Abstract

Primary care providers who evaluate torture survivors often lack formal training to identify and address their specific needs. We assessed 89 asylum seekers from 30 countries to evaluate the pattern, spectrum, and presentation of abuses and the outcomes of the medico-legal process of seeking asylum. Commonly reported reasons for abuse were political opinion/activity (59%), ethnicity (42%), and religion (32%). The most common means of abuse were punching/kicking (79%), sharp objects (28%), genital electric shock (8%), witnessing murder/decapitation (8%), and rape (7%). Persistent psychological symptoms were common; 40% had post-traumatic stress disorder. The high success rate of asylum approval (79%) in this sample highlights the need for physician witnesses trained in identification and documentation of torture, working in collaboration with human rights organizations.

Le personnel médical qui évalue les victimes de torture manque souvent de formation lui permettant d'identifier leurs besoins particuliers et d'y répondre. Nous avons examiné 89 demandeurs d'asile issus de 30 pays afin d'évaluer la forme, l'étendue et la présentation des abus et des conséquences de la procédure médico-légale de demande d'asile. Les principales causes d'abus déclarées étaient: l'opinion/l'activité politique (59%), l'ethnie (42%), et la religion (32%). Parmi les formes d'abus les plus courantes: coups de pied/de poing (79%), objets pointus (28%), décharges d'électricité sur les organes génitaux (8%), être témoin de meurtre/décapitation (8%), et viols (7%) Les symptômes psychologiques persistants sont courants; 40% souffrent de syndrome de stress post-traumatique. Le taux élevé d'acceptation des demandes d'asile (79%) de cet échantillon met en évidence la nécessité de former des médecins témoins pour identifier et documenter les cas de torture en collaboration avec les organisations des droits de l'homme.

Los proveedores de atención primaria que evalúan a sobrevivientes a las torturas a menudo carecen de capacitación formal para identificar sus necesidades específicas y solucionarlas. Evaluamos a 89 solicitantes de asilo de 30 países para estudiar el modelo, el espectro y la presentación de abusos, y los resultados del proceso médico-legal de pedir asilo. Las razones comúnmente expresadas de abuso fueron opinión/actividad política (59%), identidad étnica (42%), y religión (32%). Los medios de abuso de uso más frecuente fueron puñetazos/patadas (79%), objetos afilados o puntiagudos (28%) descargas eléctricas en los genitales (8%), presenciar homicidio/decapitación (8%), y violación (7%). Se observaron a menudo síntomas psicológicos persistentes; 40% tuvo trastorno de estrés postraumático. El índice de éxito alto de la aprobación de asilo (79%) en esta muestra pone de relieve la necesidad de testigos médicos capacitados en la identificación y documentación de tortura, que trabajen en colaboración con organizaciones de defensa de los derechos humanos.

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EVALUATING ASYLUM SEEKERS/TORTURE SURVIVORS IN URBAN PRIMARY CARE
A Collaborative Approach at the Bronx Human Rights Clinic

Ramin G. Asgary, Eva E. Metalios, Clyde L. Smith, and Gerald A. Paccione

Although international human rights and humanitarian laws prohibit torture, it is practiced in more than half of the world's countries.[1] The prevalence of torture is high, and the consequences are profound.[2] Torture can have numerous physical, psychological, and social sequelae, leaving permanent scars on both the body and the mind of the survivor, as well as the fabric of communities.[3-6] Documentation of torture can be fundamental to securing refuge for a survivor.

Article 1 of the United Nations' Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (1984) defines the term *torture* as:

> 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[/her] or a third person information or a confession, punishing him[/her] for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing

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> him[/her] or a third person, or 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.[7]

The United Nations reports that there were approximately 650,000 individuals who applied for asylum in various countries in the year 2000[8]. Every year in the US alone, more than 200,000 undocumented immigrants and asylum seekers are held in over 900 detention sites.[9] The number of refugees and asylees granted lawful permanent resident status in the US during the 1990s was more than 900,000. In the years 2001-2002, 234,590 were granted permanent resident status (approximately 85% refugees and 15% asylees).[10] Although the data are difficult to obtain, the overall prevalence of torture among this population has been estimated to be as high as 35%.[11] Between 5-10% of foreign-born persons receiving care in some urban primary care clinics in the US are torture survivors.[12] It is estimated that around 500,000 torture survivors are currently living in the US, including those who are applying for asylum and those who were granted protection.[13] The US Citizenship and Immigration Services (USCIS) approval rate for asylum seekers shifted from 43.7% in 2000 to 20.9% in 2001, and 36% in 2002.[14] These figures do not include those survivors who never applied for asylum.

