Detection and assessment of victims of ill-treatment and torture in Primary Health Care. Quick guide including developments in the 2022 updated version of the Istanbul Protocol.

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Torture can be briefly defined as situations in which severe pain or suffering is intentionally inflicted on a person by State agents for a specific purpose. In particular, but not limited to, the extraction of information, obtaining a confession, retaliation, punishment or discrimination (UN General Assembly, 1984). Where intent cannot be established or the purpose is uncertain, or where the pain or suffering is considered to be of lesser severity, it is deemed, from a legal point of view, as cruel, inhuman or degrading treatment (CIDT) (Amnesty International, 2016).

The distinction between torture and CIDT is of little relevance from a clinical point of view. Both are covered by the Convention Against Torture and are forms of legal classification that imply a duty to detect and document from the health professionals[1]. There are alternative definitions to that of the International Convention that are based on criteria closer to the field of health. Torture is referred to, from a clinical point of view, as the use of strategies to weaken and break an individuals' free will. This may be done through techniques that cause physical (pain, debilitation, manipulation of the environment) or psychological (fear, humiliation, shame, anguish, guilt) suffering and harm (Pérez-Sales, 2017).

Torture continues to exist in most parts of the world, in both the global North and South, although it can take different forms and be used in contexts very different from the classic imaginary of interrogational torture to obtain information. Much contemporary torture is about "everyday" ill-treatment involving routine or seemingly banal actions that involve severe rights violations.

The Istanbul Protocol is the international guide to the legal and forensic documentation of alleged cases of ill-treatment or torture. Initially formulated in 1999, it was revised in 2004 and has recently been expanded and updated (UNHR, 2022)[2]. This recent revision is included as part of the core of this editorial.

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1 Clinician is defined in the IP22 as a health professional who provides health-care services and/or conducts clinical evaluations of alleged torture and ill-treatment, thus including not only doctors. Mental Health Clinicians are defined as health professionals with specific mental health training and/or certification, such as psychologists, psychiatrists, social workers, psychiatric nurses and mental health counsellors.

2 Available for download at https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf

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Table 1. Examples of relevant day-to-day clinical practice where ill-treatment or torture might appear

Hospital or health centre emergency room	• Examination of detainees brought by law-enforcement agents • Mistreatment of demonstrators • Conditions in prisons or/and other detention centres • Conditions and allegations of mistreatment of migrants in removal or deportation proceedings
Primary care consultation - community health centre	• Complaints of police abuse by a patient • Assistance to persons transferred to consult from places of deprivation of liberty • First care for migrant patients, especially in airport or border contexts
Paediatric Consultations	• Children exposed to risk of institutional harm • Signs of abuse or ill-treatment within the family (duty to protect)
Aged care homes Mental health centres; Psychiatric hospitals Custodial centres - Centres for the protection of minors Care centres for people with disabilities	• Involuntary internment • Restraints • Drug abuse; Coercive treatments • Discriminatory behaviours when assigning medical treatment • Degrading treatment / Neglect
Prisons Short-stay detention centres (police stations or other)	• Overcrowding. Physical conditions of detention • Food and Nutrition • Mental illness. Treatment of drug addictions • Physical Restraints • Complaints of ill or degrading treatment
Intentional patterns of discrimination or punishment by state or parastatal actors - administrative or institutional violence	• Migrants • Gender identity and sexual orientation • Social cleansing - conditions of marginalisation or poverty • Human rights activists or defenders • People in the community who cannot act for themselves and are dependent on others (dementia, physical or intellectual disability)
Cultural practices constituting forms of ill-treatment or torture	• Virginity examinations at the request of the family or authorities • Female genital mutilation • Anal examinations to detect heteronormative sexual behaviour

Table 1 shows contexts in which acts of ill-treatment or torture may occur and where a primary care clinician can play an important role in detecting, preventing, documenting and remedying these situations[3]. We do not specifically address here the role of medical personnel attached to places of deprivation of liberty, for which there are excellent guides and specific documents and rules (Méndez, 2019).

There are, in short, many contexts in which a primary health care worker may detect or intervene in cases of ill-treatment or torture (Weinstein et al., 1996). It cannot be overemphasised that, beyond personal will and ethical commitment, there is a professional obligation on health professionals stated by different World Medical Association (WMA, 1975, 2013) and World Psychiatric Association (WPA, 2017) documents and the Istanbul Protocol[4].

