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The Truth from the Body: Medical Certificates as Ultimate Evidence for Asylum Seekers

ABSTRACT Whether through traditional law or modern torture, the body has always been a privileged site on which to demonstrate the evidence of power. But for immigrants, the poor, and, more generally, the dominated—all of whom have to prove their eligibility to certain social rights—it has also become the place that displays the evidence of truth. In France, as immigration control increases, asylum seekers are more and more submitted to the evaluation of their physical sequels and psychic traumas, as if their autobiographical accounts were not sufficient. In this article, we show how nongovernmental organizations (NGOs) deal with the dilemmas posed by this situation, how they develop protocols standardizing their expertise, and how their medical authority progressively substitutes itself for the asylum seekers' word. In this process of objectification, it is the experience of the victims as political subjects that is progressively erased. [Keywords: body, violence, truth, refugees, biopolitics]

He proceeded to tell me how he was tortured, how bad it was when they changed the handcuffs for rope, how he felt like drowning with the wet towel stuffed down his mouth, and what it was like being in the bag and shot but not killed. He leant his head forward almost on to my lap and guided my fingers through the hair to the soft bulging wounds of irregularly dimpled flesh. "Like worshippers with Christ's wounds," murmured a friend days later to whom I was telling this.

—Michael Taussig
The Nervous System

THE BODY IS THE PLACE, par excellence, on which the mark of power is imprinted. It is an instrument used both to display and to demonstrate power, which is evident when we consider the order of social reproduction: initiation rites in which "the scars drawn on the body" are "the written words of the primitive law" (Clastres 1974:159), and the accompanying "harangues" express "the commandments of the domination of men over women and the submission of the youngest to the eldest" (Godelier 1982:78). It is also evident when we consider contemporary wars in which "political rape" serves the goal of "eliminating a community" (Nahoum-Grappe 1996:283) and in which "hyperbolic evil" has invented "biopolitical practices on human material" (Assayag 2004:282). At the extreme—which is incarnated in the radicality of dictatorial or totalitarian regimes throughout the 20th century—its very dis-

appearance is the surest indication of the absolute and arbitrary nature of brute force, when all physical traces of individuals (Scheper-Hughes 2004) or entire nations are eliminated (Hinton 2002). Hence, the body seems to be political insofar as it always demonstrates, as a last resort, the evidence of power.

Yet in pacified Western societies, this embodiment of political order was gradually erased or at least reduced (Fassin 1996), as physical violence lost its legitimacy in imposing social relations of power. Even in the punishment of the guilty, the "torturing core" of criminal justice has been "enveloped more and more extensively by a penalty of the incorporeal" (Foucault 1975). The proscription of torture and the abolition of the death penalty have participated in this disembodiment of the political that is simultaneously engaged in a process of disincarnation, because the most salient feature of "modern democracy" is clearly the fact that "the representation of power attests to it being an empty space" (Lefort 1986). Yet despite having become incorporeal and disembodied, the field of politics has not lost touch with the body. Through a single turnaround in history, in contemporary societies—at least in those in which the state more or less fulfils its monopolistic function as regards legitimate violence—the body is no longer the political locus in which power is manifested but the place in which individuals' truth about who they really are is experienced. For the poor who have to exhibit the stigmas of

indigence to benefit from public welfare or private charity (Fassin 2000), or foreigners who have to report their illness or suffering to obtain a residence permit (Fassin 2001b), the body has become the place that displays the evidence of truth.

It is in light of this new moral order that we need to consider the role of medical certificates regarding applications for asylum in contemporary France. Certificates, which are drawn up by a doctor or sometimes by a psychologist and that attest to torture, have become a key piece of evidence in administrative case files submitted to evaluation. State institutions responsible for deciding on the validity of asylum applications, as well as lawyers and nongovernmental organizations (NGOs) that wish to better defend their clients' individual cases, expect such certificates to be provided. Those seeking asylum also desire certificates because of the real or imagined authority conveyed by them. The emergence of this new regime of truth occurs in the context of a profound delegitimization of asylum in the last two decades all over Europe. Although in France, during the 1970s, up to 95 percent of all seekers were granted refugee legal status, this rate rapidly declined in the 1980s and 1990s—dropping to as low as 12 percent for the administrative evaluation and 18 percent when taking into account the appeals. This dramatic evolution has led to (1) an unprecedented increase in undocumented foreigners, corresponding to dismissed asylum seekers (Fassin 2001a); (2) a worrying development of spaces of exception at the national borders, to contain the unwanted immigrants before they can even present their case (Fassin 2005); and (3) a growing suspicion toward all asylum seekers. Far from the generous ideals of the 1951 Geneva Convention, the management of refugees now falls under the mere logics of immigration control: Narratives are less often believed and more proof is often requested. In this new context, the signs left on the body by the torturer become evidence for the state.

The French procedure of recognition of refugees involves two institutions, both created in terms of the 1952 Asylum Act: Ofpra (*Office français pour la protection des réfugiés et des apatrides*), the French agency for the protection of refugees and stateless persons, rules in the first instance, whereas CRR (*Commission des recours pour les réfugiés*), the commission for refugee appeals, examines the dismissed cases. Asylum seekers file an initial application with Ofpra, which decides whether to hear them and whether to grant them asylum. In case of refusal, applicants may appeal to the CRR, the decision of which is considered final. Medical expertise may be requested at either of these stages by Ofpra or CRR, the asylum seekers themselves, or the lawyers or organizations acting as legal or social mediators between the two factions. Even though the medical certificate has not replaced the need for an autobiographical account in which candidates for political refugee status try to prove that they meet the criteria of the 1951 Geneva Convention, it is requested more and more often to verify the validity of that account. Scars, both physical and psychological, are the tangible sign that torture did indeed take place and that

violent acts were perpetrated. Like Thomas, the skeptical apostle in the Gospel, the French State needs to touch the wounds to believe.