Primary care physicians are often the first and the principal caregivers for torture survivors, and yet they are often unaware that their immigrant patients have experienced torture.[15] Such patients rarely bring their torture up in the course of routine clinical visits unless specifically asked, and the providers are not usually trained to ask about a history of torture among their immigrant patients. Identifying the symptoms and signs of torture and documenting their causes are often key to providing effective health care to a survivor. General practitioners are in a unique position to establish a trusting relationship with these individuals, to coordinate their health care with other providers, to rein-

force their social support network, and to make appropriate referrals to address their specific needs.

The United Nations Convention Against Torture (Article 10) calls for the "education of all medical personnels in the prohibition, identification, and treatment of survivors of torture."[16] Unfortunately, few medical schools and residency training programs train their medical students and residents to evaluate and treat torture survivors. Furthermore, the opportunities for continuing education of doctors on issues of human rights and torture are limited.[17]

The study presented in this article retrospectively analyzed the experience of the Bronx Human Rights Clinic (BHRC) at Montefiore Medical Center in New York, USA. It characterizes our population demographically before and following entry to the US; provides data on cause, nature, extent, timing, type, and sequelae of torture; summarizes symptoms, signs, and their relevance to the torture experience; and presents the outcome data related to clients' asylum claims. The study also discusses the importance of evaluating asylees in a primary care setting within the context of a post-graduate training program and in collaboration with independent advocacy organizations. We at Montefiore refer to our work as "clinical human rights": advocacy in a clinical context that incorporates examination for symptoms and signs of maltreatment and provision of therapy and support (both biomedical and social) for its consequences.

The Bronx Human Rights Clinic

The Bronx Human Rights Clinic was founded in the Bronx, New York, in 1993. A collaborative project between Montefiore Medical Center's post-graduate training program in Primary Care and Social Medicine and Doctors of the World-USA (DOW), it employs a comprehensive, integrated approach in caring for asylum applicants who claim that they have experienced torture. The BHRC also works within a consortium of local and international nongovernmental organizations (NGOs), community organizations, and independent lawyers to support clients' legal, social, and psychological needs and to lobby for and facilitate services such as insurance and mental and physical health care.

At the BHRC, we train medical residents (doctors pursuing post-graduate training in internal medicine) to evaluate asylum applicants and their claims of torture. Participating in the Human Rights Clinic is a requirement for the 30 residents in Primary Care and Social Medicine at Montefiore Medical Center, who are all trained to use medical skills during the second and third years of their three-year residency to evaluate and treat asylum applicants and torture survivors. The BHRC operates in a primary care clinical setting, in the same community-based facility where residents and faculty in the program see patients. The residents are precepted by a group of attending physicians experienced in the clinical evaluation of asylum applicants. Subsequent to the asylum evaluation, clients are invited to return to the facility for continuity care provided by the same doctors who evaluated them at BHRC.

Doctors of the World works closely with many grassroots advocacy organizations to identify and support torture survivors within their communities. Clients come to the BHRC after a referral by DOW for clinical evaluations. Most clients are referred to DOW by their lawyers, although some are self-referred. Only the client and doctor (and translators, as necessary) are present at the time of the interview and clinical evaluation. Prior to the evaluation, the physician typically receives a copy of the clients' primary statement—either their asylum application or a rough draft. In addition, the doctor receives background information regarding the country of origin. Since the fall of 1999, the exam and interview have been based on the *Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (also known as the Istanbul Protocol, adopted in August 1999). This manual, adopted by the United Nations as a standard guideline, standardizes the physician narrative in the following sequences:

> 1. Case Information; 2. Clinician's Qualifications; 3. Statement Regarding Veracity of Testimony; 4. Background Information; 5. Allegations of Torture and Ill Treatment; 6. Physical Symptoms and Disability; 7. Physical Examination; 8. Psychological History/ Examination; 9. Photographs; 10. Diagnostic Test Results; 11. Consultation; 12. Interpretation of Findings (Physical and Psychological

Evidence); 13. Conclusions and Recommendations; 14. Statement of Truthfulness; 15. Statement of Restrictions on the Medical Evaluation/Investigation; 16. Clinician Signature, Date, Place; 17. Relevant Appendices (Anatomic Drawing, Physician CV, Photographs, etc.).[18]

Methods

The data presented here relate to the 89 patients presenting to the BHRC from June 1998 to September 2002.

