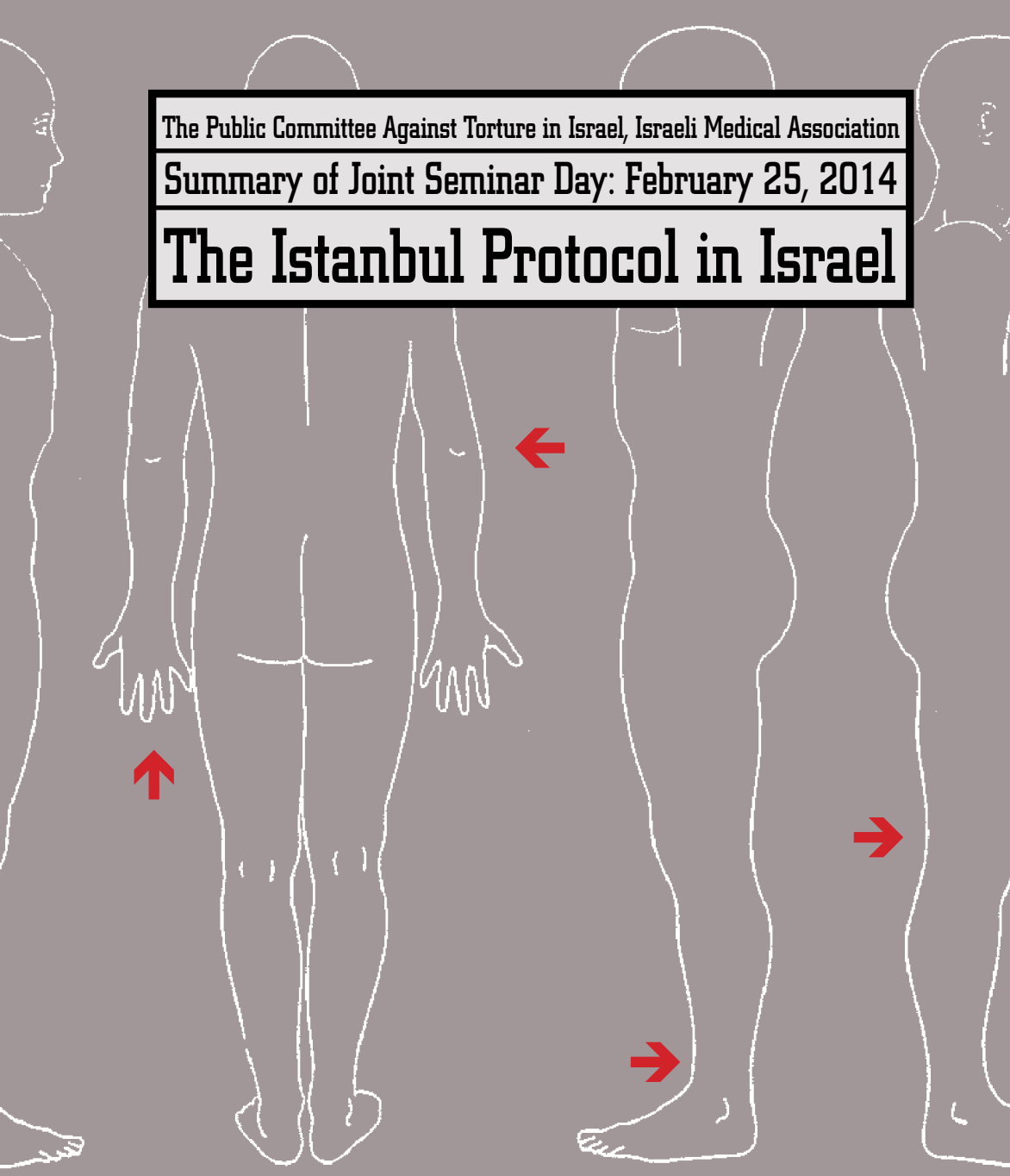
The Public Committee Against Torture in Israel, Israeli Medical Association

Summary of Joint Seminar Day: February 25, 2014

The Istanbul Protocol in Israel



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Opening Remarks

Dr. Leonid Eidelman

Chairman of the Israeli Medical Association

I would like to welcome all those present and am very happy that we are organizing this event. This entire day will be devoted to discussion of the UN's Istanbul Protocol, which concerns the examination and documentation of torture and other forms of cruel, inhuman or degrading treatment or punishment. The meeting's goal is to increase awareness of the Protocol: many are in fact unfamiliar with it and unaware of its existence, just as many people do not know that as early as 1975 the World Health Organization – of which the Israeli Medical Association is an integral part – adopted the Tokyo Declaration forbidding torture. In addition to raising awareness, we are trying to create a way to aid those who encounter patients who have been tortured or subjected to violent abuse, and to document these cases.

The Istanbul Protocol contains internationally recognized standards and procedures which address the identification and documentation of the indications of torture and ill-treatment in such a manner that the documentation may be admissible evidence in court. The Istanbul Protocol is not a binding document. However, international law obligates governments to investigate and document instances of torture and other forms of cruel punishment and abuse; and governments must do so comprehensively, efficaciously, immediately and objectively. This is an implementable tool which provides useful information to physicians and attorneys hoping to determine whether an individual has been subjected to torture and to report these findings to the justice system or other investigatory bodies.

The Helsinki Declaration notes that a physician witnessing an interrogation or torture carried out in violation of international conventions is obligated to report this fact to the proper authorities. The Ethics Bureau [of the Israeli Medical Association] also worked diligently on the matter and it too formulated stances requiring that ill-treatment or torture be reported and promising support for every physician acting within the ethical rules. In 2009 the [Israeli] Medical Association (hereafter: IMA) inaugurated a hotline to which anonymous physicians could turn with ethical dilemmas or suspicions of human rights violations encountered on

the job. Likewise, the IMA took part in the creation of a Ministry of Health committee of which the head of the Ethics Bureau is a member; this committee is also meant to handle complaints about alleged instances of torture from physicians in the field.

Today's meeting will focus on work with disadvantaged populations such as prisoners and refugees. Its goal is to assist practitioners, primarily physicians, in identifying instances of cruelty and ill-treatment; and to provide all those in the field with tools to handle such instances and report them. I hope that this meeting helps us internalize ways of using the Istanbul Protocol in hospitals and become familiar with the legal aspects, which are less well-known to physicians. I haven't the slightest doubt that each one of you sitting here has his own aspect, his own point of view; it is legitimate and appropriate that we hear differing viewpoints. We have been happy to work with the Public Committee Against Torture [in Israel] (hereafter: PCATI) to arrange this seminar together. I wish us all a fruitful and successful discussion, and thank you all for coming.

Tammi Molad Hayo

Board Member, Public Committee Against Torture in Israel

It should be noted first that this is a very moving meeting: we are present at the peak of a long, complicated and sensitive project which was no simple order for any of the sides involved. Now we only have to continue and forge a shared path – and it too will no doubt be complicated and will require complex observation and sensitive handling of matters.

Physicians, as part of their task, are keepers not only of humans themselves but of the human within. They accompany the individual from the moment of birth through the coming of death and through all the stages in between. As a result, physicians are the first and often the only ones to recognize signs of distress, whether in individuals of varying age who have experienced abuse, and in those who have undergone torture. Often, the physician is the first outside individual who can identify signs of such occurrences; the first who can investigate the happenings from the perspective of an objective and concerned caretaker, and thereby gain the trust of the sufferer. For this reason physicians' roles are especially complicated: not only too treat the

injury but also to hear and see the human being within the patient, to listen to what the patient has undergone and, if need be, to call for the protection of the patient and others, and ultimately to collect evidence so as to ensure that prohibited actions will not occur again. This is true in the case of a child, man or woman, and in the case of a prisoner.