The refugee's body, thus, becomes the place of an inscription, the meaning of which relates to a double temporality: an inscription of power, through the persecution they suffered in their home country, and an inscription of truth, insofar as it bears witness to it for the institutions of their host country. However, this new configuration presents two tragically paradoxical situations. The first comes from the parallel and contradictory evolutions of practices of torture that are more and more hidden and demands of physical evidence that are, therefore, more and more difficult to bring. In opposition to its classical counterpart, "modern torture is typically secret," as Talal Asad (1997:289) affirms, because it is both illegitimate and illegal: When war is over or when the oppressor is defeated, the torturer may be brought in front of an international or a national court of justice. The war criminal's elementary rule is, thus, to leave no physical mark. It is in this context of concealment favorable to all types of subsequent denial that the medical certificate assumes increasing importance in societies in which the victims of political violence are supposed to be accepted and protected. Although their word is systematically doubted, it is their bodies that are questioned; however, quite often these bodies speak little, for it is in the torturer's interests to silence them. The second paradox relates to the increasing expectation of physical evidence simultaneous to the state's decreasing confidence in the victim's demonstration of it. The role of "medical expertise" on "emergent forms of lives," which Michael Fischer (2003:41) considers in both its clinical and scientific dimensions, must also be considered from a political perspective. The medical certificate leads to a reification of the asylum seeker's body. Detached from the lived experience of the victims of persecution, it attempts their objectification through experts' words and ends up in desubjectifying them.

For the past two years, we have investigated this complex and ambiguous situation of the request for asylum, which turns the body into a political resource through an expert's mediation. Our study has consisted of surveys of NGOs that assist immigrants and especially asylum seekers. We collected and analyzed the abundant literature produced by these organizations, and we conducted 20 interviews with their members and leaders. We, furthermore, attended their meetings and events as participant-observers. In the case of one organization, we were present at medical examinations and studied 200 certificates, both qualitatively and quantitatively. In this framework, cooperation was developed that could formally be described as "observant participation" but that could also be regarded as related to a politics of involvement in research, because both of us have personal commitments within two of the NGOs working in the domain of asylum. Our fieldwork results have been presented and discussed with the doctors, psychologists, and social workers from the organization, to contribute to their own reflection on the implications of

the certificates and to the redefinition of their positions in this respect. The trust that made this cooperation possible is noteworthy, considering the sensitivity of the domain—one in which researchers are not always welcome—and because other institutions proved far less willing to share their data and many finally closed their doors to us.

"THE BEST OF ALL PROOFS"

Paris, [July 12, 2001] AFF: refugee status.

Sir, Further to the hearing . . . at the CRR, in order to obtain refugee status, you must *absolutely* send me a medical certificate on the traces that remained on your body after the torture and bad treatment inflicted on you, especially as regards your eye. Please feel free to contact me if you encounter any problems. Yours faithfully. [lawyer's letter to client, July 12, 2001]

Paris, [July 12, 2001] Urgent.

Dear Sir, The CRR has informed me telephonically that it will make its decision only when it has been proved by a medical certificate that the marks on your body do in fact correspond to your account. For that purpose, you must *urgently* make an appointment with the doctor at the Avre as well as a doctor of the Comede. When you have the medical certificates of these two doctors, please fax them to me immediately. Yours sincerely. [lawyer's letter to client, July 12, 2001]

These two letters are part of the corpus of lawyers' letters that the Comede (Medical Committee for Exiles [*Comité médical pour les exilés*]) coordinator collected over the past few years. They show to what extent the body has become the place of production of truth on the asylum seeker. Comede is a medical organization founded in 1979 to deliver health care to immigrants; it currently provides 10,000 consultations annually in a hospital in the south of Paris. The institution recorded twice the number of medical certificates issued as part of applications for political refugee status in 2000 as in 1990. More than 1,000 are now issued annually and some commentators have even referred to an "epidemic of requests for medical certificates" (Veisse 2003). This increase is indeed remarkable, if we refer to the annual reports of the organization. In 1984, when medical expertise started to develop, 151 certificates were issued by this organization; in 1994, this figure had risen to 584; and by 2001, it had reached 1,171. When related to the number of health consultations, the trend is even more striking: During the same period, the proportion of certificates rose from 2.2 percent to 10.9 percent. In other words, today doctors devote five times more of their activity to this type of examination than 15 years ago. This increase was brought under control recently by specific steps taken to limit the number of certificates issued. Theoretically, there should be no more than five per day, and because the demand is continuing to increase, the waiting periods for obtaining the precious appointments have stretched to over three months.

Even if institutional policies and organizational practices vary from one organization to the next, they all regularly denounce the same thing: "Does one need a paper to prove torture?" asks the indignant anonymous author of an article on medical certificates in the June 2002 newsletter of the organization Primo Levi, which specializes in aid to victims of violence. The same author refers to a "progressive inflation of requests to doctors and psychotherapists" (Association Primo Levi 2002). This trend in asylum policies has structural causes that need to be examined in the context of the history of "Western hospitality."

