evaluations of alleged torture and ill-treatment should include a detailed assessment as described in Annex IV of the Istanbul Protocol.¹
- Individuals alleging torture and/or ill-treatment should be evaluated by a qualified, independent forensic medical expert of the individual's choosing.
- Qualification of expertise in forensic medical evaluations of torture and ill-treatment should be based on a number of factors including: knowledge of 1) the physical and psychological effects of torture, 2) specific interview considerations, 3) how to conduct a physical and psychological evaluation, and 4) how to interpret such information, as well as the expert's experience in conducting forensic medical evaluations of alleged torture and ill-treatment.
- Comprehensive forensic medical evaluations of torture and ill-treatment may require considerable time to conduct, sometimes more than six hours, divided into several interviews. The evaluations require an opportunity to interview the alleged victim and to conduct both physical and psychological examinations, and possibly to obtain additional diagnostic tests and further consultations. In some cases, psychological symptoms may have a neurological (physical) basis (e.g. cases where brain injury has occurred) and therefore may require neuropsychiatric evaluation as well.
- Forensic medical evaluators should have access to the crime scene of alleged torture and ill-treatment and access to personally interview material witnesses of the alleged events.

Full disclosure of all relevant medical and other health records as well as relevant legal records is essential to ensuring transparent, impartial and objective forensic medical evaluations of alleged torture and ill-treatment

In cases of alleged torture and ill-treatment full disclosure of all medical and other health records as well as relevant legal records is fundamental and obligatory to ensuring a transparent, impartial and objective investigation of the facts and the formulation of forensic medical opinions.

A review of medical and other health records of an alleged victim of torture or other ill-treatment requires access to complete, unabridged medical and other health records. Access to complete records is of particular importance where no physical and psychological evaluations of an individual's allegations of torture and ill-treatment have been conducted, for whatever reason.

Review of complete medical and other health records must be conducted by qualified, independent forensic medical experts with specific knowledge and experience relating to the physical and psychological effects of torture and ill-treatment. The absence of qualified, independent forensic medical experts to review and render opinions on medical evidence of alleged torture and ill-treatment may preclude the proper discovery of material medical evidence and undermine the legitimacy of judicial decisions.

Forensic medical evaluations of torture and ill-treatment assess the extent to which an individual's allegations of violations may correlate with physical and psychological findings. Forensic medical opinions on the degree of consistency between individual allegations of torture and other ill-treatment and specific physical and/or psychological findings depend on the internal consistency of material medical evidence and corrobora-

tion by relevant information contained in relevant medical and other health records as well as relevant legal records.

Medical and other health records, as well as relevant legal documents are essential to forensic medical evaluations of alleged torture and ill-treatment for many reasons including the following:

- they may corroborate specific allegations of violations including: specific methods applied to the alleged victim, descriptions of instruments used, restraint positions, frequency and intensity of forces applied, protective barriers that may mitigate physical forces and subsequent physical evidence.
- some acts may be presumed by non-clinicians to be innocuous, even when practiced in combinations and over extended periods of time (e.g. forced nakedness, temperature manipulation, sensory deprivation, sensory bombardment, prolonged isolation, techniques of asphyxiation), but may cause severe and prolonged mental pain or suffering, which may only be evident following examination by a qualified forensic medical expert.
- they may contain health professionals' observations of physical and/or psychological reactions, before, during or after interrogation practices, incident reports, documentation of injuries, or lack thereof, and/or the condition of the alleged victim.
- they may be critical in establishing a timeline of the alleged violations that is necessary to understanding the development of physical and psychological symptoms and disabilities, as well as the subsequent healing of injuries.
- they may assist in identifying the alleged perpetrators, and in establishing a foundation for the intent of the alleged perpetrators to inflict physical and/or mental harm.
- the assessment of "severe physical and psychological pain or suffering," which form part of the definition of torture, usually requires specific medical knowledge and specific information gathered from the individual alleging torture or other ill-treatment in a clinical interview.
- the nature and extent of psychological reactions to torture and ill-treatment depend on the meaning individuals assign to traumatic experiences. Assessment of psychological evidence of torture and ill-treatment, therefore, requires a detailed understanding of the circumstances of the alleged violations that are often found in medical and other health records as well as relevant legal records.
- forensic medical experts need complete medical and other health records, as well as relevant legal records to form opinions on the likely physical and/or psychological reactions that may be expected from the alleged violations, with due consideration to individual mitigating and potentiating factors.
- forensic medical expert opinions on the causation of physical and psychological symptoms and disabilities (i.e. torture and ill-treatment vs. illness and disease) also require a comprehensive understanding of information contained in complete medical and other health records as well as relevant legal documents.
- forensic medical experts require access to all medical and other health records, as well as relevant legal records to assess for the possible exclusion of incriminating evidence. Such exclusions may be evident when the allegations of violations by the alleged victim are highly consistent with physical and/or psychological findings (i.e. multiple lacerations on the back consistent with allegations of whipping), but

there is no supporting documentation in the medical or relevant legal records.