In both the global North and South, the migrant population will be a particularly at-risk group for cases of ill-treatment or torture[5]. The few studies that exist in primary health care show that (1) prevalence of torture survivors may be much higher than most health professionals expect[6], (2) patients who have experienced political violence or torture in their country of origin do not refer this experience to their primary care physician, either because they think it is not relevant, due to cultural reasons, or because they believe that their physician will not have time to listen to them or will not be interested in the issue (Eisenman et al., 2000; Shannon et al., 2012) and (3) in the vast majority of cases, the doctor also did not ask, despite suspecting that the person may have suffered violence, and did not record the suspicion in the medical record. (Ostergaard et al., 2020).

Additionally, the primary health care professional can play a decisive role in the legal protection of the patients. The available evidence suggests that many of them are candidates for asylum or other forms of international protection, but lack this information and may miss the legal deadlines. Moreover, documenting the consequences of persecution or torture and making a medical affidavit in accordance with the Istanbul Protocol significantly increases the possibility of being able to obtain asylum or other forms of international protection. (Asgary et al., 2006; Atkinson et al., 2021).

In addition to this, are the primary health care centers located in countries where torture is prevalent or has been prevalent in the recent past[7]. In

3 For further elaboration on forms of ill-treatment or torture linked to the field of health, the reader is directed to specific reviews (Mendez, 2013, 2014; Wadiwel, 2017).

4 The ethical codes involving primary care workers can be expanded in Chapters II and VII of the Istanbul Protocol.

5 It is worth recalling that the world's top refugee-receiving countries are Turkey, Colombia, Uganda and Pakistan. Countries with the highest per capita income receive only 11% of asylum seekers and refugees globally (www.acnur.org).

6 In a study among a non-Western population in primary care practices in Copenhagen, 28% of people reported having been exposed to torture in the country of origin or in transit. In 75% of cases the general practitioner had not asked and it was not recorded in the medical record. (Ostergaard et al., 2020). In a similar study of migrants treated in the Emergency Department of a public hospital in New York, 11.5% of migrants reported having been tortured. 77.8% had never been asked about torture by a doctor and only 14.8% had applied for asylum. (Hexom et al., 2012). In the Internal Medicine Department, 8% of migrants questioned had suffered torture. Again, reviewing the medical records, none of the cases had been detected by the primary care physician nor had the patient reported it spontaneously. (Eisenman et al., 2000; Eisenman, 2007).

7 For example, in one study in a PHC practice in an urban area of Baghdad in 2006 found that the prevalence of torture directly suffered or suffered on a family member was found to be more than 50% (Al-Saffar, 2007).

Table 2. Screening instruments for torture and health settings

Context	Instrument	Questions
Screening of asylum seekers in Denmark (Munk-Andersen et al., 2021).	Torture Screening Checklist. 4 items - Check list meeting the legal definitions of torture	1. Have you ever been arrested, detained, or imprisoned? 2. Have you ever been subjected to severe violence, threats or degrading treatment? 3. Have you witnessed others being subjected to severe violence or degrading (abusive) treatment?
Screening of asylum seekers in the US and other countries (Cook et al., 2015; Shannon, 2014; Shannon et al., 2015).	Center for Victims of Torture -Torture and War Trauma Screening Questionnaire	1. In your life, have you ever been harmed or threatened by the following: government, police, military or rebel soldiers, or other(s)? If yes, what was it? 2. Has any of your family ever been harmed or threatened by the following: government, police, military or rebel soldiers, or other(s)? If yes, what was it? 3. Some people in your situation have experienced torture. Has that ever happened to you? If yes, what was it? 4. Has anyone in your family been tortured? If yes, what was it?
Public health epidemiological studies in Sweden (Sigvardsdotter et al., 2017).	Single General Trauma Item + Refugee trauma history checklist (RTHC) (see annex 1).	Sometimes things happen to people that would upset or frighten almost everyone. Examples of such difficult and frightening experiences are: being assaulted, or witnessing other people being hurt or killed. 1. Have you experienced any of these or some other terrifying event(s)?
Screening of foreign nationals in the outpatient Internal Medicine Department of a public hospital in New York City. (Eisenman et al., 2000) (Eisenman, 2007)	Detection of Torture Survivors Survey (DTTS)	In this clinic, we see many patients who have been forced to leave their countries because of violence or threats to the health and safety of patients and their families. I am going to ask you some questions about this: 1. In (your former country), did you ever have problems because of religion, political beliefs, culture, or any other reason(s)? 2. Did you have any problems with persons working for the government, military, police, or any other group? 3. Were you ever a victim of violence in (your former country)? 4. Were you ever a victim of torture in (your former country)?
Emergency department of a public university hospital in New York. (Hexom et al., 2012).	Short version of the DTSS + Second interview with 8 additional questions more in detail (see annex 1)	1. Were you ever threatened or harmed by groups such as the government, police, military, or rebel soldiers? 2. Some people in your situation have experienced torture. Has that ever happened to you or your family?

this case, clinical documentation will enable the patient to recognize himself or herself as a victim, to establish the facts and eventually, when political conditions allow, to seek justice and reparation.

