Chapter 5: Local justice in the allocation of medical certificates during French asylum procedures: from protocols to face-to-face interactions

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From protocols to face-to-face interactions

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At the end of World War II, the search for peace was associated with the prevention of genocide and the atrocities that had occurred during the war. Governments were also concerned with solving the problem of Europeans displaced by the conflict. In this context, a consensus was reached on 28 July 1951 over an international refugee protection regime: the United Nations Convention relating to the Status of Refugees was adopted. In France, since borders were closed to labour immigration during the 1970s, asylum seekers have

been increasingly suspected by the state of claiming refugee status illegitimately in order to stay in France. Although during the 1970s, up to 95% of all asylum seekers were granted refugee status, this rate has rapidly declined since the 1980s – dropping to less than 12% at first application in 2013 (25% when taking account the appeals). The procedures to identify eligible candidates have become exacting, and claimants struggle to convince institutions of the veracity of their claims. In this context, a medical certificate, written by a third person – a doctor or a psychologist – which attests to the compatibility between the patient's history and his physical or psychic wounds, has become a fundamental 'piece of evidence'. Thus, during the 1980s, several French medical NGOs, which were originally founded to care for refugees, responded to this increasing need for proof, thereby combining the expert and healing roles (Fassin and d'Halluin 2005).

Originally committed to relieving the suffering of refugees – often exacerbated by the harsh conditions of flight and reception – clinicians were swiftly called upon to give expert medical evidence on individual cases. The original motivation of these doctors in becoming involved in refugee care was overwhelmingly humanitarian and compassionate. It was nonetheless in the name of objective scrutiny that doctors were invited by the state to describe and assess the damage that had been inflicted on asylum seekers in their native country. Doctors were therefore asked to participate in the process of bureaucratic, rather than compassionate recognition. It is therefore important to explore the forms of local justice that emerge when medicine and law meet in the asylum field, and how clinicians try to balance their claims of objectivity with those of ethical commitment.

'Local justice', as coined by Jon Elster (Elster 1992, see also Fox and Swazey 1974), concerns distributive practices ('who gets what, when and how') and principles. The word

'local' refers to the fact that relatively autonomous institutions apply their own variants of a general scheme of distribution. The practices within a given arena in a given country are not as uniform as they could appear at first glance and, thus, ethnography is useful in order to understand the 'conception of justice held by actors who are in a position to influence the selection of specific procedures or criteria to allocate scarce resources' on a local level (Elster 1992: 5). As an analytical concept, 'local justice' was first applied to the medical field (Fox and Swazey 1974[PB1]; Calabresi and Bobbitt 1978[PB2]; Elster 1992). During the 1970s, several researchers questioned the way public institutions were allocating rare resources. The research paid special attention to the social procedures that were established and followed by institutions in order to allocate scarce resources on which the survival of each individual might depend. These were essentially 'tragic choices' – as people's lives were at stake. However, the notions of 'tragic choices' and 'local justice' can be applied in other areas. In France, such studies have been recently developed to understand how financial support is granted to poor populations at a local level (Ogien 1999; Fassin 2001a).

In regard to asylum seekers, the *Office Français de Protection des Réfugiés et des Apatrides* (OFPRA) and the *Cour National du Droit d'Asile* (CNDA) are the principal sites where such 'tragic choices' take place. Those applicants whose application for refugee status has been denied can be deported. Most of the time, they are effectively forced to live in an irregular manner, trying to escape deportation. Most research (Good 2006; Rousseau et al. 2002; Kälin 1986; Fassin and Kobelinsky 2012) has been conducted in northern democracies in order to explore the dilemmas faced by judges in deciding to grant or deny refugee status. However, to understand the asylum process, it is also important to

understand the various stages before the final interaction between asylum seekers and judges. In this process, the services of legal and medical NGOs play an important role, providing a scarce resource. With limited financial and human resources, they are unable to provide legal advice or deliver a medical certificate to all claimants. As a result, these institutions have established rules to decide who, and under which conditions, will benefit from their services.

These 'local justice' procedures were observed during research that I conducted between 2001 and 2006 with Professor Didier Fassin. We completed interviews with 20 medical doctors, psychiatrists and psychologists in the four principal NGOs working in this domain in the early 2000s: the Françoise Minkowska Center, the Comede or Medical Committee for the Exiled (Comede), the Avre or Association for the Victims of Repression in Exile and the Primo Levi Center. We also consulted the websites of these organisations, the journals they publish and the annual reports they produce. Finally, in order to account for the everyday management of asylum, long-term participant observation was conducted for two years within two organisations: one specialised in medical care (Comede) and the other in juridical assistance (Cimede). In Comede, I attended staff meetings and consultations. They also granted me access to their archives. Interviews were also conducted with the bureaucrats and judges in charge of granting refugee status. Although our research was limited to France, the exchanges and discussions we had with members of other NGOs within the European Network of Treatment and Rehabilitation Centers for Victims of Torture indicate that the problems and dilemmas we analyse in France are part of a much wider European context, with similar legal and institutional constraints, but with somewhat diverse political and moral debates and responses.