Each client's file included copies of the client's statement and claim, the legal representative's evaluation, and the physician affidavit. Other medical forms and legal documents were included in the file when available. Institutional Review Board (IRB) approval for this study was obtained from Montefiore Medical Center's IRB.

The primary author performed a systematic case review of the 89 applicant files. The system for data extraction was based on the classification used by the Istanbul Protocol (IP) on types of torture. For those methods of torture not included in the IP format, a clinically based classification was assigned. With symptoms or signs present, emphasis was placed on using the exact words offered in the client's and physician's descriptions. Accuracy was checked for each item of demographic data in the summary review and assessed by comparing the client's statement with the physician affidavit and any other legal documents. In case of a discrepancy between the client's narrative and the physician's narrative in the description of type of torture or torture tool, the physician's definition was used for the category "Documented by Physician," and client's words were used for "Reason for Asylum Seeking/Type of Torture." Marital status, number of children, occupation, education, and medical care after torture are presented exactly as clients stated them in their narratives. Similarly, for "Any Jail or Camp" and "Number of Countries Passed Through Before Getting to US," the client's statement was used.

Results

General demographic and biographic data are presented in Table 1. Not all data were available for each client, and therefore, the denominator for each data set changes ac-

Country* (n=88)					
Bangladesh	*17*	*India*	*5*	*Russia*	*2*
Mauritania	*9*	*Pakistan*	*5*	*Montenegro*	*2*
Tibet	*8*	*Guinea*	*5*	*Egypt*	*2*
Sierra Leone	*6*	*Togo*	*3*		
Liberia	*5*	*Albania*	*2*		
Occupation ‡ (n=46)					
Business	*10*	*Secretary*	*4*	*Journalist*	*2*
Labor	*5*	*Farmer*	*3*	*Butcher*	*2*
Student	*5*	*Doctor*	*2*	*Housekeeper*	*2*
Cumulative Duration of Abuse (n=79)					
1 – 29 days	*44*	*1 – 11 months*	*26*	*More than 1 year*	*9*
Duration of Time Spent in Prison (n=72)					
1–29 days	*29*	*More than 1 year*	*9*	*No prison*	*20*
Less than 1 year	*22*				

* *Single client from Afghanistan, Cameroon, China, Congo-Brazzaville, Eritrea, Georgia, Ghana, Jamaica, Kosovo, Kyrgyzstan, Lebanon, Nigeria, Romania, Suriname, Uzbekistan, Yemen, and Zaire (missing data for one client).*

‡ *Single client report as mayor, actor, musician, chemist, carpet maker, driver, engineer, shepherd, aviation officer, shopkeeper, and military person.*

Table 1. *Bronx Human Rights Clinic Clients: General Demographic and Biographic Data.*

cordingly. Men comprised 87% of the group (77 clients). The mean age was 34 (+/-8.0, range 18-59) years old. Eleven had university/college education and another four held graduate degrees. Forty-two were married. Of the 63 clients reporting information about children, 18 had one child, 18 had more than one child, and the rest did not have children. (Only eight clients had their children with them in the US at the time they were interviewed.) Fifty clients were able to speak English. The majority of our clients were from Bangladesh (17), Mauritania (9), Tibet (8), and Sierra Leone (6).

Forty-eight of 74 clients (65%) reported abuse of either their parents or siblings (29), wife (11), children (5), relatives (3), or any 2 of the above (7). Fifty-two had been in prison. Mean age at first torture was 25.7 (+/-7.5, range 15-43), and mean number of years from first torture to US entry was 5.5 (+/-4.6, range 0.5-22) years. Average years from US entry to exam was 2.9 years (range 0.5-14).

Other data pertaining to clients' flights from their countries of residence are as follows: 12 of 51 had spent time in jail or refugee camps after leaving their country, and out of 48 for whom data were available, 39 had had to pass through another country to get to the US. One had traveled to 5 different countries, and 13 had traveled to at least 2 other countries. Of 34 clients with available data, 15 had received financial assistance from friends for coming to the US, 9 from relatives, 2 from NGOs. Fifty-four clients had been granted asylum status, 14 had been refused, and the results for the rest were either pending or unavailable.