Like other countries, France is more generous when the cost is minimal. When applications for asylum are few in number, in an economic context in which labor is in demand, it shows its solidarity with victims of persecution in the world, faithful to the spirit of the June 24, 1793 Constitution that "grants asylum to foreigners banished from their home countries for the cause of freedom"—even if, in reality, suspicion has often contradicted hospitality since that period (Wahnich 1997). In this sense, we could say that throughout the 19th century, there was no real problem of asylum, even though demographic pressure was felt during certain conflicts beyond France's borders. It was only in the 20th century that the "refugee question" became an issue, especially in the aftermath of World War I and even more so in the aftermath of World War II, when foreigners fleeing persecution or violence became Europe's "unwanted" (Marrus 1985). The first international response was the creation of the High Commission for Refugees in 1921, under the aegis of the League of Nations—although it was more directly related to the Bolshevik revolution and the hundreds of thousands of exiles it produced than to the world conflict itself. The rise of totalitarianism and nationalism in Europe during the interwar period soon put more pressure on this institution's modest financial and regulatory resources than it was designed to bear.

In 1951, the signing of the Geneva Convention marked the official entry of refugees into contemporary politics. Yet, from the early years, tension has been at a peak between a humanist ideology advocating the right to asylum, with its ennobled representation of the refugee's status, and a pragmatic policy that mistrusted these stateless people and reduced them to the economic condition of immigrants (Noiriel 1991)—a fact that is often overlooked. The utopia of the former, still marked by the spirit of "never again" after the discovery of Nazi crimes, encountered the realism of the latter, already tinged with the "liberal rationale" of advancing globalization as European reconstruction led to international economic expansion and its demand for a labor force. Once the immediate postwar wave of refugees had been absorbed, European states paid relatively little attention to them, and they were more tolerated for their contribution to national wealth than recognized in a spirit of justice.

In the early 1970s, the situation changed abruptly under the effect of the "oil crisis," the rise of unemployment, and the discovery of the "living conditions of foreigners" by

NGOs who began putting pressure on the French government. The “administrative liberalism of immigration structures” was replaced by a real state policy designed to control migratory flows and promote the integration of foreigners (Viet 1998). Demographic control initially concerned migration for employment, which was strongly limited from 1974 on (July 3, 1974, Cabinet decision under Jacques Chirac’s right-wing government), and then concentrated on family reunification, especially after 1984 (December 4, 1984, Decree, under Laurent Fabius’s left-wing government). Social integration was addressed primarily through housing projects to reduce the large concentrations of temporary residences and insalubrious private buildings (Weil 1991).

In this new context, the number of asylum seekers rose steeply. In 1974, there were 2,000; in 1975, 15,000. These figures climbed steadily in subsequent years, reaching 61,422 in 1989—30 times more than 15 years earlier. The relationship between the interruption of job-related immigration and the increase in applications for asylum, glaringly obvious in Ofpra statistics, was nonetheless complex. It is generally believed that many candidates for immigration, seeing the French borders as closed to those seeking employment or reunification with their families, turned instead to asylum as a means of getting in the country. Asylum was still being widely granted at the time: In 1974, 90 percent of all asylum applications were accepted by authorities; in 1976 the rate was at its peak with 95 percent; it then slid down rapidly to 28 percent in 1989. This interpretation is partially valid, yet it overlooks the fact that until the 1970s there were no public policies for managing migratory flows. Therefore, the law of supply and demand was the only regulator of migration, and the job contract served *de facto* as a residence permit (Schor 1996). In these conditions, many potential candidates for asylum had no need to go through the Ofpra’s administrative evaluation, because finding a job provided both material and legal security.

However, in the new immigration configuration, asylum policy was redefined in depth. In the mid-1970s, 19 out of 20 asylum seekers obtained refugee status; two decades later, this ratio had plummeted to three out of 20. Since the mid-1990s, it has remained more or less stable, at that same level. In 2001, 18 percent of all Ofpra and CRR decisions combined were favorable. A quarter of a century ago, asylum was a matter of trust, in which the applicant was presumed to be telling the truth. Today, asylum is set in a climate of suspicion, in which the asylum seeker is seen as someone trying to take advantage of the country’s hospitality. It is, therefore, in the light of this “crisis in political asylum” (Legoux 1995)—marked by the increase in applications and the decrease in authorizations, but also, more fundamentally, by the loss of credit of the concept of “asylum” itself—that the development of medical expertise is meaningful.

In an NGO meeting we attended, one physician explained, “As the number of applications for certificates increased, the number of asylum seekers who obtained refugee

status dropped” (personal communication, November 9, 2002)—referring to the futility of the medical certificates that he was asked to produce. To him, their ineffectiveness was obvious. He observed a decreasing return on applications for asylum, with the proportion of successful cases dwindling steadily over the past 25 years, despite the fact that medical expertise was more and more often requested. However, the relation of inference should be seen as inverse: It is because asylum has become illegitimate—and therefore more seldom granted on the sole basis of an applicant’s account of torture—that these certificates are playing a greater role. In a context of limited recognition of the validity of applications for asylum (Séguir 1998), any evidence is welcome, but that which is produced by an agent assumed to be both neutral and expert has even more authority. An assessor of the CRR commented during an interview in August 2002:

All proof, evidence, or other is acceptable. Afterwards, the judge forms a conviction on the basis firstly of the account, that remains the basic element, and on its consistency, credibility, or contradictions, and then, somewhat like in a criminal case where the confession is perceived as the ultimate evidence, the medical certificate is seen by lawyers and asylum seekers as something like the best of all proofs. [interview, August 2002]

He nevertheless added: “In fact, it’s true and it’s not true. A certificate can’t ever serve on its own. If the account isn’t credible or coherent, if the information as a whole is probably going to be rejected, it is highly unlikely that the medical certificate will change anything. But if there’s a doubt plus the certificate, then it’ll be to the person’s advantage” (interview, August 2002). This comment points to two phenomena: (1) the importance that the imaginary power conferred to the medical certificate and (2) its very relative effectiveness. This has already been observed in the case of the residence permit: Foreigners who have been denied such a permit endow it with almost magic virtues of social integration (Fassin and Morice 2001). It is only once they have obtained the permit that they realize what limited access it provides for obtaining a job, housing, and simply a place in French society. Foreigners, thus, discover that although they were nothing “without papers,” they were hardly more once they had obtained them.

