The Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment): Implementation and Education in Israel

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ABSTRACT: All victims of violence encountered in our emergency rooms and clinics need to be recognized and documented as such. Although there has been progress in the implementation of rules concerning (domestic) violence against women, children and the elderly, the management of cases where patients have been subjected to violence while under the custody of legal enforcement agencies, or patients who have been victims of torture, is still not sufficiently standardized. We describe the Istanbul Protocol of the United Nations, an excellent tool that can help physicians and health professionals recognize and treat cases of torture or institutional violence.

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KEY WORDS: Istanbul Protocol, torture, refugees, post-traumatic stress disorder (PTSD), violence

In the last few decades, Israel's medical system has undergone a significant change with regard to recognizing victims of (domestic) violence and relating to those cases proactively, especially those in vulnerable or helpless population groups (minors, mentally impaired, institutionalized). Nurses and physicians as well as social workers undergo training to identify and deal correctly with cases of domestic violence and abuse. Many victims do not complain directly of the abuse, due to helplessness, shame or fear, and it is often the role of the examining physician to offer an opening in a private and confidential conversation. Physicians have learned that their professional obligation in these cases extends beyond providing purely medical relief and includes steps to provide for the safety and well-being of the patient. This is why we have laws for the obligatory reporting of suspicion of violence against helpless victims [1]. Despite these developments, there are still groups of vulnerable and helpless individuals where the suspicion of violence is often overlooked by medical practitioners. We present two scenarios based on real-life events in order to highlight this point.

CASE 1

A 22 year old male asylum seeker complains of severe flank pain and blood in his urine. Examination reveals white scars on his back. When prompted he says, "I got those while crossing the desert on my way to Israel." He has a scar on his forehead and says, "This is from the electricity." The physician does not enquire further. He suspects a kidney stone, prescribes pain medication and refers him for further tests. The following week he hears that the patient took an overdose of the pain medication he prescribed and is in the intensive care unit [2]. The social worker informs the physician that the patient was held in captivity and tortured in Sinai until his family paid enough ransom for him, but that his brother is still captive [3].

CASE 2

A 32 year old detainee is brought to the emergency room by prison guards. He complains of severe pain and weakness in both hands and difficulty walking. He cannot walk without support. His extremities are swollen. He has weakness in both hands in ulnar and radial distribution, abrasions on his wrists and ankles, and bruises on his back and abdomen. His creatine phosphokinase is elevated. The physician asks how those came about and the patient starts answering but is interrupted in the middle of a sentence by the guards. The physician insists on hearing the mechanism of injury and the patient replies that he was handcuffed and beaten by his interrogators for 4 days [4].

DISCUSSION

These two patients are apparent victims of torture. The first patient sought help for an unrelated matter and was not rec-

ognized as a severely traumatized victim. Consequently, he was not offered the more comprehensive help he required. The second patient is a helpless victim of institutional violence and might be in danger of continued abuse.

In the case of domestic violence the medical community has become aware of an obligation to recognize such cases and treat them in a multidisciplinary fashion. However, in the case of institutional violence and torture similar progress has not been made. Physicians are less likely to recognize such patients as victims of violence. The appropriate treatment has not been standardized, or even taught, and consequently the obligation to report is less routinely observed.

Changing this situation requires two distinct elements: a) an understanding on the part of the medical establishment that it is obliged to recognize and treat such victims and ensure as far as possible their future safety from harm; and b) the implementation of medical protocols for treating such victims, including a full and appropriate history taking, physical examination and workup, and the filing of a detailed and clear official report. Another objective is the creation of multidisciplinary teams trained to handle such cases.

CONVENTIONS ON TORTURE

In the words of the United Nations Convention against Torture, 1984:

> Torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. [5]

The World Medical Association Declaration of Tokyo [6] defines torture as

> …the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

According to the Declaration, physicians are absolutely prohibited to take part in torture or even be present in a place where torture is committed. The physician is furthermore required to report cases of torture that come to his attention to the "relevant authorities" [6]. The convention was adopted by the Israel Medical Association in December 2007 [7].

