

# 3. Prison-specific ethical and clinical problems

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## Key points

- Regardless of the circumstances, the ultimate goal of health care staff in prisons must remain the welfare and dignity of the patients.
- The results of medical examinations and tests undertaken in prison with the patient's consent as part of clinical care must be treated with the same respect for confidentiality as is normal according to medical ethics in general medical practice.
- Prison physicians should avoid dual roles with the same patient. To avoid as far as possible any confusion about the role of the doctor in medical examinations and treatment in the caregiving role and in other functions (such as providing medical expertise for, for example, forensic reports), the doctor should make it clear to the patient at the outset of the consultation that medical confidentiality will not apply to the results of any medical examinations and tests undertaken for forensic purposes.
- Regardless of security issues, health care staff should have unrestricted access at any time and any place to all prisoners, including those undergoing disciplinary sanctions.
- Health care staff should under no circumstances participate in enforcing any sanctions against prisoners or in the underlying decision-making process, as this will jeopardize any subsequent doctor–patient relationship. This includes any medical examination to determine if a prisoner is fit to undergo punishment.
- Medical staff should not carry out any medical acts on prisoners who are restrained (including with handcuffs). An exception may be considered when the person concerned suffers from an acute mental illness which may create an immediate serious risk for him/herself or others.
- Prison doctors should not carry out any body searches or examinations requested by an authority, except in an emergency when no other doctor can be called in or in cases where there is a lack of other qualified health staff. In such cases doctors must explain to the prisoner, before proceeding with the body search, that they are intervening purely as experts, and that their act does not have any diagnostic or therapeutic purpose. Any such body search must have the informed consent of the prisoner.
- During a hunger strike, doctors must avoid the risk that prisoners, the prison or the judiciary authorities manipulate medical decisions.

- Doctors have a duty to document physical signs and/or mental symptoms compatible with a prisoner having been subjected to torture or cruel, inhuman and degrading treatment, and to report through the appropriate channels any sign or indication that prisoners may have been treated violently.
- The health service in a prison can potentially play an important role in the prevention of ill-treatment within the establishment and elsewhere. The physical and psychological examinations carried out on admission are particularly important in this respect.
- All health care staff working with prisoners on an ongoing basis should have access to a specific training programme. Training should address the specificities and inner workings of different types of prison, the handling of potentially dangerous or violent situations, and the risks of ethical breaches specific to their activities as health care providers in prisons.

## Introduction

Other chapters of this guide raise important issues relating to equivalence of care, confidentiality and informed consent of the patient detainee. This chapter will address other highly specific and sensitive health problems faced by health care staff (as well as the prison administration) in the practice of prison medicine.

## Health care staff in prisons

### *General role of the medical doctor*

The role of a prison doctor is not limited to the provision of care. As already noted, prison doctors should take part in the general management of a prison establishment (such as in control of food and hygiene). As far as possible, a prison doctor should also have a say in the design of various detention regimes as well as participating in the promotion of alternatives to detention, while keeping in mind that the role of the doctor is to promote prisoners' health and social rehabilitation.

In practical terms, the doctor should submit a report to the prison director whenever he/she considers that the physical or mental health of a prisoner or the prison population is at serious risk as a result of prolonged imprisonment or of the conditions of detention, including isolation. Further, the doctor should adopt a proactive approach when the prisoner's state of health is seriously affected and release on medical grounds is required. If the prison management does not accept the doctor's

recommendations, the doctor should ensure that his/her report is submitted to a higher authority (1).

The possible subordination of prison health care to the ministry of health does not exempt doctors working in prison from any functions specific to the practice of medicine in a prison setting.

### ***Multiple loyalties***

Doctors working in prisons are frequently torn between various loyalties. Their primary duty is to protect and promote the health of prisoners and to ensure that they receive the best care possible. This duty may, however, conflict with other priorities, notably those of the prison management. In practice, the health care team is frequently obliged, despite its reticence, to take into account issues of order and security. Conversely, security staff may find it difficult to accept attitudes, beliefs and behaviour on the part of the health care staff that they perceive to conflict with prison rules and regulations (2,3).

Although it is not recommended, the prison doctor sometimes also acts as a treating doctor for security staff (and occasionally even for their families). In such a context, the position of prison doctors is extremely complex since their duty is to take care of people who are in opposition to each other, if not in conflict, at the same time. The two types of doctor's activity should preferably be clearly distinguished physically. It should be stipulated beforehand, for example, what percentage of the doctor's time is to be devoted to staff care and that two stocks of medication (for prisoners and staff) will be kept separately. Two separate consultation rooms would be best.