Physicians, the individuals behind the white robe, have made a noble choice which requires of them a different moral standard than others solely due to their choice of profession. This obligation to an especially high moral standard makes physicians the guardians of social morality. Physicians are those who can recognize the signs of what individuals can do to one another, who discern the danger and must call for such things to stop – first of all as human beings and immediately thereafter as physicians. They make the best and often the only witnesses to remind us where we must not go, how we must not behave, whom we must protect and how. The task imposed upon physicians is a complicated one. They must hear and listen, see, treat, guard, protect, and sometimes bear witness. This is not a simple task. Hence the collections of rules and medical associations and NGOs – all of which are meant in part to aid physicians in this task, even in moments when questions arise. Even in moments of difficulty. Sometimes also in a moment of fear: but doctors are never alone on this front.

This is the time to say thank you. Thank you to the Israeli Medical Association for their hospitality, to the European Union for supporting the project, to Dr. Joost den Otter, Dr. Sebnem Korur Ficanci and Dr. Steven Casnicks for training the group of volunteers for two years. Thanks to all the members of the group who invested days and nights of their time and energy to reach this point. And to all those who came: if only all the knowledge you will acquire here could remain solely philosophical; but in case it is needed, let us have the knowledge, strength and public institutional backing to act and to advance. Thanks.

Implementing the Protocol in Hospitals

Dr. Bettina Steiner-Birmanns: Greetings, and thank you very much for the opportunity to speak here. My talk today is based on an article that I wrote together with Dr. Mushira Aboo Dia, Dr. Revital Arbel, Dr. Firas Abu Akar, and medical student Zvi Benninga.

The Istanbul Protocol was published in Hebrew on the Israeli Medical Association's website a year ago: it is a guide which discusses the investigation, documentation and reporting of cases of violence and ill-treatment. The Istanbul Protocol discusses the cases of interrogees who have undergone ill-treatment or violence: throughout this talk I will use the phrase 'torture' as an abbreviation. The Protocol was written by 75 experts in law, health, mental health and human rights from 15 different countries. It was accepted by the United Nations in 1999 and since then has served as a very important tool for documenting and investigating torture on legal, public and international fronts. The Protocol is taught worldwide, including in Mexico, Uganda, Lebanon, and many other countries: 3,500 doctors have been trained under it in Turkey alone.

I would like to begin with a real case from Israel in order to demonstrate the difficulties encountered in emergency rooms. A 19-year-old Palestinian prisoner was bitten in the shoulder while being arrested by the military; as a result, the detention center physician refused to accept his intake and sent him to the emergency room, where he was examined while handcuffed and blindfolded. He knew that he was in the emergency room only because he was able to see the feet of the nurse underneath his blindfold. The medical personnel did not speak with the patient directly; rather the physician "communicated" with the patient through the police officers who had brought him. The physician treated his wound, gave him the necessary treatment and released him – in this case to the Russian Compound, where he was held for a short time before being transferred to an interrogation facility. At the facility, the physician followed the intake procedure and filled out a special form intended for the prisoner's interrogators detailing the injury; then he was sent to interrogation.

This case raises a number of ethical question marks. Firstly, in 2007 the Israeli Medical Association was a member and signee of the Tokyo Declaration which details the physician's duties to an individual undergoing interrogation and might be

undergoing torture, and prohibits physicians from even being present at a facility where torture or interrogation by cruel methods is implemented. The doctor is prohibited from participating in any related action, and s/he must not provide confirmation that an individual is healthy enough to undergo torture. The physician must not provide medical information – that is to say he may not fill out a special form intended for the interrogators. And of course the physicians must remain vigilant about confidentiality – they may not give a letter of release to the prison guards: the letter is the property of the prisoner who has come to the emergency room. The final chapter of the Tokyo Declaration states that, if the physician encounters or suspects torture, s/he must inform the proper authority.

In the case before us, we must of course point out that no individual may be examined while blindfolded, since this prevents direct communication with the patient (and remember, the prisoner or detainee is a patient just like any other). Second, physicians must naturally maintain medical confidentiality, and must examine the patient without any representatives of the law present in the room. Third, we should examine prisoners and detainees without handcuffs; while this is oftentimes very difficult in reality, it is the law. A fourth problem in this scenario is that the patient should understand that s/he is in a hospital, is receiving treatment, and has the right to accept or refuse this treatment. The problem of dual loyalty arises especially in interrogation and detention facilities, since the physicians working there are employed by the Israel Prison Service. On the one hand they are to have loyalty to their patient, and on the other hand they have an employer with different interests.

Here I would like to take a step back and consider the places where we as physicians might encounter a torture victim. Of course it could be that this happens with a patient. An individual may come to our clinic at the HMO, complaining of this or that pain and, it turns out, actually be a torture victim. The problem is that often patients will not tell us about this on their own initiative. It is a given that if a prisoner or detainee arrives in the emergency room with marks of violence, we may (carefully) assume that s/he could be a victim of torture; and of course physicians working in detention centers are exposed to the matter more than others. The Istanbul Protocol is intended for all of these cases: we are supposed to write an expert affidavit to investigate suspected cases of torture.

Every physician who encounters a case of violence or torture should provide a standard report, and should include the complaints of the patient as we are always supposed to write them, even if the individual was involved in a traffic accident: detailing the injuries, the psychological findings – which are very important in cases of torture – the examinee's explanations of all their injuries, and the doctor's conclusions. It is crucial that, no matter the physician's area of expertise, s/he records their impressions and whether or not the story sounds logical, as is accepted practice in complaints of violence.

Necessities for the interview

1) Privacy: When we examine an individual in a prison setting, we should ask to examine them in privacy. Practically speaking, it can be very difficult to carry out an examination without the presence of prison guards or the detention center physician; and of course if the latter are present the injured individual will be limited in the ability to tell their story. Also when examining a patient outside the walls of prison, the examination should take place somewhere enabling privacy. I will give one example here of the importance of this matter: with the generous assistance of the Israeli Medical Association, we recently circulated a questionnaire regarding opinions and knowledge on violence and torture. For the most part this consisted of answering questions, but the questionnaire also included a free response section, and I would like to read one answer from that section: "The detainees who were brought for examination at the emergency room claimed they had fallen while being arrested or earlier, and I did not really suspect that these were cases of police violence. Now, after answering the questions it seems I was somewhat naïve." The physician writes, after a few questions on violence and treatment of detainees in emergency rooms, that actually he now thinks that that they probably did not tell the truth, among other things because of the lack of necessary privacy.

2) Re-traumatization: Before the interview it is crucial always to remember that it is very difficult for an individual to speak about torture they have undergone; the conversation itself can cause renewed damage, even if the initial trauma occurred several years previous. Hearing the story is also difficult, and can cause trauma to the listeners, both physicians and interpreters.

3) Translation: The matter of translation is especially sensitive and essential. In the case of asylum seekers, it is common to use another person present with the victim in the same prison or prison cell to translate. Of course the complainant will have difficulty speaking freely in such cases, out of fear that their story will make the rounds of the prison. The translator must be professional, must maintain full confidentiality, and of course the interview must be carried out in an empathetic – as distinct from sympathetic – and objective manner.

4) Informed consent: The individual must understand to whom they are telling their story and why; what use will be made of their story. For example, if one is writing a professional medical affidavit, the subject must understand who will read it throughout the process and whether the information might be published in the news media. The examinee should agree or refuse to such publication. S/he must also agree to be examined and must understand what kind of interview s/he will undergo. The examinee must understand that at any stage s/he can refuse to continue speaking or refuse to portions of the examination. In this way we can return a little bit of the autonomy and control which have been taken from them.

Methods of torture:

Beating: This is the most common method – beatings all over the body, during detention and interrogation. Such beatings do not always leave long-term marks and oftentimes the interrogee is not examined by anybody until the signs disappear – except the detention center physician, which is why the latter is in such a critical position.

Prolonged shackling: This is also a very common method, whether implemented with metal handcuffs or with tight plastic zip-ties. Shackling in front of the body or behind the back causes swelling, harsh pains, nerve pressure and paralysis. There is another method known as "high cuffing" – very tight handcuffs attached above or below the elbows which are used to exert pressure for about 20 minutes, causing harsh pains and swelling.