Screening Criteria and Guiding Symptoms

We see, from the above, that if you are a health worker in an area where there is a high prevalence of migrant population, of people coming from high-risk countries or if you work in a place or a facility where you know that ill-treatment is not uncommon, it may make sense for you to have a screening and detection tool for victims of violence in general or specifically for detection of victims of torture.

You can also suspect it when you find a person with socio-demographic conditions of risk and with any of these four guiding symptoms:

1. Persistent anxiety, irritability or panic attacks in response to stimuli related to situations of violence.
2. Very severe insomnia that does not improve with healthy habits or first-choice hypnotics.
3. Difficulties in concentration, problems in orienting oneself or retaining new learnings or information. The person or family report that he/she sometimes seems to be absent.
4. Musculoskeletal lesions, skin scarring, and/or generalized pain patterns with no previously diagnosed cause.

Different tools have been proposed for the detection of torture in PHC. Table 2 (extended in annexes) reviews some instruments that have been suggested as useful in literature, either in the general or for migrant population[8]. As can be seen, the content of the questions is very similar among the different scales and can be adapted to the specific work context of each health professional depending on whether the professional wants to talk specifically about torture or in more general terms (threats, violence).

Myths, doubts and realities in interviewing potential victims of ill-treatment or torture in primary care

One of the dilemmas in PHC is the competence and limits of interventions. In the field of victims of violence, this is particularly complex due to a general lack of time for consultation in many centres, combined with the duty to *first and foremost do no harm.* But these elements have to be balanced against other realities; in many places, the clinician is the only one who can do this work and the benefits for the patient are multiple, especially when the clinician has a psychosocial and holistic approach to care. Besides, there is a legal obligation of the professional to detect and intervene, in accordance with international legislation and the relevant codes of ethics.

Table 3 attempts to reflect on some of the most common doubts and myths that PHC professionals often face when dealing with victims of abuse.

8 We do not include here screening measures for mental health problems among refugees, asylum seekers or potential victims of torture, such as the Harvard Trauma Questionnaire (Bertelsen et al., 2018; Berthold et al., 2019) or the Protect Questionnaire (Mewes et al., 2018). Several dozen instruments and excellent comparative reviews exist. (Magwood et al., 2022).

Table 3. Dilemmas in detecting and intervening with victims of torture in primary health care

Myths and doubts	Reality
"Torture" is not a clinical condition but a crime	It is not a question of making a diagnosis of "torture" but of taking an adequate medical history to detect and, if possible, document the medical-psychological impacts of having suffered extreme violence.
The interviews are best conducted by a psychologist or psychiatrist in a mental health consultation or in a specialized centre for refugees or victims.	Studies indicate that the main element of a good interview with a potential victim is empathy and the creation of a bond of trust from a genuine interest in the patient's reality. Do not assume that a mental health consultation or a refugee centre will be more empathetic than you are.
I don't have time. There is a lot of pressure here.	In primary care it is neither necessary nor useful to go into all the details of the traumatic experience. It is important to ask the basics in order to make an adequate approach and to provide orientation to the patient.
I can harm or re-traumatise the person.	A tactful interview that gives the person the freedom to express without pressure to obtain information will not be re-traumatising. Asking about experiences of ill-treatment or torture, if not in contexts of high risk or great mistrust, is a source of understanding and relief.
Fear of how what the patient might tell, will affect me.	This is shared with other types of seriously-ill patients. For example, those suffering from disabling and/or irreversible diseases, and most health professionals would be prepared to work with them.
I am afraid of not knowing what to do. I have no specific training.	The greatest source of insecurity is the lack of information and the absence of a plan. Have basic information in your consultation on four aspects: (1) the right to asylum and where to apply for it, (2) victim care centres in your area, (3) how to do a medical and psychological examination of a victim and whether to look for specific elements, and (4) how to draw up a clinical report according to the Istanbul Protocol. In this article, we will help you with the last two.
I am afraid of being cheated or manipulated.	In the life of a refugee, sometimes "constructing truths" is a mechanism of resilience in the face of survival difficulties and a hostile environment. It is a defense reaction, just like the one that occurs when we explore a part of the body that has long been adapting to an illness. It requires understanding and patience

There may be risks for me. I can attract attention from employer or boss for entering into sensitive political issues.	There is a delicate balance between the duty to support victims, as patients, and the risks that this may entail (see below). Each person must know how far he or she can go and what reasonable risks he or she can or should take.
And afterwards? I don't know exactly what my role is	The same as with any other psychosocial or community problem in primary care (bereavement, crisis, adjustment to chronic illness): provide emotional support, comprehensive understanding of the symptoms, treat them from their causes, prescribe or advise. And in some cases, document for administrative processes or report to relevant health or legal authorities.

