Medical Ethics in Custodial Settings

2013. Amended 2015[1]

1. Preamble

1.1 Prisoners and detainees have a right to humane treatment, regardless of the reasons for their imprisonment, and should be treated with respect for their human dignity and privacy. They should never be denied treatment on the basis of their culture, ethnicity, religion, political beliefs, gender, sexual orientation, the nature of their illness, the reason for their incarceration, or their criminal history.

1.2 In accordance with the World Medical Association, doctors (medical practitioners) must have complete clinical independence in deciding upon the care of a prisoner or detainee for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, should prevail against this. Participation in any form of torture or cruel, inhumane or degrading procedure is incompatible with the doctor's role as healer.[i]

1.3 Prisoners and detainees have the same right of access, equity, and quality of health care as the general population. This includes the coordinated and continuous health care from a person's first point of contact with the criminal justice system through to successful reintegration into the community. This also includes continuity of care if a prisoner or detainee is transferred from one custodial setting to another.[ii]

1.4 Governments and prison authorities have a duty of care to all prisoners and detainees under their control, including those in private correctional facilities. Governments must provide basic humane standards and should strive to achieve world's best practice in all Australian correctional facilities including police custody, prison, juvenile detention centres, and other custodial settings. Correctional facilities should accommodate the language, cultural, and religious needs of prisoners and detainees.

1.5 This position statement highlights important ethical challenges faced by doctors working with prisoners and detainees in custodial settings. It should be read in conjunction with the AMA's *Position Statement on Health and the Criminal Justice System 2012.*[2]

2. Professional autonomy and clinical independence

2.1 The primary duty of doctors working in custodial settings is to serve the health needs of prisoners and detainees. In order to fulfil this duty, doctors require reasonable professional autonomy and clinical independence without undue influence from correctional facility management.[iii] At times, the doctor's primary duty may conflict with the priorities of the corrections authorities to enforce prison rules and regulations.[iv] Corrections authorities should afford doctors the freedom to exercise their professional judgment in the care and treatment of their patients.

2.2 Corrections facilities must provide appropriate medical facilities and resources to care for the health needs of prisoners and detainees.

2.3 Corrections facilities should provide adequate protection and security for doctors and other health care personnel working in custodial settings.

3. Treating doctors and non-treating doctors

[1] In 2015, only Section 12 of this position statement was reviewed and amended.
[2] For the purposes of this position statement, 'detainee' refers to a person detained in a custodial setting, not in immigration detention. For AMA policy on health care of 'detainees' in immigration detention, please refer to the *Position Statement on Health Care of Asylum Seekers and Refugees 2011.*

3.1 Doctors working in custodial settings may serve as treating doctors or non-treating doctors. The treating doctor has a therapeutic relationship with the prisoner or detainee. The treating doctor's role is to examine, treat, and manage the health needs of their patients (prisoners and detainees) while respecting the confidentiality of information obtained in the course of the therapeutic relationship.

3.2 The non-treating doctor does not have a therapeutic relationship with the prisoner or detainee. A non-treating doctor may be asked to conduct an independent medical assessment to assess the prisoner or detainee on behalf of a third party such as the corrections administration.[v] An independent medical assessment may be conducted for a variety of reasons such as assessing a prisoner or detainee's ability to work in the corrections facility. A non-treating doctor may also be asked to conduct a medical examination for judicial, evidentiary, or security purposes.

3.3 Non-treating doctors engaged to perform an independent medical assessment or a medical examination for judicial, evidentiary, or security processes have an obligation to ensure the prisoner or detainee understands the purpose of the examination and its implications and has consented to the examination. The doctor should explain the limits of privacy and confidentiality that may occur in relation to such an examination and provide an objective, impartial opinion.

3.4 Both treating doctors and non-treating doctors working within custodial settings must adhere to the principles of medical professionalism.[vi]

4. Consent and confidentiality

4.1 Like all patients in the general community, consent should be sought from prisoners before undertaking any examination, diagnosis, or treatment unless the patient does not have decision-making capacity and requires surrogate consent or the situation is an emergency.

4.2 Trust is an essential component of any doctor-patient relationship. Confidentiality of health information should generally be maintained unless the individual consents to disclosure of that information. There may be certain circumstances where disclosure in the absence of consent is appropriate; for example, where non-disclosure poses a serious harm to others or where required by law.

4.3 Effective information management systems and other coordinating mechanisms should be instituted to enable a person's continuity of care (eg., from prison to prison and from prison to the community).[ii]

5. Body cavity searches

5.1 Body cavity searches for the sole purpose of obtaining evidence or to retrieve substances for evidentiary purposes are not medical acts and should not be undertaken by doctors.

5.2 Body cavity searches for medical purposes should be performed by doctors only. Generally, the person's consent should be obtained before such a search can be undertaken. Doctors may perform body cavity searches on individuals who are unable to consent (due to impaired capacity), only when the life of the person is likely to be endangered.

