International Association of Refugee Law Judges' Guidelines on the Judicial Approach to Expert Medical Evidence.

1. **Introduction**

1.1. The International Association of Refugee Law Judges (IARLJ) is committed to ensuring the provision of fair hearings and decisions to all claimants.

1.2. For the purposes of these Guidelines all references to judges include judicial and quasi-judicial decision makers.

1.2.1. These Guidelines are a tool designed to assist judges in the fulfillment of their task of ensuring that proper and adequate account is taken of all evidence, including any expert medical evidence,[1] within the refugee status determination process or other similar determination processes, for example immigration/migration appeals, humanitarian protection and human rights appeals, which are all matters that affect the lives of individuals directly and profoundly.

1.2.2. For the purposes of these Guidelines 'expert medical evidence' encompasses all matters relating to the physical and/or mental/psychological health/well-being of the claimant.

1.2.3. For the purposes of these Guidelines 'expert medical evidence' includes both written and oral evidence.

1.2.4. In some jurisdictions there may be no procedural provisions for expert medical evidence in place or little use is made of them. Judges should be receptive to expert medical evidence whenever it is thought helpful.

1.2.5. Any medical report or psychiatric report deserves careful and specific consideration, bearing in mind, particularly, that there may be psychological consequences from ill-treatment which may affect the evidence which is given by the applicant. Attention should be given to each and every aspect of medical reports.[2] The

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[1] See below para 1.2.5, Section 4, and 6.(c) & (d) for elaboration of 'expert'.

[2] As noted for example in ***Ibrahim*** [1998] INLR 511. These Guidelines address the subsequent criticism of ***Ibrahim*** in ***HE (DRC)*** [2004] UKIAT 00321, namely that it, "was not a sound approach, of relevance to each and every medical or psychiatric report on issues of credibility, or indeed more generally. The experience of the Tribunal…since then is that the quality of reports is so variable and sadly often so poor and unhelpful, that there is no necessary obligation to give them weight merely because they are medical or psychiatric reports. The consideration given to a report depends on the quality of the report and the standing and qualifications of the doctor." (Para 16).

consideration given to a report depends on the quality of the report and the standing and qualifications of the medical or health care professional/expert. If the judge decides to reject any medical report there is a positive obligation to do more than merely state that it had been 'considered'. The decision maker must provide some meaningful discussion as to how he or she had taken account of the applicant's serious medical condition before making a negative credibility finding. The failure to do so in this case would be likely to be considered to be a 'reviewable error.'[3]

2. **Use of Guidelines**

2.1. These Guidelines should be used and considered in conjunction with any relevant guidelines on vulnerable persons. It is necessary to ensure equal treatment, with differentiation where appropriate, before the mandated asylum determination body.[4]

2.1.2. The United Nations' *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (1999) represents an attempt to establish international guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture and for reporting findings to the judiciary or any other investigative body. The manual includes principles for the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment.[5] For the current edition of the Istanbul Protocol see Office of the United Nations High Commissioner for Human Rights Geneva Professional Training Series No. 8/Rev.1 United Nations New York and Geneva, 2004 Istanbul Protocol *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.*

3. **The Role of Expert Medical Evidence**

3.1. Expert medical evidence is obtained for one or more of the following purposes:

- to substantiate claims of ill-treatment;
- to establish a correlation between physical or psychological injuries and the alleged torture or ill-treatment;

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[3] See also note 8.

[4] See for example Guideline 8 – Guideline on Procedures with Respect to Vulnerable Persons appearing before the Immigration and Refugee Board of Canada, December 2006, which aims to provide procedures for dealing with claimants who may encounter additional difficulties due to e.g. physical or mental health problems, age or gender issues.

[5] The guidelines contained within the *Istanbul Protocol* represent minimum standards.

- to explain a claimant's difficulties in giving evidence or recounting events by

    (a) providing possible explanation(s) for inconsistencies and/or contradictions within a claimant's narrative of events;[6]

    (b) providing possible explanation(s) for reticence or reluctance in divulging a full account of events, for example delay in divulging allegations of sexual assault and/or other forms of violence directed against an individual,[7]

- to address the possible effect of removal and return to the country of origin upon a person's physical or mental well-being or that of a family member;

- to assess treatment needs.

- to reduce the need for the claimant to give testimony about traumatic events.[8]

3.2. Expert medical evidence may not prove conclusively whether or not someone was tortured or had suffered serious physical or psychological injury. Rather, the medical report provides expert opinion on the degree to which the injuries or behaviour presented correlate with the allegations of torture/ill-treatment.[9]

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[6] See for example ***Feleke,*** 2007 FC 539 in which it was stated that "[t]he medical assessment, which the Refugee Protection Division (RPD) accepted, stated that the Applicant suffered from "cognitive difficulties, avoidance behaviours, generalized anxiety symptoms", all of which could have provided an explanation for the Applicant's behaviour. The RPD, in finding a decision either way, with regards to credibility, had an obligation to explain how the diagnosis impacts the RPD's assessment of any discrepancies." (para 18).