Stress positions: In Israeli interrogation rooms we know of three primary stress positions. The first is known as the frog squat, when the detainee must squat on bent knees, standing on the toes, sometimes while being pushed as well. This causes pains mostly in the legs and knees. The second is supposed to be illegal in Israel today: sitting on a low chair with the legs forward, lower than the

chair, and the hands shackled behind the back. This also causes back and shoulder pain. A third position is known as the "banana": one is forced to lie on a chair with the stomach facing up. As far as we know, in Israel the position does not include the shackling of the hands to the chair-legs, but it nevertheless causes very harsh pain and some victims say their exposed stomach is beaten while they lie in this position.

Violent shaking: Violent shaking is forbidden in Israel; it can cause headaches, cerebral edema, intracranial hemorrhage, and has caused at least one death. The chronic signs are whiplash, headaches and neck pain.

Sexual abuse: A very common method, if one recalls that sexual abuse is not only rape and sodomy. It can begin with an individual undergoing a humiliating nude search, verbal threats, various other humiliations, and so on: these actions are also considered sexual assault for all intents and purposes. Also common are solitary confinement, exposure to extreme stimuli (loud noise or strong light for 24 hours a day) or extreme temperatures which also prevent sleep. These are accepted methods for "softening up" the interrogee: they are effective but also leave no external scars. Psychological methods can also include threats against the family of the interrogee, violating taboos, or false demonstrations of destruction or killing.

The evaluation:

Every person complaining of violence should be given a full bodily examination. During the examination, additional pieces of evidence are often exposed, for example when the complainant is asked about a certain scar and tells how it came about. We should insist on visual documentation of injuries, even if in prisons this is not always possible.

When a medical professional and a mental health expert carry out an interview together, the effects are positive for both: psychologists examine the internal mental signs which remain with the individual after torture. They seek signs of lingering Post-Traumatic Stress Disorder (PTSD) and depression, and inquire about current functionality in comparison with functionality before the interrogation. The psychological indications can include avoidance, intrusive memories, "flashbacks", nightmares, fits of rage, sleeplessness, lack of appetite, hopelessness and lack of trust in other people. The psychological indications are on the one hand personal and prolonged,

since they warn against damage to the "I" at the core of the human being. On the other hand, they impact not only the complainant but also their family and the surrounding society. The scars of psychological symptoms are not outwardly visible, and it can be difficult to prove injury and especially its causation.

Consistency:

A typical problem in the evaluation of torture victims is that their account is not consistent with previous versions they have told. There are a number of potential reasons for this:

First and foremost, the conditions of the interview. That is, if an asylum seeker is sitting opposite a representative of the Ministry of Interior with other people and a familiar interpreter, they will very likely not report the torture they have undergone; whereas in a more personal evaluation, one with more empathy, s/he will reveal their story.

It is also possible that during torture the individual does not absorb all of the information, since their eyes are covered, or because they are suffering from sleep deprivation.

Physical reasons – it is well-known that head trauma causes memory loss.

PTSD, a syndrome which is also known to cause problems with concentration.

Cultural hindrances: certain injuries may cause feelings of embarrassment or guilt which prevent the complainant from speaking about them.

Unintended gaps in the translation: for example, the same word might be translated differently throughout the course of the interview, creating an apparent contradiction.

For all of these it is very important that the expert affidavit also refer to the conditions of the interview; ultimately we must conclude whether or not the story and the examination correlate under the categorization detailed in the Istanbul Protocol.

The duty to report:

As Dr. Eidelman mentioned, there is a committee at the Ministry of Health to which physicians who encounter cases of violence are to report. Mr. Zvi Beninga attempted to inquire with the Ministry of Health whether any complaints were filed

with this committee over the course of the last two years, and they informed us that not a single complaint had been received by the committee since it was created in January 2011! Another problem is that these are issues which fall under medical confidentiality, and sometimes the victims do not wish to report their injuries, whether out of fear of being harmed or because they do not want to be exposed. Such conflicts should be resolved via anonymous reporting or attempts to convince the victim to agree to report in some framework or another.

Conclusion:

The Ministry of Health and the Israeli Medical Association generally do a very efficacious and impressive job regarding violence in general, especially violence against helpless individuals, children, women and the elderly. This effective and welcome work has brought about a major change: committees were formed in hospitals and HMOs, guidelines were published, courses trained professionals. In other words, medical professionals' approach to a certain issue can be changed, and we hope that the same can be true in the case of prisoners and detainees.

I would like to emphasize once again that the physician-patient relations which we – rightfully – emphasize so strongly, both in the Patients' Rights Law and in our medical approach, apply to prisoners and detainees as well. Sometimes the physician is the only individual except for the interrogators who sees the detainee or prisoner. Therefore their ethical obligation to the patient becomes even greater. If there is a complaint of violence, the physician must examine, document, and – if they suspect the victim might be subject to more ill-treatment or violence from the interrogators – they must not release the victim back into their hands. For all these reasons we should raise awareness of the Istanbul Protocol, of the rights of prisoners and detainees who come into contact with physicians and of the rights of all individuals who complain of violence. It is very important too that as physicians we be more aware of our ethical obligations, even if it is not always easy to implement them in interaction with representatives of the law.

Dr. Itzhak (Tzaki) Ziv Ner

Interim Chairman of the Israeli Medical Association

Hello to everyone. I do not intend to give a lecture but rather to respond, especially on the basis of my own personal experience as a volunteer at the "Physicians for Human Rights" Refugee Clinic in Yaffa and in the clinic at the Central Bus Station [in Tel Aviv] of the Israeli Medical Association and Ministry of Health. I work there as an orthopedist with an additional specialty in Physical Medicine and Rehabilitation, and I see some very difficult sights there. At these clinics we do not see individuals in their first moments here [in Israel], and there is no formal requirement to fill out a report, but I wonder if I asked every one of them, "has a report been written up on you?" It is possible that at times I took it as a given that these things had already been done: so I myself will take something from here – that maybe, even in my regular practice, I should be more pro-active.

The appearance of the [Istanbul] Protocol on the website of the Israeli Medical Association is an extremely important step, but despite the fact that all Israeli physicians are basically informed, more emphasis should be placed on physicians who are most likely to encounter such problems, for example emergency room doctors – and, as I mentioned, I wonder if we should be more pro-active regarding certain populations.

The matter of language which Dr. Birmanns mentioned is extremely important. At the Refugee Clinic where we typically do not have an interpreter present, one must typically make use of family members, though of course I would not ask a woman about her rape with her 12-year-old son assisting in translation. Likewise, I cannot ask the other individuals waiting for an examination to help in translation and thereby expose both of them. There is not a professional translator in every situation, and sometimes we must give an immediate answer. But of course at every opportunity and whenever possible an interpreter should be brought in; and it is important to distribute a list of contact numbers which will allow physicians to reach the interpreter, as is done through women social workers in hospitals. Clearly, we should bring up the topic in every forum which will allow it, and discuss it at length so that people may know that there is someone they can turn to in order to get an evaluation. Today we very easily refer them to the internet and say: "go to", "find," "there is an examination form at the end…"

The entire Protocol is here in an organized manner, with diagrams that one can draw on. Of course in the age of smartphones it is much easier to pull it out of your pocket.

Discussion

Dr. Bettina Steiner-Birmanns:

Remember that it is very important to go through a course, since there are many obstacles which must be dealt with.

Dr. Ziv-Ner:

I have no argument with you here; on the contrary, I am sure that the Israeli Medical Association will be a partner in accepting such a challenge. And nevertheless, let us be realistic and practical: I think that different levels of knowledge and expertise are necessary. I believe that part of the mission of this team is not just to deal with the examination itself, but to teach us – those of us who have not done it – and to be our reference group when questions on the matter arise. This sort of conference is nice, but it is not enough. First we must separate out our priorities: which populations do we want to reach first, knowing that we cannot reach them all promptly? We have emphasized emergency rooms, which are of course a central site, but the issue is not only emergency rooms. Detainees are brought to regular clinics, and especially hospitals that are near prisons in Israel. Therefore I think that every physician should be exposed [to this information] to some degree, and that certain segments of the population of physicians should be informed more fully. I also noted that good physicians do volunteer work and reach areas where refugees are concentrated; it may be proper to bring up the question of whether in initial treatment the subject of torture was overlooked.