- complicity of health professionals in torture and ill-treatment practices is well documented,^{5,6,7} either in the form of direct participation and/or the neglect, misrepresentation, or concealment of medical evidence. Access to all medical and other health records as well as relevant legal records is necessary to the forensic medical evaluator's assessment of possible complicity of health professionals (direct or indirect) in alleged violations, and whether medical or mental health care was needed, requested and/or provided, understanding that withholding of medical care may in itself constitute a form of torture or ill-treatment.

Determinations of relevant medical and other health records as well as relevant legal records for forensic medical evaluations

Medical and other health records serve to document medical practices, to communicate and coordinate clinical practice and the care of individuals. Understanding the content and significance of medical records requires medical knowledge and practical experience.

The use of adjudicators, legal or national security experts, to extract, summarize, or redact medical records, is contrary to best practices and susceptible to result in misconceptions and distortions that undermine the value of any materials presented as 'medical' evidence. These legal or security experts do not have the required expertise to determine the significance and relevance of the information contained in the medical or other health records; nor to interpret medical jargon and abbreviations; nor to interpret the significance of medical tests; nor to recognize any omissions in the medical records and their potential significance.

Medical records generally include components that are interrelated, (e.g. physician progress notes, nurse's notes, physician orders, diagnostic tests, prescribing and treatment records etc.). The relevance of any one entry in one or more of these components, or the lack thereof, may not be apparent to non-clinicians.

In addition, review of medical and other health records as well as relevant legal documents by a forensic medical expert in an assessment of physical and/or psychological evidence of torture and ill-treatment requires additional knowledge and experience.

Medical records may contain information that may seem irrelevant to allegations of torture and ill-treatment to individuals who are not qualified forensic medical experts. For example, psychological diagnoses of "routine stressors of confinement" or a "personality disorder" may seem reasonable unless one were to know that certain symptoms are more likely to be due to post-traumatic stress disorder associated with alleged violations than what may be documented in the medical record.⁷

Forensic medical experts are often requested by legal counsel to assess an alleged victim's mental competence and whether medical care was needed and/or was adequately provided to a particular standard. Expert opinions on such matters also require a comprehensive review of medical and other health records as well as relevant legal records by a qualified expert.

Attempts to deny, limit, and/or filter medical and/or legal information that is relevant to the independent forensic medical experts assessment of alleged torture and ill-treatment not only preclude a comprehensive forensic evaluation of material medical evidence, but in the absence of compelling legal justification, may represent willful concealment of acts or omissions that amount

to breaches of international or national law, obstruction of justice, and to breaches of medical ethics and professional conduct.

National Security Considerations

National security concerns are often advanced to deny full disclosure of medical and legal documents to the alleged victim's legal counsel and independent forensic medical experts. Under such circumstances, legal experts and/or adjudicators determine what medical and legal information is relevant for the alleged victim to make his or her claim. Legal experts and adjudicators do not have the requisite expertise to determine relevant information for forensic medical evaluations. The filtering of medical and other health records as well as relevant legal records by legal experts and adjudicators, therefore, is likely to result in the neglect and/or distortion of material medical evidence and may undermine the validity of judicial decisions.

Medical records that are professionally and ethically compiled and maintained should contain information that does not impinge upon national security. In the Inter-American Court of Human Rights it was determined that a State could not rely on the doctrine of "state secrets" as the basis for denying access to information relevant to serious human rights violations.⁸

Redaction of some information, such as names and locations, may be justified on the basis of national security, as long as the judge has full access to this information. Allegations of violations should never be redacted, however. Efforts to conceal allegations of violations limit the liability of the alleged perpetrators and obstruct justice for crimes of torture and ill-treatment, and thereby undermine national security.

Information which is deemed as "classified" should be made available to independ-

ent forensic medical experts after appropriate security clearance has been obtained.