5.3 Where possible, a doctor from outside the correctional facility should perform body cavity searches.

6. Hunger strikes[3]

6.1 Doctors should respect a competent individual's decision to enter into a hunger strike. Doctors should continue to provide care to the individual while respecting their voluntary refusal of nourishment.

[3] Adapted from the *World Medical Association Declaration of Malta on Hunger Strikers.* Adopted by the 43rd World Medical Assembly, St Julians, Malta, November 1991 and editorially revised by the 44th World Medical Assembly, Marbella, Spain, September 1992 and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006.

6.2 Where a prisoner or detainee refuses nourishment and is considered by the doctor to be capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, the doctor should refuse to co-operate in artificial feeding. Forced feeding contrary to an informed and voluntary refusal is not justifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.

6.3 The decision as to the capacity of the prisoner or detainee to form such a judgment should be confirmed by at least one other independent doctor. The doctors must explain to the person the consequences of the refusal of nourishment, ensuring the person fully understands the information. The doctors should be confident the person is entering into a hunger strike voluntarily.

6.4 Doctors should not apply any undue pressure on the person to suspend their hunger strike. Treatment or care of the individual must not be contingent on them suspending their hunger strike.

6.5 Doctors should communicate with a hunger striker on a daily basis to clarify whether the individual wishes to continue with the strike and what they would like to be done if he/she loses decision-making capacity. Advance refusals of treatment should be respected if they reflect the voluntary decision of the person when competent.

6.6 Where a doctor conscientiously objects to a hunger striker's refusal of treatment, the doctor should make this clear to the person at the outset and refer the hunger striker to another doctor who is willing to abide by the refusal.

7. Solitary confinement and protective custody

7.1 Solitary confinement, where a prisoner or detainee is confined separately from other prisoners or detainees as a means of punishment, is inhumane. Solitary confinement is medically harmful as it may lead to a number of physical and/or mental disorders.

7.2 A prisoner or detainee may need to enter protective custody if at risk of self-harm or of harm by other prisoners or detainees. A prisoner or detainee with a blood-borne or sexually transmitted infection may need to be separated for infection control. Prisoners and detainees should not be separated without adequate access to health care and appropriate medical treatment for any medical condition.

7.3 Correctional facilities should be designed so that prisoners and detainees requiring protective custody can be separated from others in an environment similar to that of the other prisoners and detainees.

7.4 Where a prisoner or detainee in protective custody is isolated from others, the person should be provided opportunities to have regular contact with people outside the correctional facility, either face-to-face or by telephone.

8. Physical and chemical restraints

8.1 The use of force, physical, or chemical restraint solely for non-medical purposes is not a medical act and doctors should not be involved in imposing such restraints.

8.2 Medical personnel should never proceed with medical acts on restrained people, except for those with potential for immediate and serious risk for themselves and others.[iv]

9. Torture, cruel, or inhumane treatment[4]

[4] Adapted from the *World Medical Association Declaration of Tokyo – Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment.* Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005 and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006.

9.1 Doctors must not countenance, condone, or participate in the practice of torture or other forms of cruel, inhumane or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the person's beliefs or motives, and in all situations, including armed conflict and civil strife.

9.2 Doctors must not provide any premises, instruments, substances, or knowledge to facilitate the practice of torture or other forms of cruel, inhumane or degrading treatment or to diminish the ability of the victim to resist such treatment. Doctors should not use nor allow to be used medical knowledge or skills specific to an individual, to facilitate or aid an interrogation.

9.3 Doctors should not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened.

10. Medical research

10.1 Doctors must abstain from participating in any form of research involving prisoners and/or detainees without prior ethics approval and adherence to research protocols developed by organisations such as the National Health and Medical Research Council.

11. Speaking out

11.1 Doctors have a duty to speak out to appropriate authorities when the health care services or environment within correctional facilities are inadequate or pose a potential threat to health.

11.2 Doctors should try to prevent coercion or maltreatment of prisoners and detainees and should speak out if such actions occur.

12. Capital punishment

12.1 Doctors must not participate in capital punishment in any way, including facilitating the importation or prescription of drugs for execution, planning, instructing, and/or training of other persons to perform executions.[vii]

12.2 The AMA does not support capital punishment.

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[i] World Medical Association. Declaration of Tokyo. *Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment.* Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975, and editorially revised at the 170th Council Session, Divonne-les-Bains, France May 2006.
[ii] Australian Medical Association. *Position Statement on Health and the Criminal Justice System 2012.*
[iii] World Medical Association. *Declaration of Seoul on Professional Autonomy and Clinical Independence.* Adopted by the World Medical Association General Assembly, Seoul, Korea, October 2008.
[iv] World Health Organization. *Health in Prisons. A WHO guide to the essentials in prison health.* 2007.
[v] Australian Medical Association. *Ethical Guidelines for Conducting Independent Medical Assessments 2010.*
[vi] Australian Medical Association. *Position Statement on Medical Professionalism 2010.*
[vii] World Medical Association. *WMA Resolution to Reaffirm the WMA's Prohibition of Physician Participation in Capital Punishment.* Adopted by the 63rd General Assembly of the World Medical Association, Bangkok, Thailand, October 2012.