The next place that I might emphasize would be medical schools. I think that it is very important to get into these schools and give lectures on this subject. All future physicians receive the Israeli Medical Association's Code of Ethics when we inaugurate them and conduct acceptance ceremonies for them, and this matter is addressed specifically there. Therefore I would like to believe that at least the next generation will constitute the initial basis [for change].

Dr. Revital Arbel:

I am a gynecologist who participated in the training course and also in preparing today's lecture. One of the first things which I told my colleagues in the course was that, when we began dealing with sexual assault about twenty years ago, the attitude was similar: there was difficulty internalizing the essentially medical nature of the matter. Medicalization of assault and violence was not a simple matter, and the Ministry of Health assisted very impressively in this. I believe that if we would like to continue to

move forward, we will need your assistance in a massive way. To go into every hospital, every department, every lecture, to teach, to hold seminars on a rather sensitive topic; all this requires the backing of the Israeli Medical Association.

Dr. Ziv-Ner:

I completely agree with you: as doctors it is easier for us to speak from the purest place. That is, from my perspective a human being is a human being, and my examination should not differ between a patient I see in a hospital, private clinic, or HMO clinic and a detainee. It is easiest for us because I do not have to take a position – I am a physician. You also spoke about a process, and I believe that where we stand today is very different from where we were ten and twenty years ago: there is much more awareness of civil rights and human rights. I will emphasize one thing: we will take the challenge in partnership, since the IMA has had many tasks in recent years. I would suggest that with your help we can define which populations we would like to prioritize and what level of publicity is realistic.

Mr. Ran Cohen:

Hello, my name is Ran Cohen and I am the Executive Director of "Physicians for Human Rights". I am very happy to hear everything that has been said here, but as you all know, the physicians of the Israel Prison Service cannot unionize, and are not members of the IMA: and a situation results wherein they are often loyal to their employer, the Israel Prison Service, and not to the patient. An appropriate step was demanded here: these physicians can be trained to identify torture, but their dual loyalty to the Prison Service and their employer will not disappear. To deal with the problem from the root, one thing that must be done is to ensure that the physicians who work for IPS are not subordinate to it. They should be subordinate to the Ministry of Health and unionized under the IMA. I would like to ask the IMA for its opinion regarding a process of removing the medical apparatus of the IPS to the responsibility of the Ministry of Health, a process which would surely increase the identification of torture victims and maybe even reduce the phenomenon: because if an interrogator knows that there is a physician who does not belong to one location or another, but will report, maybe he will think twice.

Dr. Ziv-Ner:

First of all, let's not be under any illusions: the IMA cannot force the removal of doctors from the Israel Prison Service – these are

not the decisions of a medical association. The IMA can praise such a decision or join in making recommendations, but cannot determine who will be the employer. But things are liable to change: once it was said that military physicians could not become members of the IMA, and there is a change on this front. The matter of hunger strikes by prisoners convicted of security offenses [security prisoners] was a good example of cooperation with the Ministry of Health and IPS physicians.

Mr. Zvi Beninga:

By chance I knew about the Ministry of Health's committee and for a long time I sought information about it – what its regulations are, how it works, who the members are, how many reports they have received and what was done with them. When we attempted to contact the Ministry of Health formally, they would not answer this or other questions on the operation of the committee. The IMA can be very significant in petitioning the Ministry of Health to publish clear guidelines for this committee. We need to know what cases it receives, how reports can reach it, and to begin publicizing its existence and clarify what it can do and how it will respond to cases which will be brought to its attention.

Dr. Zer-Niv:

I can tell you that, unfortunately there are many guidelines at the Ministry of Health and not all of them are enforced, though not necessarily because of any intention not to, but because of a lack of resources. Sometimes they publish an administrative notice in hopes that this will create the mechanisms. This is a subject which should be noted and which we should think how to advance.

Dr. Bettina Steiner-Birmanns:

We should remember that documenting the results of torture is distinct from treating it. Documentation is only one very important step in fighting torture on a variety of fronts, in order to give an individual legitimacy. Treatment is the next step; it is conducted in a variety of places and does not always sufficiently provide for the needs of the patient. This is a very complex matter: if the patient's suffering is documented, the type of treatment which needed can also be retrospectively estimated. Documentation and treatment are two separate fronts. At this point, physicians in emergency rooms and departments should recognize cases of violence or suspected torture and document these; at the moment this is the critical field, and sorely missing.

Prof. Ruth Stalnikovitz:

I am Ruth Stalnikowicz, Supervisor of Emergency Care at Haddassah Mount Scopus Hospital. Since over half of our patients and from the Arab population, we learned that professional translation is very important, and that translation by family members or workers is no replacement. As someone who has taught for years about dealing with domestic violence (which we were able to insert into the medical schools as part of the curriculum), it is clear that the same should be done with torture. I believe it should start with a lecture such as yours, Dr. Steiner, and to spread the information all over, because the subject is not sufficiently well-known.

Implementing the Protocol in Legal Channels

Atty. Alona Korman

The Public Committee Against Torture in Israel

The transition we are making now, from the medical to the legal, is in the spirit of the Istanbul Protocol, which is after all an interdisciplinary guide targeting a range of professions including physicians, mental health experts, judges and attorneys. It advises them in handling encounters with victims of torture, whether by chance or with the intent of documenting or investigating torture. As such the Protocol details the ethical rules for this range of professionals and includes a chapter dealing with the legal investigation of torture, a portion dealing with medical health and a portion with psychological health.

This evening I will present a legal analysis which summarizes the use of expert affidavits carried out according to the Istanbul Protocol in Israel, based on 23 requests for medico-psychological evaluations (which I will refer to as "Istanbul Protocol compliant evaluations"). Of these 23 requests, 19 evaluations were actually carried out. The Istanbul Protocol was adopted by the United Nations in August 1999 and has seen increasing use worldwide since then as a means to document and investigate torture. In January 2012 volunteers, physicians and mental health experts from Palestine and Israel began to undergo training in documenting torture under the Istanbul Protocol. Though their number is not great, they represent a huge leap from the situation which existed between 1999 and 2012 when, even if use was made of the Istanbul Protocol, it was not assimilated into the legal or medical discourses: hence the importance of this evening, which provides an outstanding opportunity to examine what has been done so far and see what remains to be done. My lecture will contain three sections. First I describe the legal tools for obtaining medical or psychological evidence of torture. Then I present an analysis of data from the use of Istanbul Protocol compliant evaluations before ending with a summary and conclusions.

The Legal Tools:

Before the introduction of Istanbul Protocol compliant evaluations began, the only legal tool which could be used to obtain medical or psychological evidence of torture was the expert medical affidavit or expert opinion (the latter being an expert affidavit given by non-physicians who have some form

of relevant expertise). Note that Istanbul Protocol compliant evaluations I – like affidavits by a physician or expert – are arranged in accordance with the [Israeli] Evidence Ordinance; they differ in that they are written in accordance with the Protocol. I will illustrate the differences between affidavits according to the Istanbul Protocol and affidavits not written according to it by describing the case of M.W.

This is possibly thanks simply to the fact that in his case expert affidavits of both kinds were written. M.W. is a Palestinian who was arrested and taken to a police station, where he was the victim of torture which included beating, the tying of his ears with a string, urination on his person, firing of a firearm next to his ear, and the insertion of an unidentified item to his anus. M.W. underwent a physical and a psychological examination as typical of Istanbul Protocol compliant evaluations. During the physical examination, M.W. complained of grave headaches which seize him several times a week and revealed that he takes about four tablets of pain relievers per week. In analyzing the findings of the examination, the woman physician who examined M.W. wrote that he suffered from chronic head pain which began after his arrest and is almost certainly related to head trauma. She also noted that there is a strong correlation between chronic pain symptoms and depression. This conclusion, which connects M.W.'s account of what occurred during his arrest to his complaints at the time of the examination, is what enables the expert affidavit to be relied upon as evidence of torture.