How to interview and examine a potential victim: ethical conditions required by the Istanbul Protocol

The Istanbul Protocol (IP), as a guide for practitioners, provides indications in two aspects: what are the *ethical* requirements for conducting an interview and what are the *technical* requirements for screening and reporting.

As you will see, this is no different from any clinical interview with another patient treated in primary care. In fact, the outline of the report proposed in Annex IV of the IP mimics the structure of a classic clinical history (reason for consultation, history - in this case biopsychosocial -, current episode - account of events -, systematic physical examination and clinical judgement). The particularity lies in creating an environment in which there are no coercive elements (use of shackles, custodial staff...), the need for an informed consent (as, in fact, is required in many invasive medical or surgical procedures) and the addition when possible of a judgement of consistency between the allegations and the medical evidence.

Let us address the first ones.

These are a set of specific rules that the healthcare professional must take into account when interviewing patients, especially in the context of custody and detention (see figure 1).

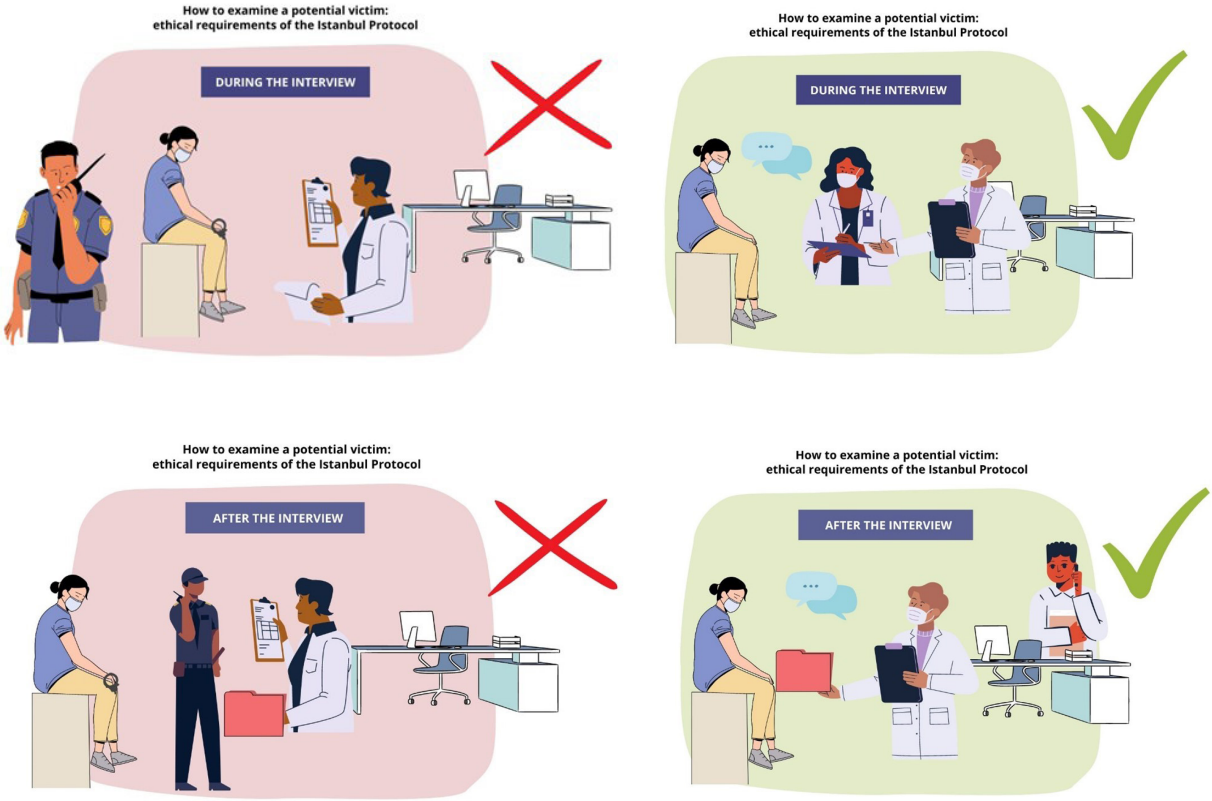
Interview conditions

1. Security conditions.

This is not usually a part of the concerns of a health worker, but in certain contexts it can be relevant and the health professional should have them in mind.

