MILITARY COMMISSIONS TRIAL JUDICIARY
GUANTANAMO BAY

UNITED STATES OF AMERICA

v.

ABD AL-RAHIM HUSSEIN MUHAMMED ABDU AL-NASHIRI

AE 140

DEFENSE RESPONSE TO GOVERNMENT MOTION FOR INQUIRY INTO THE MENTAL CAPACITY OF THE ACCUSED UNDER R.M.C 706

December 28, 2012

1. Timeliness: This response is filed within the timeframe established by Rule for Military Commission (R.M.C.) 905.

2. Relief Requested: The defense requests that the Commission find the prosecution's request for a R.M.C. 706 evaluation is premature and not supported by sufficient facts to justify a R.M.C. 706 evaluation at the present time. Should the Commission order an evaluation at this time, over the defense's objections, the defense requests that the evaluation be limited to only the matters that are arguably in dispute at this time, and comply with the conditions more fully set forth below in order that the evaluations be medically and psychologically appropriate and comply with the Military Commissions Act, the Detainee Treatment Act, the Constitution of the United States, and the accused's statutory right not to incriminate himself.

3. Overview: The prosecution filed a request for a R.M.C. 706 evaluation of the accused. The prosecution premises this request upon the defense's suggestion that as a result of the horrific torture inflicted by the United States upon Mr. Al-Nashiri he suffers from post-traumatic stress disorder (PTSD) and other *sequalae* of torture. The defense has no evidence, at this time, suggesting that in 1999 to 2001 Mr. Al-Nashiri had a mental disease or defect, and the prosecution specifically suggests that it is not making that claim. The defense believes that Mr. Al-Nashiri is presently suffering from a mental disease or defect: serious, long term and untreated PTSD. However, this does not suggest that the accused is unable to understand the nature of the proceedings against the accused or at this time to cooperate intelligently in the

defense. This is not to say that Mr. Al-Nashiri's present mental condition, the PTSD from which he suffers, his possible state of learned helplessness, and other *sequalae* of the serious and horrific torture which was inflicted upon him are not mitigating. By any standard, his present condition goes to his death worthiness.

At this time, any evaluation as to his mental status at the time of the offense or his competence to stand trial is unnecessary. Also, unnecessary at this time is any inquiry into his ability to understand the nature of the proceedings. Therefore, the defense objects and strenuously opposes any evaluation into either of these issues. However, should the commission believe that a R.M.C. 706 evaluation is necessary in light of the defense's repeated suggestions that the accused suffers from long term, functionally untreated PTSD as a result of the torture inflicted upon him, that evaluation must be carefully circumscribed so that it is medically, psychologically and legally appropriate.

4. Burden of Proof and Persuasion: The prosecution bears the burden of persuasion as the moving party on this motion and the standard is preponderance of the evidence. R.M.C. 905(c). However, granting the prosecution's request without serious and specific limitations will violate the accused's rights as guaranteed by the Fifth, Sixth and Eighth Amendments to the Constitution of the United States of America, the Military Commissions Act, the Detainee Treatment Act, treaty obligations of the United States and fundamental fairness. However, should the Commission order this evaluation it must be carefully circumscribed in order not to violate Mr. Al-Nashiri's already limited rights under the military commission regime.

5. Facts: The prosecution has filed a request for a R.M.C. 706 evaluation of the accused. The prosecution premises this request upon the defense's suggestion that as a result of the horrific torture inflicted by the United States upon Mr. Al-Nashiri, he suffers from PTSD and other *sequalae* of torture. At no time has the defense suggested, and indeed the defense could

not, at this time, in good faith suggest that from 1999 to 2001 Mr. Al-Nashiri had a mental disease or defect.

Beginning in 2002 the defendant was held in the custody of the CIA. *See* Central Intelligence Agency Inspector General's Report (unclassified version)(7 May 04) at ¶ 7. During his incarceration, the CIA admits to inflicting horrific torture on Mr. Al-Nashiri—including water boarding him, threatening his life, threatening the life of his family, threatening him with a gun near his head and holding a drill to his head. *Id.* at ¶¶ 91-95. In 2006, the accused was sent to Guantanamo. He has been imprisoned in US custody for ten years.

The defense believes that Mr. Al-Nashiri's condition is such that he is presently suffering from a mental disease or defect: specifically, serious, long term and functionally untreated PTSD. However, the defense does not suggest that the accused is unable to understand the nature of the proceedings against the accused or at this time to cooperate intelligently in the defense. This is not to say that the Mr. Al-Nashiri's present mental condition, the PTSD from which he suffers, his possible state of learned helplessness, and other *sequalae* of the serious, horrific and lengthy torture, which was inflicted upon him is not mitigating. His present condition goes to his death worthiness. The defense has, since prior to arraignment, suggested that the torture the United States inflicted upon Mr. Al-Nashiri makes it fundamentally unfair for the United States to kill him.

6. **Argument:** The prosecution's request, by its terms, is not in good faith. The prosecution admits that it cannot state any facts that justify its request. The request is based upon the defense's suggestion that because Mr. Al-Nashiri was tortured by the United States he suffers from PTSD and other *sequalae* of that torture. While Mr. Al-Nashiri does suffer from mental disease or defect, the defense does not allege, at this time, that that mental disease or defect falls within the language of R.M.C. 706(c)(2)(D) which provides: "Is the accused presently suffering

from a mental disease or defect rendering the accused unable to understand the nature of the proceedings against the accused." Moreover the defense makes no claim warranting an evaluation under 706(c)(2)(C) that at the time of the alleged criminal conduct, the accused had a severe "mental disease or defect."

However, the defense has and will forthrightly continue to state that should Mr. Al-Nashiri be convicted the fact that he was extensively tortured by the United States and suffers from the *sequalae* of that torture will be an issue during the penalty phase. While the defense believes that any examination *at this time* is premature, and would object to an examination at this time, the Commission is urged to consider the following issues that arise from the prosecution's request.

Examination is premature for several reasons: First, Dr. Rosenfeld has seen Mr. Al-Nashiri on only three occasions, all in the same week. The defense is considering whether further evaluation by Dr. Rosenfeld is necessary. Secondly, before the defense can have a full picture of the defendant's mental health, Mr. Al-Nashiri must be seen by a medical doctor, with experience treating torture victims. That doctor, Dr. Sondra Crosby, did not receive the necessary clearances to see Mr. Al-Nashiri until September 2012. Moreover, JTF is placing such unnecessary restrictions on Dr. Crosby's evaluation that the defense will be forced to litigate the conditions of that evaluation before this Commission. Only when that litigation is completed, and Mr. Al-Nashiri has met with and has been examined by Dr. Crosby will the defense have a full picture of his current mental condition.

Additionally, the defense may, after Mr. Al-Nashiri has met with Dr. Crosby, request that he have a CT or PET scan to determine if the torture inflicted upon him caused brain damage.

Finally, after consultation with Drs. Crosby and Rosenfeld the defense may request that other experts such as a neuropsychologist evaluate him. Until all the appropriate evaluations

have been completed the defense will not know the range of mental health evidence it may offer. It will not be until then that the prosecution's examination would hypothetically be ripe, and only as to issues raised by the defense. Any other procedure violates Mr. Al-Nashiri's Constitutional and statutory right to remain silent.

An example demonstrates this obvious point: Inasmuch as the defense is not raising any issues related to the Mr. Al-Nashiri's mental state at the time of the offense, why should an expert, appointed at the request of the prosecution, be allowed to question Mr. Al-Nashiri about the allegations. This would violate Supreme Court precedent. *See Estelle v. Smith,* 451 U.S. 454, 468 (1981) ("A criminal defendant, who neither initiates a psychiatric evaluation nor attempts to introduce any psychiatric evidence, may not be compelled to respond to a psychiatrist if his statements can be used against him at a capital sentencing proceeding.").

Because of the unsettled nature of the Commissions regime, the apparent lack of neutrality of the Convening Authority and the fact that the actions of the United States created any mental health issues from which the accused suffers, the Commission must, prior to entering any order for a mental examination, devise a procedure that protects the rights of the accused and insures that any examination is medically and psychologically appropriate in light of the accused's cultural heritage, his present circumstances and the fact that for four years he was tortured while in CIA custody. *See, e.g.,* CIA IG Report at ¶¶ 91-95.

THE MILITARY JUDGE RATHER THAN THE CONVENING AUTHORITY SHOULD APPOINT THE BOARD MEMBERS.

As the defense has previously argued in AE 117, the Convening Authority does not have the requisite neutrality and therefore should not appoint the board to perform any 706 evaluations. To summarize the defense's objections to the Convening Authority's fairness or neutrality,

- The Convening Authority is irreconcilably divided between his prosecutorial and judicial functions and lacks any institutional safeguards that would accommodate this inherent conflict.

- While such a dual role serves some useful purposes in a court-martial, the overriding purposes as well as the check and balances on the exercise of the CA's authority are absent in military commissions. The CA has shown an overwhelming prosecutorial bias, which makes his responsibilities for approving funding requests, and the other quasi-judicial decisions he must make unreliable and ultimately a deprivation of due process.

- The Convening Authority has requested the death penalty.

- The Convening Authority routinely rejects *ex parte* applications even when the prosecution agrees they are permissible.

- The Convening Authority believes he has standing to argue his position on behalf of the Government, separately from the prosecution.

- The Convening Authority is presently actively interfering with necessary investigations and duties of the defense team that need to be performed by the defense.

Given his personal interest in the case, and his lack of neutrality there is no reason to expect that the Convening Authority will appoint neutral or competent physicians. Additionally, under R.M.C.706(b)(2) it is the Judge's responsibility[1] to appoint the board.[2]

THE BOARD MEMBERS MUST HAVE TS/SCI CLEARANCE AND BE READ ON TO ALL RELEVANT PROGRAMS.

Everything Mr. Al-Nashiri says is presumptively classified, including everything he says about his experiences on the RDI program. It would be impossible to have a professionally competent evaluation without discerning in detail the effects of the torture to which he was subjected.

THE DEFENSE INTERPRETER MUST BE ABLE TO OBSERVE THE INTERVIEW TO INSURE THAT IT IS BEING PROPERLY TRANSLATED.

The defendant does not speak functional English and cannot participate in a meaningful manner in a psychological interview conducted in English. The current standard in psychology

[1] In making this request the defense does not waive any claim that the Judge should be disqualified. *See* AE 084.

[2] Moreover, 706 (c)(1) provides: (1) *By whom conducted.* When a mental examination is ordered under section (b) of this rule, the matter shall be referred to a board consisting of one or more persons…" Since this case is post-referral and the judge is reasonably available, only the Judge can order the board, therefore, the Judge must name the Board members.

is for the interview to be conducted in the interviewee's native language. *See* Linda Fortuny & Helene Mullaney, *Assessing Patients Whose Language You Do Not Know: Can The Absurd Be Ethical?*, The Clinical Neuropsychologist, Vol. 12, No. 1, pp. 113-126 (1998)(Attachment A). Additionally, the defense interpreter must be able to observe the interview and make note of failures to properly interpret as well as other deficiencies in the process.

THE BOARD MEMBERS MUST BE FAMILIAR WITH AND COMPLY WITH ISTANBUL PROTOCOL ON THE INVESTIGATION AND DOCUMENTATION OF TORTURE

The accused was tortured while in CIA custody. Any meaningful examination must discuss the torture inflicted upon him and his response to that torture. This can only be done properly by using the procedures required by the United Nations Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol). Any significant deviation from the Istanbul Protocol risks being incomplete, resulting in an opinion that is inaccurate.

ALL BOARD MEMBERS MUST BE KNOWLEDGEABLE ABOUT PTSD

The defense asserts that the accused presently suffers from serious, long term, and functionally untreated Post Traumatic Stress Disorder (PTSD). PTSD is a specific diagnosis recognized in the DSM-IV and the soon to be approved in more detail in the DSM-V. The diagnostic criteria set forth in DSM-IV focuses on the magnitude of the stressors, the presence of intrusive recollections, the presence of avoidant/numbing behaviors, persistent symptoms of hyper-arousal, the duration of those symptoms, and the functional significance of those symptoms. Any evaluation by individuals who are not knowledgeable about PTSD, its causes, its symptoms and its impacts will not be an accurate evaluation on which this Commission can rely. To do an evaluation about a victim of torture's present condition, without having a

thorough working knowledge of the primary *sequalae* of torture would demonstrate a lack of seriousness about this process.

ALL BOARD MEMBERS MUST HAVE REVIEWED ACTUAL INFORMATION CONCERNING THE TORTURE TO WHICH MR. NASHIRI WAS SUBJECTED, NOT THE SUMMARIES PROVIDED BY THE PROSECUTION

The prosecution has provided the defense with classified summaries. Not all of the summaries to which the defense is entitled have been provided to the defense. The defense anticipates filing an amended theory of the case in the hopes that the Military Judge will recognize the inadequacies in the summaries.[3] From what the defense can currently ascertain, those summaries are demonstrably false and misleading. There are other defects that cannot be publicly discussed. It would be difficult, indeed professionally problematic for any competent psychologist to rely only upon these summaries. The only other available source of information is Mr. Al-Nashiri himself. But history, common sense and psychological doctrine recognize that Mr. Al-Nashiri is probably not the best reporter of the details of the torture inflicted upon him. The best source of the details of the torture that was inflicted upon Mr. Al-Nashiri would be the complete records maintained by the government contemporaneously with the infliction of the torture. Only with this information will any evaluation be able to fully appreciate the abuse to which Mr. Al-Nashiri was subjected.

Insofar as the government is putting Mr. Al-Nashiri's mental health in issue by filing the request for a R.M.C. 706 evaluation, the prosecution has put the RDI program—including the torture that was a critical part of the RDI program—in issue. *See* CIA IG Report. The CIA program was consciously designed to induce disruptions in personality. These changes in personality are commonly and publicly known as learned helplessness. *CIA Background Paper*

[3] Under the military judge's ruling, while the Commission cannot reconsider the adequacy of the summaries upon request of the accused, he can "sua sponte" reconsider them in response to an amended theory of the case filed ex parte by the accused. It is unclear whether the fact that the summaries are false and misleading is grounds for the military judge to sua sponte look into their validity.

on Combined Techniques, 1 *(2004)* (Attachment B). [4] The process by which the changes in personality were created also induced PTSD. Repeated long term torture and anything associated with torture are among the most serious imaginable stressors. Knowing the full extent of the stressors is important to a meaningful exam, especially if the examiner is to suggest that the accused does not suffer from serious long term, functionally untreated PTSD.