[7] Supra note 2. See also ***Atay v. Canada (Minister of Citizenship and Immigration),*** 2008 FC 201 at para. 16 (stating "[S]imply referring in its reasons to a psychological report addressing posttraumatic stress disorder is not sufficient; the Board must consider whether the psychological circumstance might help explain an omission, lack of detail, or confusion regarding the events if these are the exact cognitive errors referred to in the psychologist's report.").

[8] ***X.E.B. (Re),*** [2002] R.P.D.D. No. 230 at para 17.

[9] See for example ***CASE OF R.C. v. SWEDEN (Application no. 41827/07),*** European Court of Human Rights, 9 March 2010, in which the "Court notes that the forensic medical report submitted at its request has documented numerous scars on the applicant's body. Although some of them may have been caused by means other than by torture, the Court accepts the report's general conclusion that the injuries, to a large extent, are consistent with having been inflicted on the applicant by other persons and in the manner in which he described, thereby strongly indicating that he has been a victim of torture. The medical evidence thus corroborates the applicant's story." (para 53).

3.3. Expert medical evidence should form an integral part of any findings of credibility and should not be separated from other evidence.[10]

3.4. The judge may, in the context of the evidence as a whole, have to consider the possibility that the claimant is feigning the symptoms he or she puts forward.

4. **Standards to Ensure Uniformity and Consistency of Expert Medical Evidence**

4.1. Expert medical evidence should include the credentials of the author of the expert medical report, including:

- medical education and clinical training;
- psychological/psychiatric training;
- medical qualification;
- membership of any professional bodies;
- experience in documenting evidence of torture/ill-treatment;
- experience of treating asylum seekers, refugees or victims of torture/ill-treatment;
- whether the expert is familiar with the *Istanbul Protocol* (see below);
- whether the *Istanbul Protocol* informs the medical opinion;
- current Curriculum Vitae including relevant publications, presentations and Continuing Professional Development.

4.1.2. In situations where no formal medical training/qualification has been gained by the examiner, any relevant practical experience working with refugees/victims of torture

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[10] ***C.A. v. Canada (Minister of Citizenship and Immigration),*** [1997] F.C.J. No. 1082 at Para. 12 ("In this case, credibility was also the 'linchpin" to the Board's decision. Nonetheless, the Board failed to indicate, how, if at all, the psychological report was considered when making its credibility finding. The Board was obliged to do more than merely state that it had "considered" the report. It was obliged to provide some meaningful discussion as to how it had taken account of the applicant's serious medical condition before it made its negative credibility finding. The failure to do so in this case constitutes a reviewable error and justified the matter being returned to a newly appointed Board."). ***Hassan v. Canada (Minister of Citizenship and Immigration)*** (1999), 174 F.T.R. 288 (F.C.) (finding that the medical evidence at issue (a psychological report), formed a part of the basis for evaluating the claimant's credibility).

which has culminated in the author of the report gaining expertise should be stated. However, this expertise must be recognised as having weight by a relevant authority e.g. the Minister of Health. As in all instances, circumstances peculiar to a particular country, e.g., having relatively few trained medical practitioners, should be considered.

4.2. Expert medical evidence should deal with the individual claimant's particular case so as to:

- advise on the duration, frequency and regularity of interviews and/or consultations the author of the report had with the claimant;
- advise on the examination (including the nature and the extent of) and diagnosis of the claimant, and make clear the diagnostic tests used and methodology employed;
- advise as to any suggested prescribed treatment;
- advise on the long term prognosis including;

(a) the likely impact return to country of origin could have on the claimant's physical and/or mental health including likelihood of re-traumatization;

(b) availability of medical and psychiatric services in the country of origin;

(c) drug availability and rehabilitation services in the country of origin;[11]

4.3. Expert medical evidence should be restricted to the author's area(s) of competence and expertise.

4.4. Expert medical evidence should demonstrate a critical and objective analysis of the injuries and/or symptoms displayed, rather than an unquestioning acceptance of the claimant's account of how any injuries were sustained.[12] As a norm the evaluation should involve:

- An objective description of the injury;
- A description of how the injury was incurred according to the claimant;

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[11] 4.2. (a)(b)&(c) should only be addressed when such knowledge lies within the recognised expertise of the report's author. However a report should not be considered to be deficient if it does not include such information.

[12] ***Mendez v. Canada (Minister of Citizenship and Immigration),*** 2005 FC 75 at Para 41 (stating "[t]he general rule is that while a diagnosis drawn from a claimant's account of facts already found not to be credible can be disregarded, a diagnosis drawn from independent observation of symptoms is not so easily set aside".).

- An opinion on the consistency between the nature of the injury and the manner in which it was incurred, preferably with precise reasons;

4.5. Expert medical evidence should address the relative likelihood of any other possible cause for the injury in question.