This chapter will focus on the way medical certificates are allocated by physicians to asylum seekers in France, a process that cannot be reduced to a straightforward medical act. The chapter will explore how NGOs attempted to produce various forms of justice, how their criteria were legitimised and how members of this NGO moved away from the norms established during regular face-to-face interactions. On one level, the chapter will provide a fine-grained understanding of the production of social inequality in the asylum process, through highlighting the role of the clinicians as gatekeepers, prior to the evaluative process conducted by administrative officers and judges. On another level, the chapter will demonstrate how clinicians can be torn between attempting to get close to the refugee's experience, often with compassion and empathy, and having to produce a formal, technical and objective report, emotionless and detached. First, though, the chapter will explain how and why medical certificates have become so important for a range of actors involved in the asylum process. Second, the chapter will examine various protocols established in the NGO sector to allocate medical certificates. Finally, the chapter will show how face-to-face interactions challenge formally established rules.

Negotiating the allocation of a medical certificate

In February 2004, in a suburb of Paris, inside a room of Comede, a medical NGO, I attended consultations, sitting next to a GP, Dr Laurence (Dr). A Sri Lankan patient (P) entered the room with a translator (T). Dr Laurence introduced me, and the patient authorised my observing of the consultation. The GP asked the patient the reason why he had come to the medical centre. It was to have a medical certificate that he could send to the OFPRA. But it

appeared that the patient had missed, without notice, an appointment to be examined and have his medical certificate established. He rummaged in his pockets and brought out a medical certificate justifying his absence.

P: …

T: He was sick

Dr (having a sullen face, with an irritated tone of voice): I don't need proof … I'm not happy, I'm not happy, I'm not happy because he didn't come. It meant that someone else who needed such a certificate could not have it that day. I won't give him another appointment. Anyway, he can have a certificate written by another GP downtown.

T: Can any GP provide it?

DR: Yes, any … you know, if I had known it was him, I would have never let him in my office. Last time, he insisted on having a certificate. Realising that I was weary of fighting, I agreed to see him …, gave him "the orange form" and he didn't come! I'm going to write a reference letter for a colleague so that he will have his foot examined.

The patient keeps a low profile, having round shoulders…

… You know, he just has one scar on his thigh and he doesn't want to understand that such a certificate would harm his case. [She emphasised the word "one"]

P: …

T: The OFPRA has just summoned him for interview.

DR: Well. He will tell his story, this is the most important thing. He has a tiny scar. He should have the foot examined. I did not find anything, neither concerning his foot, nor concerning his knee. …

Dr Laurence moved towards the patient.

… He should have come the day of his appointment. I'm not pleased. … (The other day) he was exasperating me so much.

She imitates the patient during the previous consultation:

"Please, Please", he went almost down on his knees … So, he doesn't care … I'm so displeased.

The talking continued, full of reproaches, until the translator was called upon by another GP in the medical centre. The conversation ended with some explanation in English about how to go to the medical X-ray centre. One more time, Dr Laurence insisted on the high importance of talking to OFPRA rather than presenting a 'risky' medical attestation. The patient went out and Dr Laurence turned back to me: 'I have nothing to say. He was beaten in the street; he was beaten with a stick. From the OFPRA's point of view, it is a bad claim … a tiny scar for someone beaten up … even if I would not have measured it (the scar).'

During my fieldwork in this NGO, I never saw such a scene recur. Everything during that consultation was unusual: Dr Laurence's irritated tone of voice, her flood of reproaches addressed to the patient for missing his appointment, regrets about her previous decision to grant a certificate to attest to a tiny scar. Usually, in this medical centre, medical expertise follows a two-step procedure. If a patient asks for medical certification about marks of violence during a medical consultation, the GP examines the patient's body to determine whether there is 'material or not' for such a certificate. If so, a document is issued – the 'orange form' – on which the agreement of the GP, the date of the appointment and also the date when the typed out certification will be available are mentioned. During a second consultation, entirely devoted to medical expertise, the GP undertakes an in depth examination, listens to the patient's story of violence, and writes the report.

This is the consultation that the Sri Lankan patient missed, causing Dr Laurence to lose her temper. Perhaps even more than the consultations during which GPs decide whether or not to grant a medical certificate, this scene shows the emotional strain associated with daily allocation decisions. Dr Laurence reminds the patient of his insistent request, how he begged her to provide him with a medical certificate. The patient's insistence, an expression of worry about the outcome of his asylum case, invites us to ask how medical certificates have become so important in a context of increasing selectivity of asylum grants. The medical certificate is considered a precious good, a rare resource, hence this reproach addressed by Dr Laurence: 'I'm not happy because he didn't come. It meant that someone else who needed such a certificate could not have it that day'. Dr Laurence imitated angrily the attitude of the patient during the previous consultation. In doing so,

she expressed the exasperation I observed at that time among medical staff at Comede. Most of the time, GPs expressed their annoyance around a cup of coffee, in the corridor or during staff meetings, seldom in front of the patient. Discontent with the growing demand for medical expertise can be explained through ethical, political and practical issues analysed elsewhere (Fassin and d'Halluin 2005)[1] and by the decrease in therapeutic work it implies. Finally, the scene observed puts into question principles, which had been established in the medical centre, since Dr Laurence reconsidered her previous decision, feeling she departed from Comede's principles of allocation and was 'screwed' by the patient. After recalling the increasing, but shifting, value of medical certificates in the asylum process, we need to ask: what are the principles established by medical centres in deciding whether and how to grant medical certificates to asylum seekers? How were they established? Are they based exclusively on clinical principles or does the political culture of the NGO sector influence them? And how can we explain that once these principles are established, GPs seem to be moving away from them during face-to-face interactions?