ALL BOARD MEMBERS MUST REVIEW ALL OF MR. AL-NASHIRI'S MEDICAL RECORDS, RATHER THAN SUMMARIES OF THOSE RECORDS

The defense alleges that the accused's PTSD has been functionally untreated. In order to address this claim, any government evaluators must review all of Mr. Al-Nashiri's medical and psychological records held by the government. Medical records means medical records not redacted records or summaries of records.

American and international standards for the psychological and/or medical [psychiatric] investigation of the effects of torture on an individual require the individual to have access to un-redacted, unfiltered copies of the relevant medical records.[5] To underscore this point, the defense has attached a report from the International Forensic Expert Group (IFEG) which

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[4] This CIA process specifically required reducing the detainee to a position of extreme helplessness and distress:

> Effective interrogation is based on the concept of using both *physical and psychological pressures in a comprehensive, systematic, and cumulative manner* to influence HVD behavior, to overcome a detainee's resistance posture. The goal of interrogation is to *create a state of learned helplessness and dependence* conducive to the collection of intelligence in a predictable, reliable, and *sustainable* manner. (emphasis added)

CIA Background Paper on Combined Techniques (2004), at 1

[5] Medical and other health records should be taken to include, amongst other things, all notes pertaining to an individual, whether in written or electronic format, compiled by any health professional including by physicians, psychiatrists, psychologists, nurses, medical orderlies, or any other health professionals, whether directly involved in the treatment, care or observation of an individual, or whether made by health professionals who have attended to, or assessed the individual for any other reason, including to serve the objectives and purpose of any third party. Medical and other health records also includes the results of any tests, medical imaging, screening and any other interventions whether preventive, curative or of any other nature, including photographic and video recordings. IFEG Statement on Access To Medical Records in Allegations of Torture.

cogently and concisely demonstrates why access to un-redacted, uncensored records is critical to a thorough evaluation of one who was tortured. The report states:

> Forensic medical evaluations of torture and ill-treatment assess the extent to which an individual's allegations of violations may correlate with physical and psychological findings. Forensic medical opinions on the degree of consistency between individual allegations of torture and other ill-treatment and specific physical and/or psychological findings depend on the internal consistency of material medical evidence and corroboration by relevant information contained in relevant medical and other health records as well as relevant legal records.
>
> Medical and other health records, as well as relevant legal documents are essential to forensic medical evaluations of alleged torture and ill-treatment for many reasons including the following:
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> - they may corroborate specific allegations of violations including: specific methods applied to the alleged victim, descriptions of instruments used, restraint positions, frequency and intensity of forces applied, protective barriers that may mitigate physical forces and subsequent physical evidence.
> - some acts may be presumed by non-clinicians to be innocuous, even when practiced in combinations and over extended periods of time (e.g. forced nakedness, temperature manipulation, sensory deprivation, sensory bombardment, prolonged isolation, techniques of asphyxiation), but may cause severe and prolonged mental pain or suffering, which may only be evident following examination by a qualified forensic medical expert.
> - they may contain health professionals' observations of physical and/or psychological reactions, before, during or after interrogation practices, incident reports, documentation of injuries, or lack thereof, and/or the condition of the alleged victim.
> - they may be critical in establishing a timeline of the alleged violations that is necessary to understanding the development of physical and psychological symptoms and disabilities, as well as the subsequent healing of injuries.
> - they may assist in identifying the alleged perpetrators, and in establishing a foundation for the intent of the alleged perpetrators to inflict physical and/or mental harm.
> - the assessment of "severe physical and psychological pain or suffering," which form part of the definition of torture, usually requires specific medical knowledge and specific information gathered from the individual alleging torture or other ill-treatment in a clinical interview.
> - the nature and extent of psychological reactions to torture and ill-treatment depend on the meaning individuals assign to traumatic experiences. Assessment of psychological evidence of torture and ill-treatment, therefore, requires a detailed understanding of the circumstances of the alleged violations that are often found in medical and other health records as well as relevant legal records.
> - forensic medical experts need complete medical and other health records, as well as relevant legal records to form opinions on the likely physical and/or

psychological reactions that may be expected from the alleged violations, with due consideration to individual mitigating and potentiating factors.

- forensic medical expert opinions on the causation of physical and psychological symptoms and disabilities (i.e. torture and ill-treatment vs. illness and disease) also require a comprehensive understanding of information contained in complete medical and other health records as well as relevant legal documents.
- forensic medical experts require access to all medical and other health records, as well as relevant legal records to assess for the possible exclusion of incriminating evidence. Such exclusions may be evident when the allegations of violations by the alleged victim are highly consistent with physical and/or psychological findings (i.e. multiple lacerations on the back consistent with allegations of whipping), but there is no supporting documentation in the medical or relevant legal records.

(Attachment C).

ANY TESTS ADMINISTERED BY BOARD MEMBERS MUST BE DISCLOSED TO THE DEFENSE AND THE DEFENSE PROVIDED WITH THE OPPORTUNITY TO BOTH OBJECT AND LITIGATE THE APPROPRIATENESS OF SUCH TESTS PRIOR TO THEIR BEING ADMINISTERED TO THE ACCUSED

It is the defense's position that any evaluation that may be ordered be limited to the matters that are at issue. For example, because the defense does not assert that Mr. Al-Nashiri suffered from mental disease or defect at the time of the offense there is no need for any evaluation to address that issue. The defense asserts that the accused suffers from PTSD resulting from torture inflicted upon him by the government. This torture, and his current condition, are profoundly mitigating as they may weigh against a sentence of death. However, there are few psychological tests that are appropriate to ascertain the effects of torture and none that have been normed to the circumstances here: a middle aged-Saudi/Yemeni, disappeared and held secretly for four years, tortured in many different ways such as waterboarding and having a drill held to his head,[6] and continuously re-traumatized while incarcerated.[7] Accordingly, it would be highly inappropriate to administer any such un-normed tests to the accused. Therefore,

[6] CIA IG Report at ¶¶91-95.

[7] *See, e.g.*, AE 118

the defense asserts that the Commission must order that, prior to any evaluation under R.M.C. 706, any evaluators who intend to administer any psychological tests to the accused first provide notice to the defense *prior to administering the tests* and the defense must be given reasonable opportunity to object and to litigate this, if agreement cannot be reached on which tests to administer to the accused. This is in accord with recent federal practice under Rule 12.2 of the Federal Rules of Criminal Procedure.

The Supreme Court has long recognized that the Sixth Amendment right to counsel entitles a capital defendant and his lawyers to notice of the scope and purpose of a government mental health exam, so that he may consult with them before-hand about the exam. *Powell v. Texas*, 492 U.S. 680, 686 (1989). Moreover, given judicial recognition that courts may limit the scope of the government's exam, including the tests that the government's expert administers, such notice is critical to enabling defense counsel to raises objections in court in advance of the exam. In a number of cases decided under Rule 12.2, defendants have requested notice identifying, in some fashion, the government's expert and the tests that the expert will administer. Such notice is (a) required by the Sixth Amendment and (b) necessary in order to permit the defense to challenge, if necessary, any particular tests proposed by the government. A number of federal district courts have ordered the government to provide notice, typically reasoning that this will provide counsel a better opportunity to advise the defendant, will assist in avoiding duplicative testing (and the resulting risks of practice effects) by defense and government experts, and parallels the notice requirements imposed on the defense under Rule 12.2(b).

> • *United States v. O'Reilly*, No. 05-80025, 2010 WL 653188, at *5, ¶¶ 17, 18 (E.D. Mich. 2010) (Prior to any rebuttal examination, government must give defense counsel at least 5 days advance notice of the names and professions of its rebuttal experts and any tests the experts intend to administer; if defense objects to a government rebuttal expert or test, parties must diligently work to resolve the dispute; if resolution cannot be achieved

informally, court will hold a hearing, upon defense filing, within 3 days of receiving government notice, of written formal objections. Neither side bears the burden of proof at the hearing.)

• *United States v. Hardy*, 2008 1743490, at *3 (E.D. La. 2008). Government shall advise defense counsel of the date and time of proposed examination, so that counsel may inform defendant.

• *United States v. Fell*, 372 F. Supp. 2d 753, 761 (D. Vt. 2005). Government agreed to provide notice of testing.

• *United States v. Johnson*, 362 F. Supp. 2d 1043, 1085 (D. Iowa 2005). Ordering fire-walled attorneys to provide defense with five days's advance notice of the professions of its proposed experts and the tests that the experts intended to perform; rejecting defendant's argument that notice was necessary to provide defense with an opportunity to challenge any testing of dubious validity because such challenges would more efficiently be addressed post-guilt verdict, but agreeing that such notice facilitated defense counsel's advice to client, permitted coordination to avoid overlapping tests and practice effects, and paralleled defense notice requirements.

• *United States v. Sampson*, 335 F. Supp. 2d 166, 246 (D. Mass. 2004). As agreed by the parties, ordering fire-walled attorneys to provide defense with five days's advance notice of the professions of its proposed experts and the tests they intended to perform; rejecting defendant's argument that notice was necessary to provide defense with an opportunity to challenge any testing of dubious validity because such challenges would more efficiently be addressed post-guilt verdict, but agreeing that such notice would facilitate defense counsel's advice to client, permit coordination to avoid overlapping tests and practice effects, and paralleled defense notice requirements.

• *United States v. Taylor*, 320 F. Supp. 2d 790, 791 (N.D. Ind. 2004). Permitting defendant to object to government's proposed testing and setting matter for hearing in the event of a dispute between the parties.

• *United States v. Minerd*, 197 F. Supp. 2d 272, 278 (W.D. Pa. 2002). Government must give the defense three days' notice of the intended examination date(s). Prior to any government testing, government must provide to the defense a list of the tests that its expert intends to use – and the government may not identify more than one instrument for the purpose of measuring the same mental functioning – so that defendant, within 3 days of receiving the government's list, may object, solely on the ground that its own expert intends to use the same test. Court will resolve any conflicts, and no testing may occur by either side until a final decision as to which tests the government's expert may use.

THE DEFENSE OR DEFENSE EXPERTS MUST BE ABLE TO WATCH THE TESTING/INTERVIEWS AND THEY MUST BE VIDEOTAPED

Because of the serious potential implications that an evaluation may have on the accused's Fifth Amendment rights, or his statutory right to be free from self-incrimination, and because of the possibility of overreaching by the government evaluators, the defense must be able to monitor the evaluations by having defense counsel physically present during any evaluations, and also, the government evaluation must be videotaped so that the defense experts my analyze the behavior and methods utilized by the evaluators and to provide a record for future litigation. This is also in accord with recent federal practice.

Several federal district courts have required that the government record its expert's examination and/or provide simultaneous audio-feed to defense counsel. *See, e.g., United States v. O'Reilly*, No. 05-80025, 2010 WL 653188, at *5 ¶ 20 (E.D. Mich. 2010) (defense counsel may arrange for government rebuttal examination to be audio- or videotaped; government expert must provide tapes to defense counsel by same-day or next-day delivery at the conclusion of each session; defense counsel may review tapes upon receipt); *see also United States v. Fell*, 372 F. Supp. 2d 753, 761 (D. Vt. 2005) (rejecting defense request under Fifth and Sixth Amendment to be present at government testing, upon government's agreement to provide adequate notice to defense of proposed testing and to tape record its interview with defendant and provide defense counsel the option of a simultaneous audio-feed); *United States v. Hardy*, 2008 WL 1743490, at *3 (E.D. La. Apr. 10, 2008) (government expert's entire interview and examination must be videotaped); *United States v. Johnson*, 362 F. Supp. 2d 1043, 1085-91 (D. Iowa 2005) (rejecting defense counsel's request under Fifth and Sixth Amendments to be present at government testing, but ordering that government examination be tape-recorded and copies provided immediately to defense counsel); *United States v. Sampson*, 335 F. Supp. 2d 166, 247 (D. Mass. 2004) (rejecting defense counsel's request under Fifth and Sixth Amendments to be present at

government testing, but, upon agreement of the parties, ordering that government examination be tape-recorded and copies provided immediately to defense counsel).

A FIREWALL MUST EXIST BETWEEN THE BOARD, THE CONVENING AUTHORITY AND THE PROSECUTION

Federal Courts have recognized the tension and the potential for abuse if the prosecution has improper access to the defendant's statements or material elicited during a compelled mental health evaluation that does not bear upon guilt or innocence. Accordingly, many Federal Courts have ordered that separate "firewall" or "taint" counsel be appointed to represent the Government on issues regarding mental health evaluations and that the firewall be specifically enforced with written undertakings, recorded communications between firewalled counsel and the prosecution.

The benefits of employing a government taint lawyer are two-fold: The fire-walled prosecutor serves as a point person to handle any legal and/or logistical issues arising from the government's rebuttal examination. *See United States v. Johnson*, 362 F. Supp. 2d 1043, 1083 (D. Iowa 2005) (approving request of parties to appoint taint team of fire-walled AUSAs to manage the government's examination ofdefendant); *United States v. Sampson*, 335 F. Supp. 2d 166, 243-244 (D. Mass. 2004) (upon agreement of the parties, court designated two fire-walled AUSAs to handle legal and logistical issues arising from governments testing). At the same time, the fire-walled prosecutor provides an additional barrier, beyond the explicit protections set out in Rule 12.2, to ensure that information derived from the government's rebuttal examination, including statements made by the defendant during the course of that evaluation, are not revealed to the prosecuting attorneys prematurely -- that is, unless and until the defendant is convicted of a capital count and subsequently re-confirms his intent to introduce expert mental health evidence at the penalty phase. *See Sampson*, 335 F. Supp. 2d at 245; Johnson, 362 F. Supp. 2d at 1084.