In a psychological evaluation of M.W., he was found to suffer from Post-Traumatic Stress Disorder and from Major Depressive Disorder – Single Episode, but in order to determine the level of correlation between the psychological findings and the account of what occurred another step is necessary: an examination of whether the events M.W. related entailed trauma. In his expert affidavit, the psychologist who examined M.W. determined that, indeed, the experiences undergone in detention were traumatic: both severally and, even more so, as a whole. In this way he drew a connection between the events suffered by M.W. and his current mental state. Here too, the correspondence with the account of torture is what enabled the use of an Istanbul Protocol compliant expert affidavit as psychological evidence of torture.

The conclusion reached in the medical affidavit which was **not** carried out according to the Istanbul Protocol was that M.W. suffered from subcutaneous bleeding in the left hip and that this finding was in accordance with a blunt trauma to the hip. In addition, the doctor wrote that on the basis of the data it could not be determined if the injury was the result of a direct blow or indirect due to a fall. Since this conclusion does not address the complainant's account of what occurred, making connections between the facts and the findings is done not by physicians or experts, but rather by attorneys and judges. The problem with this, of course, is that then the necessary connection becomes the conclusion of one who is not a physician or expert; it becomes an interpretation rather than evidence. Moreover, the Istanbul Protocol compliant expert affidavit includes not only physical and psychological evidence but also the joint conclusions of the physician and the psychologist regarding the degree of correlation between the physical and psychological findings and M.W.'s story of what occurred. The Istanbul Protocol describes five degrees of correlation between the physical findings and the account of what occurred, and thus improves the quality of work of the evaluator. The lowest level of correlation is **not consistent**, that is, the injury could not have been caused by the described trauma. The highest level of consistency is indicated when the injury is **diagnostic of** the trauma – it could not have been caused by any other means. In the case of M.W., the physical and psychological findings were found to be highly consistent with the account of what occurred.

But it does not end here. An Istanbul Protocol compliant expert affidavit differs from an expert medical affidavit in the recommendations for continued treatment as well. While a physician's affidavit is usually limited to questions referenced by the initiator of the evaluation, working according to the Istanbul Protocol requires that recommendations for the future be provided, when necessary of course. A central part of evaluating torture victims is making recommendations for their rehabilitation. The approach of the Protocol, like that of article 14 of the [UN] Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, is that the gravity of torture dictates the need to rehabilitate the victims. General Comment No. 3 of the UN Committee Against Torture, given in December 2012, which constitutes an authorized commentary of the Convention

Against Torture, assigns the state with the duty to holistically rehabilitate torture victims located within its territory; this is to be done through legislation and the construction of long-term plans based, among other things, on estimating the needs of torture victims in accordance with the Istanbul Protocol. Nevertheless, in Israel the burden of rehabilitating torture victims falls on the shoulders of various human rights organizations.

Legal tools to obtain evidence for the existence of torture (comparison):

	Non-Istanbul Protocol-compliant Affidavit	**Istanbul Protocol-compliant Affidavit**
Evaluators	Physician or non-physician expert	Physician together with mental health expert
Type of findings	Medical or psychological	Medical and psychological
Analysis of findings	Confirmation or rejection of medical or psychological findings	Degree of correlation between the findings and the account of what occurred
Recommendations for rehabilitation	Yes	No

This table essentially summarizes everything we have spoken about so far: while the body which drafts a non-Istanbul Protocol compliant expert affidavit can be a physician or a non-physician expert, one made in accordance with the Protocol will typically be written by a physician and a mental health expert; thus the conclusions differ as well. The importance of combining medicine and mental health follows primarily from the fact that the lack of physical evidence of torture does not necessarily indicate that torture did not occur, since violent acts against individuals often leave no fixed marks or scars but do leave behind mental scars. As for analysis of the findings, forensic affidavits connect the examination's findings with the account of the abuse, while non-compliant affidavits do not correspond with the account, thus damaging the chances of proving by means of the affidavit that the events indeed occurred. In addition, while the Istanbul Protocol requires the provision of recommendations for rehabilitation, an affidavit which is not in accordance with the Protocol does not necessarily include such recommendations.

Data Analysis:

This analysis is of 23 petitions for forensic evaluations, and consists of three sections: the goals of carrying out an evaluation under the Istanbul Protocol, potential barriers to their implementation, and the legal uses made of affidavits according to the Istanbul Protocol in a variety of legal and quasi-legal settings and by investigatory bodies in Israel.

Goals of carrying out an Istanbul Protocol compliant evaluation:

The data shows a number of goals behind requesting an evaluation under the Istanbul Protocol. In 20 of the 23 requests the goal of carrying out the evaluation was to bring those responsible for torture to justice. In one case, the goal was to back an asylum request and in the two final cases the goal was to

Barriers to carrying out the evaluation:

"The presence of psychological sequelae in torture survivors, particularly the various manifestations of post-traumatic stress disorder, may cause the torture survivor to fear experiencing a re-enactment of his or her torture experience during the interview, physical examination or laboratory studies." Para. 147 of Istanbul Protocol

- Israel Prison Service Commissioners' Ordinance No. 04.46.00: "Private physician visits to prisoners receiving medical treatment"
- Israel Prison Service Commissioners' Ordinance No. 04.41.00: "Entry of private caretakers dealing with treatment and rehabilitation"

release an asylum seeker from custody; one of the final two had the additional goal of backing a request for recognition as a victim of human trafficking. This data shows that the primary use of evaluations under the Istanbul Protocol in the past two years has been pursuing those responsible for torture. Moreover, it shows that there are additional legal contexts in which Istanbul Protocol compliant affidavits can be useful and have so far gone unutilized. For example, in the context of a ***voir dire*** – a trial within a trial during a criminal trial in which one may claim that a defendant's confession was not given freely and willingly and as such is not admissible. Here the use of Istanbul Protocol-compliant evaluations can provide physical or psychological evidence that a confession was given under the influence of torture and inhuman treatment.

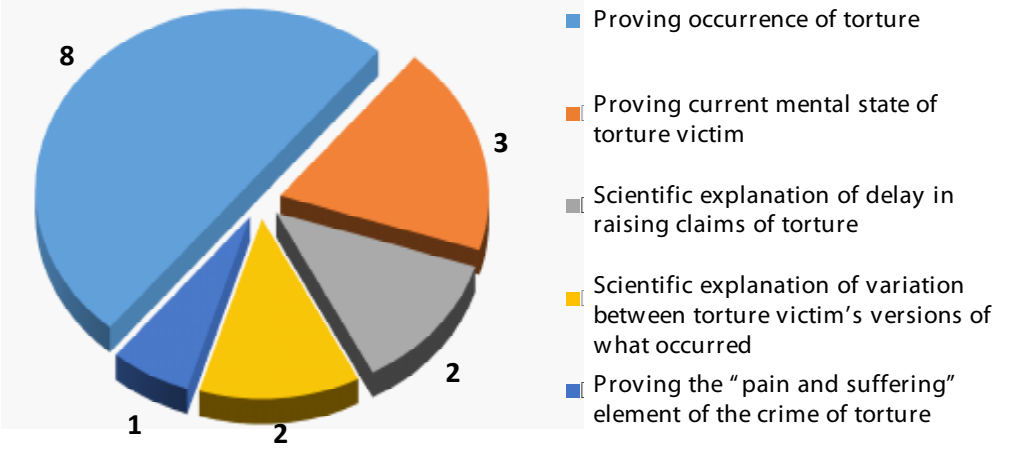
Three types of barriers can be identified. The first type has to do with the examinee; two of the requests to conduct Istanbul Protocol compliant evaluations were not carried out for reasons connected to the examinee. The Istanbul Protocol details the difficulties which torture victims may experience when arriving for an interview or physical examination, and suggests tools to handle these difficulties. For example, it explains that a torture victim suffering from any psychological repercussions may fear reliving the experience of torture. One coping mechanism offered by the Istanbul Protocol is explaining to the torture victim what to expect during the evaluation. Ultimately, even if all care is taken, the evaluation may nevertheless cause a recurrence of trauma in the torture victim, and so the evaluators must be aware of this possibility and signs of distress during the interview.

