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X **HEALTH ASPECTS OF AVOIDABLE MALTREATMENT
OF PRISONERS AND DETAINEES**

Paper prepared by the World Health Organization

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HEALTH ASPECTS OF AVOIDABLE MALTREATMENT
OF PRISONERS AND DETAINEES

Prepared by the secretariat of the World Health Organization

1. This paper is submitted to the Fifth United Nations Congress on the Prevention of Crime and the Treatment of Offenders at the invitation of the General Assembly of the United Nations to the World Health Organization 1/ to draft "in close co-operation with such other competent organizations, including the United Nations Educational, Scientific and Cultural Organization, as may be appropriate, an outline of the principle of medical ethics which may be relevant to the protection of persons subjected to any form of detention or imprisonment against torture and other cruel, inhuman or degrading treatment or punishment ...".

I. Action taken by the Director-General and the Executive Board of the World Health Organization

2. The Director-General of the World Health Organization brought the invitation of the United Nations General Assembly to the attention of the WHO Executive Board at its fifty-fifth session in January 1975. The Board noted the invitation and requested the Director-General to prepare a relevant document. It also suggested that in the preparation of the document he should consult the World Medical Association, other non-governmental organizations in official relations with WHO, relevant intergovernmental organizations including UNESCO, and member States. 2/

3. The Director-General accordingly communicated the terms of the invitation to the International Labour Organisation, UNESCO, all WHO member States, the World Medical Association, and 42 other international non-governmental organizations, inviting their comments.

4. Acknowledgements or comments were received from 10 member States and 10 international non-governmental organizations, and these have been taken into account in the preparation of this document. The World Medical Association transmitted to WHO the text of a statement approved by its Council in March 1975 for consideration by the Twenty-ninth World Medical Assembly in Tokyo in October 1975. This text is attached for information. 3/

II. Earlier decisions of WHO in respect of medical deontology

5. At its fourth session in June 1949 the Executive Board of WHO considered a resolution of the Académie nationale de Médecine of France, transmitted by the League of Red Cross Societies, proposing that an international code of medical

1/ United Nations General Assembly resolution 3218 (XXIX).

2/ WHO resolution EB55.R.64.

3/ See annex I.

deontology be elaborated "by an international medical organization". 4/ An observer from the World Medical Association (WMA) stated that this proposal would be considered by the World Medical Assembly in October 1949. 5/ The Board took note of the Academy's resolution; expressed satisfaction that WMA was studying the question; and requested the Director-General of WHO to keep in close touch with this activity, to bring it to the attention of the International Council of Nurses, and to report further on the activity to the Board at its fifth session. 6/

6. With a letter dated 9 November 1949 the Secretary-General of WMA transmitted to the Director-General of WHO the text of an International Code of Medical Ethics adopted by the Third World Medical Assembly, and stated that the WMA "is the only organization which can draft such a code and have it accepted by the profession". He requested that the WHO Executive Board should "give approval to this Code and help to publicize it throughout the world". 7/ In discussion of this matter at its fifth session in January 1950, 8/ the Board agreed that it could neither approve nor disapprove the code, but that it would note it and request the Director-General to communicate to the WMA the Board's appreciation of its work, at the same time transmitting a summary record of the Board's discussion. 9/

7. At the same session of the Board the Director-General reported 10/ that the Assistant Secretary-General of the Department of Social Affairs of the United Nations had requested from WHO an advisory opinion on the following text proposed for article 7 of the draft International Covenant on Civil and Political Rights:

"No one shall be subjected to any form of physical mutilation or medical or scientific experimentation against his will." 11/

The Director-General had previously consulted the WMA and the International Council of Nurses on this text, and he communicated to the Board proposals for its amendment which had been made by both organizations. After discussion the Board appointed a working party of six of its members to consider the matter. 12/ The working party was unable to agree, and produced a majority report by four of its

4/ WHO document EB4/9.

5/ WHO document EB4/Min/1/Rev.1.

6/ WHO resolution EB4/4.R.24.

7/ WHO document EB5/29/Add.1.

8/ WHO document EB5/Min/1/Rev.1.

9/ WHO resolution EB5/R.75.

10/ WHO document EB5/62.

11/ Article 7 of the Covenant now consists of the text of article 5 of the Universal Declaration of Human Rights followed by the words: "In particular, no one shall be subjected without his free consent to medical or scientific experimentation."

12/ WHO document EB5/Min/2/Rev.1.

members and a minority report by the remaining two. 13/ The Board decided that the Director-General should transmit to the Secretary-General of the United Nations only the views expressed by the majority of the working party. 14/ These were that the words proposed for article 7 of the draft International Covenant should be omitted on the grounds that article 5 of the Universal Declaration of Human Rights "acts as a sufficient deterrent against the type of conduct that article 7 of the Covenant is destined to prevent". 15/

III. The constitutional responsibilities of WHO in relation to the invitation contained in resolution 3218 (XXIX)

8. Thus, WHO decided, very early in its history, that it was not the competent body to propose or endorse an international code of medical ethics. Moreover, it was reluctant to enlarge upon medical implications of article 5 of the Universal Declaration of Human Rights. The question of what should be the position of WHO in relation to medical ethics has now been revived by the invitation contained in resolution 3218 (XXIX) that WHO should "draft ... an outline of the principles of medical ethics" in a certain context. This invitation makes it incumbent upon WHO to consider very carefully by reference to its Constitution what should be its position in regard to ethical problems related to health.

IV. Medical deontology

9. The term "medical ethics", in the sense of medical deontology, implies written or unwritten rules of personal conduct governing the professional relations of physicians with their patients or with each other. These rules normally require that the sole object of the physician's intervention shall be to promote or safeguard the physical and mental health of his patient. They may refer also to the abuse of legally conferred privileges - such as the right to prescribe dangerous drugs in suitable cases; the abuse of a physician's special relationship with his patient - such as by sexual overtures or breach of professional secrecy; or purely intraprofessional matters - such as self-advertisement or denigration of colleagues to patients.