Defense requests for the appointment of a fire-walled prosecutor have routinely been approved. *See, e.g., United States v. O'Reilly*, 2009 WL 3615019, at *2-3 (E.D. Mich. 2009) (granting defense motion to appoint fire-walled attorney; limiting government to one fire-walled attorney); *United States v. Umana*, 2009 WL 2489309, at *4 (W.D.N.C. Aug. 12, 2009) (fire-walled AUSA will be designated to receive notice of expert evidence of mental condition on the issue of punishment, arrange for any evaluation by an expert designated by the Government, handle any issues arising out of the evaluation process and arrange for filing of the expert's report under seal); *United States v. Lujan*, 530 F. Supp. 2d 1224, 1240 (D.N.M. 2008) (if defense files 12.2(b) notice, at least one fire-walled attorney must be assigned to handle any issues that may arise before, during, or after the government's expert's examination); *United States v. Wilson*, 493 F. Supp. 2d. 348, 357-358 (E.D.N.Y. 2006) (appointing, as agreed by the parties, firewalled AUSAs); *Johnson*, 362 F. Supp. 2d at 1083; *Sampson*, 335 F. Supp. 2d at 243-244. And, most frequently, in order to ensure strict compliance with Rule 12.2's prohibition on early disclosure, the courts have required that the fire-walled prosecutors be appointed from a district other than the one prosecuting the case. *See, e.g., O'Reilly*, 2009 WL 3615019, at *2-3 (granting defense motion, over government's objection, to appoint fire-walled attorney from outside district of prosecuting attorney's office, but permitting government to select fire-walled attorney from out of district); *Wilson*, 493 F. Supp. 2d. at 357-358 (granting defense request, over government objection, to appoint fire-walled AUSAs from outside the district of prosecuting attorney's office); *Johnson*, 362 F. Supp. 2d at 1084 (granting defense request, over government objection, to appoint taint team of AUSAs from outside the district); *Sampson*, 335 F. Supp. 2d at 243-244 (upon agreement of the parties, court designated two out-of-district AUSAs); *but see Umana*, 2009 WL 2489309, at *4 (fire-walled AUSA from within prosecuting U.S. Attorney's Office).

To further prevent even inadvertent leaks, the district court in *Johnson* took the additional prophylactic step of strictly limiting contact between the taint team and prosecuting attorneys – including ordering that any request for information from the fire-walled attorneys to the prosecuting attorneys be "one way" and either transcribed by a court reporter or made in writing with a copy filed under seal. *See also Sampson*, 335 F. Supp. 2d at 244 & n.45, 245 (entering order of protection forbidding the fire-walled attorneys from disclosing defense records and information and any records or information obtained or developed by the government's experts to the prosecuting attorneys).

The defense would request that this commission follow the practice of the federal courts in capital cases and require the prosecution to appoint a taint team for any 706 evaluation.

7. Oral Argument: Requested

8. Witnesses: Dr. Vincent Iacopino

9. List of Attachments:

A. Linda Fortuny & Helene Mullaney, *Assessing Patients Whose Language You Do Not Know: Can The Absurd Be Ethical?*, The Clinical Neuropsychologist.

B. *CIA Background Paper on Combined Techniques* (2004).

C. Statement by International Forensic Expert Group.

/s/ Richard Kammen
RICHARD KAMMEN
DOD Appointed Learned Counsel
/s/ Stephen Reyes
STEPHEN C. REYES
LCDR, JAGC, USN
Detailed Defense Counsel
/s/Allison Danels
ALLISON C. DANELS, Maj., USAF
Assistant Detailed Defense Counsel

CERTIFICATE OF SERVICE

I certify that on 28 December 2012, I electronically filed the forgoing document with the Clerk of the Court and served the forgoing on all counsel of record on the date of filing.

/s/ Stephen Reyes
STEPHEN C. REYES
LCDR, JAGC, USN
Detailed Defense Counsel

ATTACHMENT

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THE ETHICAL NEUROPSYCHOLOGIST

Assessing Patients Whose Language You Do Not Know: Can The Absurd Be Ethical?*

Lidia Artiola i Fortuny and Helene A. Mullaney
Independent Practice, Tucson, AZ

ABSTRACT

Neuropsychological evaluations of non-English speakers are frequently conducted by clinicians who do not know, or have limited knowledge of, the language of the examinee. The authors discuss the possible underlying causes of such practices, give examples of the risks involved in such practices, examine the aspects of the Ethics Code that may assist in guiding the clinician, and make recommendations on steps to take to avoid unethical or even illegal practices.

During the past few decades there has been a dramatic increase in immigration to the United States and Canada of individuals who speak languages other than English. As a result of shifts in demographics, awareness of the importance of cross-cultural issues in research and practice has grown dramatically, as suggested by a significant increase in the number of articles published during this period of time that deal with cross-cultural topics (Chávez & Oetting, 1995; Mio & Iwamasa, 1993). In response to an increase in the numbers of minorities needing psychological and neuropsychological services, there have been mandates from the American Psychological Association and the American Association for Counseling and Development to include cross-cultural issues in training programs (Atkinson, Thompson, & Grant, 1993; Mio & Iwasama). In spite of this and the fact that several generations of research make it clear that the expression of disease varies significantly across cultures (Gaw, 1993; Lipson & Meleis, 1989; Marsella, Friedman, Gerrity, & Scurfield, 1996;), the overwhelming majority of clinicians in the North American health care system come from the White Anglo majority, whereas an important proportion of their clients are members of ethnic minorities (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996).

Although professional mandates communicate a responsibility on the part of mental health professionals to respond to the mental health needs of minority populations, awareness of clinical and ethical issues surrounding the neuropsychological evaluation of non-English speakers in the North American context seems to be limited. This is particularly the case where the language of the clinician is concerned.

The Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992) generally addresses the issue of competence. The following principles and standards are applicable: Principle A: Competence, Standard 1.04: Boundaries of Competence, Standard 1.05: Maintaining Expertise, Standard 1.08: Human Differences, Standard 1.09: Respecting Others, Standard 1.10: Non-Discrimination,

* Address correspondence to: Lidia Artiola i Fortuny, Clinical Neuropsychology, 5930 East Pima Street, Suite 208, Tucson, AZ 85712, USA.
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Standard 1.20: Consultations and Referrals, and 2.04: Use of Assessment in General and With Special Populations. However, language competence by the clinician is not specifically addressed. Similarly, the Canadian Code of Ethics for Psychologists (Canadian Psychological Association, 1991) addresses the general issues of competence, nondiscriminatory practice, and respect for the dignity of individuals, but does not discuss language use per se.

The Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (Board of Ethnic Minority Affairs Task Force on the Delivery of Services to Ethnic Minority Populations, 1991) are intended to improve the quality of psychological services to ethnically and culturally diverse populations. Language is mentioned as follows: "Psychologists interact in the language requested by the client and, if this is not feasible, make an appropriate referral" (p. 3). Oddly enough, no mention is made of communicative competence on the part of the clinician. The authors take the above to mean that the clinician's competence in the target language is assumed. The potential dangers of this assumption as it applies to the Spanish language in the context of the United States have been discussed elsewhere (Artiola i Fortuny & Mullaney, 1997). Additionally, the Guidelines are not clear on what to do if referral is not possible.

The Standards for Educational and Psychological Testing (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 1985) address language competence of test takers (pp. 73–75), but, again, language competence of the test administrator and/or clinician who interprets the data is not mentioned. Similarly, there are no background requirements for clinicians wishing to assess non-English speakers.

The Specialty Guidelines for Forensic Psychologists (Committee on Ethical Guidelines for Forensic Psychologists, 1991) are consistent with the Ethical Principles of Psychologists (American Psychological Association, 1990), but provide more specific guidelines for the forensic psychologist. They assert that the clinician has an "obligation to understand the civil rights of parties in legal proceedings" and should do nothing to "diminish or threaten those rights (p. 658)." Moreover, he or she must expect that documentation demonstrating the basis of his or her opinions will be subjected to judicial scrutiny, a standard that is higher than that of general practice. Again, however, no mention is made of language use or linguistic competence.

Many neuropsychologists may logically conclude that the existing competence guidelines apply to language. Others fail to make such a connection. Hence, it appears that the existing guidelines are not sufficiently specific and are "open to interpretation." Indeed, although there appear to be no statistics relating to the prevalence of nonfluent clinicians assessing linguistic minorities, there is ample anecdotal evidence that this is occurring at an alarming rate. This could reflect a deficiency on the part of the profession to mentor and guide students regarding the profound and multifaceted differences between mainstream North American English-speaking individuals and individuals who hail from other areas of the globe.

In this paper, the authors discuss the problems that can arise when neuropsychological evaluations are performed with non-English speakers, present some examples that they have observed, and outline the ethical issues commonly raised. Most examples are drawn from cases in which the patient was a Spanish-speaker, although they are equally relevant to other non-English-speaking populations as well. Because potential for harm to the patient varies depending on the circumstances, a distinction will be drawn between when it may, and when it may not, be acceptable for a clinician who possesses less than adequate fluency to assess non-English speakers. Guidelines are offered for the concerned clinician who wishes to balance his or her obligation to provide services to those in need, and avoid ethical breaches, civil rights violations, or charges of malpractice.

In the United States, exclusive use of a language other than English is inextricably tied to minority status. Therefore, some clarifications are necessary. The importance of the language

issue may get lost when we begin to speak in the very general terms of doing work with "minorities." It may be that psychologists who believe that they possess the ability to competently work with "minorities" fail to recognize that they do not possess the competence necessary to work with "linguistic minorities." These populations unequivocally demand expertise and advanced native fluency in their respective languages.

Linguistic minorities differ in more ways than just language, not only from mainstream English-speaking culture, but also from other English-speaking minorities. Issues of culture, education, and socioeconomic status are critical as well. Hence, no discussion of language can be broached in isolation

THE PROBLEMS

Language Competence in the Neuropsychological Examination

Because verbal communication is central to psychological or neuropsychological evaluation, language is, in fact, a tool of assessment. Cognitive assessment in particular poses several unique challenges when linguistic competence is an issue. Inability to communicate directly with the patient renders it impossible to assess not only the patient's own statements, but the actual wording, the form and the content, and the modulations of phrasing and accent (LaCalle, 1987). This has an impact on the clinician's ability to assess mood, affect, level of cooperation, and language itself. It would appear obvious, therefore, that advanced native fluency is essential to valid diagnosis, just as it is in the evaluation and treatment of English-speaking patients. However, when the patient speaks a language other than English, it appears that this assumption is not similarly applied. In California, for example, at least one in four forensic psychological and psychiatric evaluations is conducted by professionals who do not speak the patient's language (LaCalle).

The Clinician

Some linguistically unqualified neuropsychologists decide to assess individuals whose language they do not speak, or speak poorly, rather than first determine if there is a clinician available who is better able to communicate with the patient. If a clinician does not know the language of the examinee, he or she will have to rely on an interpreter, which can introduce additional problems. This will be addressed further in a later section. If a clinician does speak the language of the test-taker, but does not possess the fluency of an educated native, it may be possible for him/her to gather factual information about the patient, although errors are still likely. For example, poor fluency may make it very difficult to understand critical facts in the history.

> One clinician noted in a written report that her patient, a recent immigrant from Mexico, had 12 years of formal education. In fact, the patient had stated he had gone to school until the age of 12.

Lack of advanced native fluency can also make it virtually impossible to distinguish, for example, an aphasic from a malingerer from a depressive.

> Another clinician diagnosed a patient as having had a probable vascular event based on his poor verbal skills. The patient, a 74-year-old man, had immigrated to the U.S. from Eastern Europe only a few years previously. The patient's American relatives confirmed that his English had never progressed beyond his present rudimentary level.

Frequently, clinicians may not realize that they themselves are not linguistically qualified. In fact, self-appraisal can be quite inaccurate or unreliable. Many may possess a sufficiently high level of knowledge of a second language to be able to communicate adequately in some settings, but not to diagnose cognitive impairment. However, because they do function reasonably well in conversations with family members or while visiting abroad, for example, they mistakenly believe their skill is good enough for diagnostic work.

One psychologist who specializes in Social Security disability evaluations of Spanish-speakers, and regularly testifies in court, was himself never schooled in Spanish. He was born and raised in the U.S. and has a Spanish surname, but he is unable to hold a conversation in Spanish with a native speaker beyond an elementary level. For example, in conversation he could not identify the word 'jubilarse' (to retire).

In another incident, an educational psychologist (a certified bilingual professional) had difficulty maintaining a conversation in Spanish with another colleague who was born and educated in Mexico. This individual had to keep switching back to English during the conversation in order to communicate his ideas.

Colleagues fluent in various languages have related numerous personal accounts of the same experience with mental health professionals who identify themselves as bilingual.

The Interpreter

One might argue that it is acceptable to assess a non-English speaker as long as an interpreter is used. In fact, interpreters do not necessarily solve the problem. Rather, difficulties often result when interpreters are used, and sometimes *especially* when interpreters are used.

Contrary to popular belief, it is not just bilingualism in and of itself that qualifies an individual to be an interpreter. Rather, the skills demanded of an interpreter are highly specialized, complex, and require extensive training (De Jongh, 1991) if serious communicative errors are to be avoided. At this time, only court interpreters are required to be certified, and such is the case only in a limited number of states (LaCalle, 1987). Critical errors involving interpreters in the legal settings have been well-documented in the literature (De Jongh; Hovland, 1993; Nakamura, 1992; Rees, 1991). Moreover, court interpreters are not trained in psychology. In fact, many, recognizing the degree of complexity inherent in psychological examinations and the potential risks involved, opt not to work on such cases (Cristina Storrer, Court Interpreter, personal communication). According to LaCalle (1987), given that language errors in forensic evaluations lead to wrongful denial of benefits and adequate compensation, such consequences "may be tantamount to a severe deprivation of rights" (p. 36).

The fact is that the monolingual professional has no way of personally verifying the qualifications of the interpreter (Hovland, 1995; LaCalle, 1987). Therefore, errors that may be quite grave are unlikely to be detected by the clinician signing the report. Yet, it is the clinician who is ethically and legally responsible for the interpreter (Westermeyer, 1990). Often, translators and interpreters for psychological and neuropsychological interviews and assessments are recruited haphazardly, and may end up being a family member of the patient, a community volunteer, a clerical staff member, or even a custodial worker (LaCalle).