Table 2 presents reasons noted for torture and identification category of the abuser. Political opinion and activity, ethnicity, and religious beliefs were among the most common reported reasons for abuse. Sexual orientation was a reported reason in two cases. Multiple reasons for persecution were mentioned in 36 cases. The largest categories of abusers included police and the military. The presence of more than one type of abuser was mentioned in 40 cases.

Tables 3 and 4 present medical aspects of the torture and actual tools or means of torture. Seventy-four clients reported having been beaten, which resulted in injuries to the face or head in 36 cases. Other abuses, in order of frequency, included denial of food and water (26), cuts (25), and burns (23). Broken bones (11) and teeth (9), electrical shock to genitalia (7), rape (6), and rolling a log on the body (4) were reported as well. There were also single reports of forced abortion, stones hung from genitalia, enslavement, and being half buried. Sixteen clients reported suffering from chronic pain in different part of body secondary to physical torture techniques. Twenty-seven clients had received medical care for their torture in a hospital/clinic, 11 had required admission, and eight had needed surgery as a result of their torture. ("Medical care in this context encompasses interven-

Reasons for being tortured (n=89)			
Political opinion	*56*	*Family of activist*	*2*
Political activity	*43*	*Female genital mutilation*	*2*
Ethnicity	*38*	*Slavery*	*2*
Religious beliefs	*29*	*Forced marriage*	*2*
War/social instability (tortured by military/ soldiers during active war and civil unrest)	*8*	*Violating one-child policy (in China)*	*1*
History of activism	*8*	*Multiple reasons cited*	*36*
Sexual orientation	*2*		

Type of abuser (n=89)					
Police	*43*	*Government intelligence*	*14*	*Paramilitary*	*1*
Military force	*21*	*Religious fundamentalist*	*12*	*Slave owner*	*1*
Ethnic group member	*19*	*Rebels*	*11*	*Gangs*	*1*
Political party member	*19*	*Spouse or family member*	*7*	*Multiple abusers*	*40*

* *Single reports of pin inserted under fingernail, injecting medicine, tear gas, animal bite, jaguar position (wrists bound together, ankles bound together, and the person is suspended by a pole inserted between the restraints).*

Table 2. *Bronx Human Rights Clinic Clients: Reasons for Being Tortured.*

tions such as painkillers, antibiotics, suturing, casting, and small surgical procedures.) Seven clients had received traditional medical care. Almost all clients reported needing medical care at the time of torture and being refused; the vast number episodes of medical care happened after the abuse and with the help of friends or family members (not the abuser).

Reports of psychological trauma are separated from the psychological symptoms seen at the time of interview (described below). Roughly one-third of the clients reported having received death threats (28), six reported having been raped, four had witnessed a murder or amputation of a body part, three had witnessed decapitation, and two had been detained in a cell that contained a dead body. Three had had a family member raped, three had witnessed a family member being killed, and two

Reported physical torture technique (n=89)	
Beaten	*74*
• Beaten about face/ head	*36*
Denied food/ water	*26*
Sharp cut	*25*
Prison w/o sanitation/ window	*24*
• Isolation	*4*
Burns	*23*
Forcible displacement	*14*
Forced labor (for intimidation or acquiring confession	*12*
Suspension from ceiling	*12*
Broken bone	*11*
Denied medical care for injuries inflicted by abuser	*9*
Broken teeth	*9*
Submersion in water	*8*
Electrical shock to genitalia	*7*
Raped	*6*
Beaten on soles of feet (flanga)	*5*
Forcibly deported	*5*
Loss of consciousness	*5*
Genital molestation	*4*
Hit with hammer	*3*
Female genital circumcision (FGC)	*2*
Miscarriage due to beating	*1*
Thrown from moving car	*1*
Enslavement	*1*
Pulling out nails	*1*
Stones hung from genitalia	*1*
Telephone/ slapped on ear	*1*
Half buried	*1*

Reported psychological torture technique (n=89)	
Death threat	*28*
Being raped	*6*
Witnessing murder/ amputation	*4*
Stripped naked	*4*
Family member raped	*3*
Family member killed	*3*
Witnessing decapitation	*3*
Acts against religion	*3*
Being with dead body in cell	*2*
Male sexual molestation	*2*