On either side of this “veil of ignorance” (Rawls 1972), which separates those who submit to judgment and those who judge, the symbolic value of the medical certificate is altered, if not inverted. For asylum seekers and their lawyers, it is an “open sesame”; for officials and judges, it is a piece of evidence among others; and for both it is an innovation in governmentality. Although “refugees embody a visceral human geography of dislocation” and “the involuntary migration of bodies across space is neither passive nor apolitical” (Hyndman 2000:xv), the validation of their accounts by the corporal inscription of their persecution constitutes a new form of transnational administration of peoples. If more medical certificates are requested, it is also because fewer asylum seekers are summoned to testify. Confronted by

the tragic experiences of political violence victims—many of whom find it difficult to put words to the unspeakable (Suárez-Orozco 1990) and to whom the officials of asylum pay less attention (Delouvin 2000)—the institutions providing refugee status only offer the routine of an evaluative procedure of managing migratory flows, in which the physical trace of torture represents the last form of truth telling.

TAKING AN ETHICAL STAND

- Speaker 1: On what grounds are medical certificates justified?
- Speaker 2: We know that it's a form of help that we can give them, isn't it?
- Speaker 1: Yes, but the question is: what value does it have? What we've come to do here is to ask a political question or rather a question on a political stand.
- Speaker 3: Refusing to do certificates is immediately a political position. It's a refusal to be a government office. And anyway we know that it's pointless. Have you ever tried to calculate the number of patients who obtain the status, compared to the number to whom you issue certificates?
- Speaker 4: It's not on those figures that you can judge. But, to answer your question, we haven't calculated.
- Speaker 3: By issuing certificates, we're busy judging who's guilty and who's innocent. What situation are we in? We're neither experts nor jurists.
- Speaker 5: It's not only a matter of no longer doing certificates. That decision has to be accompanied by a political declaration by all the organizations, to denounce the myth of proof and to promote the right to asylum.
- Speaker 6: But you've got to evaluate the risk, if we fail, that the requests from the institutions go to paid experts who will take advantage of it. And we'll probably be seen as extremists, if we're not understood properly.
- Speaker 4: I don't see it as so straightforward. I'm under the impression that the certificate is useful in some cases. That's what the patients tell us, and the lawyers, and the organizations.
- Speaker 3: We'll never have a complete answer. But it's important to take an ethical stand. [Speaker 1, 3, and 5 are from Primo Levi Center; Speaker 2 is from the Center for Rights and Ethics; Speakers 4 and 6 are from Comede; Field notes, November 9, 2002]

This discussion between members of organizations working to help asylum seekers took place on November 9, 2002, near Paris. The members of three of the main French organizations working in the area met to discuss the problem of medical certificates—specifically, to compare and, if possible, to harmonize their positions regarding the mounting pressure from government authorities and asylum seekers and their lawyers for certificates to confirm the validity of applications for asylum.

The Comede coordinator opened the meeting by noting that, although his organization had been founded primarily to provide free health care, the question of whether

to issue certificates had been raised from the very beginning. He also noted the eventuality of a “strike,” or refusal to issue certificates, which his organization had considered doing a few years previously, because of the increase in requests for certificates. The Comede had finally decided against it but laid down rules concerning the criteria and procedures in issuing certificates. Because the waiting period to obtain the precious document was now three months, they sent the client a letter simply stating that he or she would be summoned for a consultation during which the medical assessment would be made. Surprisingly, when presented to the governmental authorities, in particular Ofpra, such a letter without any clinical details was considered as attesting to the organization's support.

The second person to speak at the meeting was both a representative of the Center for Rights and Ethics in Health (*Centre droit et éthique de la santé*) and a medical doctor. He explained how things worked in his institution and the fact that, being specialists in forensic medicine, they had found themselves doing more and more certificates for asylum seekers. In fact, this was the organization's only activity; it did not administer health care. In their practice, the swelling demand for certificates also led to longer waiting periods—around two months for an appointment—so they had decided to see only those applicants who had been refused by Ofpra. Consequently, they had contact exclusively with CRR, for which they agreed to do emergency certificates when necessary. The members of the third organization, the Primo Levi Center, made up mainly of psychologists, then responded by harshly criticizing the practices of the experts in forensic medicine who had preceded them. The Primo Levi Center group felt that those in the medical profession were not there to collaborate with official bodies by providing medical expertise, their mission was to treat people—which is why they had decided to stop doing medical certificates. Likewise, they wanted all the organizations to put up a common front against the government authorities' approach. The argument became heated, and two psychologists stormed out of the meeting to show their disagreement.