Given that the neuropsychologist is more likely to use an unqualified, untrained interpreter, interpretation errors are even much more likely to occur in clinical settings than in legal settings. Errors in measurement probably result in diagnostic errors, the consequences of which can be devastating. Even when the clinician uses an interpreter or technician with advanced native fluency, the clinician is once-removed from direct contact with the patient. He or she must then depend on the interpreter for crucial diagnostic information – information that neither an interpreter nor a technician is trained to recognize.

Recently, a neuropsychologist used a translator to administer the MMPI-2 (Hathaway & McKinley, 1989) to a monolingual Spanish-speaker as part of a videotaped forensic evaluation. The tape showed the translator struggling many times with the language of the test, stopping frequently to look up words in a dictionary, and providing detailed explanations for several items.

It is unknown why the neuropsychologist did not use the published Spanish translation of the MMPI-2 (Hathaway & McKinley, 1989, 1993). The translator's poor linguistic skill, and lack of

knowledge of test protocol and psychometrics, was compounded by the apparent ignorance exhibited by the clinician who failed to address the multiple threats to validity introduced under these conditions.

The Technician

Neuropsychologists regularly use technicians who similarly may not have adequate knowledge of the patient's language. Taking Spanish as an example, the technician may have never been schooled in the language, but may speak varying levels of "kitchen" Spanish, a term which generally refers to some level of competence within day-to-day settings. The assumption is that anyone who is heard speaking Spanish, especially if the individual has a Spanish surname, must have knowledge of the Spanish language that is adequate to assist in psychological or cognitive assessment of native speakers. However, the use of a fluent bilingual technician does not necessarily alleviate this problem, as the technician is not a diagnostician and should not be required to act as proxy to the psychologist. In fact, in some states, this practice is expressly forbidden by the state code.

> In one setting, a neuropsychologist who has no knowledge of the Spanish language or culture, is currently doing baseline assessment and WADA procedures of monolingual Spanish-speaking epilepsy patients who are possible candidates for temporal lobectomies. To administer the neuropsychological tests, the psychologist uses a technician who was born in a Spanish-speaking country but emmigrated to the U.S. at elementary school age. The technician is functionally illiterate in Spanish, and his oral Spanish is hesitant and broken, certainly inadequate to allow him to provide specific information on language and verbal memory used to make sophisticated diagnostic – and, ultimately, surgical decisions.

This case is particularly perplexing when one considers that there are fully trained Spanish-speaking neuropsychologists in the community.

LaCalle (1987) considers the practice of haphazard selection of interpretive assistants by clinicians "deplorable." He goes on to report that, where such "abuses" are concerned, there is ample evidence indicating "a widespread lack of professionalism, frequently unethical practices and, at times, downright illegal practices" (p. 31).

Demographic Characteristics of the Examinee

Referrals for neuropsychological assessment roughly fall into the following two categories: (1) individuals with extremely low levels of education (fewer than 8 years), and (2) individuals with average or high levels of formal education. The demographic characteristics of the non-English speaking patient should dictate to an important degree whether or not the referral should be accepted.

Although the effects of education on neuropsychological performance have been addressed in the literature, the focus has been on patients in western industrialized countries where education laws have made it increasingly rare to find individuals with extremely low levels of education. Unless the clinician has extensive experience interacting with normal individuals who have not been schooled or is well versed in the abundant cross-cultural psychology literature, it is nearly impossible for him/her to grasp the interrelationship between education and cognition. In the absence of this knowledge or experience, it is easy for the clinician to "pathologize" normal behavior.

Low levels of education are much more common among immigrants from certain regions, and there is ample literature demonstrating the effects of formal schooling on tests of cognitive ability (e.g., Cole & Scribner, 1977; Rogoff & Chavajay, 1995). Although published data are difficult to find, the indication is that the majority of immigrants who have lived in the U.S. for many years, and yet remain non-English speaking, in fact possess very low levels of formal education. Unfortunately, neuropsychologists routinely compare data generated by such individuals to normative data obtained from English-speaking mainstream populations with much higher levels of education.

One example of this behavior involved a neuropsychologist who testified under oath as to a patient's competency to stand trial. The patient, a monolingual Spanish speaker, had no formal education – almost unheard of among North Americans. The neuropsychologist testified that he spoke no Spanish. He stated that he had been unable to understand the previous neuropsychological data generated by the patient, as well as the test protocols used, as all were in Spanish. He also testified that he had never examined the patient himself, and had no knowledge of the literature on the neuropsychology of populations with no formal education.

Nevertheless, this neuropsychologist testified as to the patient's mental status. The neuropsychologist estimated the patient's IQ, despite the fact that no such test had been administered, no such test has been developed for unschooled individuals, and it is as yet unknown if the construct even applies to this population. The neuropsychologist proceeded to give an opinion as to the patient's competency to stand trial and to confer with his attorney. When this individual was confronted with the possible ethical violations raised by his courtroom behavior, he responded that there had been no ethical violation as he had only "consulted" on the case.

The second group of immigrants, those who obtain higher levels of education, is comprised of two subgroups of individuals. Those who immigrated after completing their education appear to learn English quickly as they assimilate into mainstream society. Those who immigrated as young children and then obtained their education in the US will show varying levels of competence in English, depending on demographic factors such as years of education completed and length of residence in the US. Such factors must be carefully assessed because they will determine the language of assessment. The clinician cannot simply assume the dominant language of the patient based on his or her surname or even accented articulation.

In one case, a monolingual neuropsychologist assessed a patient with a Spanish surname using Spanish-language questionnaires and tests. This was presumably carried out with the assistance of a Spanish-speaking technician, although the report made no mention of this. The patient did very poorly in the assessment. During independent examination by the first author, it emerged that the patient was born, raised, and educated to the 11th grade in a Mid-Western state. The patient had learned Spanish at home, but was unschooled in it. She had had difficulty adequately understanding the Spanish-language tests during the initial evaluation.

This entire group of individuals with higher education, once they have obtained fluency in English, should probably be assessed in English because of the availability of test materials in this language. However, there is a period of transition during which their native language may be more appropriate for assessment. Decisions as to which language should be used should be made only by a clinician who has the ability to ascertain the patient's degree of fluency in each language. If the patient is tested in his or her nondominant language, poor performance may be due primarily to the examinee's limited proficiency in the test language, rather than cerebral dysfunction (Pennock-Román, 1992).

Availability of Testing Materials and Norms

Testing materials and norms in languages other than English are scant. This renders the evaluation of non-English speakers that much more difficult. Some of the materials in circulation are of poor quality. For example, language inadequacy in Spanish test materials as used in the United States has been addressed elsewhere (Artiola i Fortuny & Mullaney, 1997). The existence of such materials is unfortunate; a clinician's inability to evaluate them critically only exacerbates the problem.

One neuropsychologist was confronted with his use of an unauthorized and poorly translated version of the MMPI. He explained that he was unaware of the origin of this transla-

tion as it was given to him by a colleague who claimed to speak Spanish. He indicated that he had did not know that the language quality was so poor because his own training in Spanish had been limited to a 3-week language immersion program.

After reviewing the problems resulting from linguistic inadequacy, one could argue that practicing neuropsychology in a language one does not know, or knows poorly, is not just unethical, it is also absurd. Furthermore, it is no small matter that diagnostic inaccuracy resulting from linguistic obstacles has been documented for some time (DelCastillo, 1970; Dodd, 1983; Edgerton & Karno, 1971; Malgady, Rolger, & Constantino, 1987; Peck, 1974; Sabin, 1975). The errors that result from inappropriately translated materials, the inability to comprehend the subtleties of a language, or a lack of knowledge of the population and the characteristics of the population to which the patient belongs can have far-reaching and devastating effects. These include inappropriate treatment, that in some cases might even be contraindicated. On the other hand, treatment that is in fact warranted may be denied. When child custody, disability, competency to stand trial, compensation for injuries, or a host of other legal matters hinge to some degree on the evaluation, the issue may be one of civil rights violation and/or malpractice. Beyond the personal and psychological harm that may come to the patient as a result of inappropriate assessment procedures, the costs to the individual, as well as to society, can be substantial.

Unfortunately, many of the examples cited above come to our attention because of litigation. One has to wonder about the prevalence rates of such incidents outside of that very public arena, and also why there has been no general public outcry to date. In his candid indictment of current practices in forensic assessments of Spanish-speakers, LaCalle (1987) expresses the opinion that although the Hispanic community has to this point been reluctant to bring legal action against health-care providers for language-based malpractice, the situation is changing. He writes: "In the near future, we are going to see an increasing number of law suits reaching the courts that challenge forensic evaluations, especially in workers' compensation, personal injury, family law, and, ultimately, in criminal cases" (p. 41)

WHY DO THE PROBLEMS EXIST?

There may be different reasons why clinicians who are in all other respects adequately qualified indulge in assessing patients whose language they do not know. These appear to include poor judgment and ignorance, and seem to be accompanied by a conspicuous absence of accurate self-appraisal with regard to the impact that these factors have on one's decision-making.

Poor judgment is implicated in situations in which the clinician may be well-aware that he or she is not qualified to undertake the assessment of someone who speaks little or no English, but does it anyway. When confronted with their actions, clinicians may offer various justifications. They sometimes cite the fact that the population is under-served and that there are very few assessment tools that can be reliably used with non-English speakers. They frequently generate the inference that their guess-work will be as good as anyone else's and, therefore, their competence will never be called into question. However, linguistic incompetence is obvious to fluent speakers, and will only become more easily recognized as the number of fluent professionals increases. It is one's signature on the report that never fades.

A degree of intellectual passivity also appears to be an aspect of this poor judgment. This is expressed in behaviors that suggest the following: *If I do not seek the information that might challenge my behavior, then I can pretend it does not exist.* Such individuals appear to wear blinders; they may show little interest in applying the accepted standards of professionalism and ethics to novel situations. In other words, they often fail to recognize that the guidelines that warn psychologists not to practice outside of their areas of expertise may very well apply to them in such cases.

Ignorance also appears to be a root cause of this type of abuse. Ignorance manifests in pre-

dictable ways that include a lack of knowledge about what fluency really is, a lack of awareness about one's own level of fluency in a second language, or a more general cultural ignorance or ethnocentrism.

North Americans, predominantly monolingual themselves, generally demonstrate a very poor understanding of the concept of fluency. Individuals with marginal knowledge of a second language routinely assess themselves as fluent. In fact, they are notorious for underestimating the point at which, along the language proficiency continuum, an individual can begin to be described as fluent. When the concept of fluency is poorly understood, so too is the criterion that different levels of language proficiency are necessary to function in different settings. In other words an individual heard conversing rapidly in a foreign language is often thought to be fluent enough for any task, including cognitive assessment or interpreting. However, the linguistic demands for diagnosis of cognitive function are quite challenging, and any communication errors could be costly or even dangerous.

Another aspect of ignorance appears to occur among some individuals who have been, at one time, fluent in a particular language, but who, without realizing it, lose a degree of their linguistic ability from a lack of use. This commonly occurs among immigrants who find themselves using English most often to the relative exclusion of their native language. A lack of awareness of this loss of fluency has been addressed elsewhere (Artiola i Fortuny & Mullaney, 1997). Because language fluency is a skill, and not an inherited characteristic like eye color, one must work diligently on a daily basis to maintain it when one does not live, work, or study in an environment in which that language predominates.

Ethnocentrism, an exaggerated and therefore inaccurate view of one's own culture's place in world (cultural narcissism, if you will), is also a type of ignorance that is likely to play a role in one's decision to assess non-English speakers. Given the relative geographic isolation of the U.S., Americans have comparatively less experience with a multicultural environment than do many other regions of the world where people of different countries, cultures, and languages live in much closer proximity, and often on more of an equal footing, in socioeconomic and political terms.

It would be hopelessly naive to assume that the members of our profession have somehow managed to avoid or escape the cultural and racial biases that are so pervasive in our society. In fact, much discussion has taken place about the lack of awareness in our profession of the fact that such bias guides our perceptions as well (e.g., Atkinson, 1993; Chávez & Oetting, 1995; Helms, 1993; Ivey, 1993; Parham, 1993; Sue, 1993). Brown (1993) defines "internalized domination" as "the sense of self within dominant group members in which images of inherent superiority of ourselves and our cultural reference group are predominant, leading us to define normalcy, reason and wisdom in terms of our own experience, to assume that 'human' is isomorphic with membership in our group" (p. 83). Prilleltensky (1997) argues eloquently for recognition and respect of people's unique individual identities as expressed through their larger cultural identity. He argues that without such recognition, individuals in power, such as mental health professionals, inflict a form of oppression on their patients. Pedersen and Marsella (1982) put it this way: "Appropriate services have typically self-served the dominant culture that has written the rules and internalized the unspoken assumptions of integrity" (p. 495).

Ethnocentrism, as a sense of cultural superiority, frequently operates outside of our awareness and can be expressed in a similarly unspoken attitude of linguistic superiority. The idea manifests in various ways that imply that English is a complex language complete with subtlety and nuance, but that someone else's language is not so blessed. A clinician may recognize the absurdity of a non-fluent neuropsychologist attempting to assess an English-speaking patient, but will not apply the same standard when the patient is not an English speaker. Frequently, neuropsychologists go to great lengths to discuss the finer points of ethical practice, but will ignore the glaring injustice(s) imposed on non-English-speaking patients by nonfluent colleagues.

The reader might ask why these underlying causes of the problem are important. We would argue that unless and until each neuropsychologist examines the issues carefully and confronts the possibility of ignorance playing a role in his or her own decision making, the abuses secondary to linguistic inadequacy will likely continue.

GUIDELINES AND STANDARDS ARE AVAILABLE: RECOMMENDATIONS

An examination of the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992) reveals a number of standards that can guide the concerned neuropsychologist on this issue. Existing standards are used to make recommendations on how to proceed in the event of non-English-speaking referrals.

Recognize and Respect Cultural Differences

First, "Psychologists accord appropriate respect to the fundamental rights, dignity, and worth of all people" (Principle D). Furthermore, they "are aware of cultural, individual, and role differences, including those due to age" (Principle D), and "they do not engage in unfair discrimination based on age, gender, race, ethnicity, national origin, religion, sexual orientation, language, and socioeconomic status, or any basis proscribed by law" (1.10).