This permanent state of tension can only be dealt with through regular meetings between the prison director and the medical director to make any necessary adjustments. The exchanges during such meetings are even more essential as, in a large proportion of establishments, the acute lack of health care staff can force the prison management to delegate certain tasks related to health care to the security staff.

Regardless of the circumstances, the ultimate goal of health care staff must remain the welfare and dignity of the patients. It should be made clear to the patients, prison staff and the prison director that the primary task of the prison health care staff is the health care of prisoners, and that all work is based on the strict medical and ethical principles of health care professionalism: independence, equivalence and confidentiality of care.

### ***Parallel and conflicting activities***

A doctor working in a prison may be called upon to play

two somewhat opposing roles: that of a care provider to the prisoner as a patient, and that of an independent medical expert providing medical evidence concerning a patient to a court or other official body. While the care-provider is concerned with the well-being of the individual patient, the doctor acting as a medical expert is asked to reveal medical information that would otherwise be confidential, in the interests of justice and in the service of the community. The latter role may not be in the doctor's patient's interest. According to common ethical rules, a doctor should be one or the other. Only in an emergency is it tolerated for a doctor to combine these two functions without the formal consent of the patient.

In practice, however, the reality of prison life frequently obliges doctors to go beyond their role as care providers. For instance, the judiciary or prison authorities may ask doctors to establish a person's fitness to be detained or to prepare forensic reports in cases of allegations of ill-treatment. Ideally, such tasks should be performed by an independent doctor from outside the prison system. If, however, a prison doctor has to perform such a task, the doctor charged with examining a prisoner as a medical expert should clearly inform the patient at the outset of the consultation that medical secrecy will not apply to the results of the medical examination and tests, to avoid a confusion of the two roles.

A prison doctor may be asked to evaluate the threat to society posed by a prisoner in connection with, for example, a request for parole or leave of absence. In such situations, the doctor must respond with extreme caution and clearly establish that his/her opinion can only be based on a current assessment of physical and mental function and must not predict future criminal conduct. Doctors are neither trained nor qualified to predict criminal behaviour. In such cases, since the prisoner may see the prison doctor as effectively playing a role in his/her release or continued detention, this has the potential to affect the doctor-patient relationship. Thus again, it is best for an independent opinion to be given by a professional qualified to make judgments on criminality.

### ***Issues of conscience and serious ethical conflict***

The multiple parameters affecting the work of prison doctors may run contrary to their personal convictions. It is, therefore, highly preferable to employ prison health care staff who choose to work in prisons and to provide them with focused training. In countries where prison health care services have been integrated with the community health services, patients inside the prison are considered as simply another group within the wider community and the health staff are expected to deliver services at the same level as in the wider community.

In attempting to carry out their duties according to the usual professional and ethical standards, doctors may face conflicts not only with the decisions of the prison administration but also with local regulations and even national laws. In such cases, doctors should ask their national professional organization (national medical association) for advice and, if needed, ask the opinion of colleagues working in other countries in the same field, including seeking the support of the World Medical Association. Another possibility is to contact the national prevention organization, if one exists in the country.

### **Disciplinary measures**

In any prison, access to health care facilities may be difficult because of security practices. This is particularly the case in disciplinary and maximum security units. The prison authorities often want to limit contact with certain prisoners to a strict minimum.

Regardless of the security issues, health care staff should have unrestricted access at any time and any place to all prisoners, including those subject to disciplinary measures. The doctor in charge is responsible for ensuring that each prisoner can, in practice, exert his/her right of access to health care at any time.

When the prison authorities decide to punish a prisoner for breach of regulations, sanctions may take different forms. Health care staff should never participate in the initiation or enforcement of any sanctions, as this is not a medical act and thus to participate will jeopardize any subsequent doctor–patient relationship with this prisoner and with all prisoners.

Doctors may frequently be approached when the sanction considered is solitary confinement. Solitary confinement has clearly been shown to be detrimental to health (4). In cases where it is enforced, its use should be limited to the shortest time possible. Thus, doctors should not collude in moves to segregate or restrict the movement of prisoners except on purely medical grounds, and they should not certify a prisoner as being fit for solitary confinement or any other form of punishment. Prisoners who are placed in isolation should be evaluated initially and periodically for acute mental illness, drug or alcohol withdrawal and injuries. If these are identified, prisoners should have access to prompt and effective treatment. Doctors should not certify fitness for isolation.