The haunting question among all these organizations is whether or not to carry on doing medical certificates. What purpose do they serve and how are the people that issue them used? On the basis of our assessment of the minutes of their meetings, their annual reports over the past 15 years, and our conversations with long-standing members, these organizations have constantly been faced with questions on the effectiveness and signification of these certificates. In a Comede document from 1991 found in their archives, the rapporteur of the “certificates commission” writes: “It is difficult to transcribe the richness of the arguments of each person which in the final analysis provide no clear and simple solution. We note a general uneasiness in the current situation, where no one is satisfied, between a wish to stop everything, a feeling of saturation, dissatisfaction concerning the lack of time now available for writing the report.”¹ An article written during the same period by the

coordinator of this organization explains this uneasiness:

Almost instinctively the government agents and magistrates attach greater importance to the physical effects of torture, when in fact it is part of a programme designed to destructure and depersonalize the individual. The certificate lies in a legal gap. The Ofpra, the administrative body that is supposed to apply the law by asking the applicant to produce a certificate, brings the doctor and the Comede into the picture in a procedure that is neither provided for nor evaluated. While ambiguities are unavoidable, they are also worsened by some of the administration's attitudes. They reflect an infringement of civil rights and contravene the Geneva Convention. [Didier 1992]

Thus, the organizations' recriminations concerning medical certificates are nothing new and neither are the institutional demands. In fact, Ofpra's and CRR's attitudes can be seen as responses to a double bind: the increase in the flow of asylum seekers from the mid-1970s on and, partly as a result, restrictive instructions by the government from the late 1980s on. Because the government had to substantially limit the number of people who obtained refugee status, they also had to find criteria to decide who would be allowed access to this rare resource. In the practices of "local justice" (Elster 1992) that, thus, became a necessity—which had previously not been so when demographic and political pressures were weaker and allowed a generous distribution of refugee status—medical expertise was progressively given precedence over the victim's word.

Even though the organizations are divided as to the best strategy to follow, their analysis of the situation is similar. If we consider their discussions in the documents we found and the interviews they gave us, they identify four main problems.

The first is a political problem. In terms of Article 1, Chapter 1, of the Geneva Convention, a *refugee* is any person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country" (1951). Agreeing on the necessity to provide evidence of marks on the body—which assumes that such marks were made (even though certain forms of violence are not physical) and that they remain visible (despite the fact that torturers find ingenious ways of ensuring that no evidence is left)—considerably reduces the scope of the Geneva Convention. This is underlined by a report of the Comede in 2001: "By replacing the word of the victims, the certificate tends to replace their right" (Comede 2001:3). Admittedly, medical certificates are not required to obtain refugee status, but the value granted to physical marks diminishes the principle of "fear of being persecuted," which, by definition, has no physical translation.

The second problem is an ethical one. A psychologist from the Primo Levi Center recalls: "Once an officer from Ofpra called me: 'If you tell me that this woman was raped, I'll see her.' But why did I have to confirm that she'd been

raped for her to be received?" (Field notes, NGO meeting, November 9, 2002). More generally, by requesting that the doctor certify that the person has been subjected to the treatment they claim to have undergone, more credit is granted to the expert's word than to that of the victim. The certificate of the former, describing symptoms and signs, validates the account of the latter, reporting his or her personal experience. This depreciation of the asylum seeker's word is obviously particularly problematic when the medical doctor has little to say about the facts, as in the case of sexual violence where the physical marks can rapidly fade. Psychological scars then sometimes replace the missing corporeal inscription of the trauma. But in all cases, the experts replace the victims. By trying to help refugees, physicians and psychologists deprive them of their truth.

The third problem is therapeutic. As a Comede doctor explains: "For me, there is a huge problem, and that is certification. Because it alters the therapeutic relationship. I feel like I'm reduced to an instrument. I very often see a person who has medical problems and who asks me for a certificate. Once the certificate is done the relationship is over. It's frustrating" (Field notes, NGO meeting, November 9, 2002). The conflict between expertise and care revolves around the very principle of the "therapeutic relationship": By subordinating clinical activity to medical expertise, the confusion of genres runs counter to its effectiveness and induces a form of instrumentalization of the medical professional.

The fourth problem is of a practical nature. The very effectiveness of the certificate is doubtful, at both an individual and a collective level. On the one hand, contrary to the beliefs of asylum seekers and their lawyers, medical expertise probably has a limited effect on the final decision. "What's the point?" wondered one member of the Primo Levi Center at an NGOs meeting in November 2002. In Ofpra and CRR refusals, they sometimes specify that the certificate was not convincing. On the other hand, clinical expertise, by testifying in certain cases only, implicitly recognizes that others show no evidence, thus admitting that there are degrees of truth, or at least of proof. As one Comede doctor commented, "By doing certificates we're dis-serving the right to asylum. . . . This creates the illusion that the number of false refugees, without certificates, is increasing" (Field notes, NGO meeting, November 9, 2002).

Despite these pleas against the uses and abuses of clinical expertise, it remains that medical certificates still give an asylum seeker an extra chance at asylum and that, therefore, it is unacceptable to turn down someone who is requesting a certificate. It is usually this combination of an uncertain hope and a moral demand that carries the most weight in the decision of whether or not to provide a medical certificate.

Thus, an ethical line divides the involved organizations. For some, irrespective of their disagreement with the way the procedure is developing and the manner in which requests are directed to them, it is not possible to shirk the expert's role. People have the right to ask for a certificate, doctors must respond to those requests, and, in the end, the

certificate may be the additional humane touch that enables a candidate to obtain refugee status. Moreover, if the organizations were to stop issuing certificates, there would be a risk of them being replaced by a body of government experts who might charge more for their services and who might be less personally inclined to help clients. Comede has decided to carry on issuing certificates. So has the Minkowska Center, a mental health service founded in 1951, whose main activity is to provide psychological and psychiatric care. The same applies to the Center for Rights and Ethics in Health, a forensic medicine service in Lyon that has no clinical activity and for which issuing certificates is consequently not a problem. For the other organizations, the refusal to enter into the ambiguities and contradictions of the system of certificates prevails over the assumed benefits. Therefore, to avoid any collaboration in the current procedure, which they would see as a form of complicity, they have made a clear break from the administration and magistrates who use the organizations for issuing certificates. The Primo Levi Center, which was created in 1995 to provide medical and psychological support for victims of torture and gives 3,000 consultations annually, once announced that it would no longer issue certificates.