Assess Linguistic Competence

Psychologists are obligated to provide only those services that fall "within the boundaries of their competence, based on their education, training, supervised experience, or appropriate professional experience" (1.04a). As was mentioned earlier, with regard to level of fluency, competence cannot be assumed but must first be verified. A simple rule of thumb would be to ask oneself, "Could I enroll in a foreign university's graduate or professional program and successfully engage in all academic activities (reading, writing, speaking, listening, and thinking at an advanced level)?" If the answer is no, the clinician should either seek the necessary language training in order to obtain that level, or simply decline to work with this particular linguistic group. The vast majority of those who possess this level of fluency have completed advanced studies in the target language, and this does not mean majoring in French in a domestic university, or spending a semester in Mexico. Individuals meeting this fluency requirement usually have lived and studied in the country of the target language for some years.

Some clinicians may feel confident that they are linguistically qualified because of the informal endorsement by a colleague. This is not an appropriate seal of approval unless fluency can be corroborated professionally. Linguistic competence can be evaluated, and there is literature on the subject (Savignon, 1985). One's claim of fluency can be immediately verifiable and simply cannot be feigned in the absence of true ability.

Get Trained

According to the ethical standards, psychologists must engage in professional duties "in new areas or involving new techniques only after first undertaking appropriate study, training, supervision, and/or consulting from persons who are competent in those areas or techniques" (1.04b). In the case of an emerging area in which no generally recognized training standards exist, they "take reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants, and others from harm" (1.04c).

Where language is concerned, psychologists who do not possess an adequate level of fluency, but who still wish to work with non-English speaking populations, simply need to obtain the necessary training. Language classes, tutoring, and immersion programs are plentiful. Professionals need simply to take advantage of them.

Training is also necessary beyond language. Familiarity with specific cultural idiosyncrasies of the target population is an essential building block for competence in the assessment of the poorly educated. The profound effects of schooling, and more specifically Western schooling, on tests of cognitive ability, is very well-documented in a large body of literature generated by the field of cross-cultural psychol-

ogy (e.g., Cole & Scribner, 1977; Rogoff & Chavajay, 1995). Knowledge of this literature will assist the clinician in making decisions as to the appropriateness of using existing neuropsychological tests for assessment of individuals with very low levels of education.

Maintain Language Skills

In cases in which a neuropsychologist possesses advanced fluency in a particular language, it must be kept in mind that, as for any other skill, fluency will decline over time without the work and commitment required to sustain it. It is mandated that neuropsychologists "undertake ongoing efforts to maintain competence in the skills they use" (1.05). Fluent clinicians should therefore be working to maintain their language skills in all five modalities by speaking, listening, writing, reading and thinking at an advanced level in the language, on a regular (even daily) basis.

Ensure Linguistic and Cultural Competence of Subordinates

Psychologists are also responsible for verifying the linguistic skills of any subordinate involved in the assessment procedure. The neuropsychologist must only delegate responsibility to individuals when "such persons can reasonably be expected to perform competently, on the basis of their education, training, or experience" (1.22a). This standard is directly relevant to the use of translators, interpreters, or bilingual technicians. It is clearly not enough, for example, for a monolingual English-speaking clinician to be satisfied that an assistant is bilingual based only on that individual's claim of fluency. The clinician will ultimately be held accountable for the veracity of such a claim.

Refer If Not Fluent

Psychologists should "arrange for appropriate consultations and referrals based principally on the best interests of their patients or clients" (1.20a). This occurs quite readily in the profession whenever a clinician believes the client would be better served by referral to, or collaboration with, another professional. In the case of a patient who is from a country with a variety of different languages, (e.g., China, India), it is important that the clinician refer to another neuropsychologist who is fluent in the patient's *specific* language. Failure to make a referral when the neuropsychologist does not possess linguistic and cultural competence adequate to meet the demands of cognitive assessment, and when another neuropsychologist who does possess such competence is available, violates the spirit of this standard.

There will be cases in which no fluent bilingual clinician is available. However, it is never acceptable for a neuropsychologist to simply assume this. Rather, he or she must always have current information about which colleagues in the geographic area are fluent. This information undergoes constant change as new clinicians become licensed and others may become adequately trained in a second language. Even if a linguistically qualified clinician is a considerable distance away, that option should be made available to both the patient and referral source.

The concerned neuropsychologist may also collaborate with a bilingual psychologist in planning and carrying out the assessment. Approaching national or international neuropsychological associations for names of colleagues who claim fluency in other languages is also a possibility, as is seeking the guidance and assistance of a colleague from the patient's country or linguistic group of origin through the Internet.

The clinician's ability to locate a fluent colleague clearly depends on how common the language of the patient is. In the event of a highly uncommon language, use of an interpreter may be unavoidable. The neuropsychologist is obligated to locate an interpreter, ideally with formal professional training and established competence. If a professional interpreter is not available, the next choice might be another individual with advanced fluency such as a university language professor or someone schooled in the assessment language through the university level. An interpreter should *never* be used when there is a fluent neuropsychologist or psychologist available, and no clinician with less than advanced fluency should ever assess unassisted. Convenient bystanders, such as friends or relatives of the patient or facility staff members,

should not be considered as options under any circumstances because of the potential to contaminate data collection in ways that the neuropsychologist cannot appreciate.

Base All Statements on Verifiable Evidence

Neuropsychologists' "assessments, recommendations, reports, and psychological diagnostic or evaluative statements are based on information and techniques (including personal interviews of the individual when appropriate) sufficient to provide appropriate substantiation for their findings" (201b). Also, a psychologist's use of all techniques, interviews, and instruments is done "in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques" (2.02a).

Clinicians must be aware of the origin of any diagnostic measure used, including information on the standardization sample and the instrument's reliability and validity. This is particularly important when considering the use of translated instruments. "Bootleg" translations of standardized measures are in circulation, and the language used in many is of extremely poor quality (Artiola & Mullaney, 1997). For this reason, unpublished instruments should never be employed unless there is powerful justification for doing so. Even when instruments have been published, the clinician should appraise their quality critically before using them. This goes for the instrument's psychometric qualities as well as its linguistic adequacy, and this applies to both verbal and nonverbal instruments.

With non-English-speaking populations who possess very little education, the challenges are not just linguistic; they embrace all other aspects of behavior. Errors can also occur when one assumes that non-linguistic aspects of cognition will be identical to those observed in the mainstream U.S. population. The contribution of lack of familiarity with testing situations in general, and the perception of the clinician as a figure of power and authority who cannot be challenged may be important variables affecting the results with an examinee who has very little formal education.

For non-English-speaking clients with higher levels of educational attainment, the bilingual clinician who chooses to assess may stand on slightly more solid ground. Indeed, based on preliminary data collected by the first author, for some tests at least, such individuals appear to obtain similar results to those of monolingual English-speakers. However, even when education level is not an issue, normative data for non-English-speaking populations is scant. For some populations, normative information may be available in the patient's country of origin (e.g., Italy) and the clinician is encouraged to contact scientists or practitioners in that country to consult on availability of tests and guidelines for administration.

In some cases, the referral source may be interested in specific diagnostic information, such as the presence or absence of brain damage after craniocerebral trauma or toxic exposure, or the presence of a dementing process versus depression. Diagnostic conclusions based on test performance of non-English speakers may be highly inappropriate, particularly if there are no demographically adequate normative data available. If severe brain injury is suspected, neuroimaging data and examination by a neurologist will likely be far more valid than any results obtained through such questionable psychometric practices. If the severity, or even the existence, of an insult cannot be based on "verifiable evidence," clinicians should avoid making diagnostic statements altogether. They should, in fact, usually decline to assess linguistic minorities whenever the referral question is one seeking diagnostic information.

If the clinician still wishes to conduct an evaluation in the absence of demographically and linguistically relevant normative data, it is advisable not to administer any tests. In such a situation, it is recommended that the clinician take a thorough personal and social history from the patient and, from collateral sources, carefully study all available medical records. Then, make only tentative conclusions based on the history and what is known about the natural progression of the disease/injury in question. The clinician must always specify the fragility of his or her position in the report.

Ultimately, it is up to the clinician to educate referral sources about the limitations and appropriate uses of our diagnostic tools. Referring professionals may incorrectly assume that a neuropsychological diagnostic evaluation is feasible for a particular patient for whom appropriate normative data does not exist. Therefore, they may request information that is simply unobtainable. It is our responsibility to firmly decline referrals to test such patients.

In other cases, the referral source may be less interested in a diagnosis than in a determination of the patient's functional ability in a particular English-language setting (e.g. school, rehabilitation program placement, or vocational retraining). Responding to such a referral question may be entirely possible. In such situations, and provided the patient does possess sufficient English fluency to justify test administration, it may be appropriate to assess the patient's scholastic skills as well as abilities to learn material presented in English. Here, the clinician must ensure that the report of neuropsychological evaluation indicates clearly that the conclusions are not meant as a diagnosis, but merely as an assessment of the individual relative to mainstream individuals with otherwise similar demographic characteristics. Regardless of how a clinician decides to proceed, he or she should clearly state in the report the limitations of the following: the techniques and measures used, the normative comparisons made, and the confidence of interpretive statements. These caveats are essential in order to communicate the degree of confidence that one may have in the assessment and its findings. Obviously, if the number of caveats renders the report useless, it is better not to conduct the assessment in the first place. Furthermore, whenever the language used in the assessment was one other than English, this information should also be provided in the report, as well as the specific qualifications of anyone who assisted in the evaluation.

Whenever an evaluation of this sort is initiated, the clinician should obtain informed consent from the patient. This should consist of a clear written statement that includes the limitations outlined in the preceding paragraph and information on the level of linguistic fluency of the clinician (including educational achievement in that language). Whenever the clinician possesses anything less than the fluency of an educated native, the consent should outline the risks involved, such as the possibility of inaccurate diagnosis due to linguistic difficulty. The consent should also specify that the patient was informed about the location of the nearest trained neuropsychologist with advanced native fluency, regardless of how far away that professional is, in order to demonstrate that the patient made an informed choice to proceed. This information should also be provided to the referral source at the time of referral. Informed consent, as usual, serves as a protection for both the patient and clinician.

Do Not Release Raw Data to Nonfluent Clinicians

Psychologists are warned to avoid misusing assessment techniques, measures, and interpretations, and to prevent others from doing the same. "This includes refraining from releasing raw test results or raw data to persons, other than to patients or clients as appropriate, who are not qualified to use such information" (2.02b). Clearly, clinicians who do not speak or read a given language are not qualified to use data and protocols generated in that language and, therefore, data should not be released to them unless they have named a fluent colleague with whom they will be collaborating. All other things being equal, data may then be released directly to that colleague.

CONCLUSIONS

Some neuropsychologists underestimate the extreme importance of linguistic competence when assessing non-English speakers or they simply fail to recognize when their own linguistic skill is substandard. In addition, clinicians are accustomed to viewing behavior and test results through a particular lens, one that assumes the presence of certain demographic characteristics, and accordingly derives diagnostic meaning from those behaviors which have been identified as clinically relevant for those particular popula-

tions. It is altogether too easy to continue in this mind-set even when a patient's demographic characteristics do not match those of the standardization sample and despite the ample literature on the effects of culture and education on tests of cognitive ability. Such carelessness obviously vitiates any results obtained. This practice probably constitutes a breach of the accepted methodological and ethical guidelines of our profession, it may leave clinicians vulnerable to charges of malpractice, and, given its discriminatory and disrespectful nature, may be considered a violation of an individual's civil rights.

Although our ethical guidelines do not address linguistic competence per se, and do not go into detail about aspects of cultural variability, they do mandate competence, in more general terms, and insist on respect for individual differences where culture and language are concerned. This situation should be remedied, while the opportunity to do so is still within our hands.

Despite the evidence presented, some readers may be concerned that the linguistic qualifications outlined in this work "set the bar too high", thus resulting in fewer linguistic minorities being served by neuropsychologists. They may claim that although these guidelines represent an important goal, they are currently too restrictive. After all, is it not the case that the standard of care for linguistic competence in most communities is defined by the clinician who is not at the level of the educated native? The authors strongly assert that this application of the "standard of care" argument is inappropriate. No practice with a high risk of harming the patient is ever justifiable. The absence of a neuropsychological evaluation is preferable to one in which faulty diagnostic conclusions are based on a clinician's compromised communication with the patient and/or his or her unfamiliarity with appropriate cultural and normative information.

The recommendations offered by the authors serve only as stop-gap measures at a time when, in the United States and Canada, our profession can count on a relatively small group of individuals who are truly qualified, both linguistically and neuropsychologically, to conduct assessments in languages other than English. Although this is regrettable for the present, and is no excuse for the behavior illustrated in the examples cited, the shortage of qualified clinicians need not continue into future generations. There can be no adequate substitute for the clinician who can fully and directly communicate with his or her patient at all levels of discourse, and one who is armed with thorough knowledge of the patient's culture. It is up to our field to correct the situation; it should not be the responsibility of individual clinicians to "police" one another at the local level. This can most effectively be accomplished through neuropsychology training programs (Cripe, 1995). Recruiting and retaining individuals who are fluent in languages other than English is likely to advance research with underserved populations, improve clinical services for cultural and linguistic minorities, and ultimately preserve public confidence in the profession.

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ATTACHMENT

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FAX COVER SHEET
Central Intelligence Agency

Washington, DC 20505

30 December 2004

To:	DOJ Command Center For Dan Levin
Organization:	Office of Legal Counsel U.S. Department of Justice
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Number of pages (including cover sheet): 20

Comments: (S//NF) Dan, A generic description of the process. Thank you.

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Background Paper on CIA's Combined Use of Interrogation Techniques

Note: This paper provides further background information and details on High-Value Detainee (HVD) interrogation techniques to support documents CIA has previously provided the Department of Justice.

This paper focuses strictly on the topic of combined use of interrogation techniques.