The *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment – Istanbul Protocol* was written in 1999 by more than 75 experts in mental health and medicine (including forensic medicine), human rights and law. The aim of the protocol is to improve the (medical/forensic) documentation of the physical and psychological effects of torture or cruel, degrading or inhuman treatment [8]. It was recently published in translation on the Israel Medical Association website [9].

THE ISTANBUL PROTOCOL

The experience of a torture victim is in most cases one of severe traumatization – physical and psychological. The Protocol is meant to equip the treating physician with the tools to correctly assess and address the needs of a person who is or was the victim of torture whether he/she is a patient or a person seeking a professional medico-legal opinion. The Protocol defines the legal and international standards and procedures in relation to torture and describes the ethical principles from which these stem, as well as the implications of a claim of torture in the legal framework. The main body of the protocol relates to the medical and psychological examination of the torture victim and to the actual writing of a medico-legal opinion in those cases.

The informed consent of the client is of utmost importance, as the examinee has to understand to whom and for what purpose he is telling his story. In some settings the complaint of torture will put the victim at risk for reprisal especially if he is still in the custody of the authorities. In a refugee situation, on the other hand, the proof that a person suffered persecution and torture in his country of origin or during his flight can be an important piece of evidence in the application process for asylum.

Consent is also psychologically important. It puts the examinee in control of the situation. The examinee should understand that he can give or withdraw consent at any time or for any part of the examination and that he dictates the conditions and pace of the examination. The purpose of the examination has to be clear and agreed upon: medico-legal opinion, treatment and rehabilitation, or simple documentation of injuries.

Creating an appropriate physical setting for the examination can be challenging. If the examination takes place in a detention center or prison there are problems of privacy and time constraints. In prison, there is always a question of the safety of the examinee. His complaints might make him vulnerable to further harassment or violence from both the prison personnel and from fellow inmates. As such, privacy and confidentiality must be assured. According to international standards as specified in the Declaration of Tokyo, the physician has the duty to examine the patient without

restraints and in privacy – in other words to make sure in the case of examinations of detainees or prisoners that handcuffs and shackles are removed during interviews and physical examinations [7]. Even if the examination takes place in the offices of the physician or an organization, it is important to assure that privacy and an appropriate setting are provided so that re-traumatization does not occur.

There is often a need for translation, which has to be provided by an independent translator who is not connected to either the examinee or the authorities. A word-for-word translation is of utmost importance. In addition, notes regarding the cultural significance and meaning of the victim's words should be added as necessary.

The detailed narrative of the victim and its documentation are crucial. The questions should be formulated in an open manner. The way in which the story is told can in itself be diagnostic for memory gaps and mental health issues. These should be noted as they can be indicative of post-traumatic stress disorder or traumatic brain injury, common sequelae in victims of violence.

Methods of torture vary around the world. The examining physician should be familiar with the local practices and their consequences. The physician should be able to recognize acute and chronic signs of abuse and know how to document them both by description and by photography. For example: signs of beating, kicking and punching can be identified in acute cases, *falanga* (beating the soles of the feet) can leave typical signs on the feet, prolonged handcuffing can cause acute and sometimes chronic nerve damage, and suspension and overstretching can leave injuries of the musculoskeletal system. Electrical injury and cigarette burns leave typical scars. Also, physical or psychological sexual abuse should not be overlooked, as this is frequently part of the torture [10]. All physical signs need to be identified and documented and differentiated from signs of unrelated injuries [11].

The documentation of physical signs has to be as accurate as possible. Sometimes auxiliary examinations can help, but painful or invasive examinations should be avoided unless absolutely necessary [12]. It must be remembered that perpetrators of torture often deliberately strive to avoid leaving any physical signs of their actions and in many cases use techniques that do not leave physical signs, such as sleep deprivation, humiliation, exposure to noise, degrading conditions of imprisonment, threats directed towards the victim or those close to him, forcing the victim to witness the torture of others, sensory deprivation including hooding, and solitary confinement [8,13].

In addition to physical consequences, torture frequently has prolonged psychological effects. Prolonged stress that is both severe and unpredictable can cause post-traumatic stress disorder and depressive reactions, with memory and concentration problems, irritability, sleep disturbances and flashbacks. These symptoms may affect the daily functioning of the victim as well as those around him [14,15].