[1] First, the value granted to physical marks diminishes the Geneva Convention principle of 'fear of being persecuted', which, by definition, has no physical translation. Second, with certificates, more credit is granted to the expert's word than to that of the victim. The experts deprive refugees of their voice, of their truth. Finally, therapeutic aspects are often overshadowed by medicolegal ones and recounting violence may produce retraumatisation, especially when hurried by a fast-track procedure.

The shifting value of medical certificates in the asylum process

In the past decades, the body has become a legal resource for asylum seekers, and more broadly for undocumented migrants. As Liisa Malkki noted in East African refugee camps, sometimes, scars that can be seen are placed above words that are spoken by refugees (Malkki, 1996: 384). When there is suspicion about an applicant's story, the pain marked on their bodies, certified by a member of the medical profession, seems more difficult to deny. How though has the value of medical certificates been defined in the French asylum process? First, the increasing value granted to medical certificates in the French asylum process is linked to the broader global immigration policy. Second, the value of medical certificates is not uniform across those people who decide on whether or not to grant refugee status. Finally, considering the high value placed in certain types of medical certificates produced by medical NGOs specialised in medical care for exiled people, there are important questions about how asylum seekers gain access to these organisations.

The enforcing of asylum rights in France depends on the specific political, economic and social contexts, even if international refugee law (such as the Geneva Convention and recent European legislation) is formally binding and universal. During the interwar period, when nation-state building and authoritarianism forced numerous refugees to flee, if one wanted to benefit from refugee status, it was sufficient to belong to a community that was recognised as persecuted (Armenians from Turkey, etc.). After World War II, the 1951 Geneva Conventions established universal protection. But these did not challenge state sovereignty, which left nation-states the power to organise the recognition and protection

of specific refugees. Most European states created individualised procedures, which became more demanding after the economic crises of the late twentieth century made foreigners more 'undesirable'. Widely ratified by western European countries, these conventions were applied liberally until the 1980s. Factors such as post-war reconstruction and economic growth, as well as the logic of the Cold War, favoured the reception of refugees, as their number was steadily decreasing. Yet asylum gradually lost its legitimacy in Europe, as economic and social conditions deteriorated. The rise in unemployment and xenophobia led the French government to restrict the immigration of a labour force. Paradoxically, at that time, NGO mobilisation facilitated access to certain basic social rights for immigrants. Since 1975, the French state has delegated and given funds to a network of NGOs that shelter asylum seekers (Massé 1996). At the same time, the number of demands for asylum in Europe has grown, and a discourse that criminalises them has developed. Thus, starting in the late 1980s, the reception of refugees was gradually subordinated to a logic of controlling migratory flows, and policies designed to limit the flow of those requesting asylum were put in place at the national and European levels: surveillance at borders in detention centres, limitation of the expansion and access to shelters, removal of work permits, removal of French language courses and a fast-track procedure. In this process, the French government has been increasingly selective in granting refugee status (Legoux 1995).

If governmental policy thus shapes refugee law enforcement, lower-level decision-makers' activity should also be considered (Anker 1990). Through their daily evaluation practices, what standards do civil agents and judges elaborate and apply? By all accounts, asylum seekers' case histories and interviews remain the major element on which the

decision, 'the final verdict', is based. However, a thicker description should be made of rules not created by formal regulation (Gilboy 1991). Anthropologists have carried out interviews with bureaucrats and observed court hearings (Good 2006; Rousseau et al. 2002; Blériot 2003; Kälin 1986; Fassin and Kobelinsky 2012). However, there are relatively few studies based on long-term fieldwork in the bureaucracy, enabling one to observe the whole process, including the training, informal discussions, investigation, deliberation and the interventions of bureaucratic hierarchies. Without such access during the fieldwork upon which this chapter is based, we interviewed members of the French institutions in charge of granting refugee status. In relation to medical evaluation, certificates were viewed differently from one judge to another. They could be 'one clue among others' or, for certain judges, 'what attracts attention' or 'overcomes all remaining doubt'. For others, it was absolutely convincing. Such attitudes explain why, over the past 20 years, the demand for certification has increased, not only in France, but in most European (Berlin Institut for Comparative Social Research 2006) and North American countries. In a legal and administrative framework in which institutions call into question the truth of the words that asylum seekers produce, the body becomes the site where the subject's truth is tested – or, rather, the site where it is tested by a third party, the doctor, who is supposed to be neutral and knowledgeable (Fassin and d'Halluin 2005).

The writing of medical certificates does not follow a formal, written legal procedure in France. This is why practices are so heterogeneous: some healthcare providers decide that they have to deliver what they are asked for, others decide that they do not have to answer an informal demand, and, if so, can do so on their own terms. Some doctors are trained to produce medical certificates, others are not. Some doctors have a broad

knowledge of refugee populations and their experiences, others do not. GPs can indifferently produce an evaluation of physical and psychic wounds, precisely because there is a certain degree of informality; there are no court-appointed experts, even if CNDA is entitled to do it. And yet, this does not mean that each evaluation has the same credibility with decision-makers. To understand the practices of medical evaluation, we need to focus on the medical NGO sector.