The purpose of interrogation is to persuade High-Value Detainees (HVD) to provide threat information and terrorist intelligence in a timely manner, to allow the US Government to identify and disrupt terrorist plots and to collect critical intelligence on al-Qa'ida

In support of information previously sent to the Department of Justice, this paper provides additional background on how interrogation techniques are used, in combination and separately, to achieve interrogation objectives. Effective interrogation is based on the concept of using both physical and psychological pressures in a comprehensive, systematic, and cumulative manner to influence HVD behavior, to overcome a detainee's resistance posture. The goal of interrogation is to create a state of learned helplessness and dependence conducive to the collection of intelligence in a predictable, reliable, and sustainable manner. For the purpose of this paper, the interrogation process can be broken into three separate phases: Initial Conditions; Transition to Interrogation; and Interrogation.

A. Initial Conditions. Capture, contribute to the physical and psychological condition of the HVD prior to the start of interrogation. Of these, "capture shock" and detainee reactions are factors that may vary significantly between detainees

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Regardless of their previous environment and experiences, once an HVD is turned over to CIA a predictable set of events occur:

1) Rendition.

a. The HVD is flown to a Black Site A medical examination is conducted prior to the flight. During the flight, the detainee is securely shackled and is deprived of sight and sound through the use of blindfolds, earmuffs, and hoods. There is no interaction with the HVD during this rendition movement except for periodic, discreet assessments by the on-board medical officer.

b. Upon arrival at the destination airfield, the HVD is moved to the Black Site under the same conditions and using appropriate security procedures.

2) Reception at Black Site. The HVD is subjected to administrative procedures and medical assessment upon arrival at the Black Site.

the HVD finds himself in the complete control of Americans;

the procedures he is subjected to are precise, quiet, and almost clinical; and no one is mistreating him. While each HVD is different, the rendition and reception process generally creates significant apprehension in the HVD because of the enormity and suddenness of the change in environment, the uncertainty about what will happen next, and the potential dread an HVD might have of US custody. Reception procedures include:

a. The HVD's head and face are shaved.

b. A series of photographs are taken of the HVD while nude to document the physical condition of the HVD upon arrival.

c. A Medical Officer interviews the HVD and a medical evaluation is conducted to assess the physical condition of the HVD. The medical officer also determines if there are any contraindications to the use of interrogation techniques.

d. A Psychologist interviews the HVD to assess his mental state. The psychologist also determines if there are any contraindications to the use of interrogation techniques.

Transitioning to Interrogation - The Initial Interview. Interrogators use the Initial Interview to assess the initial resistance posture of the HVD and to determine--in a relatively benign environment--if the HVD intends to willingly participate with CIA interrogators. The standard on participation is set very high during the Initial Interview. The HVD would have to willingly provide information on actionable threats and location information on High-Value Targets at large--not lower level information--for interrogators to continue with the neutral approach.

to HQS. Once approved, the interrogation process begins provided the required medical and psychological assessments contain no contraindications to interrogation

C. Interrogation.

For descriptive purposes, these techniques can be separated into three categories: Conditioning Techniques; Corrective Techniques; and Coercive Techniques. To more completely describe the three categories of techniques and their effects, we begin with a summary of the detention conditions that are used in all CIA HVD facilities and that may be a factor in interrogations.

1) Existing detention conditions. Detention conditions are not interrogation techniques, but they have an impact on the detainee undergoing interrogation. Specifically, the HVD will be exposed to white noise/loud sounds (not to exceed 79 decibels) and constant light during portions of the interrogation process. These conditions provide additional operational security: white noise/loud sounds mask conversations of staff members and deny the HVD any auditory clues about his surroundings and deter and disrupt the HVD's potential efforts to communicate with other detainees. Constant light provides an improved environment for Black Site security, medical, psychological, and interrogator staff to monitor the HVD.

2) Conditioning Techniques. The HVD is typically reduced to a baseline, dependent state using the three interrogation techniques discussed below in combination. Establishing this baseline state is important to demonstrate to the HVD that he has no control over basic human needs. The baseline state also creates in the detainee a mindset in which he learns to perceive and value his personal welfare, comfort, and immediate needs more than the information he is protecting. The use of these

conditioning techniques do not generally bring immediate results; rather, it is the cumulative effect of these techniques, used over time and in combination with other interrogation techniques and intelligence exploitation methods, which achieve interrogation objectives. These conditioning techniques require little to no physical interaction between the detainee and the interrogator. The specific conditioning interrogation techniques are:

a. Nudity. The HVD's clothes are taken and he remains nude until the interrogators provide clothes to him.

b. Sleep Deprivation. The HVD is placed in the vertical shackling position to begin sleep deprivation. Other shackling procedures may be used during interrogations. The detainee is diapered for sanitary purposes, although the diaper is not used at all times.

c. Dietary manipulation. The HVD is fed Ensure Plus or other food at regular intervals. The HVD receives a target of 1500 calories per day per OMS guidelines.

3) Corrective Techniques. Techniques that require physical interaction between the interrogator and detainee are used principally to correct, startle, or to achieve another enabling objective with the detainee. These techniques-the insult slap, abdominal slap, facial hold, and attention grasp-are not used simultaneously but are often used interchangeably during an individual interrogation session. These techniques generally are used while the detainee is subjected to the conditioning techniques outlined above (nudity, sleep deprivation, and dietary manipulation). Examples of application include:

a. Insult Slap. The insult slap often is the first physical technique used with an HVD once an interrogation begins. As noted, the HVD may already be nude, in sleep deprivation, and subject to dietary manipulation, even though the detainee will likely feel little effect from these techniques early in the interrogation. The insult slap is used sparingly but periodically throughout the interrogation process when the interrogator needs to immediately correct the

detainee or provide a consequence to a detainee's response or non-response. The interrogator will continually assess the effectiveness of the insult slap and continue to employ it so long as it has the desired effect on the detainee. Because of the physical dynamics of the various techniques, the insult slap can be used in combination with water dousing or kneeling stress positions. Other combinations are possible but may not be practical.

b. Abdominal Slap. The abdominal slap is similar to the insult slap in application and desired result. It provides the variation necessary to keep a high level of unpredictability in the interrogation process. The abdominal slap will be used sparingly and periodically throughout the interrogation process when the interrogator wants to immediately correct the detainee

, and the interrogator will continually assess its effectiveness. Because of the physical dynamics of the various techniques, the abdominal slap can be used in combination with water dousing, stress positions, and wall standing. Other combinations are possible but may not be practical.

c. Facial Hold. The facial hold is a corrective technique and is used sparingly throughout interrogation. The facial hold is not painful and is used to correct the detainee in a way that demonstrates the interrogator's control over the HVD.

Because of the physical dynamics of the various techniques, the facial hold can be used in combination with water dousing, stress positions, and wall standing. Other combinations are possible but may not be practical.

d. Attention Grasp.

It may be used several times in the same interrogation. This technique is usually applied

grasp the HVD and pull him

into close proximity of the interrogator (face to face). Because of the physical dynamics of the various techniques, the attention grasp can be used in combination with water dousing or kneeling stress positions. Other combinations are possible but may not be practical.

4) Coercive Techniques. Certain interrogation techniques place the detainee in more physical and psychological stress and, therefore, are considered more effective tools in persuading a resistant HVD to participate with CIA interrogators. These techniques--walling, water dousing, stress positions, wall standing, and cramped confinement--are typically not used in combination, although some combined use is possible. For example, an HVD in stress positions or wall standing can be water doused at the same time. Other combinations of these techniques may be used while the detainee is being subjected to the conditioning techniques discussed above (nudity, sleep deprivation, and dietary manipulation). Examples of coercive techniques include:

a. Walling. Walling is one of the most effective interrogation techniques because it wears down the HVD physically, heightens uncertainty in the detainee about what the interrogator may do to him, and creates a sense of dread when the HVD knows he is about to be walled again.

nterrogator
An HVD may be walled one time (one impact with the wall) to make a point or twenty to thirty times consecutively when the interrogator requires a more significant response to a question. During an interrogation session that is designed to be intense, an HVD will be walled multiple times in the session. Because of the physical dynamics of walling, it is impractical to use it simultaneously with other corrective or coercive techniques.

b. Water Dousing. The frequency and duration of water dousing applications are based on water temperature and other safety considerations as

established by OMS guidelines. It is an effective interrogation technique and may be used frequently within those guidelines. The physical dynamics of water dousing are such that it can be used in combination with other corrective and coercive techniques. As noted above, an HVD in stress positions or wall standing can be water doused. Likewise, it is possible to use the insult slap or abdominal slap with an HVD during water dousing.

c. Stress Positions. The frequency and duration of use of the stress positions are based on the interrogator's assessment of their continued effectiveness during interrogation. These techniques are usually self-limiting in that temporary muscle fatigue usually leads to the HVD being unable to maintain the stress position after a period of time. Stress positions requiring the HVD to be in contact with the wall can be used in combination with water dousing and abdominal slap. Stress positions requiring the HVD to kneel can be used in combination with water dousing, insult slap, abdominal slap, facial hold, and attention grasp.

d. Wall Standing. The frequency and duration of wall standing are based on the interrogator's assessment of its continued effectiveness during interrogation. Wall standing is usually self-limiting in that temporary muscle fatigue usually leads to the HVD being unable to maintain the position after a period of time. Because of the physical dynamics of the various techniques, wall standing can be used in combination with water dousing and abdominal slap. While other combinations are possible, they may not be practical.

e. Cramped Confinement. Current OMS guidance on the duration of cramped confinement limits confinement in the large box to no more than 8 hours at a time for no more than 18 hours a day, and confinement in the small box to 2 hours.

.. Because of the unique aspects of cramped confinement, it cannot be used in

combination with other corrective or coercive techniques.

D. Interrogation - A day-to-day look. This section provides a look at a prototypical interrogation with an emphasis on the application of interrogation techniques, in combination and separately.

2) Session One.

a. The HVD is brought into the interrogation room, and under the direction of the interrogators, stripped of his clothes, and placed into shackles

b. The HVD is placed standing with his back to the walling wall. The HVD remains hooded.

c. Interrogators approach the HVD, place the walling collar over his head and around his neck, and stand in front of the HVD.

d. The interrogators remove the HVD's hood and explain the HVD's situation to him, tell him that the interrogators will do what it takes to get important information, and that he can improve his conditions immediately by participating with the interrogators. The insult slap is normally used as soon as the HVD does or says anything inconsistent with the interrogators' instructions.

e. If appropriate, an insult slap or abdominal slap will follow.

f. The interrogators will likely use walling once it becomes clear that the HVD is lying, withholding information, or using other resistance techniques.

g. The sequence may continue for several more iterations as the interrogators continue to measure the HVD's resistance posture and apply a negative consequence to the HVD's resistance efforts.

h. The interrogators, assisted by security officers (for security purposes) will place the HVD in the center of the interrogation room in the vertical shackling position and diaper the HVD to begin sleep deprivation. The HVD will be provided with Ensure Plus (liquid dietary supplement) to begin dietary manipulation. The HVD remains nude-. White noise (not to exceed 79db) is used in the interrogation

room. The first interrogation session terminates at this point.

i.

j. This first interrogation session may last from 30 minutes to several hours based on the interrogators' assessment of the HVD's resistance posture.

The three Conditioning Techniques were used to bring the HVD to a baseline, dependent state conductive to meeting interrogation objectives in a timely manner.

3) Session Two.

a. The time period between Session One and Session Two could be as brief as one hour or more than 24 hours

In addition, the medical and psychological personnel observing the interrogations must advise there are no contraindications to another interrogation session.

b.

c. Like the first session, interrogators approach the HVD, place the walling collar over his head and around his neck, and stand in front of the HVD.

d.

Should the HVD not respond appropriately to the first questions, the interrogators will respond with an insult slap or abdominal slap to set the stage for further questioning.

e.

The interrogators will likely use walling once interrogators determine the HVD is intent on maintaining his resistance posture.

f. The sequence may continue for multiple iterations as the interrogators continue to measure the HVD's resistance posture.

g. To increase the pressure on the HVD,

water douse the HVD for several minutes.

h. The interrogators, assisted by security officers, will place the HVD back into the vertical shackling position to resume sleep deprivation. Dietary manipulation also continues, and the HVD remains nude. White noise (not to exceed 79db) is used in the interrogation room. The interrogation session terminates at this point.

i. As noted above, the duration of this session may last from 30 minutes to several hours based on the interrogators' assessment of the HVD's resistance posture. In this example of the second session, the following techniques were used: sleep deprivation, nudity, dietary manipulation, walling, water dousing, attention grasp, insult slap, and abdominal slap. The three Conditioning Techniques were used to keep the HVD at a baseline, dependent state and to weaken his resolve and will to resist. In combination with these three techniques, other Corrective and Coercive Techniques were used throughout the interrogation session based on interrogation objectives and the interrogators' assessment of the HVD's resistance posture.

4) Session Three.

a.

In addition, the medical and psychological personnel observing the interrogations must find no contraindications to continued interrogation.

b. The HVD remains in sleep deprivation, dietary manipulation and is nude.

c. Like the earlier sessions, the HVD begins the session standing against the walling wall with the walling collar around his neck.

d. If the HVD is still maintaining a resistance posture, interrogators will continue to use walling and water dousing. All of the Corrective Techniques (insult slap, abdominal slap, facial hold, attention grasp) may be used several times during this session based on the responses and actions of the HVD. Stress positions and wall standing will be integrated into interrogations

Intense questioning and walling would be repeated multiple times.

Interrogators will often use one technique to support another. As an example, interrogators would tell an HVD in a stress position that he (HVD) is going back to the walling wall (for walling) if he fails to hold the stress position until told otherwise by the HVD. This places additional stress on the HVD who typically will try to hold the stress position for as long as possible to avoid the walling wall.

the

interrogators will remind the HVD that he is responsible for this treatment and can stop it at any time by cooperating with the interrogators.

e. The interrogators, assisted by security officers, will place the HVD back into the vertical shackling position to resume sleep deprivation. Dietary manipulation also continues, and the HVD remains nude. White noise (not to exceed 79db) is used in the interrogation room. The interrogation session terminates at this point. In this example of the third session, the following techniques were used: sleep deprivation, nudity, dietary manipulation, walling, water dousing, attention grasp, insult slap, abdominal slap, stress positions, and wall standing.

5) Continuing Sessions.