IMPLEMENTATION OF THE ISTANBUL PROTOCOL

The Istanbul Protocol has been taught to physicians, psychologists and law experts in various countries around the world. In Turkey more than 5500 professionals including primary physicians and ER physicians, who are likely to meet torture victims at the obligatory examination after arrest and interrogation and before the transfer to prison, have taken part in a course on the Protocol conducted by the Turkish Medical Association. Physicians have undertaken similar training programs in the United States, Mexico, Cuba, Egypt, Morocco, Lebanon, Uganda, Georgia, Philippines, Sri Lanka, Uzbekistan, Armenia, Azerbaijan and New Zealand [16].

Physicians and psychologists might meet victims of torture in different treatment scenarios, including the ER, outpatient clinics, prisons or detention facilities, and in medical encounters with refugees and asylum seekers. The victim of torture does not always connect his current symptoms with his history of torture and frequently does not want to talk about his experiences to strangers, including physicians. The reasons are manifold – lack of trust in the physician, shame, guilt, fear of re-traumatization through telling, fear of traumatizing the health care provider, and fear of the consequences of telling the story (especially if the victim or his family are still in a vulnerable position). Even patients who are in long-term treatment for various mental and somatic problems, including pain syndromes, and who have a history of torture may not tell their treating physician about this history [17]. A study performed in an American primary care setting found that 6% of non-American born patients reported experience of torture in their past, yet in none of the cases was the primary treating physician aware of this fact [18].

The health care provider cannot see what he or she does not suspect, or does not want to see. The Istanbul Protocol is a tool to assist the physician or psychologist to fulfill the obligation to recognize, document and report the evidence of torture.

SIGNIFICANCE AND IMPLEMENTATION IN ISRAEL

Israel is a signatory to the Convention against Torture [5]. Despite this, the Landau Commission (1987) reached the conclusion that "use of a moderate degree of physical pressure, in order to obtain crucial information, is unavoidable under certain circumstances." The Commission defined measures that are meant to keep the moderate physical pressure in check (advanced directives have to be in place, pressure shall never reach the level of torture, and mandatory supervision). The state compiled a (classified) catalogue of permitted interrogation techniques. In 1993 the guidelines were updated, including an added clarification that it is not permissible to humiliate

ER = emergency room

a person under interrogation, deny him water or food or access to a toilet, or subject him to extreme temperatures [19].

Not infrequently, victims of torture and institutional violence are encountered by medical personnel in the ER, who due to insufficient training and awareness will not adequately record the complaints, document a directed examination of the victim, and report to the relevant authorities [20]. Military physicians might also encounter victims of torture. Their dual loyalty and the situation they find themselves in might make an appropriate examination even more difficult. Knowledge of international ethical and procedural standards are all the more important in these situations [21].

In addition, many arrested persons suffer violence at the hands of the arresting authority. Though it does not amount to torture, it should be documented and reported nevertheless, especially if the victim is still in custody when a timely report may have implications on the patient's safety and well-being [22].

Refugees and asylum seekers constitute another population in Israel that is most likely to have a history of torture, either in their home countries or in the Sinai Desert [3]. A history of torture is hugely significant in these cases, as a person who was tortured in his home country may not be sent back under the principle of non-refoulement [5]. The documentation of the refugee's narrative and the physical and psychological findings – according to the Istanbul Protocol – can be instrumental in substantiating a claim of torture.

The example of other countries like the UK, Turkey, the Philippines and Venezuela can teach us that the education of physicians with regard to their ethical duties and how to manage situations where violence and torture are suspected can make a significant difference [23]. The first course for physicians based on the Istanbul Protocol took place this year in the framework of the Public Committee against Torture in Israel. The chairman of the ethics committee of the Israel Medical Association has announced the Association's intention of instituting courses about the Protocol for Israeli physicians [24].