10. While the Constitution of WHO provides that the organization shall collaborate with "professional groups" (art. 2b) promote co-operation "among scientific and professional groups which contribute to the advancement of health" (art. 2i), and promote improved standards of teaching and training "in the health, medical and related professions" (art. 2o), there is no constitutional provision requiring or implying that WHO should be concerned with medical deontology.

13/ WHO document EB5/98.

14/ WHO resolution EB5.R69.

15/ WHO document EB5/98. Article 5 reads: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

11. The organization that has been widely accepted as having special competence in the field of medical deontology is the World Medical Association (WMA). Specialized international biomedical non-governmental organizations in relation with WHO have also given attention to medical deontological questions within their own particular fields, and the International Council of Nurses has been concerned with the ethical rules that should regulate the professional conduct of members of the nursing profession.

12. One of the first acts of WMA when it was constituted in 1947 was to elaborate a modern version of the Hippocratic Oath, which is known as the Declaration of Geneva. This was amended by the Twenty-second World Medical Assembly in 1968, and is a statement of general principles that should guide a physician in his professional relations with his patients and colleagues. WMA also amplified these principles in more concrete form as the International Code of Medical Ethics. In 1964 WMA drew up a code of ethics to govern the conduct of medical research involving human subjects, and this is well known as the Declaration of Helsinki and has been very widely accepted and quoted. Other ethical codes adopted by WMA are the Declaration of Sydney (1968) on criteria for determining the moment of death and the Declaration of Oslo (1970), which deals with therapeutic abortion. Both the Geneva and the Helsinki Declarations apply to all physician/patient relationships, whether or not the patients are prisoners or detainees. The texts of both these Declarations are attached as annex II.

V. Health ethics

13. The position of WHO in relation to ethical implications of health may be better expressed by the term "health ethics" than by "medical ethics", the former referring to the accountability of Governments to their populations in regard to health matters, and the latter to person-to-person relationships of individual health personnel and those whom they serve, to which the State is not normally a party except in cases falling within the provisions of the civil or criminal law. The WHO Constitution contains a single objective: "the attainment by all peoples of the highest possible level of health". Member Governments of WHO are therefore, by virtue of their acceptance of its Constitution, under the ethical obligation to do what is within their power to protect their subjects from avoidable hazards to physical or mental health and to ensure that they have access to medical care. It follows that WHO and its constituent Governments must necessarily be opposed to any procedures that offer a deliberate threat to physical or mental health, whether such procedures are undertaken with or without the active or passive connivance of physicians or members of any other health profession. Any such procedures are in flagrant conflict with the WHO Constitution, and WHO must therefore condemn them as unethical in any circumstances, for its Constitution contains no exclusions of prisoners or detainees or any other special social groups. The position of WHO in respect of the right to health of prisoners or detainees is well expressed by the more general statement of the National Council on Crime and Delinquency of Canada: "A prisoner retains all the rights of an ordinary citizen except those expressly, or by necessary implication, taken from him by law." 16/

16/ Quoted in Medical Care of Prisoners and Detainees, Ciba Foundation Symposium 16 (new series), Amsterdam, London, New York, Associated Scientific Publishers, 1973, p. 111.

14. In summary, WHO is concerned with "health ethics" in the sense of the right of all peoples, including prisoners and detainees, to be spared avoidable hazards to physical or mental health and to have access to the best facilities for medical care that it is feasible to provide, rather than with medical ethics in the sense of medical deontology.

VI. Interpretation of terms used in resolution 3218 (XXIX)

15. It is assumed that in the framework of the United Nations Congress on the Prevention of Crime and the Treatment of Offenders, the words "any form of detention" are not to be interpreted literally. For example, victims of accidents or sufferers from communicable diseases may be detained in hospitals for treatment and mentally retarded or mentally ill persons for custodial or curative purposes. In the latter case the lines of distinction may be unclear, for recidivists who are mentally retarded or mentally ill may at different times be committed either to prison or to a mental hospital in accordance with the national legislation or practice in force at the time or the attitudes of individual magistrates.

16. For the terms "torture", "cruel", "inhuman", and "degrading" no medical or scientific definitions exist, and general definitions consist of the exchange of one form of words for another. The physician or the psychologist may advise on the probable effects on physical or mental health of a specific procedure, but cannot determine whether the procedure constitutes "torture", or is "cruel", "inhuman" or "degrading" or merits all these epithets, which is a question for society as a whole. The statement of the WMA Council defines torture as "the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason".

17. The authors of the "Compton Report" 17/ on allegations of physical brutality by security forces, among whom was an eminent jurist, considered that "brutality is an inhuman or savage form of cruelty, and that cruelty implies a disposition to inflict suffering, coupled with indifference to, or pleasure in, the victim's pain". In the subsequent "Parker Report" 18/ on procedures for the interrogation of persons suspected of terrorism another eminent jurist ridiculed "this remarkable definition" of cruelty and hence brutality.

18. As to the specification of what constitutes "degrading treatment or punishment", the difficulties of arriving at useful definitions are even greater, because the whole prison experience may be degrading, especially to the first offender, for example, in terms of deprivation of liberty, consciousness of being a social

17/ Great Britain, Home Office, Report of the enquiry into allegations against the security forces of physical brutality ... cmd. 4823, London HMSO, /n.d./.

18/ Great Britain, Privy Council, Report of the Committee of privy counsellors appointed to consider authorised procedures for the interrogation of persons suspected of terrorism, Cmd. 4901, London, HMSO, /n.d./.

outcast, isolation from family and friends, forced association with irredeemable criminals, obligation to wear special clothing, and exposure to aesthetically repugnant measures for the disposal of excreta.