Interrogation techniques assessed as being the most effective will be emphasized while techniques will little assessed effectiveness will be minimized.

a.

b. The use of cramped confinement may be introduced if interrogators assess that it will have the appropriate effect on the HVD.

c.

d. Sleep deprivation may continue to the 70 to 120 hour range, or possibly beyond for the hardest resisters, but in no case exceed the 180-hour time limit. Sleep deprivation will end sooner if the medical or psychologist observer finds

H.

contraindications to continued sleep deprivation.

e.

f

g. The interrogators' objective is to transition the HVD to a point where he is participating in a predictable, reliable, and sustainable manner. Interrogation techniques may still be applied as required, but become less frequent.

. This transition period lasts from several days to several weeks based on the HVDs responses and actions.

h. The entire interrogation process outlined above, including transition, may last for thirty days

On average, the actual use of interrogation techniques can vary upwards to fifteen days based on the resilience of the HVD.

If the interrogation team anticipates the potential need to use interrogation techniques beyond the 30-day approval period, it will submit a new interrogation plan to HQS for evaluation and approval.

2. Summary.

- Since the start of this program, interrogation techniques have been used in combination and separately to achieve critical intelligence collection objectives.
- The use of interrogation techniques in combination is essential to the creation of an interrogation environment conducive to intelligence collection. HVDs are well-trained, often battle-hardened terrorist operatives, and highly committed to jihad. They are intelligent and resourceful leaders and able to resist standard interrogation approaches.
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However, there is no template or script that states with certainty when and how these techniques will be used in combination during interrogation. However, the exemplar above is a fair representation of how these techniques are actually employed.

- All CIA interrogations are conducted on the basis of the "least coercive measure" principle. Interrogators employ interrogation techniques in an escalating manner consistent with the HVD's responses and actions. Intelligence production is more sustainable over the long term if the actual use of interrogation techniques diminishes steadily and the interrogation environment improves in accordance with the HVD's demonstrated consistent participation with the interrogators.

ATTACHMENT

C

International Forensic Expert Group
Statement on Access to Relevant Medical and Other Health Records and Relevant Legal Records for Forensic Medical Evaluations of Alleged Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Background

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

Despite international recognition of Istanbul Protocol standards for the effective medical evaluation of alleged torture or other ill-treatment, there have been a number of recent legal cases in which the access to information relevant to the discovery of medical evidence material to the case has been denied, limited, and/or filtered by legal experts and adjudicators on the basis of "national security" or other concerns.[4]

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

The International Forensic Expert Group (IFEG)* consists of 33 forensic medical experts[5] from 18 countries with a combined total of more than 500 years of experience in the evaluation and documentation of physical and psychological evidence of torture and ill-treatment. The opinions expressed in this statement are based on international standards and the experience of IFEG members in documenting the physical and psychological effects of torture and ill-treatment of thousands of detainees.

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[1] See: Iacopino V., Ozkalipci, O., Schlar, C., Allden, K., Baykal, T., Kirschner, R. et al. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol). Office of the High Commissioner for Human Rights. New York and Geneva, United Nations Publications HR/P/PT/8. 2001. Available at: http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf.

[2] Grossman, Claudio. "The Normative Value of the Istanbul Protocol." In Shedding Light on a Dark Practice: Using the Istanbul Protocol to Document Torture, edited by Susanne Kjær and Asger Kjærum, 11-13. Copenhagen, Denmark: International Rehabilitation Council for Torture Victims, 2009.

[3] Annex 1 of the Istanbul Protocol, "The Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" are annexed to General Assembly resolution 55/89 of 4 December 2000 and to Commission on Human Rights resolution 2000/43 of 20 April 2000, both adopted without a vote.

[4] The limitation of access to medical and other health records be manifest in a number of ways, including: providing an incomplete set of the original records; the editing/redaction of certain information from copies of the original records; providing summaries of the records, which summaries may be in the form of a single report or short extracts drafted using the original records.

[5] The term "forensic medical experts" refers to health professionals who are qualified to evaluate physical and/or psychological evidence of alleged torture and ill treatment. They may be physicians and/or mental health professionals.

International Standards for the Medical Evaluation of Alleged Torture and Ill-Treatment

The Istanbul Protocol provides international, legal standards on protection against torture and sets out specific guidelines on how effective legal and medical investigations into allegations of torture and ill-treatment should be conducted.

The Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol principles[6]) require that any investigation into such allegations must have not only the power, but also the obligation, to obtain all the information necessary to the inquiry. (Principle 3.a.). Moreover, the alleged victim and their legal representative must be provided access to any hearing and all information, and shall be entitled to present other evidence. (Principle 4). The standards require a complete, impartial medical assessment by qualified, independent medical experts, including a review of the complete medical and other health records as well as the relevant legal documents.

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

Access to other information must also include relevant legal documents that pertain to the case, including any statements made by material witnesses, including relatives of the alleged victim, access to first information reports, logs of any detaining authority showing dates of arrest or capture and the dates and to which authority any transfers were made; interrogation logs, internal investigations etc. The compilation of all this information is particularly important where the alleged victim is deceased and therefore unable to provide direct testimony. In the case of a deceased victim, if the body is retrieved, information on the circumstances of the retrieval and access to any post-mortem reports, where an autopsy has been, or can be conducted, is also essential. Any investigation into cases of suspected extra-legal, arbitrary or summary executions must be conducted according to the UN standard known as the Minnesota Protocol.[7]

Medical and other health records should be taken to include, amongst other things, all notes pertaining to an individual, whether in written or electronic format, compiled by any health professional including by physicians, psychiatrists, psychologists, nurses, medical orderlies, or any other health professionals, whether directly involved in the treatment, care or observation of an individual, or whether made by health professionals who have attended to, or assessed the individual for any other reason, including to serve the objectives and purpose of any third party. Medical and other health records also includes the results of any tests, medical imaging, screening and any other interventions whether preventive, curative or of any other nature, including photographic and video recordings. The complete medical and

[6] Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Annex 1 of the Istanbul Protocol.
[7] UN Manual on the effective prevention and investigation of extra-legal, arbitrary and summary executions - 1991 - ("Minnesota Protocol").

other health records must be made available following any treatment, care, observation, intervention or assessment for any purpose, whether these are done with or without the consent of the individual. According to the Istanbul Protocol:

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

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

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

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

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

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

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

- they may corroborate specific allegations of violations including: specific methods applied to the alleged victim, descriptions of instruments used, restraint positions, frequency and intensity of forces applied, protective barriers that may mitigate physical forces and subsequent physical evidence.

- some acts may be presumed by non-clinicians to be innocuous, even when practiced in combinations and over extended periods of time (e.g. forced nakedness, temperature manipulation, sensory deprivation, sensory bombardment, prolonged isolation, techniques of asphyxiation), but may cause severe and prolonged mental pain or suffering, which may only be evident following examination by a qualified forensic medical expert.

- they may contain health professionals' observations of physical and/or psychological reactions, before, during or after interrogation practices, incident reports, documentation of injuries, or lack thereof, and/or the condition of the alleged victim.

- they may be critical in establishing a timeline of the alleged violations that is necessary to understanding the development of physical and psychological symptoms and disabilities, as well as the subsequent healing of injuries.

- they may assist in identifying the alleged perpetrators, and in establishing a foundation for the intent of the alleged perpetrators to inflict physical and/or mental harm.

- the assessment of "severe physical and psychological pain or suffering," which form part of the definition of torture, usually requires specific medical knowledge and specific information gathered from the individual alleging torture or other ill-treatment in a clinical interview.

- the nature and extent of psychological reactions to torture and ill-treatment depend on the meaning individuals assign to traumatic experiences. Assessment of psychological evidence of torture and ill-treatment, therefore, requires a detailed understanding of the circumstances of the alleged violations that are often found in medical and other health records as well as relevant legal records.

- forensic medical experts need complete medical and other health records, as well as relevant legal records to form opinions on the likely physical and/or psychological reactions that may be expected from the alleged violations, with due consideration to individual mitigating and potentiating factors.

- forensic medical expert opinions on the causation of physical and psychological symptoms and disabilities (i.e. torture and ill-treatment vs. illness and disease) also require a comprehensive understanding of information contained in complete medical and other health records as well as relevant legal documents.

- forensic medical experts require access to all medical and other health records, as well as relevant legal records to assess for the possible exclusion of incriminating evidence. Such exclusions may be evident when the allegations of violations by the alleged victim are highly consistent with physical and/or psychological findings (i.e. multiple lacerations on the back consistent with allegations of whipping), but there is no supporting documentation in the medical or relevant legal records.

- complicity of health professionals in torture and ill-treatment practices is well documented,[8] either in the form of direct participation and/or the neglect, misrepresentation, or concealment of medical evidence. Access to all medical and other health records as well as relevant legal records is necessary to the forensic medical evaluator's assessment of possible complicity of health professionals (direct or indirect) in alleged violations, and whether medical or mental health care was needed, requested and/or provided, understanding that withholding of medical care may in itself constitute a form of torture or ill-treatment.

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

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

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

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

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

Medical records may contain information that may seem irrelevant to allegations of torture and ill-treatment to individuals who are not qualified forensic medical experts. For example, psychological

[8] See: Stover E. *The Open Secret: Torture and the Medical Profession in Chile.* Washington, DC: American Association for the Advancement of Science; 1987; Iacopino V, Heisler M, Pishever S, and Kirschner RH. Physician Complicity in Misrepresentation and Omission of Medical Evidence in Post-Detention Medical Examinations in Turkey. *JAMA.* 1996; 276:396-402; and Iacopino V, Xenakis SN. Neglect of Medical Evidence of Torture in Guantánamo Bay: a case series. *PLoS Medicine.* 8(4): e1001027. doi:10.1371/journal.pmed.1001027. Available at: http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001027.

diagnoses of "routine stressors of confinement" or a "personality disorder" may seem reasonable unless one were to know that certain symptoms are more likely to be due to post-traumatic stress disorder associated with alleged violations than what may be documented in the medical record.[9]

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

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

National Security Considerations

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

Medical records that are professionally and ethically compiled and maintained should contain information that does not impinge upon national security. In the Inter-American Court of Human Rights it was determined that a State could not rely on the doctrine of "state secrets" as the basis for denying access to information relevant to serious human rights violations.[10]

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

Information which is deemed as "classified" should be made available to independent forensic medical experts after appropriate security clearance has been obtained.

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[9] See: Iacopino V, Xenakis SN. Neglect of Medical Evidence of Torture in Guantánamo Bay: a case series. *PLoS Medicine*. 8(4): e1001027. doi:10.1371/journal.pmed.1001027. Available at: http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001027.

[10] Inter- American Court of Human Rights Gomes Lund et. al. v. Brazil 2010.

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

The right to access personal information is enshrined in international law. It is recognized that everyone has the right of access to data which has been collected concerning themselves, whether this information is held by governments or by private entities, and to have this information rectified.[11,12] In particular, States must guarantee that people can access the information contained in their medical records.[13]

Where there are prima facie reasonable grounds to believe that any act of torture has occurred under a States' jurisdiction, the United Nations Convention Against Torture stipulates that a prompt and impartial investigation must occur.[14] The UN Committee Against Torture concluded that the alleged victim must be allowed access to their medical records as a part of the investigation into the allegation.[15] Even in cases where there was no allegation of torture or ill-treatment, the Committee Against Torture established that a detainee and their legal representative have the right to access all the registers kept in relation to their detention, including their medical records.[16]

The UN Subcommittee on the Prevention of Torture (SPT) [17] has adopted the position that any medical records made during deprivation of liberty form a part of the information relevant to the investigation of any allegation of torture or other ill-treatment.[18] The UN Committee Against Torture further confirmed the importance of the access to medical records when it concluded that the National Preventive Mechanisms, established under the Optional Protocol to the Convention Against Torture, had the right to examine all detention related documents, including medical records.[19]

The Standards of the European Committee for the Prevention of Torture[20] (CPT) state that patients should have the right to consult the contents of their prison medical files, unless this is inadvisable from a therapeutic standpoint, and the patient should be able to ask for this information to be communicated to their families and lawyers or to an outside doctor. Therefore according to the CPT standards, if the patient consents to their medical files being transmitted to a third party, then the State is under an obligation to do so.

The alleged victims of torture who are seeking access to their complete medical and other health records, have usually been, or may still be a detained or imprisoned person, whose detention was, or is under the control of the jurisdiction that now refuses to provide access to the complete records. The Human Rights Committee found that in lodging a complaint against a State of serious human rights violations, the State is often the sole holder of key evidence, for instance personal medical records.[21] It is

[11] European Union Charter of Fundamental Rights. 2010/C 83/02. Protection of Personal Data.
[12] Annual report of the Inter-American Commission on Human Rights 2008. Volume II Report of the Office of the Special Rapporteur for Freedom of Expression.
[13] Inter-American Commission on Human Rights. Access to Information on Reproductive Health from a Human Rights Perspective. OEA/Ser.L/V/II. 2011.
[14] United Nations Convention Against Torture 1984. Articles. 12 and 13.
[15] UN Committee Against Torture Concluding Observations on Bosnia and Herzegovina. CAT/C/BIH/CO/2-5 (CAT 2011).
[16] UN Committee Against Torture Concluding Observations on Tajikistan. CAT/C/TJK/CO/1 (CAT 2006).
[17] Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment Adopted on 18 December 2002 by UN General Assembly. A/RES/57/199.
[18] See for example UN Subcommittee on the Prevention of Torture country visit to the Maldives. CAT/OP/MDV12009.
[19] UN Committee Against Torture Concluding Observations on Moldova.CAT/C/MDA/CO/2 (CAT, 2010) Moldova.
[20] CPT Standards. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) CPT/Inf/E (2002) 1 - Rev. 2010.
[21] *Telitsin v. Russian Federation* (888/1999), ICCPR, A/59/40 vol. II (29 March 2004) 60.

thus incumbent on the State to provide access to this information, including complete medical records to allow a determination of whether a violation has occurred.