4.6. Expert medical evidence should provide an overall evaluation of all lesions and note the consistency of each lesion with a particular form of torture. However, the overall conclusion should not go further than what is commensurate with findings as detailed by the expert. That is, if all that a doctor does is say that the scarring/injury is 'highly consistent' with the claimed history, without also addressing the relative likelihood of the few other possible causes, the report will clearly be of less potential value than if it does and an immigration judge may hold that a finding of "highly consistent" has very limited value.[13]

4.7. Expert medical evidence should remain impartial and refrain from giving any opinion as to the overall credibility of the claimant or of the merits of the claimant's case.

4.8. A holistic approach should be adopted to the evaluation of expert medical evidence. A report which does not contain all of the above should not be disregarded as deficient.

5. **Assessment of Injuries Pursuant to the *Istanbul Protocol* Criteria:**

The following has been extracted from the *Istanbul Protocol* and is offered as what may be regarded as aspirational best practice. The *Istanbul Protocol* sets out in some detail the terms which should be generally used in describing/establishing the correlation between the alleged ill treatment and the injury sustained.

5.1. Visible Injuries

It is advocated that in cases of visible scarring each lesion and the overall pattern of lesions the physician should indicate the degree of consistency between the lesion(s) and the alleged injurious conduct. The following terms, referred to as the five-fold hierarchy of degrees of consistency between the injury and "the attribution", are generally used:

(*a*) *Not consistent*: the lesion could not have been caused by the trauma described;

(*b*) *Consistent with*: the lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes;

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[13] Reservations have been expressed that this could demand speculation and enumeration about a range of other possible causes. It is enough for the expert to state that there are other possible causes for the injury, and how likely they are considering what is known about the claimant's life history and experiences. The problem of this not being addressed can be seen in ***RT (medical reports – causation of scarring) Sri Lanka*** [2008] UKAIT 00009 (paras 28-35).

(*c*) *Highly consistent*: the lesion could have been caused by the trauma described, and there are few other possible causes;

(*d*) *Typical of*: this is an appearance that is usually found with this type of trauma, but there are other possible causes;

(*e*) *Diagnostic of*: this appearance could not have been caused in any way other than that described. [14]

5.2. Non-visible Scarring

The *Istanbul Protocol* at para 287, whilst referring to cases of torture, suggests in assessing persecution/abuse/ill-treatment that the following should likewise be considered:

(a) The extent to which the psychological findings are consistent with the alleged report of torture, abuse/ill-treatment;

(b) Given the individual's circumstances the extent to which the psychological findings are expected or may be typical reactions to extreme stress;

(c) The stage at which the individual is in the course of recovery given the timeframe in relation to the torture events and the fluctuating nature of some psychological symptoms;

(d) The impact of external factors on the individual, such as ongoing persecution, forced migration, exile, loss of family and social role;

(e) Special physical conditions, such as head injury sustained during torture or detention.

5.3. Clinicians should comment on the consistency of psychological findings and the extent to which these findings correlate with the alleged abuse. The emotional state and expression of the person during the interview, his or her symptoms, the history of detention and torture and the personal history prior to torture should be described. Factors such as the onset of specific symptoms related to the trauma, the specificity of any particular psychological findings and patterns of psychological functioning should be noted.

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[14] This hierarchy is taken from the *Istanbul Protocol,* para 187 and has received judicial endorsement in the UK in ***RT (medical reports - causation of scarring) Sri Lanka*** **[**2008] UKAIT 00009*;* ***SA (Somalia)*** [2006] EWCA Civ 1302*; R (on the application of PB) v. Secretary of State for the Home Department* [2008] EWHC 364 ; and in the Republic of Ireland in ***S v MJELR & Anor*** [2007] IEHC 305**.**

6. **The Application of Expert Medical Evidence**

6.1.

(a) Expert medical evidence should be treated as an integral element of all the evidence considered in establishing the facts;[15]

(b) If expert medical evidence is dismissed by a decision-maker as being of little evidential value, this should be stated accompanied by appropriate reasoning.[16] This is particularly the case if the expert medical evidence has been submitted by an organisation which has established itself as an objective and reliable provider of medico-legal reports in asylum or asylum related cases;

(c) A decision-maker, as a layperson, should not attempt to substitute his or her own opinion in preference to that of a reliable expert.[17]

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[15] See ***Mibanga vs SSHD*** [2005] EWCA Civ 36. See also Paragraph 42 of the UNHCR Handbook further advocating such a holistic approach to evidence.

[16] ***Bains v. Canada (Minister of Employment and Immigration)*** (1993), 63 F.T.R. 312 at para. 9 (F.C.)

[17] ***Lozano Pulido,*** 2007 FC 209 in which in response to a decision not to give weight to a psychiatric report it was reiterated that "while members of the Refugee Protection Division have expertise in the adjudication of refugee claims, they are not qualified psychiatrists, and bring no specialized expertise to the question of the mental condition of refugee claimants." (para 28).

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