19. In view of the impossibility of arriving at workable definitions of the points at which neglect becomes ill-treatment, ill-treatment becomes cruelty, and cruelty becomes torture, the general term "avoidable maltreatment" has been used in the title of this paper.

VII. Health professions in relation to prisoners and detainees

20. As has already been indicated, Governments that have adhered to the WHO Constitution are under the ethical obligation to preserve the physical and mental health of prisoners and detainees, and this obligation can be met only by ensuring that environmental and sanitary conditions are adequate and that preventive and curative health services are available and correspond to demonstrable needs. Such services can be provided only by the engagement on a full-time, part-time, sessional, or fee-for-service basis of health professionals, who may include physicians (including psychiatrists), clinical psychologists, nurses, or medicosocial workers, with an infrastructure of auxiliary health workers, normally full-time, including medical orderlies.

21. Health workers of all specialties and levels have been trained for the sole purpose of safeguarding, within the limits of their defined responsibilities, the health of those with whom they are in a vocational relationship. Any attempt by a governmental authority to utilize the special knowledge and experience of health workers in the application of procedures detrimental to health would constitute a gross violation of the principles of health ethics that stem from the WHO Constitution.

22. In the peculiar circumstances of life in prisons or other institutions in which civil liberties are restricted, health workers employed by the responsible authority should be given clearly to understand that one of their important duties is to detect and report any signs of physical or mental illness or distress that might call for special treatment and that, in particular, they should be alert to detect and report any evidence of physical or mental maltreatment by fellow prisoners or by custodial staff.

23. It is implicit in the considerations advanced in paragraph 21 that the utilization of health workers as active participants in the application of procedures detrimental to health would be unethical. On the other hand, the question of passive participation offers great difficulties. For example, is it unethical to employ the services of a physician to determine whether a severe restriction of diet, or solitary confinement, would constitute an irreversible hazard to health? In such a situation a negative opinion constitutes a medical sanction to deprive a prisoner or detainee temporarily of his right to conditions favouring health. Conversely, in what circumstances is it ethically permissible that a prisoner who refuses nourishment should be forcibly fed? Forcible feeding is not passive participation by the physician, and other health personnel, but

active intervention to protect the prisoner from a self-imposed hazard to health. It would be entirely unrealistic to attempt to frame general rules of conduct for the many situations in which there may be sincere differences of opinion as to what course of action on the part of health workers is in the best interest of the prisoner or detainee. The ethical implications of some specific situations are considered below.

VIII. Evolving attitudes to the treatment of offenders

24. It is well known that there has been a progressive evolution towards the concept of penal systems as a framework for the reformation and rehabilitation of offenders rather than as a means of inflicting punishment upon them. Crime tends increasingly to be viewed as a social disease calling for prevention and treatment rather than punishment, and etiologically related to such factors as socio-economic environment, family relationships, educational and employment opportunities, and, in some cases, specific social tensions. In general, this reorientation of attitudes to crime does not stem from new medical or scientific knowledge of its aetiology, but rather from a more permissive and compassionate approach to the offender.

25. In some countries acts that were punishable offences only a few years ago - such as attempted suicide, induced abortion, homosexual relations between consenting adults - are no longer so. For such acts as are still indictable offences, there are also continuously evolving attitudes in respect of the most effective methods by which society should deal with the offender, the trend being towards a diminishing severity of penalties. It is evident that these attitudes differ not only from one country to another, but also within each country. For some, routine incarceration in a prison or other "correctional" establishment is a too simplistic approach to the problem of crime, unless the criminal be an acknowledged danger to the health or lives of his fellows. The supreme penalty - capital punishment - is perhaps the simplest example of inter- and intranational differences in attitudes towards the treatment of offenders. While capital punishment has been abolished in many countries, in others a prisoner who attempts suicide in order to avoid the ordeal of hanging, decapitation, electrocution, the gas chamber or the firing squad may be brought back to health in order that society may take his life in the manner and at the time prescribed by the law. If such wide differences of attitudes exist in regard to the supreme penalty, it is hardly to be expected that there should be unanimity about less drastic incursions into the integrity of the prisoner's person.

IX. Forms of maltreatment of prisoners

26. When prisoners or detainees are subjected to forms of maltreatment so extreme that they would be generally accepted as justifying the appellation "torture", these are typically practised in secret in total disregard of the prisoner's legal rights, and the responsible authorities may deny that such practices exist. It follows that precise and verifiable information about the extent to which extreme forms of maltreatment are employed and the degree of participation, if any, by

members of the health professions, is not available. However, it is obvious that such procedures must be inimical to mental health, and may also be to physical health. Such practices are in such flagrant contradiction to the principles of health ethics implicit in the WHO Constitution that it would be idle to pursue the matter further.

27. It is in regard to the relatively minor forms of maltreatment that there is room for discussion and for sincerely held differences of opinion. Whether imprisonment itself may in some circumstances constitute an unwarrantable form of maltreatment is a question on which wide differences of opinion exist, particularly in the case of mentally disordered offenders, juvenile delinquents, and those whose only offence is the possession or use of dependence-producing drugs.

X. Mentally disordered offenders

28. Some of those who repeatedly commit minor offences are suffering from longstanding mental disorder. This places society in the quandary of deciding whether they should be punished for their crime or treated for their mental illness. Further, as "no one is very clear when mental illness finishes and disturbed or deviant behaviour begins, it is inevitable that there will be doubts about whether certain sorts of persons should be in prisons or hospitals". 19/ The view has been expressed that there may in some cases be no line of demarcation, and that an offender may not be either mentally ill or criminally inclined but may be both. 20/

29. Whatever may be the difficulties of drawing a clear distinction - if such must necessarily exist - between criminality and mental disorder, it is widely recognized that a person charged with an offence should have the mental capacity to conduct his own defence or to give suitable instructions to an advocate, and that it would be unethical to punish a person who, by reason of his mental incapacity, was not capable of appreciating the significance of an offence at the time that it was committed. In the light of such considerations, there is a growing tendency for the courts to dispose of offenders medically certified to be suffering from a mental disorder by arranging for them to be admitted to a psychiatric hospital instead of a prison. Such admissions may either be informal, when the offender accepts to be received for observation and any necessary treatment, or compulsory, when the offender is committed to a psychiatric hospital by a court order either for a specified period or until such time as he is considered medically fit for discharge.