Means by which abusers inflicted torture* (n=89)	
Blunt trauma (inclusive)	*76*
• Punching/ kicking	*71*
• Stick/baton/ club	*70*
• Rifle butt	*30*
• Hammer	*1*
• Bicycle chain	*2*
• Other blunt instruments	*11*
• Knife	*19*
• Gun shot	*4*
• Iron rod	*2*
• Ice pick	*1*
• Glass	*1*
• Letter opener	*1*
• Razor	*1*
• Shovel blade	*1*
Sexual harrassment	*11*
Electric shock	*9*
Water submersion	*8*
Cigarette burn	*7*
Burning sticks	*7*
Boiling water/ oil	*5*
Wood log rolled over body	*4*
Human bite	*2*
Multiple tools/ means	*47*

Table 3. *Bronx Human Rights Clinic Clients: Reported Torture Techniques.*

Psychological symptoms reported at time of interview (n=89)					
Difficulty sleeping	*46*	*Poor appetite*	*8*	*Poor memory*	*4*
Nightmare	*43*	*Recollections*	*7*	*No pleasure*	*3*
Feeling sadness	*26*	*Startling*	*6*	*Depersonalization*	*3*
Flashbacks	*26*	*Chronic headache*	*5*	*Feelings of guilt*	*2*
Avoidance	*19*	*Isolation/poor social interaction*	*5*	*Attempted suicide*	*1*
Difficulty concentrating	*11*				

Clinical findings (inclusive) (n=89)					
Scars	*78*	*Physical deformities*	*17*	*Limited joint motion*	*4*
• *Multiple scars**	*68*	*Missing teeth*	*9*	*Decreased hearing*	*4*
• *Unrelated to torture*	*44*	*Broken bone*	*7*	*Genital scar*	*3*
• *Face/head*	*31*	*Poor vision (due to forced looking into sun/head trauma)*	*4*	*Absent testicle*	*1*
• *Burn marks*	*15*				
• *Bullet scars*	*5*				

* *Mean size: 4.8 cm +/- 3.7 cm.*

Table 4. *Bronx Human Rights Clinic Clients: Outcomes of Torture.*

pregnant women had been beaten to miscarriage. Male-on-male sexual assault was reported by two clients.

The most common means of torture or abuse recorded were punching and kicking, seen in 80% of the cases. Sharp and penetrating objects were used in 27 cases, 19 of which included use of a knife. Eleven clients reported being sexually assaulted, 9 were subjected to electrical shock, and 8 were submerged in water. Gunshot injuries were reported in four cases. Though punching and kicking were the most common form of maltreatment, a combination of methods (for example, knife and water submersion) was seen in 47 cases. Human bites (two) and hammering (three) were described as well.

Psychological symptoms experienced at the time of interview (a mean of 2.9 years after entry to the US) included difficulty sleeping (46), nightmares (43), sadness (26), flashbacks (26), and avoidance of situations or people that reminded them

of their abuse (19). There was one case of attempted suicide. Diagnosis of post-traumatic stress disorder (PTSD) and major depression was based on the classification of the *Diagnostic and Statistical Manual of Mental Disorders — DSM IV.*[19] Physicians diagnosed PTSD (either acute or chronic) in 40% of the clients (36 people) and major depression in four of them.

On physical examination, physicians documented scars consistent with the alleged torture in 87% of the cases (78). The average of the maximum diameters of the scars was 4.8 cm (+/- 3.7, range 0.1-19 cm). Multiple scars (more than two) were noted in 68 cases. More than half of the clients (48) reported that other scars found on exam were secondary to causes unrelated to the torture, which, in the doctor's opinion, served to bolster the credibility of their claims. Deformities (such as grossly mal-aligned limbs or digits, depressed skull fractures, and obvious bony calluses) were documented in 17 clients, and burn marks were noted in 15 clients. This clinical diagnosis was made based on: 1) consistent history (appropriate mechanism of injury, medical or surgical intervention, appropriate time course to heal), 2) physical findings, 3) radiological evaluation, and 4) a combination of these criteria.

Discussion

High rates of PTSD and depression have been observed among torture survivors and refugee populations. Lavik N.J *et al,* 1996, reported a 46.6% PTSD rate among their refugee population.[20-23] In our cohort, physicians made diagnoses of PTSD in 40% of clients. However, physicians diagnosed major depression in only 5% of clients. The striking difference between reported rates of PTSD and major depression in this group could be due to several factors. These include a bias to neither consider nor look for major depression in BHRC's clients, a bias either to preferentially diagnose or record the diagnosis of PTSD in a client's affidavit, insufficient documentation of major depression in the client's affidavit, the overlap of several symptoms of major depression with PTSD, or the fact that our population is not a representative sample of torture survivors in the US. Nonetheless, our study reveals high levels of psychiatric illnesses and symptomatology, particularly given the length of time between client's entry into the US and the time of exam (a duration of 2.9 years, on average).