To use the distinction posed by Max Weber (1959:172), the first position corresponds to an ethics of responsibility and the second to an ethics of conviction. The former judges by predictable facts; the latter relies on a superior doctrine. Of course, the advocates of refusal do not disregard the effects of their decision (or, by contrast, the maintenance of the status quo), but they give precedence to principles over immediate consequences. Likewise, those who agree to issue certificates are not operating without a doctrine (they do participate with the others in the political fight for asylum rights), but they highlight the expected, albeit limited, advantages of doing so. The fact remains, however, that there are two types of relationship between a means and an ends. In one of the positions analyzed here—that of being grounded in an ethics of responsibility, particularly in the case of the Comede—the refusal to certify is considered primarily from the applicants' point of view. In the short term, refugees' probability of obtaining asylum status may be lessened because of the lack of a medical certificate. However, in the long term, their chances may be hurt by the replacement of the activist organizations by new experts reputed to be less militant and, therefore, less favorable toward refugees. In the opposite position, grounded in an ethics of conviction—that of the Primo Levi Center, in particular—this loss of an individual's chances is seen as the price to pay to avoid compromises (collaboration with the authorities in a restrictive asylum policy) and to force the government to take responsibility for its choices (and not leave the experts to carry the burden). One can interpret these positions as a pragmatics of dialogue, on the one hand, and a strategy of rupture, on the other hand. Although all the organizations share the same attitude of "voice"—in the sense that Albert Hirschmann (1970) gives to this form of solution to a frustrating situation—

their political choices are based on different ethical premises.

The options described above correspond to the more or less stable official positions of the different organizations. They describe a state of the public sphere or, more precisely, of the domain that Nikolas Rose (1999:188) qualifies as "ethico-politics," but they do not account exactly for practices. Within each of the organizations, the positions of the doctors and psychologists vary: It was obvious in our interviews with them, in our observation of their consultations, and in our examination of the certificates issued. Furthermore, practices of the organization as such may depart from its official line: Although it took a strong position against the certificates, the Primo Levi Center never completely stopped doing them. Yet, even when members distance themselves from the local norm of their NGO, what is remarkable is the depth of the ethical reflection and discussion in the daily politics of the organizations. There are the emotions and rifts that such contemplations cause in debates (we witnessed some heated discussions, not only in meetings within an organization but also in relations with patients, for example when patients requested medical expertise in a too-insistent manner). Then, too, there are the doubts and difficulties these contemplations produced in the daily practice of each clinician (several of them told us about their hesitation to carry on working in their organization, especially because of the expert role that they were asked to play when all they wanted to do was treat people).

To do or not to do medical certificates: Around this dilemma, everyone, both in conversation and in action, manifests real ethical passion corresponding to the emotional logic peculiar to the management of asylum (Graham 2003). Apart from their dissensions, physicians and psychologists both perceive the gap between the meaning that violent acts can have for the people who were subjected to them and the semantic reduction that the clinical examination affects by describing physical scars. In addition, they recognize the gap between the profound reasons for their own commitment to the refugees' cause that first prompted them to do such work, and the administrative acts of verification that they are expected to perform. As advocates of the right to asylum, they find themselves used for policing bodies.

As Marilyn Strathern notes, "Ethical practices refer to the interests of third parties, which are at once the reason for and lie outside the loop through which professionals demonstrate (to other professionals) their adherence to standards" (2000:292). In the dialogue between the actors from the organizations and the public authorities—a dialogue that is often virtual because the production of reflection and discussion remains limited essentially to the field of the promoters of asylum—it is the refugees that constitute the reference, both as individuals who are being helped to obtain a status and as a collective whose cause is being defended. We can posit that the ethical tensions between the organizations and within each of them are particularly strong because they have so little room to maneuver. In a

sense, the questions of knowing whether to do certificates and whether they are effective are settled outside the space in which they are debated.

At the international level, it was in the EU Dublin Agreements of 1990 that relations of solidarity between states regarding asylum were decided. It was in the Amsterdam Treaty of 1997 that the Europeanization of asylum policies and immigration was instituted. Finally, it was at the Tampere Summit in 1999 that asylum policies and immigration were linked, even though the specificity of each of the two was affirmed (Berger 2000). In parallel, at a national level, the question of defining and implementing restrictive criteria is settled in the instructions given by the government and the administration to its agents to limit the number of people who obtain refugee status, and probably also in those agents' interiorization of a set of common ideas about the exponential growth in the number of asylum seekers, on the absence of validity of many requests, and on the need to put an end to granting the status too generously, none of which is specific of the French situation (Heyman 1998). In these conditions, it is noteworthy that, since 1995, independently of the international situation and the number of applications, the combined rate of successful applications to Ofpra and CRR has remained stable—specifically between 15.6 percent and 19.5 percent, as if an implicit “norm” on the right proportion of “genuine” asylum seekers were now being applied. Hence, the influence of certificates can but be marginal: They “save” a few cases without denting the general economy of asylum. The administrative concept of a “secure country,” or the bureaucratic zeal of certain Ofpra officials or CRR assessors, carries far more weight than the medical certificates with which the organizations torment themselves. However, it is their burden and their duty to testify, through their expertise, to the persecuted persons' truth—through the words they can put on the evidence of their bodies.