30. It has been pointed out, notably by Rollin, 21/ that the policy of preferring committal to psychiatric hospitals rather than to prisons of offenders medically

19/ Scott, P. P., "Punishment or Treatment: Prison or Hospital?", British Medical Journal, 1970, 2, 167-169.

20/ Rollin, H. R., The mentally abnormal offender and the law. Oxford London, etc. Pergamon Press, 1969.

21/ Rollin, H. R., "Social and Legal Repercussions of the Mental Health Act, 1959", British Medical Journal, 1963, 1, 786-783 and op. cit. 1969 (foot-note 20).

judged to be mentally disordered has given rise to new problems, particularly as this policy has developed pari passu with the evolution of the "open door" policy for psychiatric hospitals. In the United Kingdom, this new attitude to mentally abnormal offenders is reflected in the Mental Health Act, 1959, which came into full effect towards the end of 1960. Rollin cites the example of one psychiatric hospital that had had in the last full year before coming into effect of the new Act 19 admissions of mentally disordered offenders. In the first full year after the Act, the number rose to 98. It is evident that this substantial influx of patients who are not only mentally disordered but also socially delinquent imposes new strains upon the management of psychiatric hospitals.

31. According to the experience of Rollin, more than 80 per cent of offenders committed to psychiatric hospitals were schizophrenic. In spite of optimistic claims that have been made for the effect of psychoactive drugs in improving the prognosis in schizophrenia, such a diagnosis implies that a number of schizophrenic offenders are likely to prove refractory to any form of treatment. However, there is no unanimity among psychiatrists as to the frequency of schizophrenia in mentally ill offenders. Thus Kloek was able to find only 1 out of 500 such offenders in whom schizophrenia could be diagnosed with certainty. 22/ Such a vast difference - from more than 80 per cent to 0.2 per cent - can only be explained by the application of different diagnostic criteria, and different criteria for committal to psychiatric hospitals. Some part may perhaps have been played by differences in the nature of the offences. However, this part must be very small because many recidivists perpetrate different offences at different times, and their dossiers may be veritable anthologies of such minor offences as larceny, wilful damage to property, indecent exposure, shoplifting and being drunk and disorderly. A special problem is that in the conditions of "open door" psychiatric hospitals there is a high rate of abscondences, and this rate is much higher for offenders than for non-offenders against the law.

32. It is clear that many mentally abnormal offenders are, in Rollin's words "incorrigible in legal terms and incurable in psychiatric terms", 23/ and are destined to spend their lives alternating between periods of unproductive liberty and, after repeated infractions of the law, spells of incarceration in prisons or psychiatric hospitals. Few of them are violent and in general they represent a social nuisance rather than a danger. An intermediate solution to the problem whether to commit mentally disordered offenders to prison or to hospital is the establishment of psychiatric wings in prisons. In such wings a therapeutic intention and atmosphere may coexist with the safeguards for security of the prison. The conclusion must be reached that no universally applicable guidelines exist for determining whether an offender would more fittingly be detained in a prison or committed to a psychiatric hospital for observation and treatment, but

22/ Kloek, J., "Schizophrenia and Delinquency: The Inadequacy of our Conceptual Framework", In Reuck, A. V. S. and Porter, R. The mentally abnormal offender. London, J. and A. Churchill, 1968, p. 19.

23/ Rollin, H. R., op. cit., 1969, p. 121.

that in either case he should have adequate access to medical care for the treatment of physical or mental illness.

XI. Drug-dependent persons

33. The attitudes to what are the appropriate measures for dealing with the problem of the abuse of dependence-producing drugs vary widely from one country to another, as reflected by their legislative provisions. ^{24/} In some countries the mere possession and/or use of small quantities of such drugs for personal use are offences punishable by imprisonment, sometimes for as long as two years. In others, addicts may be committed for treatment for fixed or indeterminate periods in psychiatric hospitals or special disintoxication clinics. And in some the decriminalization of the use of marijuana is under consideration. Those who favour committal to an institution believe ambulatory treatment to be ineffective, but in some countries an addict may not be subjected to detention if he gives a formal undertaking to undergo medical treatment. This treatment may take the form of gradual withdrawal of the drug or the substitution of methadone, or other drugs, and in both cases psychotherapy may also be employed. Provision may be made for an addict to register as such and to receive maintenance doses of a drug from a physician approved by the appropriate authorities for this purpose. Although there are differences of medical opinion as to the respective merits of institutional and ambulatory treatment, there is virtual unanimity that dependence on drugs, including alcohol, is a form of ill health for which penal sanctions are entirely unsuited. The foregoing applies to the possession and use of a drug per se. There are, of course, drug-related offences such as forged or fraudulently altered medical prescriptions, stealing drugs, robbery with or without violence for the purpose of buying drugs illicitly, and being in charge of a motor vehicle while under the influence of a drug. While these are all offences punishable by imprisonment in most countries, they are also side-effects of a pathological condition that is amenable only to suitable medical treatment, and it is in this light that they should be considered. In a statement presented to the World Health Organization, an extract from which is attached for information as annex 3, the International Council on Alcohol and Addictions "calls for the removal from the penal codes of all laws which prescribe penal sanctions for individuals whose sole offence is addiction to a chemical substance and the transferring of jurisdiction of these individuals from penal authorities to medical and health authorities in the state".