The degree of psychiatric morbidity (40% of PTSD and 5% of depression) emphasizes the importance of psychological skill in the initial evaluation of torture survivors.

In comparison to the national rate of less than 25% of applicants granted asylum, our rate of successful application was almost 79% (54 granted asylum out of 68 clients for whom decisions have been made).[24] We attribute this success to two principle factors: 1) our collaborative approach of working with independent human rights organizations, advocates, and lawyers, and 2) expert medical opinion expressed through a narrative and affidavit submitted by physicians trained in effective evaluation and documentation of torture. The physician affidavit and narrative most likely helped the judges understand the large majority of refugees' testimonies and lent them credibility.

The countries of origin of our clients reflect many of the areas where human rights abuses and torture are documented and well known.[25,26] These countries vary over time as the pattern of refugee migration varies, affected by changing international crises, refugee policies of destination countries, geographical proximity, and cultural familiarity. As the countries of origin vary, so do the types of torture perpetrated on asylum seekers. Our sample reflects the experiences of one institution and cannot be broadly generalized. In addition, we do not have any information about people who may have been tortured but never applied for asylum (non-documented), have been deported, or simply never came to the US. It is not clear to what degree these differences affect the presentation of clients or their health needs, but they are likely to be relevant.

It is possible that some clients forgot details of their experiences or symptoms due to the time gap between the alleged abuse and the time of exam, or failed to report abuse due to fear of re-traumatization. During the chart review, the authors noticed multiple statements by the examining physicians regarding clients who became silent, tearful, or unable to talk about the experience, or who clearly refused to talk about the specifics of the torture (including, but not limited to, sexual torture or witnessing the torture of family members).

Another potential limitation in generalizing from our data is the possibility of referral bias. For this type of bias to exist, one should postulate that the experiences of clients

referred to the BHRC somehow do not reflect the experiences of applicants who were tortured but never referred to the BHRC. Selection bias within our population was avoided by including all consecutive clients referred during the study period. Only one reviewer extracted data from the charts and, thus, inter-observer variability for both the primary interview and the chart review was not evaluated.

Summary and Conclusion

The clients seen at the BHRC were mostly young, educated men. Eighty-seven percent reported having experienced multiple types of torture. The most common type of torture reported by clients was being repeatedly beaten (80%). Roughly 65% reported associated abuse of a family member and 30% received death threats. Commonly reported reasons for being targeted for abuse were political opinion or activity, ethnicity, and religion. Approximately 40% of clients were diagnosed with PTSD at the time of the interview.

Nearly 80% of clients evaluated at the BHRC had been granted asylum. We believe that these unusually high success rates of asylum approval reflect the effectiveness of physician witnesses trained in the evaluation and documentation of torture and asylum applicants and the collaborative approach of working with independent lawyers and human rights organizations.

Almost none of our clients were accustomed to a stable relationship with a primary care provider. Although episodic medical care for acute illnesses is common among the clients evaluated, most lack ongoing access to care for many reasons, including cultural barriers, while they struggle within the US legal system to secure asylum from persecution. In part, this reflects the lack of vigilance by primary care providers in screening and identifying survivors, the lack of access to mental health professionals for this population in general, and the lack of an established mechanism to support torture survivors in our society. It also, however, reflects the dire need to incorporate the medico-legal evaluation of torture and human rights as basic components of medical education.[27–29] This is particularly important for medical residents and physicians practicing in settings where significant numbers of refugees and immigrants reside.

At the Bronx Human Rights Clinic, we formally train medical residents to evaluate asylum applicants and torture survivors. By providing a first-hand experience of the interface between law, human rights, and medicine, we hope to encourage the development of a community of doctors skilled and dedicated to work effectively with these often ignored populations. This practice of clinical human rights implies an awareness that human rights abuses occur in unexpected situations and calls for proactive clinical acumen to recognize them. We also hope the concept of clinical human rights extends human rights advocacy beyond the ethical and legal domains by making it tangible to clinicians – those who must often deal with the many chronic consequences of torture, both psychological and physical.

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References

1. Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Istanbul Protocol (New York: United Nations, August 1999).