Under the UN Convention against Torture and the World Medical Association Tokyo Declaration, Israel and the Israel Medical Association have ratified that physicians are under obligation to file a complaint with the appropriate institution if they suspect torture or violence by the arresting authorities. In January 2012, the Ministry of Health announced the establishment of a committee to investigate reports by physicians of injuries inflicted on arrestees during investigation [25]. Although we petitioned the Ministry of Health, they declined to answer any questions regarding the work of this committee, and to the best of our knowledge it has not dealt with a single complaint. Furthermore, the committee has not published any protocol of its work or guidelines for physicians regarding instances that fall under its purview.

The approach of the physician to a person who appears to have suffered maltreatment should be structured and conducted according to clear guidelines, and should not be affected by the patient's place of origin, who brought him to treatment, or who might be responsible for the possible abuse. Teaching of the Istanbul Protocol to Israeli physicians would be an important step in that direction.

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Capsule

Intranasal epidermal growth factor treatment rescues neonatal brain injury

There are no clinically relevant treatments available for improving function in the growing population of very preterm infants (less than 32 weeks gestation) with neonatal brain injury. Diffuse white matter injury (DWMI) is a common finding in these children and results in chronic neurodevelopmental impairments. As shown recently, failure in oligodendrocyte progenitor cell maturation contributes to DWMI. Scafidi and colleagues, who demonstrated previously that the epidermal growth factor receptor (EGFR) has an important role in oligodendrocyte development, now examine whether enhanced EGFR signaling stimulates the endogenous response of EGFR-expressing progenitor cells during a critical period after brain injury and promotes cellular and behavioral recovery in the developing brain. Using an established mouse model of very preterm brain injury, they show that selective overexpression of human EGFR in oligodendrocyte lineage cells or the administration of intranasal heparin-binding EGF immediately after injury decreases oligodendroglia death, enhances generation of new oligodendrocytes from progenitor cells, and promotes functional recovery. Furthermore, these interventions diminish ultrastructural abnormalities and alleviate behavioral deficits on white-matter-specific paradigms. Inhibition of EGFR signaling with a molecularly targeted agent used for cancer therapy demonstrates that EGFR activation is an important contributor to oligodendrocyte regeneration and functional recovery after DWMI. Thus, our study provides direct evidence that targeting EGFR in oligodendrocyte progenitor cells at a specific time after injury is clinically feasible and potentially applicable to the treatment of premature children with white matter injury.

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Eitan Israeli

Capsule

Estrogen increases hematopoietic stem cell self-renewal in females and during pregnancy

Sexually dimorphic mammalian tissues, including sexual organs and the brain, contain stem cells that are directly or indirectly regulated by sex hormones. An important question is whether stem cells also exhibit sex differences in physiological function and hormonal regulation in tissues that do not show sex-specific morphological differences. The terminal differentiation and function of some hematopoietic cells are regulated by sex hormones, but hematopoietic stem cell function is thought to be similar in both sexes. Nakada and group show that mouse hematopoietic stem cells exhibit sex differences in cell cycle regulation by estrogen. Hematopoietic stem cells in female mice divide significantly more frequently than in male mice. This difference depends on the ovaries but not the testes. Administration of estradiol, a hormone produced mainly in the ovaries, increased hematopoietic stem cell division in males and females. Estrogen levels increased during pregnancy, increasing hematopoietic stem cell division, hematopoietic stem cell frequency, cellularity, and erythropoiesis in the spleen. Hematopoietic stem cells expressed high levels of estrogen receptor-α (ERα). Conditional deletion of ERα from hematopoietic stem cells reduced hematopoietic stem cell division in female, but not male, mice and attenuated the increases in hematopoietic stem cell division, hematopoietic stem cell frequency, and erythropoiesis during pregnancy. Estrogen/ERα signaling promotes hematopoietic stem cell self-renewal, expanding splenic hematopoietic stem cells and erythropoiesis during pregnancy.

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Eitan Israeli

"If people knew how hard I worked to get my mastery, it wouldn't seem so wonderful after all"

Michelangelo (1475-1564), Italian sculptor, painter, architect, and poet. Michelangelo has been considered the greatest artist of all time, with some of his works ranking among the most famous in existence, such as the sculptures *Pietà* and *David*, and the frescoes in the Sistine Chapel