Another type of barrier depends upon the evaluators. Until the training of medical and mental health experts from Israel and Palestine began, there was a serious scarcity of physicians and experts who could carry out Istanbul Protocol compliant evaluations. Today there is a group of such physicians and experts, but it remains a small non-establishment group which works ***pro bono*** and certainly cannot offer assistance to all those whom an Istanbul Protocol compliant evaluation could explicitly assist in legal proceedings.

An additional group of barriers depends upon external factors, primarily the Israel Prison Service. This institution is encountered every time entry is requested for a physician or mental health expert to carry out an Istanbul

Protocol compliant evaluation within the walls of the prison. Yet no arrangements exist in the Service's guidelines setting norms for physicians' entry to prisons for the purpose of writing legal affidavits. To date, the procedure arranging physicians' entry relates only to examining prisoners receiving medical treatment – the problem being, of course, that not all those in need of Istanbul Protocol compliant evaluations currently receive such medical treatment. This situation makes the decision arbitrary and complicates and prolongs the request process. To give one example, a physician entry request sent in March 2013 has received no response to date. As for the entry of non-physician experts, in October 2013 an Emergency Regulation was passed which severely limited the possibility of bringing private caretakers into prisons – a matter being pursued by various bodies including the Public Defender and groups of private caretakers who formed for this purpose. Ultimately, difficulties in working with the Israel Prison Service bring about a situation of inequality between prisoners and non-prisoners in terms of their right of access to the courts.

Legal uses:



Now that I have described the difficulties that can be encountered before evaluations according the Istanbul Protocol have been carried out, I will present the legal uses made of the affidavits written on the basis of these evaluations in a range of legal forums.

Affidavits written according to the Istanbul Protocol were attached to legal documents in eight cases and in all of them preliminary use was made in order to prove the occurrence of torture. This statistic is in accord with the broader goal of Protocol compliant evaluations – to determine the degree of correlation between the physical and psychological findings and the account of the abuse. Additional uses of affidavits included proving the mental state of a torture victim, explaining the delay in raising claims of torture, and explaining variation between a victims' accounts. In the following section I shall explain each use through specific cases.

I shall illustrate the use of an Istanbul Protocol compliant affidavit to prove the occurrence of torture through the case of A.I., who was obliged to prove that he had suffered torture as part of his request for asylum in Israel. A.I. complained of torture at the hands of Palestinian security forces which included being hung by his hands from the ceiling with a dirty sack around his head while being beaten and given food once every three days. At one point, after his interrogators poured boiling water from a kettle on him, A.I. attempted to take his own life. Fearing for his liberty and his life if returned to Palestine, he petitioned the Israeli Ministry of the Interior for a permit to reside in Israel, but was rejected. A.I. was examined by a woman physician and a woman psychologist, whose impression was that his story was credible, consistent and coherent, and found a correlation between specific interrogation methods he described and their own findings: for example between burns and his account of being assaulted with boiling water. The affidavit was attached to his petition, and as part of his appeal to the High Court of Justice, the court instructed him to petition the "Threatened-persons' Committee" [which hears requests from endangered Palestinian collaborators with the Israeli security forces] for examination of his request. The High Court issued an order prohibiting A.I.'s deportation from Israel until after the decision of this committee, and A.I. remains in Israel.

In three cases, the Istanbul Protocol compliant affidavit was used to prove the current

mental state of the torture victim. A legal claim of this kind was raised in the context of two different petitions to release an asylum seeker from custody and in the context of another petition demanding compensation for damages caused by torture. To illustrate this use I shall describe the case of A.S., a Palestinian who was tortured to the point of attempted suicide. A.S. was examined by two foreign experts, who determined that marks on his hands, as well as his grave mental state, correlated with his account of torture. As part of the petition for compensation which was filed in his name, he was obliged to prove current damage, but also to connect the damage and his earlier abuse, since in the absence of damage or of a connection between his account and the damage, no compensation can be received. The affidavit attached to the petition included both of these elements, and hence it accorded nicely with this legal need. Istanbul Protocol compliant affidavits were also used to provide a scientific explanation for delay in raising claims of torture.

In two of the cases in which legal use was made of the affidavits, the State authorities claimed that the complainants were not credible because they did not raise claims of torture immediately upon meeting a representative of the establishment for the first time. One example was the case of S.M., an Eritrean citizen who left his country in order to avoid the military draft and was ultimately kidnapped to the Sinai Peninsula. There he was held hostage for two months; he was subjected to serious beatings; cigarettes were put out on his skin; his hands and feet were shackled and his eyes covered; he was forced to stand at night with his hands tied above his head; and he was forcefully sodomized both by sexual organs and by a pole which was inserted into his anus. After ransom was paid for his release, he was transferred to Israel via the Egyptian border and imprisoned at the Saharonim Prison [for asylum seekers in the Negev Desert]. S.M. filed a request for asylum in Israel and his case was even examined by a Human Trafficking and Crime Officer, who ruled that in the absence of a claim of forced labor, S.M. was not a victim of slavery. In addition to this, S.M. filed a petition to be released from custody. His request was rejected because the judge was not convinced of the claims of sexual abuse, since S.M. had not raised the matter at the first opportunity – seven days after entering Israel when he met with a border officer – and since he did not raise this claim before the court. The evaluator, a social worker

and psychotherapist who examined S.M., found that, "S.M.'s inability to express what he underwent in the Sinai demonstrates the severity of the trauma. The social taboo on male rape as an issue completely absent from the social consciousness also prevented S.M. from speaking about it." Upon receipt of the affidavit it was attached to the petition to reconsider the request for his release from custody. In support of the claim it was argued that S.M.'s failure to tell the border officer of the act of sodomy or to mention it in court hearings did not indicate the claim's fraudulence but was rather a symptom of trauma. Meanwhile, the affidavit was sent back to the Human Trafficking and Crime Officer for review, and S.M. was recognized as a slavery victim. S.M. was released from custody and transferred to a rehabilitation center where he is currently being treated.

It should be noted that the argument against the credibility of torture victims due to delay in reporting is not limited to asylum seekers hoping to be released from custody. The December 2009 periodic report of The Public Committee Against Torture in Israel, ***Accountability Denied,*** details the justifications for shelving complaints of torture against General Security Service (hereafter: GSS) interrogators; one of them was delay in filing the complaint. This means that if a torture victim does not raise claims of torture in the hearing for remand of detention, for example, the credibility of his/her complaint is damaged, which becomes a factor in the complaint's examination. Such an approach obviously ignores completely the difficulties inherent in complaining about torture before official bodies, and the fear which can accompany this. Another justification described in the aforementioned report is the existence of contradictions between facts given by the complainant and those given during the complainant's meeting with the Examiner of GSS Interrogee Complaints. The Istanbul Protocol addresses the possibility of inconsistency in accounts and inaccuracy of memory regarding the events, and provides several explanations of the phenomenon.

I shall illustrate the use of Istanbul Protocol compliant affidavits to provide a scientific explanation for changes in the account given by a torture victim by looking at the case of S.I., a Palestinian woman interrogated by the GSS and sexually harassed during her interrogation. S.I.'s complaint was thrown out and no criminal investigation was opened, in part because the complainant repeated to the EGIC some of the claims noted in the complaint of the Public Committee

Against Torture, but added additional facts not mentioned then. In an appeal filed against the decision to reject her complaint without a criminal investigation – to which the affidavit was attached – unessential differences between versions of the account were rejected as a possible indication of the falsehood of the complaint; this on the basis of the affidavit of the two women experts who had examined S.I. and found her credible. In conclusion, the fact that the two uses mentioned here – providing a scientific explanation for the delay in raising claims of torture, and differences between the torture victims' accounts – respond to two of the justifications for shelving complaints of torture, illustrates not only the existence of the phenomenon but also the need to legally incorporate the characteristics of torture victims, which are similar to the characteristics of victims of other traumas and sexual violence. Therefore, the Istanbul Protocol, which includes these insights, can be of use to all those who deal with the various aspects of complaints against torture, whether as part of investigatory bodies or the Ministry of the Interior.

Finally, because of its importance, I would like to present you with the legal use of affidavits according to the Istanbul Protocol in order to prove the element of pain and suffering in the definition of the crime of torture. I will illustrate this use through the case of A.A.