- Before assessing the person, the practitioner must assess whether there is a *risk of reprisals* for the person for speaking to the practitioner or being examined. This may occur in a detention setting (police station, prison...) or when the person is brought to consultation under police custody.
- As a rule, it is important to remember that the Protocol indicates that it should NOT be the same officers who made the arrest or who could be the potential aggressor, who bring the detainee into custody to the consultation. When this is the case, it is necessary to assess whether there are any risks to the patient. A good measure is to *ask the patient themselves* in private and get his/her opinion.
- Custodial officers will sometimes warn the practitioner of the alleged dangerousness of the detainee in order to demand to be inside the consultation room. We know that this is often information that is intended

Figure 1.



to intimidate the health worker and gain access. Except for some people in a state of mental or emotional disturbance, the professional will not be in danger if he or she is left alone with the patient. If this is the case, the general measures adopted for all agitated patients can be taken with the support of the other members of the staff.

2. Privacy and Confidentiality

Both are essential elements to build a space of trust and confidence and are basic ethical requirements.

- *Privacy* has to do with the absence in the room of any person other than health personnel or persons trusted by the potential victim who they request to be present (for instance close relative or a lawyer). Certainly not, under any circumstances, persons who could coerce the free account of the person to be examined, including custodial officers. If it is not possible to get the officers to leave the examination room, or on the grounds that they have to guard the detainee, they should remain in a place and out of sight, or at least where they cannot hear the dialogue

between doctor and patient. For example, in a waiting room, with the door closed.
- *Confidentiality* is related to the fact that the clinical report belongs only to the patient, and therefore, unless it is in response to a court order or unless the detainee expressly so indicates, the clinical report should not be given to custodial officers. If there is a duty to give the report to third parties, the patient should be informed of this obligation before beginning the interview and be allowed to decide, or consent to, on what information they wish to share with the health professional, knowing that the clinician will have to answer all the questions asked by the legal authority.

Informed consent

- If it is not the person themselves who has requested to be seen or assessed by a health professional, it is necessary to *inform the patient in a way that is understandable* and adapted to their capacity and cultural context what the assessment consists of and what the purpose of the assessment is. It is important to obtain the necessary consent before carrying out the medical and psychological examination. If the detainee refuses the medical assessment, the doctor shall not act against their will.

During the evaluation

It is important that the consultation to a health professional is produced in a normal, trusting, environment. Therefore:

- If the person is subjected to any *mechanical restraint (shackles, restraints or something similar), there needs to be a removal* which should be requested prior to the physical and psychological examination, allowing for a comprehensive and full examination.
- It is important to minimize the risk of re-traumatization, following the principle of first, to do no harm. To this end, measures such as using an *empathetic, culturally sensitive and gender-sensitive approach* to clinical interviewing are important. Also, when there is a language barrier, consider the possibility of including an interpreter, whether informal or formal, depending on the patient's preferences. (Kumar, 2022).

It is advisable to perform the physical examination in the presence of at least one person of the same gender as the person being interviewed, especially if a genital examination is to be performed or if the patient is a minor.

After the evaluation: What do I do with the report?

The procedure is similar to any other health report issued for a patient:

- In primary health care, all reports belong to the patient and therefore, unless otherwise ordered by a court, i*t will be given only to the patient or his/her legal representative*. A copy must remain in the health record of the patient. Exceptions are when the patient declines keeping the report and prefers it to remain only in the medical files for the future or authorises the report to be given to the custody agents. Alternatively, if necessary, the custody officers shall be provided with a sheet of advice and treatment recommendations for the next hours.
- Many countries also provide regulations that Discharge Reports from the outpatient consultation or the emergency room describing situations of violence with legal implications should always be forwarded to the relevant

authorities (duty law court, prosecutor's office).
- Finally, depending on the case, refer patients to other medical services for further assessment with forensic clinicians or specialized training, especially when sexual or gender-based torture is suspected, or in minors.

What structure should the clinical report have?

In a PHC setting, the aim is not to produce a full Istanbul Protocol, as would be done in a forensic setting, but to produce a clinical report that meets at least the technical requirements of the Protocol. This can be summarised in five basic points:

- Identification of the alleged victim and conditions of the evaluation
- A detailed account of allegations including torture or ill-treatment methods and physical and psychological symptoms
- A record of physical and psychological findings
- Interpretation of all findings, making a judgement of consistency and an opinion on the possibility of torture and/or ill-treatment, and clinical recommendations
- Identification and the signature of the medical expert(s)

In an emergency room or where scarce time is available:

- Produce a short narrative account of the facts in the words of the patients.
- Document the physical and psychological consequences through a full physical and psychological examination.
- Make a judgement of consistency between the account of events and the physical and/or psychological findings observed.

In addition, if the clinician has basic training on the definition of torture, the Istanbul Protocol demands to formulate an opinion on the possibility of ill-treatment or torture.