Legal anthropology has taught us precisely how to examine how legal cases and discourses can be reproduced outside formal legal institutions (Felstiner and Sarat 1991). In relation to the asylum process in France, medical and legal NGOs constitute two kinds of sites where legal evidence is 'produced' and where asylum seekers are socialised into the formal and informal standards applied by bureaucrats. Multisite observation is important not only because legal institutions are mobilising various kinds of expertise, but also because social movements defending asylum seekers turn to this expertise in order to support their claims as well. In Foucauldian terms, if knowledge can be used as a technology for disciplining or governing a population (Ewijk and Grifhorst 1998), it can also be subverted by subjects to contest the ways they are governed. Legal strategies of subversion are probably the most studied (Coutin 1998; Harvey 2000; Marek 2001; Israel 2001). Nonetheless, medical expertise, anthropological expertise (Good 2006) or 'asylum-seeker narrative expertise' (d'Halluin 2008; Franguiadakis et al. 2004; Barsky 2000) are important elements of refugee law enforcement, partly shaping inequalities in access to refugee protection. As a result, refugee claimants turn 'freely' – influenced by their social network – to the medical associations for help. These medical NGOs have rapidly acquired credibility in the eyes of OFPRA and CNDA – as a result, their services are increasingly in

high demand. In turn, their members have had to redefine the division of labour in the institution, and to formulate ethical and practical principles with respect to their role (Hughes 1956) and humanitarian convictions.

Based on faith or on medical gaze? The different procedures for allocating certificates

Do we have to write a certificate when asked for it (to adopt an activist stand or a merely medical one)? Has a GP, at Comede or any other institution, the right to decline the patient's request for medical expertise? What standards should we set to define who is entitled to a medical certificate and who is not? How should we answer lawyers who have increasingly appealed to us because they are under pressure due to the acceleration of the asylum procedure?[2]

These four questions were raised in a Comede staff meeting report in the late 1990s. At that time, asylum requests had increased in France (from 34352 in 1988 to 54813 in 1990) and the French government took measures to reduce delay when preparing an asylum case for judgement. In this context, GPs faced an increasing demand for medical certification and decided to organise several staff meetings to discuss the ethical, political and practical stands they should adopt. First, they had to decide whether or not they had the right to decline a patient's request for a medical certification. Article 76 in the Code of medical ethics of France specifies the obligation to deliver a medical certificate prescribed

[2] Comede, 'Eléments sur la question des certificats après la journée d'équipe du 6.10.1990, le CA du 18. 10. 1990 et le staff médical du 22.10.1990', 18 October 1990, archive, p. 11.

by laws or regulations. Thirteen years later, Comede made a clear-cut answer to this question in its guidebook: 'A doctor can always refuse to deliver a certificate which has not been prescribed by regulation'. Although some regulations enable the National Asylum Appeal Court to ask for formal medical expertise, these have never been implemented. As a result, Comede's medical practitioners consider that they do not have to answer unconditionally an informal request. But in doing so, they have to answer precisely the third question: 'What standards should we set to define who is entitled to a medical certificate and who is not?' Even if during an interview in 2002 the director of the medical centre stated that 'medical certification is based on a special relationship between a doctor and his patient, a matter of personal ethic', there are few rules which guide their allocation in the centre.

The principles followed by GPs for granting medical certificates in medical centres are sometimes described in guidelines. At other times, guidelines are more informal and can be only be understood by interviewing medical practitioners about their actual practices. Different kinds of procedures seem to exist across the medical NGOs sector. In *Local Justice*, Jon Elster (1992) identifies the distributive criteria and mechanisms, including lotteries, queuing, need, effort, merit, efficiency or some combination of these, which govern the distribution of justice in practice. Similar criteria are also used by NGO actors to decide whether or not an asylum seeker will be helped, or at least, to define the highest priority. Here we will present three different procedures and their justifications: one is mainly based on the medical gaze. In contrast, the second is based on faith. In between is Comede's procedure which associates moral consideration with its medical criteria.

A purely medical gaze

The first model of allocation is based on the clinical apprehension of asylum seekers. The activity of a centre located in the second French metropolis, Lyon, for example, corresponds to this model. During a 2002 meeting, gathering three associations to discuss medical certificates in the asylum process, Dr Martin presented the activity of his centre:

> Our centre does not give medical care to asylum seekers. A forensic expert founded it twenty years ago. At the beginning, the centre was designed to solve medical disputes and to be a space for ethical debate. Over the last years, it has been faced with increasing requests from asylum seekers for a medical certificate. At the present time, all the appointments are booked for the next two months. So, we choose to provide medical certificates only for the asylum seekers rejected by OFPRA and going to appeal to Court. … We see people for one hour and a half on average. … Our practice is as close as possible to forensic expertise. We review some of the key events, kinds of torture endured and their dates. We register what the patient is complaining about and the psychological aspects. We pay attention to post traumatic stress disorder. We make a global exam and report it. We measure and describe scars. We mention if it is compatible or not with the allegation. … Finally, we conclude briefly about the compatibility of the whole elements.