A.A. is a Palestinian who was interrogated by the Israeli security forces. During his interrogation by the GSS, he suffered from torture which included beating; prolonged and painful shackling; painful stress positions including standing next to the wall, the frog squat and the banana position; threats against his life; curses; humiliation; sleep and food deprivation; and the false demonstration of an explosion which supposedly caused the demolition of his home (while in reality only a portion of the house was demolished). After the State decided not to open a criminal investigation into those responsible for his torture, an appeal was filed with the High Court of Justice. In handling the appeal, four worldwide experts in international law and human rights were asked for their opinion on whether the interrogation methods implemented against A.A. constitute torture in accordance with their definition in the Convention Against Torture and Other Cruel, Humiliating and Inhuman Treatment? As noted, one of the elements of the crime of torture is grave pain and suffering, and since this is a very subjective element, it is also especially difficult to prove. The international

experts specifically discussed several interrogation methods such as the frog squat, the banana position, and painful cuffing, and concluded that these methods caused A.A. grave pain or suffering: "the above conclusion is further strengthened by forensic evidence directly linking specific torture pathologies to specific GSS interrogation methods, each one of which alone can constitute torture under the definition in article 1(1)." They were able to do this because the forensic affidavit connected: the frog squat to nerve damage; the banana position to lower back and neck pain; and shackling in a high position on the arms and forearms while applying pressure to ongoing muscle weakness five years after the events occurred. It should be noted that although in this case it was international experts who utilized the connection between the findings and the interrogation methods to prove the pain and suffering element of the crime of torture, such a conclusion can also be reached as part of the affidavit by the evaluators themselves.

Summary and conclusions:

As we have seen so far, the Istanbul Protocol provides a comprehensive solution for the documentation and investigation of torture by physicians and mental health experts. First, the Istanbul Protocol obliges the examination of both physical and psychological evidence of torture. Second, it requires an answer to the question of the correlation between the account of the abuse and the various findings. Third, the Protocol requires that recommendations for the rehabilitation of torture victims be given. Fourth, it constitutes a central source of knowledge based on the experience of the world's leading scholars on the characteristics of torture victims, such as inconsistency of accounts or difficulties revealing information about the torture, and as such sharpens our understanding of things that, to one who is not familiar with the Protocol, might appear to indicate a lack of credibility. Thus, carrying out evaluations according to the Istanbul Protocol is not only a need but indeed a compelling necessity when suspicions of torture arise.

Much progress has been made over the past two years. From a reality in which there was no use of Istanbul Protocol compliant affidavits to one in which such affidavits are filed with various bodies in Israel, recognized, and bring about significant change in individuals' legal status. Yet despite the advances, a long path awaits before forensic affidavits become an obligatory norm whenever suspicions

of torture arise. In two of the cases which saw an asylum seeker released from custody following the filing of an Istanbul Protocol compliant affidavit – in one the victim was also recognized as a human trafficking victim – the decisions given did not mention the Istanbul Protocol or even its relevance to the discussion of torture, although this was in fact the foundation for the affidavits which effectively changed these individuals' legal status. Thus, despite the Istanbul Protocol's unique suitability, it has failed to become common knowledge, a prerequisite for the effective documentation and investigation of torture. The word effective seems to contain within it this connection between the findings of the evaluation and the account of what occurred: without this connection the expert affidavit has no effect. Since legal proceedings in Israel are generally 'adversarial' – that is, driven by claims raised by the different parties rather than by the court – I call upon attorneys to begin employing Istanbul Protocol compliant expert affidavits and in parallel to mention the Protocol as the professional basis of these affidavits: this in order to turn the affidavits from a need to a compelling necessity, and to improve its status from carrying probative weight to carrying enhanced probative weight.

Likewise, I call on physicians and mental health experts to participate in the training courses for torture documentation under the Istanbul Protocol. In addition, I also call on the Israel Prison Service to remove the barriers preventing physicians and mental health experts from entering the prisons in order to carry out Istanbul Protocol compliant evaluations as part of the professional service provided by attorneys. Finally, I call on official bodies to adopt the Istanbul Protocol and to investigate claims of torture in accordance with its guidelines, whether in the Ministry of Justice or the Ministry of Interior, in order to ensure the effectiveness of their investigations. For what is an effective investigation if it does not reach the truth of the matter?

Prof. Yuval Shani

Dean, Faculty of Law, The Hebrew University of Jerusalem

For me the Istanbul Protocol is not only a subject of research but a practical vocational: for the past year I have also sat on the UN Committee for Human Rights, where we are in dealings with states over the manner in which they implement human rights standards and torture prevention, including the Istanbul Protocol. For me, as a jurist concerned with attempts to enforce human rights law, the Protocol is a very important working tool. I will attempt to speak from the perspective of international law, and to place the Istanbul Protocol within a slightly broader context of enforcing the international prohibition against torture. I would also like to address the legal status of this Protocol, since it is actually a rather odd creature: though neither a convention nor a law, we nevertheless have "normative expectations" of this document.

Those present here will take it as a given starting point that international law prohibits torture absolutely. More relevant for us is that this prohibition has a number of layers: one important layer beyond the state's duty not to torture is its duty to prevent torture. That is to say, the state must take steps which will reduce the chances that someone in its territory might torture, whether a public official or a private individual. The UN Convention Against Torture specifically uses the phrase "to prevent torture". The International Covenant on Civil and Political Rights, too, speaks of the duty "to respect" and also the duty "to ensure". From this idea of the duty to prevent, we derive a number of things. We derive guarantees such as the audiovisual documentation of interrogations; supervision of detention centers and interrogation centers; training of interrogators; and access for both attorneys and physicians to the interrogation rooms in order to assist the state in meeting its obligation to prevent torture.

Beyond the duty which we call primary obligation, the duty not to torture and to prevent torture, the State also has an obligation which we jurists call a secondary obligation. That is, the duty to take steps which are compensatory or corrective when the primary obligation is violated, that is, when we have reason to suspect that the norm has been violated – here, that torture has been implemented. In such a case both the Convention Against Torture and the Covenant on Civil and Political

Rights discuss the state's duty to provide an effective remedy. In other words, the State must take action to clarify what has occurred, investigate the events, bring those responsible for torture to trial, and provide effective remedy in the form of compensation and treatment for the victim of the crime. The entirety of these duties, both the direct ones and the preventive and corrective ones, applies across the spectrum. They face the future: the duties to investigate and to punish are meant to protect possible new victims by uprooting these phenomena. And they also face the past: they are meant, insofar as is possible, to treat those whose human rights have been violated.

The Istanbul Protocol places the duty to investigate claims regarding torture upon the state. In recent years, the Turkel Commission accepted the claim that international law requires that an investigation be as independent, non-biased, expeditious, honest, effective and transparent as possible. In effect, the Istanbul Protocol can be understood as the partial implementation in a specific field of the state's duty to investigate. The mechanism is also based on the idea of independence, and upon professionalism: who carries out the evaluation. It also contains the idea, which we find in other aspects of investigatory law, of the need to invest resources. And of course the investigatory bodies which make use of the findings of Istanbul Protocol compliant evaluations must be the appropriate legal authority in order to lead to the proper solution. The Protocol makes reference to the entirety of investigatory law, to the need to protect those involved in the process – the investigators, the writers of the expert affidavit, and the interrogees.

The idea of the low threshold, that no complaint is necessary and an investigation must be opened on the basis of physical findings even in the absence of a complaint by the victim, is also an idea shared by general investigatory law and the Istanbul Protocol. So too is the idea of passing information on to the interrogee and her/his attorney – transparency; as is the public nature of the investigation as it appears in the Protocol, though of course there are exceptions which result from ethical limitations and the need to protect the privacy of the victim. Thus we can actually understand the Protocol's implementation of investigatory law as a specific link in the chain ensuring the pursuit and implementation of investigatory law which international law mandates.