Table 4 suggests a more detailed report structure. The schema proposed here is not an official IP suggestion but a summary based in the Annex IV of the Istanbul Protocol, where you can find an even more complete report template, intended for the forensic setting. You can make your own adaptation depending on your work conditions and possibilities provided the Istanbul Principles are followed[9]. As can be seen, the structure is the same as any clinical report with a few elements added[10].

There are two possible scenarios:

1. Assessment of a patient that has been recently subjected to violence (assessment in the following hours or days): We will

9 As stated in paragraph 607, *the Istanbul Protocol allow for some flexibility with regard to the level of detail provided in a medico-legal report. (…). The content can vary as long as the evaluations follow the Istanbul Principles.*

10 In Chapter 7 of the IP22 there is a shorter outline than the schema sugested in Table 4: *Obtain informed consent, Exclude any third parties from the evaluation room, Inquire about the cause of any injuries or psychological distress, Document physical and/or psychological symptoms or disabilities related to the alleged abuse, Conduct a directed physical examination including a brief mental status examination and a risk assessment for harm to self and to and from others, Document all injuries with body diagrams (see Annex III), and photographs if possible. If ill-treatment is alleged or suspected, make appropriate referrals and notify appropriate authorities and inform the individual of his or her right to clinical evaluations by independent, non-governmental clinical experts. Clinical interpretation of findings & conclusions on the possibility of torture may be considered by clinicians who have knowledge and experience applying the Istanbul Protocol and its Principles, but is not required.*

Table 4. Structure of a brief report of an alleged torture victim based on the suggestions of Annex IV of the IP-2022[10].

1. Health centre, date, time
2. Identification data of the person assisted
3. Conditions of the interview:
   - Consent: Who requests the report (patient, authority...) and whether the patient agrees
   - Privacy: Who is present in the consultation, especially persons who may restrict the interaction between the health personnel and the patient
   - Restrictions to which the patient may be subjected (shackling or others)
   - Confidentiality: To whom the report is given and whether medical recommendations are given to custodial persons, if necessary.
4. Reason for the report (injuries...) and person/s causing the injury/s according to the patient
5. Brief account of events *using the patient's own words verbatim*, including all relevant aspects. Include date, time and place where the ill-treatment allegedly took place.
6. Personal history of interest (in relation to the injuries). Only if there is relevant information.
7. Physical examination. Make a detailed examination of all organ systems. If there are injuries, prepare a description of the injuries which includes the shape, size or dimensions, location, descriptive aspects of the colour and the origin that the person refers to for each of the documented injuries. Consider taking photographs, if possible, and if consent is given.
8. Psychological examination: emotional reactions and relevant clinical psychological impacts associated with the episode(s).
9. Complementary examinations, if performed: analytical tests (including determination of muscle enzymes), imaging tests, and if necessary, specialised gynaecological, traumatological, dermatological or neurological examinations.
10. Medical diagnostics.
11. Prognosis of physical and/or psychological injuries or impacts.
12. Consistency or compatibility judgement. Assessment of the consistency between the medical and psychological examination data and the patient's allegations of ill-treatment/torture.
13. If the person has received training, provide a medical opinion as to whether the facts could constitute ill-treatment or torture.
14. Therapeutic recommendations
15. Name, address and signature of the person making the report

explore acute symptoms and signs and look for recent injuries. Remember that although pain has classically been considered a *symptom* (because it has been considered as allegedly subjective), the tendency in modern medicine is to treat it as a *sign* and to try to give it objectivity by using validated scales of measurement. Although not explicitly recommended in the IP22, but it is a good medical practice to make a detailed exploration of pain symptoms in the physical examination as a "sign" and described in the same way as other physical signs (wounds, haematomas, etc.). (See below).

2. Assessment of a patient subjected to violence sometime after the event. In most cases, you will probably not find any acute physical injuries. In this case, it is advisable to ask about the acute symptoms and signs that the person remembers having at the time of the events and how they evolved through time. On the other hand, perform an active search for sequelae that have lasted over time (including persistent pain, sensory deficits, insomnia, etc.). In any case psychological symptoms may be much more marked and evident and might need careful assessment and appropriate referral if necessary.

What to assess, are there specific elements?

The following constitute a synthesis of key aspects in the medical assessment of suspected survivors of ill-treatment or torture. The updated version of the Istanbul Protocol provides a much more comprehensive and complete guide (chapter 5 on physical examination and chapter 6 on psychological examination). This section is intended as a quick reference guide.

Main considerations of the medical assessment

Take special care during the physical examination. The physical and psychological sequelae of torture, if they occur, occur in the context of complex trauma, superimposed on the impact of the different social determinants of health[11] and other chronic medical conditions, which make this diagnosis a challenge for the medical professional. (Kalt et al., 2013). Therefore, it is important to avoid the risk of re-traumatization in the medical examination by explaining empathetically, for instance, the need to remove clothing or to perform certain invasive examinations.