BELIEVING IN THE VERACITY OF ALLEGED FACTS

Mr B.'s account of the circumstances of his arrest and torture and his subsequent internment in the N. jail is particularly detailed, coherent and sometimes even tinged with emotion. Yet the clinical examination remains poor. Thoracic pains appear to be related to a post-traumatic chondro-sternal arthritis that cannot be identified by X-ray. The fact that Mr B. has a missing tooth, whereas the rest of his teeth are in a good condition, is very likely to be due to the stated cause. The abdominal scar cannot be related to a precise injury by Mr B., who says that he more or less lost consciousness. On the whole the alleged facts are nevertheless plausible. Certificate handed directly to the interested party.²

How can one write about violence? How can one express the suffering of its victims? To these questions the anthropologist can only answer, as Veena Das (1997) did in the case of Indian women, by talking of the necessity and simultaneously the powerlessness that the anthropologist feels. But for the expert responsible for testifying to the traces of torture on a body, the problem is not ontological; it is technical. It is a matter of mobilizing competence at the

service of a cause. The expert has to describe consequences to validate an account. The preceding excerpt concludes a long medical certificate drawn up by a Comede doctor concerning a man “of Zairian nationality.” They attest to the medical professional's expertise and to the veracity of the applicant's discourse.

The form of this type of document is standardized. It starts with “I, the undersigned,” continues with the person's “statement,” his or her “grievances,” the “examination,” and finally the “conclusions.” In the present case, the statement, in a direct style and in the indicative mood, is rather long: 36 lines. The political circumstances are mentioned: “Mr B. tells us: ‘I was working for the company S. as a storeman when one of the officials asked me to let through propaganda material transported by the air company in the name of Mr V., a Belgian socialist who was supporting the clandestine opposition party, the UDPS. I agreed and I let several through.’ ” The account of the arrest is detailed: “On 30 July 1985, five BCRS agents came to arrest me at my home. I was hit from the moment they arrested me and in the jeep that transported me. When I was kicked in the left cheek I felt that one of my teeth had been touched, it was very painful, I started to bleed, then I realized that the tooth had fallen out.” The physical torture during his internment in the detention camp is then reported:

In the afternoon they came to fetch me and took me to the office to be questioned by one of the commissioners. I told the truth about what had happened and then one of the soldiers slapped me and since I didn't want to answer anymore, they hit me with a rubber truncheon on the head and shoulders. I couldn't stand it anymore, I was stunned. They threatened to kill me. Then they handcuffed me behind my back and took me outside. They threw cold water on me and told me to stay lying there. That's when I saw that I was injured in the stomach. They made me stand up again after an hour, they carried on punching me and telling me to talk. They wanted to force me to carry someone on my back and because I wasn't able to, I was kicked three times in the chest. The third kick knocked me out.³

The grievances listed in the certificate are “the thoracic pains,” “the absence of a tooth,” and “a scar on the abdomen”: They represent the victim's discourse on the sequels of the violence to which he or she was made to submit. Compared to this account, the examination adds very little: “The pain is revived by anterior-posterior pressure on the thorax” but the X-ray “shows no lesion on the bone.” Of course “the absence of the second upper left premolar” is noted, but there are many reasons for losing a tooth. To be sure, there is “a rough horizontal and rectilinear scar” on the abdomen, but it is difficult to ascertain its origin. Hence, the above conclusion attests to a profound conviction attached to the narrative, far more than to a clinical truth read on the body. Unable to ascribe the physical signs with certainty to a violent cause, the author of the certificate mentions the detail, coherence, and even emotion of the account, ending with the statement that “on the whole the alleged facts are nevertheless plausible.” This last

statement, in absence of clinical evidence, amounts more to a profession of faith than anything else.

This medical certificate was drawn up in 1987, the early days of clinical expertise on torture. It belongs to the corpus of two hundred certificates we analyzed. The institutional demand had just emerged and the organizations had not yet established its doctrine. Each of the doctors solicited by asylum seekers or by the government administration responded as best as he or she could, combining the canons of medical certification (standard expressions, careful description, and cautious interpretation) with a sense of the just word (faithful transcription of the account, highlighting of important details, and personal engagement in the conclusion). Yet none of the expert's styles were hampered by general rules. Our analysis of a series of certificates written during this period shows widely diverse styles, as can be expected when people are left to their own devices. However, this "free style" practice belongs to the past.

From the early 1990s, under the pressure of the social and political demand, the Comede has established standards, first synthesized in an internal document in November 1991. The new rule was to "try to be brief and accurate," especially in the account. Whereas certificates were previously one and a half page long, they now consist of only a few lines in an indirect style and with a distant mode, as in the following example from 2002: "This patient of Tamil origin was reportedly arrested in 1996, due to his involvement in aiding the Tigers, and incarcerated. He claims to have been tortured, hit with a bayonet, and burned with cigarettes."⁴ The contrast is striking with the detailed report in which Jonathan Spencer (2000) describes scenes of violence in this civil war through the history of a young Sri Lankan. In the clinical part of the certificate the instruction is to "give precise information on the grievances or observations of the examination."⁵ Everything concerning medical expertise is detailed: "At the root of the left thumb, two scars, one longitudinal, 3cm, and the other oval, related to a cut; on the left upper arm, five round lesions typical of cigarette burns; on the right leg, several scars from knife-wounds."⁶ The following recommendation connects the account to the examination: "Draw a conclusion," it suggests, by trying to "link up the stated facts and the observed sequels" and avoid any mention of "negative elements in the grievances or the examination."⁷ Hence, the author will no longer refer to "a poor clinical examination," or note that "the scar could not be related to a precise injury," thus manifesting honesty that the author may have believed could be effective for the asylum seekers' case—such practices are no longer acceptable. In fact, the concluding remark is coldly standardized: "On the whole, the observations correspond to the patient's statements." By following an established rhetorical structure, the medical certificate, thus redefined in its informative content, takes on a different social meaning.