In this centre, every asylum seeker should be provided with a detailed medical certificate, and they try to treat them on an equal basis by introducing the principle of queuing (the first arrived is the first examined). However, facing a huge demand, another criterion has been introduced based on need: medical certificates will be delivered to asylum seekers at the appeal stage, because it is their last chance, and so any document could be crucial. In this model, every clinical fact should be mentioned, and their consistency with the patient's account assessed.

Medical practitioners who refer to this model are the most often supporting the strict application of the UN-backed Istanbul Protocol for the documentation of torture, even if lack of time impedes them in practice from doing so. Any kind of sign of violence (e.g. shrapnel, shard) which could be identified by advanced technologies (such as medical imaging) should be examined, reported, evaluated and related to the patient's story. To identify and bring to light the harms experienced by asylum seekers, clinicians tends to favour the kind of 'mechanical objectivity' which Lorraine Daston (1995) described for scientists in the nineteenth century. Mechanical objectivity battles to suppress 'the universal human propensity to judge' or 'interpret' when collecting observation. In this model, it doesn't matter how a piece of information reported in the medical certificate could be misused by agents in charge of granting refugee status (e.g. pointing that some scars are not consistent with the patient's story, or consistent with other causes, may be interpreted by the agent as a lack of evidence). Every clinical fact, such as a 'tiny scar' or a pathology without any link to the asylum case, are mentioned. Sometimes, doctors who follow this model are just unaware that some decision-makers in charge of granting refugee status, over- or misinterpret their conclusions. Doctors do not necessarily follow an unshakeable belief in a division of labour between a medical profession in charge of a detailed clinical examination and reporting on the patient's body, and a judicial system in charge of evaluation and final decision about the asylum case, as if medical discourse was obvious, transparent and its conditions of reception neutral. Such a view prevailing in the social world (Dumoulin 2007) was seldom promoted in centres exclusively dedicated to expertise. During the meeting mentioned above, Dr Martin easily took another perspective, once he was warned that mentioning the patient's seropositivity could harm his asylum

case. More specifically, he moved to the second model of local justice, which is promoted in the Comede Guidebook.

A clinical gaze tempered with political and moral considerations

In the different versions of the Comede Guidebook, three pages are dedicated to medical expertise in the French asylum procedure. Designed for social and healthcare providers, the Guidebook recommends 'a preliminary assessment of the request' and warns doctors against requests that do not directly come from patients, but from a third person – e.g. a solicitor, a judge or a social worker (Comede 2003: 173).[3] Here we see the figure of the doctor who is aware of power relations in which they are caught up. Since the late 1960s, criticism about medical power (Illich 1966) and social control exerted on patients has had feedback effects on the medical field. For doctors caring for people on the fringes of society a healthcare provider working for a selective or punitive administration has become increasingly objectionable. More often than not, patients made the request for medical certificates on their own, as they feared their application for asylum would be rejected without one. During the medical consultations observed as part of this research, all requests were made by patients themselves, even if a third person had influenced them. As Gerard Noiriel has noted (Noiriel 1999: 312), in state-led identification procedures, 'it is

[3] During an interview conducted in 2002, the medical staff coordinator explained to me how reluctant he was to deliver a certificate when it was not an initiative from his patient: 'when a solicitor uses a patient in order to have a thicker file, a priori, I will be less welcoming than when the patient comes spontaneously'.

the individual who calls on requirements which powerful political institutions inflict on him'. Aware of the phenomenon, the authors of the Guidebook highlight the risks of potential distress caused by a refusal to provide a medical certificate when a patient has made the request his own (Comede 2003: 173). The Guidebook also states that the veracity of patients' allegations was not a relevant criterion in distinguishing whether patients deserve a certificate or not. A document from the archive of Comede, reads 'Medical practitioners do not have to give an opinion on veracity of patients' story, which is the role of institutions in charge of granting refugee status'.[4] For the Guidebook, clinical facts make the difference. Trauma, whether physical or psychic, is the criterion to grant a medical certificate.[5] This principle of allocation plays a part in the credibility that Comede has gained inside the institutions in charge of granting refugee status.

Nevertheless, clinical considerations may be tempered by ethical and political considerations. In Comede's archive, I found a note written in 1999, which set the following rule (included afterwards in the Guidebook):

> Medical practitioners should answer the patient's request provided time and communication enable it, and on condition that medical expertise will not harm the patient. … e.g. providing a patient with a medical certificate which mentions seropositivity may cause damage to the patient, since his request can be mistaken with a request for regularization on medical and humanitarian grounds.

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[4] Comede, 'Mise à jour des propositions. Principes de la certification médico-psychologique destinée à la demande d'asile', archive, late 1999.

[5] GPs are not supposed to evaluate this psychic trauma, but to rely on an account written by a psychologist or a psychiatrist following the patient.

Here, there are two ways to interpret 'harm'. What is at stake is either the psychological risk of the patient's retraumatisation if a certificate is produced without enough time and consideration, or the 'administrative' risk of rejection if the medical certificate is written without taking into account the perceptions of the decision-maker in charge of granting refugee status.