Once a sanction is enforced, however, doctors must follow the prisoner being punished with extreme vigilance. It is well-established that solitary confinement constitutes an important stressor and risk, notably of suicide. Doctors must pay particular attention to such prisoners and

visit them regularly on their own initiative, as soon as possible after an isolation order has taken effect and daily thereafter, to assess their physical and mental state and determine any deterioration in their well-being. Furthermore, doctors must immediately inform the prison management if a prisoner presents a health problem.

### **Physical restraint**

In prison, situations of extreme tension can occur. In such cases, the prison authorities can decide to use physical restraints on one or more prisoners for the purpose of preventing self-harm or harm to other prisoners and staff. Restraints must only be applied for the shortest time possible to achieve these purposes and should never be used as a form of punishment. Since the decision to use restraints in situations of violence is not a medical act, the doctor must have no role in the process.

There may, however, be instances where some form of restraint must be applied for medical reasons, such as acute mental disturbance in which the patient is at high risk of injuring him/herself or others. The decision to use restraints or to move a prisoner to a cell for such purposes must be confirmed in each case by health care staff, based purely upon clinical criteria.

Medical personnel should never carry out medical acts on prisoners who are under restraint (including handcuffed), except for patients suffering from an acute mental illness or delirium with potential for immediate serious risk for themselves or others. Moreover, doctors should never agree to examine a blindfolded prisoner.

### **Intimate body searches**

For security reasons, it may be necessary to search a prisoner to ensure that he/she is not hiding anything in a natural body cavity. In many cases it may suffice to keep the prisoner under close surveillance and wait for the illicit object to be naturally expelled. Prison doctors and nurses should not carry out body searches, blood or urine tests for drug metabolites or any other examinations except on medical grounds and with the consent of the patient. Vaginal, anal and other intrusive bodily inspections are primarily a security rather than a medical procedure, and thus should not form part of the duties of prison health care staff. On the rare occasions when intimate body searches are deemed necessary, they should be performed by doctors who are, as far as possible, external to the prison.

### **Prisoners who stop eating or go on hunger strikes**

#### ***Differential diagnosis***

It is vital to understand why a prisoner stops eating since the medical care will differ completely depending on the reason for refusing food. Prisoners may stop eating:

- for religious reasons, as a part of specific religious festivals or if food is served that is not prepared in accordance with religious precepts; the prison administration should deal with such issues and ensure that religious considerations are taken into account in the preparation of food for prisoners;
- because of somatic problems such as dental problems, ulcers, obstructions of the digestive tract, very poor general health and fever; the appropriate treatment should be provided;
- because of mental disorders such as psychosis, poisoning, delusion, major depressive disorders and anorexia nervosa; such prisoners should benefit from health care support of the kind they would receive in open society;
- with the intention of protesting to achieve some change in their regime or to obtain perceived or actual rights.

In the last case, two sets of values clash:

- the duty of the state to preserve the physical integrity and life of those directly under its charge, notably people it has deprived of liberty; and
- the right of every individual to dispose freely of his/her own body.

### **Ethical aspect**

Such situations are challenging for prison health care staff. Pressure is often brought to bear on the doctor, who should avoid the risk that the prisoner, prison or judiciary authorities manipulate medical decisions.

The most important guidance for prison doctors regarding hunger strikes is the World Medical Association's Declaration of Malta (5). This Declaration is summarized below and some important issues are discussed.

- Physicians have the duty to act ethically. Whatever their role, they must try to prevent coercion or maltreatment.
- The autonomy of the patient must be respected. In order to do so, the physician must assess an individual's mental capacity. Getting a second opinion from an independent psychiatrist as to soundness of mind is always wise in every case of food refusal.
- A thorough examination of the patient should be made and the physician should make sure that the patient fully understands the consequences of his/her hunger strike. It is important to recognize that the refusal of certain treatments must not prejudice any other aspect of medical care, such as treatment of infection or pain.
- The wish to continue the strike must be ascertained on a daily basis, and the physician should talk to the prisoner concerned in private.

The physician must visit patients regularly and, if they

agree, conduct regular follow-up examinations. These consultations should be held in a positive, personalized climate, and the physician should inform the patient of the progressive decline in his/her health. In this way, hunger strikers can freely change their mind at any time and abandon the strike, having been duly informed of the worsening nature of the risks to which they are exposing themselves. The doctor must evaluate each prisoner individually and should be particularly careful in case of a collective hunger strike, as prisoners are often subjected to external pressure.