Take a brief medical history with a detailed examination of all organ systems, as you would do with any other patient in your daily practice. This will include:

- *Anamnesis* of the symptoms the person suffers from and what the person attributes them to. Classify symptoms into acute and chronic.
- *Physical examination*. This is not simply the observation of possible injuries, but a systematic and detailed assessment by apparatus. If specific training is available, some elements suggestive of torture may be detected, but an examination as one would do with any other patient in which the general condition is assessed is already extremely useful. There may be symptoms or signs that disappear within a few days, and others that are sequelae of past injuries.

11 In the case of migrants, the social determinants of health cut across the lives of torture survivors, both in their country of origin (violence, discrimination, flight...) during the migration journey (grief, trauma, crisis) and in the host country (loss of status, racism, housing, work, access to health...).

- *Clinical judgement*
- *Degree of consistency* between the observations and the allegations of torture[12]. If trained, interpretation of the findings or conclusions.
- *Therapeutic recommendations.*
- In addition, it may include *prognostic* assessments, a statement on the *degree of disability and its socio-occupational impact*, as well as recommendations for possible *referrals to medical specialists*, if needed.

It is important not to forget that the absence of physical or psychological evidence on examination does not rule out torture. In the contemporary world, torture often aims to inflict the greatest trauma with the least residual evidence, and there is scarce presence of physical findings. (Amris & Williams, 2015).

Symptoms related to torture episodes and especially forms of pain are often misdiagnosed and sometimes treated as a manifestation of psychological trauma, psychogenic pain or somatisation. There is an under-diagnosis of pain due to its atypical presentation. (Kaur et al., 2020).

Pain as a major symptom. It is estimated that 87% of torture survivors experience chronic pain. Most commonly are headaches (93%), musculoskeletal pain (87%) and pain in the extremities (72%). (Williams & Amris, 2007). This localised pain often correlates with the mechanism of injury. However, there is a generalised pattern of pain that the patient may not understand, may not associate with the torture events, and is sometimes medically unexplainable (MUS). (Edwards et al., 2010). Knowing this, it is important in the examination to use specific pain measures, such as the VAS scale or others. (Hawker et al., 2011).

Pain in torture victims has some peculiar characteristics that make it different from other types of pain. It is persistent, generalised, non-specific, and mostly disabling. It does not usually improve with rehabilitation or analgesia, and so it must be treated with a holistic approach that includes psychological components. (Edwards et al., 2010).

Psychological and emotional assessment

All reports should always include, in addition to the physical examination, a psychological examination. Even if the psychological evaluation was carried out by another professional, it is advisable that both assessments are included in the same report signed by all the professionals involved.

The primary care clinicians are not expected to conduct an in-depth psychiatric interview, but rather a brief mental status examination. Nevertheless, pay special attention to the person's emotional state when describing the events, and explore the most frequent psychological symptoms such as panic attacks, irritability, symptoms of generalised anxiety or depression, insomnia, nightmares or signs of emotional overflow. Try to explore their connection with the alleged facts.

These psychological symptoms may be directly or indirectly related to the physical symptoms, either as somatisation or as elements that aggravate the underlying symptomatology both in its acute process and in its chronicity. Therefore, psychological symptoms may have a major impact on the person's overall state of health and are an essential consideration for general practitioners.

12 For clinicians who have knowledge and experience applying the IP, may consider providing an interpretation on the level of consistency according to the five levels recommended in legal settings: Not consistent - consistent - highly consistent - diagnostic – unrelated (see paragraph 360 of the IP).

Table 5. Recommendations for taking photographs of injuries.

General terms and conditions	• As soon as possible - the lesions disappear quickly. • Ask for the person's consent and/or permission • Any (mobile) camera will do.
How to take the photographs?	• Display the current date (if not available on the camera itself, include a calendar or newspaper in the photo). • Show the identity of the alleged victim (face) in any of the photographs or include full body photographs and then photographs of details. • It is desirable to display a scale (ruler or common object) to see the size of injuries • Use natural light instead of flash • Do not manipulate the picture, use filters or change its format.

Supplementary material for the medical assessment: Photographs and anatomical drawings

To complement the medical assessment, the Istanbul Protocol includes an annexe of anatomical drawings (annex III, pg 179) . In the drawings it is important not only to reflect external injuries, but also reflect painful areas and sites of functional disability.

Nowadays, high quality photographs can be taken with any mobile phone. Table 5 lists some basic recommendations.

Other complementary tests may also be carried out to help corroborate allegations of torture. However, when considering such tests, the risk-benefit to the individual should be considered, and the indication of such tests is generally not justified unless they would make a significant difference in a medico-legal case.

