Consensus Statement on

Best practice in the clinical management of survivors of torture and human rights abuses in the detention estate

Medact conference

Held at the Royal Society of Medicine

21/05/2015 1600-1900h

This meeting was held under Chatham House Rule to facilitate discussion.
That is to say that the points made participants can be reported by in a statement which sets out views expressed but the participants and the organisations with which they work cannot be identified.

Background:

Seven doctors working in IRCs and six from voluntary organisations took part as well as representation and administrative support from the RSM.
The views expressed by the participating doctors do not necessarily represent those of any organisation with which any of us are associated, or those of the RSM.

Points of agreement:

Medicine in detention is a remarkably difficult job, for reasons we do not need to rehearse in detail here. Obviously these include issues such as culture, language, trauma, and trust, but especially resources.
The major issues discussed were confidentiality, and the
assessment, documentation and reporting of

- fitness to fly,
- need for medical hold,
- Rule 35 evidence a history of torture, FGM, etc
- and of serious medical or psychological harm resulting from detention

Confidentiality:
A fairly strict construction of informed consent is a necessary protection for both doctors and patients in IRCs. A blanket consent to supply all medical notes to the Home Office signed at induction screening by a detainee is not valid informed consent to release all confidential information which subsequently comes into the possession of the healthcare centre or its doctors.

Fitness to fly:
Demands to assess fitness to fly can and do pose serious questions of medical ethics. It was agreed that doctors should not (and the doctors at the meeting who have received such requests do not) certify patients as fit to fly without their informed consent (which may in some cases be forthcoming if properly sought). Doctors can, do, and should sometimes certify patients as NOT fit to fly.

Medical hold:
The ability of doctors to exercise medical hold is too frequently undermined by Home Office decisions, with adverse medical effects on patients who are seriously physically or mentally ill. This includes occasional need for the short-term NON-release and (and, of course, NON-transfer) of a detained patient should that be in the best interests of the patient's health and with their consent.

Rule 35:
Many doctors were clear that they don't have the training and all doctors were clear that there is insufficient time to adequately assess evidence of torture or medical harms consequent upon detention. The task is made more difficult because of inadequate definition of the purposes and requirements of rule 35 and/or IS91 RA part C.
There was agreement that the demand for rule 35 or part C work cannot be met within existing resources of medical time.
Nor have the Home Office clarified what they require in order that they can comply with their duties to exercise "anxious scrutiny" of such reports. This means that much, if not most, of the doctors' work in this area is wasted effort.

Points not resolved:

Rule 35:
Can the difficulties identified best be resolved by transferring these responsibilities to some other group of doctors such as forensic medical examiners, or by further training of existing medical practitioners and redesigning the Rule 35 process, or both?
When is it incumbent on a doctor who has written a R35 and who has received a Home Office letter refusing to accept the report as "independent evidence of torture" to reply and how? (For example if the refusal manifestly misunderstands or misrepresents the doctor's statement under 35iii and/or the Istanbul Protocol definition of consistent.)

Duty to refer:
How does the general GMC guidance apply to the documentation of clinical evidence of torture in IRCs?
Is there a complementary duty where possible to accept referrals or otherwise assist, if that is within the capacity of the referee.

Raised subsequent to meeting:

Can appraisal/revalidation structures be used to support IRC doctors in securing the training and resources they need to complete R35 reports?

Conclusions:

There are several parallel initiatives with regards to clinical care in IRCs, including those by the BMA, Faculty of Forensic Medicine, Secure Environments Group of the RCGP, CNWL NHS Trust, the Expert Reference Group at NHS England (and perhaps others). It is important that these not duplicate effort. That said, the results of the present meeting should be communicated to all of these parties.
It was agreed that training needs regarding documentation of torture should be addressed, among other means, by a review of existing training offered by two of the participants' clinical organisation.
Further steps suggested included:

- establishing an online discussion group, starting with email sharing
- joint examination of selected (consenting) patients by doctors experienced in the forensic documentation of torture evidence and IRC doctors (whether by skype or in person)
- a formal training session on recognition and documentation of torture evidence, perhaps by teleconference.
- Exploring the use of appraisal/revalidation structures to support IRC doctors in securing the training and resources they need to complete R35 reports.