XII. Forcible feeding

34. In psychiatric hospitals, forcible feeding is for certain patients a routine procedure. Such patients are commonly described as "mute, stuporose and inaccessible", and they repudiate all activity, including the taking of nourishment.

^{24/} "Treatment of Drug Addicts: A Survey of Existing Legislation".
Int. Dig. Hlth. Leg., 1962, 13, 4-46.

There is no solution intermediate between letting them die of starvation or forcibly feeding them, usually via a flexible tube passed down the oesophagus. The procedure of forcible feeding is disagreeable for all concerned. The patient may have to be immobilized by two or more nurses, while the physician forces open the mouth with a metal gag, dips the end of the tube into a lubricant, passes the tube into the oesophagus, and administers through it suitably balanced nutriment in fluid form. Although this procedure may be performed daily for some years, it is not without danger for, especially with resistant patients, fluid may enter the trachea and provoke a pneumonia that may be fatal. Nevertheless, no one would deny that it is an ethical imperative to do all that is possible to preserve the life of a psychotic patient for whom there may be little or no hope of ultimate restoration of reason and social integration.

35. It is in this context that the forcible feeding of prisoners or detainees should be considered. Prisoners or detainees who decide on a "hunger strike" may have committed crimes, even appalling crimes involving the death or maiming of innocent victims, but their motives may be primarily social rather than personal. In such cases, deliberate refusal of food is an additional form of protest and a means of calling public attention to the social cause in question. Some are willing to carry their voluntary starvation to the point of suicide, in the hope of achieving a martyrdom that will further their cause. In other cases the motivation may be less idealistic, representing a mere desire to confound and embarrass the prison authorities, and to evoke public sympathy.

36. Article 6 of the "guidelines" adopted by the Council of the World Medical Association condemns without reservation "artificial" feeding of prisoners who refuse nourishment and are considered by the physician to be capable of forming an "unimpaired and rational judgement" concerning the consequences of such refusal. However, the objections to feeding a person against his will are not that the methods used are artificial but that they are forcible. As has already been seen, artificial feeding may be an entirely non-controversial life-saving procedure in certain circumstances. Moreover, it is conceivable that a prisoner might be forced to take nourishment naturally by threats to torture him or to harm his family. It is therefore suggested that the usually employed terms "forcible feeding" or "force feeding" would more accurately reflect the intention of this recommendation.

37. Notwithstanding the unconditional rejection of the forcible feeding of prisoners implied by the WMA recommendation (annex 1) medical opinion on this question is by no means unanimous. Persistent refusal of food until death supervenes is a form of suicide, and the only form for which it has ever been suggested that the physician should not take all necessary preventive or remedial measures to preserve life. Article 63 of the French penal code, for example, provides for heavy penalties, including imprisonment for up to five years, for anyone who abstains from coming to the assistance of a person in danger if he can do so without risk to himself or others. ^{25/} In the United Kingdom the Home

^{25/} Ordres des Médecins. Guide d'exercice professionnel à l'usage des médecins. Paris, Masson et Cie, 1969, p. 84.

Secretary stated in 1974 that a prison medical officer would be neglecting his duty if he let the health of a prisoner on hunger strike be endangered. 26/ At an international symposium on the medical care of prisoners held in 1972 a prison medical officer stated:

"At the moment I am dealing with a man who hasn't eaten voluntarily for 18 months. I am not prepared to let him die. It is as simple as that. It is a very distasteful business but the sanctity of human life comes first." 27/

Another said:

"That situation seems to me quite clear: one has to feed them".

38. The question of what constitutes "an unimpaired and rational judgement" to refuse food is clearly not a simple one, and it might be held, and has been in some cases, that such refusal constitutes in itself evidence of impaired judgement. Even should the physician decide that a prisoner's judgement is unimpaired at the outset of a hunger strike, there remains the question whether such unimpairment is maintained during the whole of the period of progressive inanition that must inevitably lead to death, or whether extreme physical debility or disturbance of consciousness might become the cause of a lack of the will to live. Moreover, it is conceivable that some prisoners might, while resisting forcible feeding, secretly welcome it as a formula for simultaneously preserving both their martyrdoms and their lives.

XIII. Punishment for disciplinary offences

39. Suspension of privileges: This form of punishment may involve such measures as the temporary limitation or suspension of the right to receive visitors, to send or receive letters, to watch television or use the prison library, or to participate in sports or in useful occupations. While such sanctions may make an unhappy prisoner unhappier, this is precisely their intention, and to regard them as constituting a threat to mental health would be unrealistic.

40. Corporal punishment: The Standard Minimum Rules for the Treatment of Prisoners (hereafter referred to as the Standard Minimum Rules) unreservedly reject any form of "corporal punishment". 28/ It would therefore be superfluous to comment on its health implications. However, these rules do not specify what

26/ British Medical Journal, 1974, 3, 52.

27/ Medical care of prisoners and detainees, Ciba Foundation Symposium 16 (new series), Amsterdam, London, New York, Associated Scientific Publishers, 1973, p. 91.

28/ Rule 31.

procedures are comprised by the term "corporal punishment". It is manifest that this term would include the infliction of pain by blows with a cane, birch, rope, or other blunt instrument. It does not include reduction of diet, which is dealt with separately in Rule 32. Whether it includes the infliction of bodily discomfort by such measures as the removal of a mattress, forced assumption of uncomfortable postures, or physically exhausting exercises is not specified. It is to be noted that Rule 31 is not observed in all countries, some of which require a physician to be present during the execution of corporal punishment by blows with a blunt instrument.