Physicians should offer detainees the possibility to access a special diet whenever this is possible. It is widely accepted that liquids, vitamins, sugar and trace nutrients protect the striker's health from irreversible damage (6). By lengthening the time of the fast, it can allow both the prisoner and the authorities to propose a mutually acceptable solution in order to avoid lethal deadlock.

- Confidentiality must be respected, unless it is necessary to share information in order to prevent a serious threat to the patient or to others.
- The doctor must keep the prison and judicial authorities informed of the evolution of the health condition of the patient through regular and successive health reports. These carefully established and strictly objective health reports are part of the medical care for a person in danger and allow the authorities to take more adequate decisions.
- If no discussion is possible with the patient (for example because he/she has already lost mental capacity), the physician must respect the patient's wish, but has to consider very carefully the instructions given by the patient as the situation might have changed or the instructions may have been written under pressure. In case of doubt, the physician must act in the patient's best interest.
- In a case of conflict between loyalty to the authorities and to the patient, the physician's primary obligation is to the patient.
- Forcible feeding of prisoners is never ethically acceptable.

Such a procedure can only be justified if a serious mental disorder affects the decision-making capacity of the patient (see Differential diagnosis above). In such a case, this constitutes artificial nutrition and not force-feeding, and must be carried out in a hospital setting.

If there is no obvious alteration in the prisoner's decision-making capacity, the doctor must carefully consider a course of action, keeping in mind that, in the vast majority of cases, the prisoners do not want to die. On the contrary, they want to enjoy better conditions. Patients frequently expect that the doctor,

who will invariably be called in if a hunger strike is kept up, will act as an intermediary and may act to protect them in this struggle.

In these situations, the medical approach should sometimes be frankly paternalistic. It should entail a discussion with the patients on hunger strike to try and persuade them to accept at least a minimal calorie intake. Faced with a firm medical attitude, the prisoner may recover some hope and accept a normal healthy diet later. Some patients do not consider dying as part of their struggle and may even accept artificial feeding, but will not indicate this explicitly. The evaluation of the real volition of the detainee in these situations is very difficult.

Patients may ask for hospitalization to give their case more weight. In this situation, hospitalization unwarranted by clinical status should not appear as an indirect support to achieve their aims. Nevertheless, early hospitalization may allow better follow-up of biological parameters. Further, a radical change of atmosphere could lead to a situation in which the prisoner may choose to interrupt the hunger strike without losing face in front of his/her comrades.

- If the patient's position remains firm, based on his/her free will to exert pressure through his/her body to modify his/her prison situation or to conduct a political struggle, doctors should limit interventions to warning of the dangers to which strikers expose themselves by refusing to eat.

### **Clinical aspects**

The capacity of the human body to survive starvation or water deprivation is not yet fully understood. Obviously, data in this area tend to be anecdotal rather than interventional studies.

In dry fasting, the person refuses all solid or fluid intake. Death occurs in 4 to 10 days, depending on factors such as ambient temperature and humidity and the striker's level of stress and physical activity.

Severe electrolytic imbalance can rapidly cause death due to cardiac arrhythmia or damage to the central nervous system. A hypovolemic state causes multiorgan dysfunction and acute renal insufficiency, worsening an electrolytic imbalance (7,8).

In total fasting, the individual only consumes clear water, with no other intake of nutrients.

### **Clinical evolution of a hunger strike**

The usual clinical evolution of a hunger strike in a healthy, young patient who continues to drink water is as follows:

- first week: sensation of hunger and fatigue; possible occasional abdominal cramping;
- second and third weeks: increasing weakness accompanied by dizziness, making the upright position difficult to maintain; progressive disappearance of the feelings of hunger and thirst; permanent sensation of chilliness;
- third and fourth weeks: progressive worsening of the symptoms mentioned above; slowing down of intellectual faculties;
- fifth week: alteration of consciousness from mild confusion to stupor and sleepiness, apathy and anosognosia, followed by anomalies of ocular movements (initially uncontrollable movements followed by paralysis); generalized lack of motor coordination with notable difficulty in swallowing; diminished vision and hearing, leading to loss of vision and hearing; sometimes diffuse haemorrhaging.

Death can occur abruptly either due to cardiac rhythm alterations, sepsis or several hours after the induction of a comatose state due to hypoglycaemia (11).

In theory, the reserves of the human body should allow a person to survive for 75–80 days without absorbing a single calorie.