And then?

In a qualitative focus group study, torture survivors were asked what they would expect from their primary care physicians. Victims highlighted five aspects. Refugees recommended that physicians should take the time to make refugees feel comfortable, initiate direct conversations about mental health, inquire about the historical context of symptoms and provide psychoeducation about mental health and healing (Shannon, 2014).

Conflicting ethical obligations.

The new version of the Istanbul Protocol devotes much attention to Conflicting ethical obligations within the medical profession. This is referred to as a situation in which a physician or mental health professional is faced with two competing interests: the primary one, which is the duty to look after the best interests of the patient, and the secondary one, which derives from obligations to the institution for which he or she works. For interested readers, refer to Chapter II and VII of the IP-22.

Conclusions

Specialised centres for the care of torture victims exist in many countries. However, most torture victims will not be aware of their existence or be able to access them. (Piwowarczyk & Grodin, 2016). Torture is an important and critical public health problem, especially among at-risk groups. Early detection and documentation depend on good treatment of patients and the possibility of access to protection and rehabilitation measures. Training on documentation of torture in medical schools is minimal or non-existent, as the Istanbul Protocol itself points out[13] .

13 Chapter 8 on implementation of the Istanbul Protocol by authorities

It is important that primary care and emergency department professionals in both the global North and South develop skills in the detection and management of torture survivors because of the severity of suffering and the biopsychosocial implications involved.

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Annex 1

DIGNITY and Danish Red Cross Screening Instrument for Torture

Part 1. Questions for the interviewee

Have you ever been arrested, detained, or imprisoned?	□ Yes □ No
Have you ever been subjected to severe violence, threats or degrading treatment?	□ Yes □ No
Have you witnessed others being subjected to severe violence or degrading (abusive) treatment?	□ Yes □ No

If the answer is no to all the first three questions, the screening closes with the conclusion that the interviewee has not been subjected to torture. If the answer is yes to just one of the three questions, the interviewee is encouraged to provide a narrative account:

Would you mind telling me what happened?

Help questions for the narrative presentation:

a. What did they do to you?
b. Who exposed you to it?
c. Do you know why they did it?

The help questions are intended as inspiration to guide the interviewee's narrative and do not necessarily need to be read out. The answer also serves as a guide to the interviewer as to whether there has been inhuman treatment or punishment. If the interviewee has been subjected to several incidents, he/she is asked to choose the incident that affected him/her the most. After the interview, the interviewer completes Part 2 of the form encoding the torture criteria

Part 2 Coding of Torture Criteria

To be filled in by the interviewer based on the interviewee's narrative statement

Was the person exposed to severe pain or suffering, physically or mentally?	□ Yes □ No
Was it done intentionally?	□ Yes □ No
Was there a purpose to the action?	□ Yes □ No
Was it a public official who committed or instigated the action?	□ Yes □ No

Conclusion

Coding result	Screening result
YYYY	The interviewee has probably been subjected to torture
Y N NY	The interviewee has probably been subjected to ill-treatment
Any other combination	The interviewee has probably been subjected to other forms of trauma

The Refugee Trauma History Checklist (Sigvardsdotter et al., 2017)
The questions in this section concern difficult and frightening experiences, and can awaken distressing memories. It is important for us that many people answer these questions. However, if you find it is too distressing, please take a break or skip this section.

Before you left your home, have you experienced any of the following situations or events?

War at close quarters	□ Yes □ No
Forced separation from family or close friends	□ Yes □ No
Loss or disappearance of family member(s) or loved one(s)	□ Yes □ No
Physical violence or assault	□ Yes □ No
Witnessing physical violence or assault	□ Yes □ No
Torture	□ Yes □ No
Sexual violence	□ Yes □ No
Other frightening situation(s) where you felt your life was in danger.	□ Yes □ No

The Single General Trauma Item (SGTI)
Sometimes things happen to people that would upset or frighten almost everyone. Examples of such difficult and frightening experiences are: being assaulted, or witnessing other people being hurt or killed. Have you experienced any of these or some other terrifying event(s)?

Torture and Trauma Screening Interview (Hexom et al., 2012)

1. Were you ever threatened or harmed by groups such as the government, police, military, or rebel soldiers?
2. Some people in your situation have experienced torture. Has that ever happened to you or your family?

Those who answered positively to one of the two questions were given an additional short interview.

1. Who were you tortured by?
2. What best describes what happened to you?
3. Why you were tortured?
4. Did you leave your home or country as a result of being tortured?
5. Do you have any physical disabilities as a result of being tortured?
6. Do you have any recurrent intrusive or distressing memories as a result of being tortured?
7. Has a doctor ever asked you if you have been tortured?
8. Have you ever applied for political asylum?