41. Severely restricted diets: A severely restricted diet, usually for a stated period, may be imposed upon a prisoner as a punishment for a disciplinary offence. The Standard Minimum Rules do not reject "reduction of diet" as a punishment, but require that a physician shall certify in writing that the prisoner is fit to sustain it 29/ and that he "shall visit daily prisoners undergoing such punishment and shall advise the director if he considers the termination or alteration of the punishment necessary on grounds of physical or mental health". 30/ Normally, restricted diets are deficient in the protein-calories, vitamins, and minerals (including trace elements) that are essential to the maintenance of physical health, and may even lack the carbohydrate content that is necessary to maintain body-weight. Whether it is ethically acceptable that a prison health service should be used as an instrument to determine the extent to which measures prejudicial to health, if only temporarily, should be imposed on a prisoner as a form of punishment is surely very doubtful. Such a concept is tantamount to degrading the mission of a prison health service from that of preserving and improving the health of prisoners to that of advising to what extent their health may be impaired without permanent or lethal consequences.

42. Solitary confinement: The Standard Minimum Rules provide for the same medical surveillance of what is called "close confinement" as in the case of "reduction of diet". 31/ That such surveillance should be required implies that "close confinement" may offer a threat to mental health. If this be so, the question then arises, as in the case of severely restricted diets, whether it is a proper function of a prison health service, whose function is to maintain the health of prisoners, to assist the prison authorities to determine the lengths to which they may go in imposing measures that are harmful to health. When solitary confinement is imposed not as a punishment but as a means of protecting other prisoners, the prison health service would not normally be required to assume responsibility for advising on its effects.

43. It is obvious that both in the case of severely restricted diets and of solitary confinement, the prison medical officer may, as indicated in section XV of

29/ Rule 32 (1).

30/ Rule 32 (3).

31/ Rules 32 (1) and 32 (3).

this report, be faced with a dilemma for which there is no simple and universally applicable answer.

XIV. Methods of restraint

44. Mechanical: Unruly and violent prisoners who damage prison property, offer a threat to other prisoners and to custodial staff, and may even attempt to commit self-destructive acts must evidently be restrained by some method in their own interest and that of others. Such restraint may be the prelude to transfer to a psychiatric hospital, where measures of restraint may still be necessary, perhaps intermittently. Such restraint may take the form of confinement in a locked prison cell or hospital room. Where the person concerned shows self-destructive tendencies, confinement in a padded cell - sometimes euphemistically described as a "quiet room" - may be considered necessary, but the modern tendency is to prefer chemical restraint to seclusion and sometimes, if feasible, the continuous company of a nurse or relation. However, there is not medical unanimity on this point. For example, the view has been expressed that it is "far better to seclude an unruly, angry person than to hold him down and give him an injection". ^{32/} Rule 54 (2) of the Standard Minimum Rules reads: "Prison officers shall be given special physical training to enable them to restrain aggressive prisoners." It is suggested that the words "without harming them" should be added to this rule.

45. The Standard Minimum Rules condemn the use of chains or irons in any circumstances but, by implication, do not exclude the use of handcuffs or straitjackets as "a precaution against escape during transfer" or "on medical grounds by the direction of the medical officer". However, no modern psychiatrist would accept the view that there were any medical grounds for such mechanical methods of restraint. The Standard Minimum Rules do not refer to chemical restraint, or restraint by electroconvulsion therapy or by psychosurgery, but such methods have all been used and the first of them is certainly by far the most common method.

46. Chemical: Chemical restraint is far from being a modern method, having started with the use of bromides, usually potassium bromide, about a century ago. It took almost half a century for it to be generally realized that the long-term use of bromides as tranquillizers resulted in their cumulative concentration in the blood and tissues leading to a state of chronic bromide intoxication that was responsible for or exacerbated manifestations of mental illness. Many patients detained for years in psychiatric hospitals were able to be discharged in a state of adequate mental health as a result of interruption of their treatment. Other chemical substances used successively and sometimes simultaneously for restraining disturbed patients were chloral, paraldehyde, and the early barbiturates. Entire populations of psychiatric hospitals were routinely drugged with one or more of these chemical substances with a view to making them more tractable as a result of a drug-induced diminution of their intellectual and affective faculties.

^{32/} Scott, P. D., op. cit., 1970, (foot-note 19).

47. Today there is a much wider range of drugs that can be used for various kinds of chemical restraint for mentally disturbed detainees, whether hospital patients or prisoners. At one end of the scale there are the modern "tranquillizers", which favourably influence mood without apparent impairment of intellectual capacity or social adjustment, and which may improve the latter, while at the other end there are soporific drugs used to induce a state of torpor or even unconsciousness. It is evident that no use of minor or major chemical restraint is desirable in itself, and that such restraint is justifiable only when restraint is clearly necessary and when it appears to be the lesser evil by comparison with other means of restraint. A related problem is that of the offender who has already come to rely upon tranquillizing drugs, with or without a medical prescription, on admission to prison. Here the question arises whether he should continue to be provided with such drugs. The converse of this situation is the case of the prisoner or patient for whom tranquillizing drugs are prescribed for the first time only after detention, and who by the time of his release may have come to rely upon such drugs. The ethical problems posed by such situations are very complex, and there is no simple answer to them. It is salutary, however, to recall that forms of chemical restraint that were accepted within living memory are today regarded as unacceptable. There is little room for doubt that today's practices may be repudiated in the future, but that they will have to be continued, always under medical supervision, until such time as there is a better solution.

48. Electroconvulsion: In a review of the status of electroconvulsion therapy (ECT) in psychiatrically abnormal prisoners, the authors 33/ express the hope

"that this method of treatment will soon be routinely applied to well-selected psychiatric cases seen in prison. Its use promises ample reward to the physician engaged in the treatment of the criminal who is mentally ill."

The method is said to be of value in the treatment of "psychotics, psychoneurotics, and psychopaths". 33/ It is to be noted that these three groups comprise the entire range of mental illnesses except mental retardation. The authors also quote a publication by the medical officer of a large prison,

"who treated a considerable number of inmates manifesting early signs of mental illness, with the purpose of avoiding, as much as possible, the development of major psychoses". 34/

33/ Almensi, R. J. and Impastato, D. J., "The Use of Electroshock Therapy in Correctional Institutions". In: Lindner, R. M. and Seligor, R. V., Handbook of correctional psychology. New York, Philosophical Library, 1947.