So one reason to refuse to produce a certificate or not is 'therapeutic' risk. Since the 1990s, research has been conducted on anxiety created by an ever more restrictive asylum policy, pointing to the risks of retraumatisation of asylum seekers (Silove et al. 1993; Watters 2000). The 'first, do not harm' principle is placed under strain, as the time for submitting an asylum request – and so too for obtaining a medical certificate – has been reduced. For some medical practitioners, an inquisitive mode of expertise, aiming to extract some facts about traumatic events in order to assess compatibility with physical and psychological evidence, is a far cry from the rehabilitation process, which is often a slow and tortuous progression in the labyrinth of the psychic reality.

In October 2002, during a staff meeting about trauma in Comede, the problem of medical certification was promptly tackled. One GP underlined the importance of silence and the painful expression of stories during the medical expert consultation. Another added: 'We feel intrusive. We have to know the details and it's very hard to elicit them. We are nearly acting like a perpetrator, even if you feel you can help. They don't want to tell their story in detail.' A similar concern had already been raised in the first reflection paper produced by the medical NGOs. In 1992, we could read: 'In his haste, the doctor takes the risk of reproducing a "police" interrogation that reactivates the victim's suffering.' (Didier 1992[PB3]).

A second reason for declining a certificate is a political one. Comede's doctors are of the opinion that they have to anticipate how their products will be used, and give maximum opportunities to their patients to obtain refugee status. As a result, they set rules that enable doctors to refuse to provide patients with a medical certificate which could be harmful for their asylum case. Such 'harmful' certificates could, for example, be considered as 'poor' by a judge, as Dr Laurence anticipated in the scene described at the start of this chapter.[6] Mere clinical analysis of the case is in tension with a political judgement based on several years' experience of the institutions in charge of granting refugee status, and with doctors' concern about the administrative situation – and thus the living conditions affecting health – of a patient. As Nicolas Dodier (1993: 44) underlined, medical experts not only examine cases, they also establish connections between cases. Here, in Jon Elster's (1992) terms, a criterion of efficiency is introduced in the process of allocating a medical certificate: looking to the future, rare resources are allocated as a priority to the one who will use it best.

The example about seropositivity, quoted in the note above, can be understood with regards to changes that occurred in the 1990s in the French administration of foreigners:

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[6] At the end of the consultation, the debriefing by Dr Laurence was 'I have nothing to tell. He was beaten in the street; he was beaten with a stick. From the OFPRA point of view, it is the kind of bad attestation … a tiny scar for someone beaten up … even if I would not have it measured (the scar)'. However, Dr Laurence, during an interview explained to me that there 'very tiny scars can hide terrifying stories'. But here, because she took into account conditions of reception of her medical certificate, she wished she had not accepted to provide the patient with a certificate about a tiny scar. She had worked in Comede for ten years and anticipated the judgement of the OFPRA's agent: this kind of certificate would discredit allegations of being brutally assaulted because they may think that more marks would remain.

the growing suspicion toward asylum seekers was concomitant with recognition of a (limited) right of residence for foreigners suffering from a serious disease (Fassin 2001b).[7] At the beginning of the 1980s, Comede's GPs drew up an exhaustive report about patients' health conditions (all diseases were recorded). But now, Comede's doctors have interiorised norms of judgement activated by judges: some judges may come to the opinion that 'migration was motivated by medical reasons' (Comede 2003: 172) when they read in a medical certificate that an asylum seeker suffers from a serious disease. An instruction was made by the GP coordinator at Comede not to mix genres of asylum and humanitarian reports. This instruction was grounded in a political stand: to resist the delegitimisation of asylum, when humanitarian protection turns out to be problematic.

Moral considerations are also mixed with political ones. During a staff meeting in 2004, the GP coordinator underlined that a medical certificate should not be delivered when the patient's scar is visible at first sight. He reminds the audience that it is appropriate to write a certificate when the patient has a scar on his belly, or his back, so that he does not have to expose it in front of the judges. Here, medical certificates are less granted to attest a degree of compatibility between scars and allegations, but to prevent the patient from having to expose himself, especially during public audience. This principle established by Comede sheds light on current socially sanctioned approaches to the

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[7] According to the 1998 Law, an applicant must be suffering from a serious medical condition for which no adequate treatment is accessible in the country of origin, which would entail a real risk to his life or physical well-being or a real risk of inhuman or degrading treatment owing to the lack of adequate treatment. The permit granted is revised every year. To limit this right, a recent reform (2011) put the word 'available' instead of 'accessible'.

assaulted and tortured body. Changes in an affective economy, grounded in the civilising process described by Norbert Elias (2000), not only make the sight of torture (Foucault 1995) unbearable, but they also stigmatise exhibition in public space of any intimate sign of violence. The current norm is to have the marks of violence exposed through the discourse of a medical professional, who reports his examination in the doctor's office where privacy is guaranteed. Moral considerations are thus entangled with political and medical ones.

What is the procedure for the allocation of medical certificates, once patients turn out to meet the criteria presented above? At the time of writing this chapter, Comede's staff set great value upon equal treatment, and have introduced the principle of queuing. Fifteen years previously, this was not the case. Priority was given to their regular clients, and a sharp debate occurred in order to reform this rule and 'set every client on an equal footing', as the GP coordinator put it during an interview.