2. *Torture Worldwide: An Affront to Human Dignity* (New York: Amnesty International, 2000): pp. 2–3.

3. A. B. Thomsen, J. Eriksen, and K. Smidt, "Chronic Pain in Torture Survivors," *Forensic Science International* 108/3 (February 2000): pp. 155–63.

4. D. Silove, "The Psychosocial Effects of Torture, Mass Human Rights Violations, and Refugee Trauma: Toward an Integrated Conceptual Framework," *Journal of Nervous Mental Disease* 187/4 (April 1999): pp. 200–7.

5. N. J. Lavik, E. Hauff, A. Skrondal, and O. Solberg, "Mental Disorder Among Refugees and the Impact of Persecution and Exile: Some Findings from an Outpatient Population," *British Journal of Psychiatry* 169/6 (December 1996): pp. 726–32.

6. A. S. Keller, J. M. Saul, and D. P. Eisenman, "Caring for Survivors of Torture in an Urban, Municipal Hospital," *Journal of Ambulatory Care Management* 21/2 (April 1998): pp. 20–9.

7. United Nations Office of High Commissioner for Human Rights (OHCHR): Article 1 of Convention Against Torture available at http://www.ohchr.org/english/law/cat.htm#part1.

8. United Nations High Commissioner for Refugees. Asylum Statistics

available at (http://www.unhcr.org/cgi-bin/texis/vtx/home?id=search)
9. Doctors of the World, Human Rights Clinic, A Training Manual for Physicians and Mental Health Professionals: First Edition, 2003 (New York: Doctors of the World-USA, 2003): pp II-3, I-3, and II-1.
10. US Citizenship and Immigration Services (USCIS) website — Tables 20–2. Available at http://uscis.gov/graphics/shared/aboutus/ statistics/ RA2002yrbk/RA2002list.htm.
11. L. Piwowarczyk, A. Moreno, and M. Gordin, "Health Care of Torture Survivors," *Journal of the American Medical Association* 284 (2000): pp. 539–41.
12. D. P. Eisenman, A. S. Keller, and G. Kim, "Survivors of Torture in a General Medicine Setting: How Often Have Patients Been Tortured and How Often Is It Missed?" *Western Journal of Medicine* 172/5 (May 2000): pp. 301–4.
13. Doctors of the World (see note 9).
14. Ibid.
15. Eisenman et al. (see note 12).
16. OHCHR (see note 7).
17. American College of Physicians, "The Role of Physician and the Medical Profession in the Prevention of International Torture and in the Treatment of Its Survivors," *Annals of Internal Medicine* 122/8 (April 1995): pp. 607–13.
18. An in-depth description of the Istanbul Protocol's guidelines can be found at http://www.phrusa.org/research/istanbul_protocol/isapdx4.html.
19. Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 4th Edition, 2000, Washington, DC, pp. 375–6 and 467–8.
20. Lavik et al. (see note 5).
21. Silove (see note 4).
22. J. L. Miller, "Post-Traumatic Stress Disorder in Primary Care Practice," *Journal of the American Academy of Nurse Practitioners* 12/11 (November 2000): pp. 475–82.
23. H. M. Weinstein, L. Dansky, and V. Iacopino, "Torture and War Trauma Survivors in Primary Care Practice," *Western Journal of Medicine* 165/3 (September 1996): pp. 112–8.
24. United State Department of Justice: Immigration Courts Statistics, 2000–2002 available at http://www.usdoj.gov/eoir/statspub/syb2000main.htm& http://www.usdoj.gov/eoir/efoia/foiafreq.htm.
25. E. Edston, "Bodily Evidence Can Reveal Torture: Five-Year Experience of Torture Documentation," *Lakartidningen* 96/6 (February 1999): pp. 628–31.
26. J. Cohn, "Torture Survivors in Norway: Physician's Responsibility," *Tidsskr Nor Laegeforen*, 121/29 (November 2001): pp. 3383–5, Pub Med 11826781.
27. American College of Physicians (see note 17).
28. J. Cohn, "Medical Education on Violations of Human Rights: The Responsibility of Health Personnel," *Medical Education* 30/3 (May 1996): pp. 161–2.
29. J. Sonis, D. W. Gorenflo, P. Jha, and C. Williams, "Teaching of Human Rights in US Medical Schools," *Journal of the American Medical Association* 276/20 (November 1996): pp. 1676–8.