

The Tortured: Sorrow and Respect



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“They kept me for 10 weeks and left me for dead.” Mr. M’s eyes shouted anguish and teared above his coronavirus disease 2019 (COVID-19) mask. His experiences were as dreadful as those of many of the torture survivors I have evaluated, and, similar to the others, his narrative evoked both sadness and great respect for his emotional and physical strength.

I provide pro bono medical evaluations for Survivors of Torture, International, a nonprofit organization in San Diego, California, that provides medical, psychological, and other services for asylum seekers. Amnesty International reports that torture is perpetrated in three-quarters of countries.¹ Most of the people I have evaluated were tortured because of their minority racial or ethnic, sexual or political identity, or their promotion of human rights. Many torture survivors seek safety in the United States, despite the great difficulties they encounter in obtaining legal residence here. After surviving life-threatening experiences abroad, many victims travel to Latin America or originate there and then endure additional hazards while migrating to the U.S.-Mexico border. They request political asylum from border officials and are then typically locked in detention centers for months to years while pursuing the complex, lengthy process of obtaining asylum status.

As Mr. M had done, all clients whom I evaluate have created a legal declaration with a U.S.-licensed attorney that supports their well-founded fear of persecution if forced to return home. Without assistance of an attorney, victims usually do not obtain asylum. I interview clients to confirm and expand the details in their declarations, inquire about continuing posttraumatic symptoms, examine them for physical findings that correlate with their accounts, and prepare summaries that accompany psychological

evaluations by mental health professionals for the immigration court.

During my interview, the detail I elicit resembles that of other features of a thorough medical history, but inquiry about torture rarely occurs in usual medical practice, even from foreign-born immigrants who may have originated in countries where torture is committed. For example, about 1 in 9 foreign-born individuals seeking care at a Boston primary care clinic reported a history of torture, which most had not previously reported to their U.S. physicians.² Some clients disclose maltreatment to me that they did not report to their attorney, especially sexual abuse. Many have witnessed the murder of family members or friends. Nearly all have insomnia, nightmares, intrusive thoughts, and other symptoms of posttraumatic stress disorder. I proceed slowly and gently, knowing that many victims experience renewed mental trauma when they describe their torture, as Mr. M displayed. I dislike triggering such distress, but the importance of associating the details of how physical injuries were inflicted with the resulting examination findings motivates me to continue, as empathetically as I can.

Two armed guards, whose large physiques contrasted with Mr. M’s slender build, brought him from the detention center with chains restricting his wrists and legs. After more than 20 years of volunteering, I still have a sense of shame when I meet a chained client who appears subjugated after having already endured extraordinarily severe hardship. After the interview, I request removal of the restraints for the physical examination, to which the guards respond by releasing only one chain at a time, allowing clients to sequentially remove their shirts and pants. The guards often require a partially opened examination room door to maintain sight of the client, which I close as much as I think they will accept to minimize further humiliating the victim. I think, *don’t you realize that you don’t need to watch him. He is chained and wants my help and is not going to jump out of a second-floor window.*

Mr. M, previously a journalist, had reported on government-backed suppression of peaceful human rights demonstrations and on beatings and rapes of citizens by police with impunity. He described uniformed men firing guns at

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people in demonstrations and arresting some who were never seen again. Police had threatened him with death if he did not stop publicizing these accounts, but he persisted. I questioned whether I would have had the courage to do that.

Three years before my evaluation, police arrested him at work, beat him with batons and gun butts, and detained him in a dark, filthy cell with little food and water for 10 weeks. The perpetrators frequently beat much of his body with a wooden rod, including the soles of his feet (a form of torture called *falanga*³), administered electrical shocks to his genitalia and feet, immersed him shoeless in a water-filled hole containing broken glass, stabbed his abdomen with a bayonet, and finally abandoned him near the confinement facility. Fortunately, his family took him to a hospital where he underwent urgent abdominal surgery, treatment of a left wrist fracture, and a long recuperation.

Nurses told his family that the police had come to the hospital looking for him after his discharge. He knew that to prevent being killed he had to leave his country. He fled, aided by smugglers whom he paid with money from his family. He flew to Ecuador, a common initial destination for asylum seekers due to its favorable visa policies. After starting northward, he was captured and held with his legs shackled and repeatedly beaten for 1 year until his family paid for his release. He hired more smugglers, was incarcerated by immigration authorities in a South American country for 7 months, traversed the notoriously dangerous Darién Gap in Panama, and finally reached the United States. Some survivors of severe torture in their home countries undoubtedly die on route to the United States, but little information exists on such tragedies.

Physical examination of Mr. M revealed multiple skin scars that would be expected from the trauma he described, focal hyperpigmentation typical of healed bruises, and chronic foot findings characteristic of *falanga*.^{3,4} He had a long, vertical, midline laparotomy scar with suture marks, small scars typical of peritoneal drainage sites, and a linear transverse scar near the umbilicus the length that would be produced by a bayonet wound. His left wrist was tender. Using the hierarchy of causation in the United Nations Istanbul Protocol,⁵ I assigned major degrees of consistency to the physical findings with his attributions for them, bolstering his case for asylum.

Aided by his attorney, the declaration, a psychological evaluation, and my medical assessment, the immigration court granted Mr. M asylum status, and he moved to

another state to live with a relative. When I phoned him a few months later, he still had flashbacks and other symptoms of posttraumatic stress disorder and worried about the welfare of his family remaining in his home country. But he described walking daily to reduce anxiety and “clear my mind.” He was awaiting a work permit, explaining that he wanted employment to support himself and adding, “If you help people, God will help you.”

I was deeply moved that he expressed such enduring humanity despite the horror of what people had done to him. Immediately after evaluating Mr. M and other torture victims I feel drained yet privileged to meet and assist these exceptional human beings, one of the most rewarding aspects of my medical career. Teaching medical students⁶ and residents⁷ how to evaluate torture survivors could increase the number of physicians who do this valuable work. The victims deserve our efforts to make their lives safer.

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