Deserving patient

In some medical centres, an opposite model of allocating certificates prevailed. Medical certificates were not delivered on the basis of clinical signs, but on the basis of the doctor's belief in the asylum seeker's story. In an NGO specialised in care for victims of torture, the director explained to me that he only provided his regular clients with a medical certificate and only if 'he was convinced of the veracity of their speech':

> We cannot attest torture on the basis of scars. Somebody who was dragged in a cell, who had his knees burnt and somebody who fell from his bicycle in the street, it will be the same scars. So it is

> impossible to attest to these scars … except for people who have marks from an iron. Then, even clumsy, even an ironer, could not have marks like that … So, to write a medical certificate, we have to be convinced that there is a real pain, etc. Otherwise, we say no to people, without any problem. … We usually deliver certificates in the long run. (Interview with the director of a medical centre for the victims of torture, Paris, 2002)

In this vein, we can quote the conclusion of a certificate delivered by another GP at the same NGO, which I read at Comede, when a patient went there for some advice: 'I'm intimately convinced about his experience of ill-treatment and suffering.' Basing their opinion on the patient's 'experience', these doctors put their intimate conviction forward in a manner very similar to the agents in charge of granting refugee status. As the latter make their judgement on the basis of investigation and hearing, the former base their opinion on the patient–doctor relationship built up during several consultations. Empathy is valued, and the GP does not attempt to shift from empathetic proximity to seemingly objective distance. In contrast to the two previous models, this model of justice is one exclusively based on a 'clinical gaze on the story', refusing, with a few exceptions, forensic techniques and any judgement about consistency between scars and account. GPs who adopt this point of view often claim skills for psychotherapy, sometimes due to their long experience with refugees, but without training in this field.

The history of Comede shows how an organisation can slide from one model to another. In 1991, patients received differential treatment according to the doctor's assessment of their story. Some patients were provided with a typed and more detailed

medical certificate, others a more concise handwritten report (less valued by the institutions in charge of granting refugee status). Lack of time and the overload of the secretary were invoked to explain unequal treatment received by asylum seekers. But a note from the archived files underlined 'among criteria to provide a handwritten certificate' 'disbelief of the doctor toward his patient's account' and the fact that 'most of the handwritten certificates are delivered not to say no to patients'.[8] Entangled with use of forensic techniques, judgements about credibility were also important. Comede put an end to this differential treatment during the 1990s, coming to the conclusion that it was not their role to assess the patient's account, which was a very risky exercise, considering the lack of solid grounds upon which to base their judgement. This example shows how individuals, and even groups, can move from one model in the context of practical, political and moral about their consequences.

'Tired of fighting…' beyond the principles

Beyond models, the scenes described above invite us to question how individuals might move away from their guiding principles during face-to-face interactions. At the time of writing, there is a broad consensus among Comede's staff on the rules established to allocate medical certificates to asylum seekers. GPs seldom break the rules despite the lack of monitoring.[9] Nevertheless, during my fieldwork, a few 'transgressions' occurred. A note,

[8] Comede, 'Remarques – analyse des données. Certificats de mars – avril 1991', internal records, Kremlin-Bicêtre, 4 September 1991, p. 2

[9] From time to time, a monitoring group is created to assess the medical certificates provided in order to improve standards, but never on a regular basis to supervise the doctors' daily practices.

dated 2001, found in Comede's archive demonstrates the relatively frequent occurrence of such transgressions, warning staff that: 'without clinical facts supporting the account of the patient, the certificate is nothing but medical'. In January 2004, in an informal conversation with Dr Laurence, she talked to me about the nature of medical expertise. She shared her regrets about the end of a time when they wrote more detailed medical certificates, but also insisted on how hard and time-consuming this was. Afterwards, she started to criticise the kind of medical certificates provided by two GPs, both recently recruited: 'They give them too easily'. She was blaming the first GP for providing a patient with a medical certificate about back pains, and the second one for giving his agreement to write a certificate for a patient on the basis of his allegation alone, without any examination. In relation to back pains, the issued certificate was only based on the patient's claim of suffering, without any clinical signs. Providing a medical certificate for a patient with back pains is simply reproducing their verbal account.[10] The second GP she blamed agreed to provide a certificate to a patient who said he was tortured (nails pulled out, testicles beaten). One month later, I was in Dr Laurence's office when she saw this particular patient. He was from Sri Lanka, 50 years old, and did not speak either French or English. She examined the patient and noticed there were no marks on his nails. Willing to fill the medical report with clinical facts, 'to have something coherent', she had ordered a scan of his testicles. While we were waiting for the translator, she explained that the previous time, the doctor had let things get on top of him: 'Nothing surprising, with ten cases per half-a-

[redacted] It would be different if it was part of an overall clinical picture which included other clinical facts.

day's work, it's a production line!' He agreed without examining the patient, but the latter 'had just a tiny scar on his hand, that's all'.