34/ The names of the author and the prison are given without a bibliographical reference.

49. The authors state that the treatment requires a physician and three assistants, or four assistants for "particularly strong patients", and that

"Reluctance to submit to treatment is sometimes the first difficulty encountered ... We manage these cases by the administration of 0.5 mg of sodium amytal intravenously or intramuscularly."

A criticism that has been made of the use of ECT for violent or unruly patients is that, while it may be ostensibly therapeutic in intention, it is in fact used as a form of restraint. 35/

50. Whatever may be the merits and demerits of ECT, it would seem entirely unacceptable that an unwilling prisoner should be drugged into submission to this or any other treatment. Moreover, ECT is an entirely empirical form of therapy having no scientific rationale, opinions within the medical profession as to its value are divided, and it is not devoid of complications such as compression fracture of the vertebrae or fractures of other bones, although the use of muscle relaxants has minimized this danger. The conclusions may be drawn that a prisoner should not be forced by administration of drugs or otherwise to submit to any form of medical treatment against his will, and that he should not be subjected, while in prison, even though willing, to ECT or any other form of medical treatment that is in the least degree controversial.

51. Psychosurgery: The suggested objections to the use of ECT on prisoners apply even more forcefully to the use of psychosurgery, in which critical areas in the brain are irreversibly damaged with a view to inducing behavioural changes. Nevertheless, medical opinion on this point is not unanimous. At the international symposium on the medical care of prisoners to which reference has already been made, a participating psychiatrist expressed the view that

"With modern advances in procedures like operations on the temporal lobe and so on, it would be quite unfair not to offer a prisoner this, even if it was experimental in the sense that the result wasn't entirely predictable." 36/

Another psychiatrist stated, referring to lobotomies,

"I regard them as anathema. They are permanently damaging and without any redeeming feature as far as I am concerned. A number were done on so-called sociopaths and all they did was to make them more sociopathic." 37/

A participating anatomist referred to "the ethical question of the rights of society to order the partial execution of a prisoner by surgery." 38/ He also

35/ For example, Hunter, R. A., "The Rise and Fall of Mental Nursing". Lancet, 1956, 1, 98-99.

36/ Medical care of prisoners and detainees. Ciba Foundation Symposium 16 (new series), Amsterdam, London, New York, Associated Scientific Publishers, 1973, p. 72.

37/ Ibid., p. 97.

38/ Ibid., p. 97.

repudiated the idea that it was possible by psychosurgery to abolish criminal aggression while leaving other aspects of personality and behaviour intact. Psychosurgery is probably the most controversial of all forms of medical treatment currently practised, and it is therefore a method that should in no circumstances be used on prisoners.

52. Castration: There are wide divergences of opinion both as to the ethical justification of castration as a means of restraining aberrant sexual behaviour and as to the extent to which the procedure is effective in attaining its object. Castration of prisoners convicted of repeated sexual offences may be provided for, subject to certain conditions, in the legislation of one country, while in that of another castration for any reason other than the relief of organic disease is a tort and a crime. In one small European country prison authorities may advise those detained for sexual offences that they may apply for a permit to be castrated. The application must be in writing and the prison medical officer must have explained to the prisoner the nature and probable consequences of the operation. Applications are considered by a Forensic Medical Council, which reports to the Minister of Justice. Authorizations are given by the Minister, and the operation must not be performed until 6 months after receipt of the authorization. In cases of mental illness or mental retardation an application may be submitted by a parent or other legal guardian. No one under the age of 21 can be so castrated "unless there are special reasons for so doing". ^{39/} These reasons are not specified. "The testes are usually replaced by prostheses in order to keep the appearance of the scrotum unchanged." ^{40/}

53. In the country to which reference is made above, there were 900 castrations in the period 1929-1959. Of these, about a third of the subjects were prisoners or detainees, another third patients in psychiatric hospitals and institutions for the mentally retarded, and the remaining third non-institutionalized men who had requested the operation. ^{41/} A follow-up of these subjects, all of whom are described as "sex offenders", showed that only 20 (2.2 per cent) recidivated. It has been claimed that "more than 90 per cent of these patients were satisfied with the operation", and that this experience is "in full accord with results obtained from studies conducted in other European countries". Also that "it is not unusual for a defence lawyer to broach the question" of castration. ^{42/} The inference that must be drawn from this last statement is that a defendant who undertakes to make an application for castration may be hoping that by so doing he will receive a lighter sentence.

^{39/} These requirements are laid down in a law of 1967 of which extracts are given in English in Int. Dig. Hlth. Leg., 1968, 19, 746-749.

^{40/} Stürup, G. K., "Sex Offenders in Denmark". In: Ramsey, I. T. and Porter, R., Personality and science, Edinburgh and London, Churchill Livingstone, 1971.

^{41/} Stürup, G. K., op. cit., 1971.

^{42/} Idem.

54. As has been stated by a distinguished criminologist,

"any irreversible intervention affecting the physical integrity of a man is one of the few instances where basic principles are involved. One either agrees or disagrees: one cannot compromise." 43/

Those who disagree with the castration of sexual offenders claim that the practice is unethical, as the offender or prisoner who volunteers for this operation is influenced by the hope of a lighter sentence or, if he is already in prison, of earlier release from detention, and is therefore not in a position to offer free consent, untrammelled by considerations of secondary gain, for a mutilation that he might later regret. Prisoners who opt for this operation have been described as "bartering their testicles for their freedom". 44/ An intermediate point of view is that a prisoner should be advised to defer a decision on the operation until after he has been released from prison. However, some authorities question not only the ethical justification of castration but also its efficacy, citing, for example, the case of a rapist who volunteered for castration and "was back in prison within two years, having turned to child molestation and murder". 45/ A less drastic form of hormonal restraint is the subcutaneous implantation of stilboestrol pellets, but this method has also been criticized as ineffective.