International law regarding standards for access to or review of medical records by medical experts or legal representatives

The right to access personal information is enshrined in international law. It is recognized that everyone has the right of access to data which has been collected concerning themselves, whether this information is held by governments or by private entities, and to have this information rectified.^{9,10} In particular, States must guarantee that people can access the information contained in their medical records.¹¹ The World Health Organization (WHO) states that the information contained in medical records is a confidential communication between the health professionals and the patient and the data is the property of the patient.¹² As such, the data must be kept confidentially and used only by health professionals for the continuing care of the patient.^b It can only be released with the written consent of the patient or a court order.

Where there are prima facie reasonable grounds to believe that any act of torture has occurred under a States' jurisdiction, the United Nations Convention Against Torture stipulates that a prompt and impartial investigation must occur.¹³ The UN Committee Against Torture concluded that the alleged victim must be allowed access to their medical records as a part of the investigation into the allegation.¹⁴ Even in cases where there was no allegation of torture or ill-treatment, the Committee Against Torture established that a detainee and their legal representative have the right to access all the registers kept in relation to their detention, including their medical records.¹⁵

The UN Subcommittee on the Prevention of Torture (SPT)¹⁶ has adopted the po-

sition that any medical records made during deprivation of liberty form a part of the information relevant to the investigation of any allegation of torture or other ill-treatment.¹⁷ The UN Committee Against Torture further confirmed the importance of the access to medical records when it concluded that the National Preventive Mechanisms, established under the Optional Protocol to the Convention Against Torture, had the right to examine all detention related documents, including medical records.¹⁸

The Standards of the European Committee for the Prevention of Torture¹⁹ (CPT) state that patients should have the right to consult the contents of their prison medical files, unless this is inadvisable from a therapeutic standpoint, and the patient should be able to ask for this information to be communicated to their families and lawyers or to an outside doctor. Therefore according to the CPT standards, if the patient consents to their medical files being transmitted to a third party, then the State is under an obligation to do so.

The alleged victims of torture who are seeking access to their complete medical and other health records, have usually been, or may still be a detained or imprisoned person, whose detention was, or is under the control of the jurisdiction that now refuses to provide access to the complete records. The Human Rights Committee found that in lodging a complaint against a State of serious human rights violations, the State is often the sole holder of key evidence, for instance personal medical records.²⁰ It is thus incumbent on the State to provide access to this information, including complete medical records to allow a determination of whether a violation has occurred.

In responding to individuals who allege torture or other ill-treatment, as well as having been subject to poor conditions of de-

tention and a lack of adequate medical care, some States have refused access to the medical records but provided a medical certificate purporting to fully correspond to the contents of the actual records. This summary certificate was deemed insufficient by the UN Human Rights Committee, who found this to be a violation of article 10 of the International Covenant on Civil and Political Rights (the right to humane treatment), and stated that a prisoner does not lose the entitlement to access his actual medical and other health records.²¹

Further, in the European Court of Human Rights it was deemed that hand written extracts of medical records would not be sufficiently comprehensive to establish an expert opinion, and that copies of the complete medical records were required. Not allowing access to copies of the complete medical records violated the right to privacy (article 8 of the European Convention on Human Rights) since no effective access to information concerning the alleged victims' health was granted.²² Moreover, the European Court ruled that the failure to provide complete copies of the medical records, violated the rights of the applicants to a fair hearing by a tribunal (article 6 of the European Convention) since their case could not be properly considered without the complete medical files as evidence. It was ruled that providing the courts with handwritten extracts of the medical files in place of the originals or complete copies would not allow any inconsistencies to be properly checked, and therefore was a bar to their seeking redress for violation of their civil rights.

Professional and ethical standards for health professionals in their interactions with a detainee

Health professional ethics dictate that any

interactions, whatever their nature, between health professionals and an individual must be solely for the best interests of that individual. The purpose of any intervention must be clearly explained to the individual as well as how the information gathered from any intervention will be used.²³ This is of particular importance where third parties may be involved such as prison or other detaining authorities or the courts.

All interaction between a health professional and an individual must be fully documented,²⁴ including as a minimum the date, the time, the identity and reasons of those present, the location, the nature of the interaction, symptoms, clinical examination and/or psychological and psychiatric examination, diagnostic tests and results, differential diagnosis, management/treatment and the informed consent of the patient. The medical and other health records must be maintained securely and confidentially in written/hard copy form and/or electronic format.