In responding to individuals who allege torture or other ill-treatment, as well as having been subject to poor conditions of detention and a lack of adequate medical care, some States have refused access to the medical records but provided a medical certificate purporting to fully correspond to the contents of the actual records. This summary certificate was deemed insufficient by the UN Human Rights Committee, who found this to be a violation of article 10 of the International Covenant on Civil and Political Rights (the right to humane treatment), and stated that a prisoner does not lose the entitlement to access his actual medical and other health records.[22]

Further, in the European Court of Human Rights it was deemed that hand written extracts of medical records would not be sufficiently comprehensive to establish an expert opinion, and that copies of the complete medical records were required. Not allowing access to copies of the complete medical records violated the right to privacy (article 8 of the European Convention on Human Rights) since no effective access to information concerning the alleged victims' health was granted.[23] Moreover, the European Court ruled that the failure to provide complete copies of the medical records, violated the rights of the applicants to a fair hearing by a tribunal (article 6 of the European Convention) since their case could not be properly considered without the complete medical files as evidence. It was ruled that providing the courts with handwritten extracts of the medical files in place of the originals or complete copies would not allow any inconsistencies to be properly checked, and therefore was a bar to their seeking redress for violation of their civil rights.

Professional and Ethical Standards for Health Professionals in their Interactions with a Detainee

Health professional ethics dictate that any interactions, whatever their nature, between health professionals and an individual must be solely for the best interests of that individual. The purpose of any intervention must be clearly explained to the individual as well as how the information gathered from any intervention will be used.[24] This is of particular importance where third parties may be involved such as prison or other detaining authorities or the courts.

All interaction between a health professional and an individual must be fully documented,[25] including as a minimum the date, the time, the identity and reasons of those present, the location, the nature of the interaction, symptoms, clinical examination and/or psychological and psychiatric examination, diagnostic tests and results, differential diagnosis, management/treatment and the informed consent of the patient. The medical and other health records must be maintained securely and confidentially in written/hard copy form and/or electronic format.

The individual is entitled to receive any information about themselves contained in the medical or other health records made while they were held in any form of detention,[26] unless this is contraindicated for

[22] See Human Rights Committee communication No. 726/1996, *Zheludkov v. Ukraine*. CCPR/C/76/D/726/1996 29 October 2002.
[23] European Court of Human Rights, *K.H. and Others v. Slovakia*, Judgment 32881/04 of April 28, 2009.
[24] World Psychiatric Association. Madrid Declaration on Ethical Standards for Psychiatric Practice. Approved by the General Assembly on August 25, 1996 and amended by the General Assembly in Yokohama, Japan, in August 2002.
[25] Principle 26. UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment Adopted by General Assembly resolution 43/173 of 9 December 1988.
[26] Principle 26. UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment Adopted by General Assembly resolution 43/173 of 9 December 1988.

purely therapeutic reasons such as when the information may prove a hazard to their health.[27,28] To exercise this right the individual must be entitled to a complete copy of these medical and other health records, both for the purposes of ensuring continuity of care upon transfer or release,[29] and also for use in seeking legal remedy or reparations concerning any allegations of unethical or unprofessional health care practices, or concerning allegations of any other acts or omissions that may give rise to civil or criminal liability in domestic or international law. When an individual alleges, or there is reason to suspect, that torture or other forms of ill-treatment have taken place, there is a further obligation on the authorities holding this information to provide full access.[30]

A proper assessment that any intervention by a health professional was warranted, appropriate, and was carried out according to accepted standards of practice can only be made through verification of the accuracy and completeness of medical and other health records.[31] International standards of professional ethics expressly prohibit participation, whether through acts or omissions, of health professionals, especially physicians, psychiatrists and nurses, in torture or other cruel inhuman or degrading treatment or punishment.[32] Ethical standards also prohibit any form of participation in the interrogation process of a detainee, or indeed, the use of any individual's medical information to aid an interrogation.[33] An assessment of whether health professionals participated in acts of torture or other ill-treatment, through acts, omissions or through the provision of medical information, may only be made through examination of the complete medical and other health records. The deliberate withholding of medical care for detainees, either for mental or physical illness or injury, but in particular for victims of torture or other ill-treatment may in itself constitute cruel, inhuman or degrading treatment or punishment.[34] Any omission in the provision of appropriate care by health professionals may be revealed through examination of the complete medical and other health records.

Access to complete medical and other health records are necessary to enable a proper determination of whether health professionals, who were either directly involved in the assessment, treatment or care of an individual who alleges to have been tortured, or who were involved in any form of physical, psychological or psychiatric assessment or evaluation of an individual, acted in accordance with accepted national and international principles and standards or professional care and professional ethics, as well as in conformity with national and international law. This includes the duty to report any suspected cases of torture or other ill-treatment that they may have witnessed or been aware of. In recognition of the fundamental nature of the prohibition of participation in torture for physicians, the

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[27] WMA Declaration of Lisbon on the Rights of the Patient. Adopted 1981 and Revised 2005.
[28] The European Committee for the Prevention of Torture Standards. 2010 Paragraph 46.
[29] WMA Declaration of Lisbon on the Rights of the Patient. Adopted 1981 and Revised 2005.
[30] The European Committee for the Prevention of Torture Standards (2010) at paragraph 61 states that any signs of violence observed when a prisoner is medically screened on his admission to the establishment should be fully recorded, together with any relevant statements by the prisoner and the doctor's conclusions. Further, this information should be made available to the prisoner.
[31] The European Committee for the Prevention of Torture Standards (2010) at paragraph 39 states that medical records provide an overall view of the health care situation in the prison, at the same time as highlighting specific problems which may arise.
[32] United Nations Principles of Medical Ethics Relevant to the Role of Health Personnel, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment. Adopted by General Assembly resolution 37/194of 18 December 1982; World Medical Association. Declaration of Tokyo - Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment Adopted 1975, Revised 2006; International Council of Nurses. Position Statement on Torture, Death Penalty and Participation by Nurses in Executions. Adopted in 1998 Revised in 2003 and 2006. International Council of Nurses. Position Statement on Nurses' Role in the Care of Detainees and Prisoners. Adopted in 1998, Revised in 2006. World Psychiatric Association. Madrid Declaration. Adopted 1996 and Revised 2006.
[33] World Medical Association. Declaration of Tokyo. Paragraph ; UN Principles of Medical Ethics, principle 4.
[34] Reports of the UN Special Rapporteur of Torture to the UN Human Rights Council 2011.

World Medical Association has recently promoted the creation of a mechanism to monitor States adherence to the Declaration of Tokyo.[35]

Conclusion

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

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

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

***About the International Forensic Expert Group**

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

Alempijevic, Djordje
Associate professor, Institute of Forensic Medicine, University of Belgrade,
Serbia

Beriashvili, Rusudan
Associate Professor of Forensic Medicine, Tblisi State Medical University,
Georgia

Beynon, Jonathan
Medical doctor, Independent expert on visits to places of detention and the documentation of torture. Formerly Co-ordinator for Health in Detention, International Committee of the Red Cross, Geneva, Switzerland

Duque, Maximo Alberto Piedrahita
Forensic Pathologist, former head of national forensic services in Colombia,

[35] WMA Recommendation on the Development of a Monitoring and Reporting Mechanism to Permit Audit of Adherence of States to the Declaration of Tokyo. Adopted by the 62nd WMA General Assembly, Montevideo, Uruguay, October 2011.

Colombia

Duterte, Pierre
Medical doctor and psychotherapist, private practice therapist/family counselor,
Founder of Parcours d'Exil
France

Fernando, Ravindra
Senior Professor of Forensic Medicine and Toxicology, University of Colombo,
Sri Lanka

Fincanci, Sebnem Korur
Professor in forensic medicine, Istanbul University, member of IRCT council,
Turkey

Hansen, Steen Holger
Deputy Chief Pathologist,
Denmark

Hardi, Lilla
Psychiatrist, head of section on torture issues at WPA, director of Cordelia Foundation,
Hungary

Hougen, Hans Petter
Professor; Chief Forensic Pathologist,
Denmark

Iacopino, Vincent
Senior Medical Advisor, Physicians for Human Rights; Adjunct Professor of Medicine,
University of Minnesota Medical School
USA

Mendonça, Maria Cristina
Consultant Forensic Pathologist, Portuguese National Institute of Forensic Medicine.
Professor of Forensic Medicine, University of Coimbra,
Portugal

Modvig, Jens
Health Programme Manager, Clinical Associate Professor, Rehabilitation and Research Centre for Torture Victims. Former Secretary-General of IRCT,
Denmark

Morcillo Mendez, Maria-Dolores
Forensic Medical Doctor, National Institute of Legal Medicine and Forensic Sciences,
Colombia

Payne-James, Jason
Consultant Forensic Physician, Director Forensic Healthcare Services Ltd, Honorary Senior Lecturer

Cameron Forensic Medical Sciences. Barts & the London School of Medicine & Dentistry, London. President of WPMO,
UK

Peel, Michael
General Pracitioner - Clinical Lead for Central London Community Healthcare; Former senior medical examiner at Medical Foundation,
UK

Rasmussen, Ole Vedel
Former member of UN Committee Against Torture and European Committee for the Prevention of Torture,
Denmark

Reyes, Hernàn
ICRC doctor working on detention issues since 1982; currently based in Beijing,
Chile/Switzerland

Rogde, Sidsel
Forensic Pathology Professor,
Norway

Sajantila, Antti
Professor, Specialist in forensic medicine. Head of the Department of Forensic Medicine, Hjelt Institute, University of Helsinki,
Finland

Treue, Felicitas
Psychologist and psychotherapist. General Coordinator, Colectivo Contra la Tortura y la Impunidad, Mexico,
Germany

Vanezis, Peter
Professor Forensic pathology
UK

Vieira, Duarte Nuno
Professor of Forensic Medicine and Forensic Sciences, University of Coimbra; Head of the National Institute of Forensic Medicine of Portugal. Former President of IAFS, IALM, WPMO and ECLM,
Portugal

Appendix I
(Istanbul Protocol, Annex IV, Guidelines for medical evaluation of torture and ill-treatment)

I. Case information
Date of exam:
Exam requested by (name/position):
Case or report No:
Duration of evaluation: hours, minutes
Subject's given name:
Birth date: Birth place:
Subject's family name: Gender: male/female
Reason for exam: Subject's ID No:
Clinician's name: Interpreter (yes/no), name:
Informed consent: yes/no If no informed consent, why?:
Subject accompanied by (name/position):
Persons present during exam (name/position):
Subject restrained during exam: yes/no; If "yes", how/why?
Medical report transferred to (name/position/ID No.):
Transfer date: Transfer time:
Medical evaluation/investigation conducted without restriction (for subjects in custody): yes/no
Provide details of any restrictions:

II. Clinician's qualifications (for judicial testimony)
Medical education and clinical training
Psychological/psychiatric training
Experience in documenting evidence of torture and ill-treatment
Regional human rights expertise relevant to the investigation
Relevant publications, presentations and training courses
Curriculum vitae

III. Statement regarding veracity of testimony (for judicial testimony)
For example: "I personally know the facts stated below, except those stated on information and belief, which I believe to be true. I would be prepared to testify to the above statements based on my personal knowledge and belief."

IV. Background information
General information (age, occupation, education, family composition, etc.)
Past medical history
Review of prior medical evaluations of torture and ill-treatment
Psychosocial history pre-arrest.

V. Allegations of torture and ill-treatment
1. Summary of detention and abuse
2. Circumstances of arrest and detention
3. Initial and subsequent places of detention (chronology, transportation and detention conditions)
4. Narrative account of ill-treatment or torture (in each place of detention)
5. Review of torture methods.

VI. Physical symptoms and disabilities

Describe the development of acute and chronic symptoms and disabilities and the subsequent healing processes.

1. Acute symptoms and disabilities
2. Chronic symptoms and disabilities.

VII. Physical examination

1. General appearance
2. Skin
3. Face and head
4. Eyes, ears, nose and throat
5. Oral cavity and teeth
6. Chest and abdomen (including vital signs)
7. Genito-urinary system
8. Musculoskeletal system
9. Central and peripheral nervous system.

VIII. Psychological history/examination

1. Methods of assessment
2. Current psychological complaints
3. Post-torture history
4. Pre-torture history
5. Past psychological/psychiatric history
6. Substance use and abuse history
7. Mental status examination
8. Assessment of social functioning
9. Psychological testing: (see chapter VI.C.1. for indications and limitations)
10. Neuropsychological testing (see chapter VI.C.4. for indications and limitations).

IX. Photographs

X. Diagnostic test results (see annex II for indications and limitations)

XI. Consultations

XII. Interpretation of findings

1. Physical evidence

A. Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities with allegations of abuse.

B. Correlate the degree of consistency between physical examination findings and allegations of abuse. (Note: The absence of physical findings does not exclude the possibility that torture or ill-treatment was inflicted.)

C. Correlate the degree of consistency between examination findings of the individual with knowledge of torture methods and their common after-effects used in a particular region.

2. Psychological evidence

A. Correlate the degree of consistency between the psychological findings and the report of alleged torture.

B. Provide an assessment of whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual.

C. Indicate the status of the individual in the fluctuating course of trauma-related mental disorders over time, i.e. what is the time-frame in relation to the torture events and where in the course of recovery is the individual?

D. Identify any coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) and the impact these may have on the individual.
E. Mention physical conditions that may contribute to the clinical picture, especially with regard to possible
evidence of head injury sustained during torture or detention.

XIII. Conclusions and recommendations
1. Statement of opinion on the consistency between all sources of evidence cited above (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and allegations of torture and ill-treatment.
2. Reiterate the symptoms and disabilities from which the individual continues to suffer as a result of the alleged abuse.
3. Provide any recommendations for further evaluation and care for the individual.

XIV. Statement of truthfulness (for judicial testimony)
For example: "I declare under penalty of perjury, pursuant to the laws of ..... (country), that the foregoing is true and correct and that this affidavit was executed on ..... (date) at ..... (city), ... (state or province)."

XV. Statement of restrictions on the medical evaluation/investigation (for subjects in custody)
For example: "The undersigned clinicians personally certify that they were allowed to work freely and independently and permitted to speak with and examine (the subject) in private, without any restriction or reservation, and without any form of coercion being used by the detaining authorities"; or "The undersigned clinician(s) had to carry out his/her/their evaluation with the following restrictions: ....."

XVI. Clinician's signature, date, place

XVII. Relevant annexes
A copy of the clinician's curriculum vitae, anatomical drawings