Medicolegal certificates in investigations of asylum applications

Sir

According to the Swedish Immigration Board (SIB), about 26,500 people per year have applied for asylum in Sweden during the last decade. Experiences from Denmark show that up to 20% of those who seek asylum have been subjected to torture or severe ill-treatment in their home countries. Since 1992, most of these applicants have been examined at the Centre for Torture and Trauma survivors (CTD) in Stockholm. The findings are described in medicolegal certificates submitted to the immigration authorities.

The present study was primarily aimed at analysing the relationship between the medicolegal certificates and the chances of obtaining asylum in 52 randomly selected CTD cases from the years 1994-96. The medicolegal certificates were classified according to whether they were “supportive” or “informative” in the medicolegal certificates. A majority (53%) of the 30 people granted residence permits had “supportive” medicolegal certificates. There was no statistically significant association between the motivations given by the authorities and the formulations (supportive or informative) in the medicolegal certificates (χ² square p > 0.05).

Furthermore, CTD investigations were described as crucial to the decisions in only 14/52 cases (26%). Mental health was evaluated by a psychiatrist in 47 cases, 37 of whom (78%) were found to suffer from post-traumatic stress disorder. There was no statistical association between the PTSD diagnosis and outcome of the asylum application (χ² square p > 0.05). Neither was an impending risk of suicide, as registered in 14/33 cases (27%), significantly associated with the authorities’ decisions (χ² square p > 0.05). The only social and circumstantial factor statistically associated with a positive verdict was to have relatives already living in Sweden (p < 0.05).

In conclusion: the CTD examinations of alleged torture are meant to give reliable and unbiased information to the Swedish authorities involved, but the certificates provided are apparently often ignored. One reason may be lack of validation of the certificates, which is a considerable problem as absolute truths rarely can be demonstrated. Application of statistical probability methods and double-blind interview techniques might increase the validity of the medicolegal certificates. However, so far only a few studies have taken up this problem. Another possible explanation is that the Swedish Immigration Board as well as the Alien Appeals Board are political, not judicial, institutions, and thus may lack the competence correctly to evaluate medicolegal certificates that are normally intended for use in the courts.

References
2. Edston E. Superficial physical evidence may reveal torture; 5 years experience of torture documentation. Läkarutbildingen 1999;96:528-31 (in Swedish with abstract in English).

LINA FORSMAN AND ERIK EDTON
MD, PhD
Department of Forensic Medicine, Umeå University, Umeå, Sweden

Ethical ethics committees?: a response

Sir

Following Dr Barber’s letter relating to the mechanism for approval of Local Research Ethics Committees (LREC), I have also had concerns over the intense pressure for a fast turn around for local approval. Projects may have been six months or more in the Multicentre Research Ethics

www.jmedethics.com
Committee (MREC) process and then arrive on my desk with multiple telephone calls requiring turn around in a few days. Frequently researchers are not even aware of the number of copies we may require for perusal, and getting administrative details correct causes further delays.

If the process is to be truly ethical I believe that it must be performed with an appropriate number of people, always including a lay person, who, except in exceptional circumstances, should be in the same room together to get optimum examination of the issues. In addition, my understanding of the Good Clinical Practice (GCP) guidelines is that committees should do their business primarily by meeting. When our committee has spent considerable time developing standing procedures in conformity with guidelines and our own consciences, surely these should not be set aside on a case by case basis?

Members of the committee cannot override their normal commitments (particularly lay members who do not work for the National Health Service) instantaneously, and a considered response requires a certain amount of time. This is likely to be particularly pertinent in District General Hospitals where research is not the focus of the trust. I would not support excessive delays, but in my opinion, from the comments made to me by researchers, I feel that there are times when I am called upon to make up for delays elsewhere in the system. If MREC applications are to pass through LRECs (and I do mean if) then they cannot be considered as a rubber stamp, but must fulfil their collective ethical responsibility.

Reference


DR G J TILDSLEY
Consultant Pathologist,
The Princess Royal Hospital,
Haywards Heath,
West Sussex
RH16 4EX