How can one explain that doctor's move away from the institution's set of criteria, providing certificates when they should not? How can one understand that 'things get on top of one'? One possible answer to the question is given by Dr Laurence: ten cases per half-a-day's work is a high work rate for consultations during which different types of questions are dealt with, often not without time-consuming communication difficulties: health problems, access to social security, recalling of past experience, complaining about living conditions in France, anxiety about administrative case issues. For new doctors, time is necessary to learn about the large range of topics involved in the health of refugees. Furthermore, during face-to-face interactions, doctors find it difficult to turn down the request of a patient who has invested his hopes into a medical certificate. Some of the documents archived as far back as in 1990 mention how difficult it was to refuse a patient's request and underlined all the know-how necessary to explain why this has been done, so that patients do not consider themselves victims of injustice.[11] More recently, during an interview, Dr Abu Jalah still remembers that, 13 years ago, at the beginning of her work in Comede, she 'backed down' and provided an asylum seeker 'begging her' with a medical certificate about one scar related to 'what happened in prison'. Yet, she was more convinced that it was a scar due to varicella or something dermatological, rather than due to ill-treatment. Not to feel overburdened, she quickly wrote a medical certificate where her doubt filtered through. It was easier than 'arguing during half an hour and trying to

[11] Comede, 'Si le Comede décide de ne plus faire de certificat, conséquences pour le patient', no date. Late 1990 considering a reference to a journal article.

convince him that it was useless'. In so doing, she departed from her usual caution. As Everett C. Hughes (1996: 85) remarked, such tensions characterise service jobs, which on a daily and routine basis deal with problems which are vital and urgent for their clients.

There were other deviations from the norm at Comede. At Comede, a rule specifies that GPs should not certify the psychic sequelae of violence which were claimed by the patient during the first visit. Instead, the GP should refer the patient for therapy with a psychologist. If the patient is reluctant to do so, GPs may follow the psychological state of the patient. Comede had decided to exempt psychologists from the role of medical experts. However, psychologists can nonetheless add elements to the file of their patient. GPs are told to certify only psychological elements if the patient has consulted with them on a regular basis. During first examination, contrary to what can be observed in other countries, none of the scales available to evaluate post traumatic syndromes are used (Newman et al. 1996[PB4]). No systematic investigation is conducted to find what, in other countries, constitutes an objective, albeit psychological, trace of violence. Despite the rule, I observed several doctors introducing considerations about the patient's mental condition, even if they were seeing him for the first time. Every time, it was with a patient who had important physical effects of violence. According to the GP coordinator, psychological symptoms should be mentioned in the section of the certificate headed 'Claim of the patient'. However, I often observed psychological symptoms written alongside clinical facts reported after examination. Compassion experienced during face-to-face interactions might explain this lower attention to clinical standards. Furthermore, to mention the patient's mental health condition even without diagnosing it, might be a way for the doctor to take their patient's speech into consideration, to report back the suffering

that asylum seekers face every day, which seems to stand in stark contrast to the large number of asylum applications refused by the French state.

Thus, at a local level, NGOs not only produce their model of expertise, but during face-to-face encounters they also move away from the very procedures of local justice they have previously established. Three protocols of local justice in the French NGO sector in France have been set out above: a 'pure' clinical gaze and the use of forensic techniques; a restrained use of forensic techniques based on a 'first, do not harm' principle extended to the political field; and a contempt for forensic techniques where narrative insight prevails. Subsequently, what is at stake for doctors, and especially for new recruited members, is how to stand their ground and negotiate through these different sets of principles. For asylum seekers, the various protocols established by NGOs represent a new set of rules to learn in the complex asylum process. Ultimately though, the attempt made by the medical NGO sector to invent forms of local justice, or the least unjust order they can promote, cannot overcome the French management of asylum based on dissuasion and repression.

What prevails in France, and more broadly in the European Union, is an unbalanced logic of compassion and repression (Fassin 2005), or more precisely compassion and selection. Successive governments have formally reaffirmed asylum right in the face of rising xenophobia. They have also set out minimum standards for reception conditions for asylum applicants and supported the NGOs sector in providing care and shelter for them. French governments have also consolidated regulations designed to promote basic procedural guarantees for asylum applicants. According to the liberal principles of equal opportunity (Rawls 1971), civil society organisations are financially supported by the state in order to provide claimants with social, linguistic and legal assistance. But the

implementation of these regulations faces barrier caused by fiscal restraint and an increasingly restrictive immigration policy, where a large part of the French population considers foreigners as a potential threat (national security, job opportunities for nationals, welfare system and/or a specific conception of national cultural identity). Thus, the left hand of the state finances health centres – but with not enough means to assure equal and full access to them – while the right hand uses expert testimony 'to separate the wheat from the chaff' – in an informal manner – without any considerations for the variety of protocols that are followed by NGOs. As in other fields, such as monitoring and supporting the unemployed, the same professionals are charged with the duty of reconciling contradictory demands: promoting equal opportunities with rare resources involves classifying, prioritising and selecting; providing a personalised and humanised form of assistance while meeting the requirements of a more restrictive fast-track process.

Here, if most of the professionals pursue their activity despite their worry about the arbitrariness of the system and the potentially counter-therapeutic effects of its technologies, it is because of the tragic consequences that their defection could have on their patients (e.g. increase the risk of rejection and deportation). This ethical dimension is undoubtedly an important part of what sustains this model of regulation. This model of regulation is thus based on the 'twin movement of autonomisation and responsabilisation' (Rose 1999: 170[PB5]) which affects citizens in liberal democratic societies. This is in the name of the responsibility for individuals forced into exile for their safety that the solidarity practices continue, even if the logic of immigration and asylum policies are undermining the scope for the many asylum seekers who remain rejected by physical and bureaucratic hurdles.

chapter-references

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