The individual is entitled to receive any information about themselves contained in the medical or other health records made while they were held in any form of detention,²⁴ unless this is contraindicated for purely therapeutic reasons such as when the information may prove a hazard to their health.¹⁹ (Paragraph 46),²⁵ To exercise this right the individual must be entitled to a complete copy of these medical and other health records, both for the purposes of ensuring continuity of care upon transfer or release,²⁵ and also for use in seeking legal remedy or reparations concerning any allegations of unethical or unprofessional health care practices, or concerning allegations of any other acts or omissions that may give rise to civil or criminal liability in domestic or international law. When an individual alleges, or there is reason to suspect, that torture or other forms of ill-treatment have taken place, there is a further obligation on the

authorities holding this information to provide full access.^c

A proper assessment that any intervention by a health professional was warranted, appropriate, and was carried out according to accepted standards of practice can only be made through verification of the accuracy and completeness of medical and other health records.^d International standards of professional ethics expressly prohibit participation, whether through acts or omissions, of health professionals, especially physicians, psychiatrists and nurses, in torture or other cruel inhuman or degrading treatment or punishment.^{23,26,27,28,29} Ethical standards also prohibit any form of participation in the interrogation process of a detainee, or indeed, the use of any individual's medical information to aid an interrogation.³⁰ An assessment of whether health professionals participated in acts of torture or other ill-treatment, through acts, omissions or through the provision of medical information, may only be made through examination of the complete medical and other health records. The deliberate withholding of medical care for detainees, either for mental or physical illness or injury, but in particular for victims of torture or other ill-treatment may in itself constitute cruel, inhuman or degrading treatment or punishment. Any omission in the provision of appropriate care by health professionals may be revealed through examination of the complete medical and other health records.

Access to complete medical and other health records are necessary to enable a proper determination of whether health professionals, who were either directly involved in the assessment, treatment or care of an individual who alleges to have been tortured, or who were involved in any form of physical, psychological or psychiatric assessment or evaluation of an individual, acted in accord-

ance with accepted national and international principles and standards or professional care and professional ethics, as well as in conformity with national and international law. This includes the duty to report any suspected cases of torture or other ill-treatment that they may have witnessed or been aware of. In recognition of the fundamental nature of the prohibition of participation in torture for physicians, the World Medical Association has recently promoted the creation of a mechanism to monitor States adherence to the Declaration of Tokyo.³¹

Conclusion

The Istanbul Protocol standards for the investigation of allegations of torture and other ill-treatment require a complete, impartial medical assessment by qualified, independent forensic medical experts, including the review of complete medical and other health records as well as relevant legal documents.

Based on our extensive experience in criminal and civil cases, full disclosure of all relevant medical and other health records as well as relevant legal records is fundamental and obligatory to ensuring a transparent, impartial and objective investigation of the facts and the formulation of forensic medical opinions in cases of alleged torture and ill-treatment.

Relevant medical and other health records as well as relevant legal records should not be denied, limited, and/or filtered by legal experts and adjudicators as this may preclude the discovery of material medical evidence and undermine the validity of judicial decisions.

About the International Forensic Expert Group
The International Forensic Experts Group (IFEG) was established in 2009 by the International Rehabilitation Council for Torture Victims (IRCT) in partnership with the Department of Forensic Medicine, University of Copenhagen. It consists of prominent international forensic experts with extensive experience in the evaluation and documentation of torture and ill-treatment. These independent experts participate in investigations of alleged torture and ill-treatment and provide impartial forensic reports and legal testimony on their findings. They also provide consultative and technical advice on medical legal issues related to torture and ill-treatment.

Notes:

- a. The limitation of access to medical and other health records be manifest in a number of ways, including: providing an incomplete set of the original records; the editing/redaction of certain information from copies of the original records; providing summaries of the records, which summaries may be in the form of a single report or short extracts drafted using the original records.
- b. The data may also be used for research and for compiling health statistics but in each case it must be anonymised.
- c. The European Committee for the Prevention of Torture Standards (2010) at paragraph 61 states that any signs of violence observed when a prisoner is medically screened on his admission to the establishment should be fully recorded, together with any relevant statements by the prisoner and the doctor's conclusions. Further, this information should be made available to the prisoner.
- d. The European Committee for the Prevention of Torture Standards (2010) at paragraph 39 states that medical records provide an overall view of the health care situation in the prison, at the same time as highlighting specific problems which may arise.

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