As for the place of the Protocol, some of the preventative obligations to which the state is obliged include advancing the use of the Istanbul Protocol as well as the compensatory and corrective duties to which the state is obliged. And what is the status of this Protocol? As I mentioned, it is not a convention or a law; it is what is known in international jurisprudence as "soft law". What is such law? Soft law walks like a duck, sounds like a duck and looks like a duck, but is not a duck: it is not a law for all intents and purposes. It is phrased like a law, or at least contains elements which resemble law: but it is not a law in the formal sense and hence states are not legally bound to operate on the basis of its norms. There is no direct obligation, unlike the prohibition against torture for which the state is under an absolute prohibition, a clear and explicit legal prohibition. Here we are speaking of something which will develop into a kind of best practices document – desired laws or norms which we would like states to act under.

Nevertheless, we observe states and even more so international bodies which interpret the state's duty to prevent torture and to correct cases in which torture has occurred to includie within it the duty to act in accordance with the Istanbul Protocol. Thus, the committee of which I am a part and other UN committees which work opposite states, especially those which discuss claims regarding human rights violations, ask for clarifications regarding the implementation of the Istanbul Protocol and call on them to implement it in a broad fashion.

I shall give several examples from the past two years: when the Human Rights Committee discussed the status of rights in various states such as Peru, Slovakia and Turkmenistan, the committee's recommendation to each country specifically mentioned enacting plans to train experts in the Istanbul Protocol. That is, to instill the Protocol among medical professionals in those countries. When the Committee Against Torture met the representatives of Holland last year, it recommended that the Istanbul Protocol be enacted in facilities where asylum seekers are held. When the same committee met representatives of Cuba, it recommended that the state implement the Istanbul Protocol with regard to detention centers within its territory.

When the Human Rights Committee met the State of Israel in 2010, it recommended that the government implement the Istanbul

Protocol and incorporate it in handling claims regarding torture. This matter has not fallen from the committee's attention, and Israel shall appear before it again this October. In preparation for this appearance, Israel received a list of questions and topics for which the committee requested clarifications; one of the considerations was whether Israel implements the Istanbul Protocol. That is to say, although it does not constitute obligatory law, and although Israel may not be under legal duty to act, the committee projects to Israel that the Protocol is the standard expected of states which would at least like to have a good record on human rights. Explicitly, to be among the civilized regarding human rights, states must implement the Istanbul Protocol.

In fact, the Chairman of the Human Rights Committee, Claudio Grossman, published an article several years ago declaring that a state which does not implement the Istanbul Protocol takes upon itself the obligation to prove that it does not torture. He claims that when his committee hears about the existence of torture in a state which does not enact the Istanbul Protocol, it assumes that torture was indeed carried out unless the state is able to prove otherwise. Typically, the opposite rule applies: the burden is upon those claiming that torture occurred to prove that it indeed took place. We observe that, since the Istanbul Protocol is perceived as a best practice and is seen more and more as part of a package of duties to which the state is obligated, the state faces a greater burden to prove its integrity if it does not make an effort to achieve the international standard which the international community expects of it. Grossman says that this also constitutes customary law; I am not sure that I agree, since I am not convinced that we are at a point where most of the world's states accept or precisely implement the Istanbul Protocol; but we are certainly moving in that direction. We face a future in which more and more states will act in accordance with this Protocol and more and more bodies will count on it; thus I predict that it will indeed become a norm of international law.

I would like to give my blessing again not only to my being invited, but to the fact that this event is taking place and that these trainings are proceeding. But at least from the perspective of international law, the duty to assimilate the Istanbul Protocol is not the obligation of the Israeli Medical Association or of the Public Committee Against Torture: it is the duty of the State. And as with many matters, in this field too there is unfortunately

a privatization of the international obligations of the state through its transfer to civil society organizations. Therefore alongside the call which we heard earlier, to use the Istanbul Protocol more often and more intelligently, we should at least call upon the State (insofar as the State is represented in this room) to take ownership of the process of instilling this Protocol. This doesn't mean it shouldn't be assisted by [human rights] organizations or cooperate with these organizations and the IMA, but the responsibility for medical professionals in the State of Israel who come into contact with torture victims being familiar with the Istanbul Protocol and acting in accordance with it, is the duty of the State. Thank you.

Discussion

Question:

A short question regarding your opinion on the duty to rehabilitate torture victims who were not tortured within the state. Today we are dealing with several thousands of torture victims who were tortured in Egypt. They are here, they have nowhere to go and they cope with the Ministry of Health; when the State says that, because they were not tortured in Israel, the State's obligation is supposedly diminished… Thank you.

Prof. Yuval Shani:

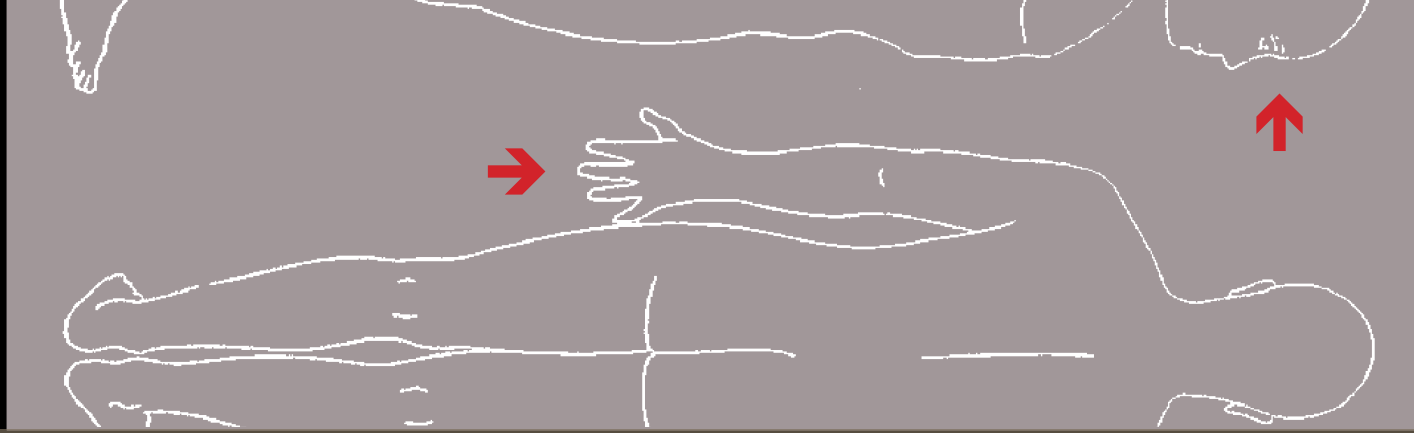
That is a big question. There is something, in my opinion, to the State's claim, in the sense that if the State is neither responsible for the crime nor for preventing the crime – at least in the sense that it occurred in an area outside the state's jurisdiction – then the its obligation is indeed a smaller one; certainly in comparison with an individual who underwent torture in Israel, in regards to whom Israel violated the norm, resulting in its duty to correct the crime. Still, the state has an obligation to protect the human rights of the individuals located within its territory, even if it is not responsible for the situation; just like, even if a cancer patient who is located in Israel became sick outside the country, the State of Israel still has the duty to treat her/him. The same is true of an individual who has suffered mental or physical harm outside the territory of the State of Israel, and is currently within the state and will not be leaving in the coming days – the State of Israel is obliged to treat her/him. True, the duty owes to a different origin, not from the responsibility for the crime but from a general duty upon the state to protect the right to health of all individuals within its territory. To the degree that Israel is responsible for what takes place in the border area, the answer may vary in accordance.

Question:

Thank you for the very interesting presentation of the problem. I would like to ask what your perspective is on the unique problem of Israel, which in fact enacts two parallel legal systems – a civil one for citizens of the State and a military one for residents of the territories – is a military legal system also obligated to the Istanbul Protocol or must it take the Protocol into account?

Prof. Yuval Shani:

That is easy for me to answer, since in terms of international law there is no significance to the distinction you draw. There is a state, and that state has people over whom it holds control, some of them within its sovereign territory, and some within a territory which is subjected to military government. All of these people have human rights, the state may not torture them, it has a duty to protect them from torture and it has a duty to correct cases in which torture was carried out. Insofar as the Istanbul Protocol is seen as part of that package of defense and correction, it must apply both within the sovereign territory of the State of Israel and in the territories which Israel holds as occupied territories.



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