In practice, it is usually accepted that there is little risk of dying within the first six weeks of a fast for a previously well-nourished and healthy person (9). Nevertheless, serious, sometimes deadly, clinical disorders may appear after a few weeks of complete fasting, mainly because of susceptibility to infection due to decreased immunity and impaired wound healing. As with dry fasting, renal insufficiency also often causes complications (10).

It should be noted that death is not usually due to tissue loss per se but to organ failure or infection. The limit of a body mass index compatible with life itself is thus not the only parameter that should be taken into account.

It is vital to recognize that certain medical factors can predispose to the rapidly fatal evolution of a fast. The major factors include heart disease, renal insufficiency and diabetes, especially if the patient is insulin-dependent. Gastric or duodenal ulcers can manifest as problems as early as one week after the start of the fast.

Today most hunger-strikers follow dietary fasts with the absorption of certain vitamins, trace minerals and some food (sweet drinks, candy or small amounts of various foods). This type of hunger strike allows them to hold on for several months. Prisoners going on a fast should have access to this diet because the risk of permanent damage

to the nervous system is significantly reduced. However, a prolonged hunger strike poses a substantial risk of permanent damage to the nervous system (12) (such as Wernicke syndrome), and it should be emphasized that glucose intake without vitamin B1 accelerates the process of neurological damage.

In practice, because many different factors affect a fast, such as the type of fast, conditions of detention (temperature, humidity) and mental stressors, it is virtually impossible to determine medically the risk and timing of death.

### **Re-feeding**

The major electrolytes and vitamin depletion in people suffering from malnutrition cause serious threats when it comes to re-feeding. Indeed, glycaemia triggers insulin secretion, which in turn starts the movement of electrolytes and fluids across cellular membranes (mainly of phosphates and potassium). These very rapid changes can lead to lethal consequences, such as cardiac arrest. As mentioned above, glucose intake in a case of vitamin depletion can also precipitate Wernicke syndrome. In consequence, re-feeding should be considered very carefully in people at risk, that is, those who have had no food intake for more than 10 days (5 days if the body mass index is under 18.5 kg/m<sup>2</sup>) or with laboratory low levels of phosphate and potassium (13).

### **Torture and inhumane or degrading treatment**

Medical personnel seriously violate the rules of medical ethics if they:

- in any way assist in (even by merely being present) sessions of torture or inhumane and degrading treatment or advise the torturers or those inflicting such treatment;
- provide facilities, instruments or substances to that effect;
- certify that a prisoner is able to withstand a torture or inhumane treatment session; or
- weaken the resistance of the victim to torture or inhumane treatment.

The health service in a prison can, however, potentially play a very important role in the fight against ill-treatment within prisons and elsewhere, specifically police stations. In the context of medical consultations, people sometimes show physical signs or mental symptoms compatible with having been subjected to torture or other forms of cruel, inhumane or degrading treatment.

In view of this, the physical and mental examinations carried out on admission of a prisoner are particularly important.

During a physical examination (most specifically, the one carried out on arrival), any trace of violence compatible with torture or inhumane treatment must be duly noted and registered (photos are desirable) both in the prisoner's personal file and in any general register of traumatic injuries. Likewise, any psychological or psychiatric disturbances that may indicate that a person has been subjected to ill-treatment must be recorded. Such information must be automatically transmitted without delay to the supervising authorities. Prisoners should be entitled to obtain a copy of the medical report concerning them at any time.

However, the simple fact of being identified by the health care services as bearing traces of traumatic lesions or mental symptoms compatible with torture or inhumane treatment can trigger reprisal measures against the victim. To protect patients from this risk of retaliation, doctors must formally inform them that they are going to report to the competent authority the evidence they have gathered during the consultation. If the patients fear that they will be subjected to reprisal, they may decide not to divulge how the lesions were inflicted and even lie about them.

In their reports, doctors must clearly distinguish between the patient's allegations (circumstances of the physical or mental trauma as described by the patient) and complaints (subjective sensations experienced by the patient), and the clinical and para-clinical objective findings (such as mental state; size, location, aspect of the lesions; X-rays and laboratory results). If the doctors' training and/or experience allow, they must indicate whether the patients' allegations are compatible with their own clinical findings.

### **Capital punishment and executed prisoners as sources of organs**

Health professionals should never be complicit in any way (even by their presence) with capital punishment, and should not be involved in examining the detainee immediately before the execution nor in confirming death or issuing the death certificate. The donation of organs after an execution associates the medical profession with the execution and should, therefore, be prohibited (14).

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