Reduced to its simplest expression, there are three main reasons for the reduction of the patient's case history: (1) as an effort to avoid redundancy with the patient's own words, which could lose their legitimacy; (2) as an effect of exhaus-

tion related to the number of applications, which leads to a sort of routine established in practice; and (3) as an attempt to adhere to the deontological principle that a doctor should only discuss that to which he or she can attest. Political, practical, and procedural reasons, thus, combine to put the account at a distance from the expertise. This separation is set in a broader movement that can be described as a differentiation of functions and a sharing of roles in the construction of public causes (Sarat and Scheingold 1998). In this case, the defense of asylum seekers takes place primarily on three fronts: (1) the law, through which the public authorities are called to act; (2) the account, which enables people to construct the case history to present to the officials and the assessors; and (3) medical expertise, based on the certification of traces of violence for those same institutions. In individualized support for asylum seekers, the narrative and the body are separated. As Liisa Malkki (1996) notes, with the loss of individual histories, it is the collective dehistoricization of refugees that is set off.

To be sure, the doctor has to link up what the body reveals and what the story tells. However, the doctor operates only on his or her home ground—that of clinical medicine—leaving the biographical reconstruction to specialized agents: lawyers, naturally, but also to such organizations as Cimade (Committee Interorganizations for Displaced Persons [*Comité intermouvements auprès des évacués*]) and Cada (Centers for Asylum Seekers' Accommodation [*Centres d'accueil pour les demandeurs d'asile*]), who have developed this sort of activity. The validity of the doctor's expertise depends on the limitations of his or her competence in the medical field. Giving up the moral sentiment that originally prompted him or her to engage in this activity of "care and support" is the price to pay for the medical certificate to be credible and, therefore, effective. Consequently, doctors no longer talk of "emotion" in the account and no longer claim to "believe" the applicant's words. They examine and describe "observed scars," trying to affirm the probability of a link with the "alleged facts." Finally, they state the compatibility between the two on the basis of the same expert's logic as that of the occupational health specialist who expresses an opinion on an employee's ability to work (Dodier 1993). The militant doctor has been turned into an expert of forensic medicine.

By a sort of inversion of meaning and return to sender, the expertise nevertheless has a function other than the openly announced utilitarian one. Although the medical certificate was originally intended for the Ofpra official or the CRR assessor working on the asylum case, this precious document turns out to be invested with a therapeutic function as well. Drawing up a certificate is a way of recognizing that the person has indeed been a victim of the violent acts to which he or she claims to have been subjected. Not only are the people listened to, they also know that they have been heard. Although, as Michael Pollack (1990:29) notes, all those who have experienced extreme horror are faced with the painful fact of having to "manage the unspeakable," often they are also confronted with the no less painful fact of having to manage the inaudible.

Today, the government administration's ethos regarding asylum is dominated by suspicion. People's case histories are questioned, facts are challenged, and evidence is disqualified. Having convinced the physician or the psychologist is therefore a first step, and possibly a decisive one, in the production of the person's truth. Henceforth, the mark is no longer only on—or in—the body. It is present in a document that has legal value. Whether it reproduces the account or attests to the consequences, the scriptural trace envelopes the fragile words and invisible wounds of the asylum seeker in its legitimacy. Writing has not only the practical, and thereby intellectual, values that Jack Goody (1977) revealed; it also has a symbolic value, and consequently a political one, that can be seen in the medical certificates. In a context of generalized skepticism, the written testimony is the highest form of truth telling. However, obviously, the ultimate recognition of the victims of persecutions and their most efficient therapeutic remains, in the end, obtaining the precious grail: the document asserting their refugee status.

CONCLUSION

No matter how marginal their presence may be in the European world—both quantitatively and qualitatively—the condition of the asylum seekers is crucial to the contemporary human condition. One could even suggest that, if the refugee was the historical subject of the 20th century, as Hannah Arendt (1951) asserts, the asylum seeker might be the anthropological figure of the 21st century. Not so long ago, the refugee represented the individual fleeing violence or oppression from his or her home country and often becoming a stateless person. The asylum seeker now represents the individual in quest of a legal status and often being denied a citizen's identity. This new figure tells us not so much about the wandering of the stranger as about the expectation of the foreigner, "on the verge of politics," in Jacques Rancière's words (1998). This distinction is not only temporal but also geographical—and the Western world here radically differs from the Third World. Whereas Allen Feldman (1994:407) sees an "anonymous corporeality" in the massive displacements on the African continent, whether considered through media representations or in aid policies, the European situation can, by contrast, be conceived in terms of an overindividualized corporeality. Asylum seekers are expected to unveil themselves, to recount their histories, and to exhibit their wounds. The casuistry underlying the supposedly fair processing of applications is itself based on an extreme singularity of situations. Each case is different, we are told, and therefore justifies distinct treatment. Accordingly, it is each biography that is explored, each anatomy that is searched. As in the case of other dominated categories—the poor or the foreign—the government of refugees in French society operates through "a dual process of subjectification and subjection" (Fassin 2004:259)—in other words, of production and submission of the subject whose body is supposed to deliver the "ultimate truth." The

medical certificate, a modest object in asylum policies, is far more than a mere expert's assessment. It is the tenuous thread on which hangs the entire existence—both physical and political—of the asylum seeker.

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NOTES

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