55. A weakness of either form of hormonal restraint is that rape, as with other sexual offences, is not simply the product of a strong sexual impulse, but a combination of a sexual impulse, not necessarily stronger than that of those who do not commit rape, with the will to commit rape. In other words, there is no proven statistical correlation between strength of sexual impulse - for which, in any case, there is no means of objective measurement - and liability to commit rape. In fact, sexually motivated murders by the impotent or near-impotent are not unknown. Further, there is not even an accepted correlation between the level of circulating androgenic hormones and strength of libido. The conclusion may be reached that whatever may be the ethical considerations involved, it is not a generally accepted medical opinion that castration or hormonal demasculinization are effective treatments for sexual offenders, and that these are therefore questionable methods for dealing with prisoners.

43/ Medical care of prisoners and detainees. Ciba Foundation Symposium 16 (new series). Amsterdam, London, New York, Associated Scientific Publishers, 1973, p. 73.

44/ Ibid., 1971, p. 72.

45/ Ibid., p. 75.

XV. Intensive interrogation methods

56. It is a matter of common knowledge that intensive interrogation methods involving varying degrees of maltreatment have sometimes been used to exact information or confessions from prisoners of war in defiance of the Geneva conventions and also from civil prisoners or detainees, often in defiance of national laws or constitutional rights. There is a special temptation to use such methods on non-convicted detainees suspected of very serious crimes that arouse the indignation not only of the general public but also of the forces of law and order, such as murder, rape, and bombing outrages as a result of which innocent victims are killed or maimed. These methods may be used on detainees suspected of having committed, or intending to commit, or knowing of intentions of others to commit, acts of terrorism. The fact that such methods are generally regarded with abhorrence, and are harmful to the international reputation of any Government that permits their use, leads to concealment and denials by the authorities. Normally the only information that is available about such methods is from declarations of ex-detainees who claim to have been subjected to them. While such declarations may in fact be truthful, their status is that of allegations rather than of verdicts pronounced as a result of confrontation of accuser and accused and of an objective evaluation of the merits of the case by an impartial tribunal.

57. A rare example of detailed public and official investigations into allegations of cruel methods of intensive interrogation became available a few years ago as a result of civil disturbances. This example is not selected for mention in this report because the procedures practised were particularly flagrant incursions upon the rights of detainees. On the contrary, the Government concerned took the honourable and unusual course of appointing on two occasions independent panels of men eminent in public life to hear evidence both from detainees who claimed to have been subjected to objectionable procedures and from the prison officers concerned, including medical officers, with the final outcome that the procedures against which the detainees had protested were discontinued. The reports of both panels were issued as government publications.

58. While it is distasteful to revive memories of unacceptable practices that have since been voluntarily renounced by a particular Government, the very frankness of the official publications of this Government make them unique sources of information on the nature of certain intensive interrogation procedures. There is little doubt that in other countries procedures of equal or even greater severity have been employed, but any information on these is derived from allegations by those claiming to be victims rather than from a truly impartial inquiry.

59. The two published reports referred to above are generally known as the Compton Report and the Parker Report, to which reference has been made in section VI of this report, and the authors of each were different three-man panels. The Compton Report summarizes evidence taken both from 11 detainees suspected of involvement in terrorist activities and from prison officers. All detainees complained that their heads had been covered with hoods except during interrogation or when in cells by themselves, and that while in their cells they were submitted to continuous and monotonous noise. They also complained that during interrogation they were forced

to stand for long periods facing a wall, with their arms raised and legs apart, that their diet was restricted to bread and water, and that they were deprived of sleep. The panel found that all these allegations were true, and that each of the procedures practised - hooding, continuous noise, posture against the wall, deprivation of sleep, and severely restricted diet - constituted physical ill-treatment that did not amount to "brutality". The panel also found that there had been "an insufficient awareness of the medical hazards involved in this type of operation" and that there were defects in the arrangements for "medical cover".

60. The authors of the Parker Report were members of a panel consisting of three Privy Counsellors. Two of them made a majority report condoning the interrogation procedures subject to certain safeguards. The third member, a former Lord Chancellor, made a minority report denouncing the procedures as not only morally unjustifiable but also as illegal. The Government accepted the minority report.

61. In the example mentioned above, the medical officers responsible for the health of detainees had the duty of certifying whether such detainees were fit to undergo the physical maltreatment that was part of the interrogation procedure. The authors of the Compton Report commended "the medical officers concerned for the efficient manner in which they carried out these unexpected duties", the only criticism being that this medical screening was not sufficiently systematic. In that the interrogation procedure in force was subsequently declared to be illegal, these medical officers were unwittingly co-operating in illicit practices.

62. Where physical maltreatment of detainees is a part of interrogation procedures, either in conformity with the law or in violation of it, the prison medical officer is placed in a quandary, the complexity of which should not be oversimplified. If he examines a detainee, fails to find any evidence that the interrogation procedure is likely to result in a permanent injury to health, and reports accordingly, he becomes a participant in the total interrogation procedure. If he refuses to express an opinion as to the detainee's ability to withstand the interrogation procedure, he may be passively participating in the infliction of procedures that could permanently injure the health or even threaten the life of a detainee, for it is unlikely that the mere lack of a medical opinion would deter those responsible from carrying out the interrogation. It would seem therefore that the only effect of medical screening would be to preserve from the infliction of physical maltreatment some detainees who would otherwise have been subjected to it.

63. As in the case of solitary confinement and severely restricted diets, it seems anomalous that a prison health service should be placed in the position of, as it were, selecting prisoners or detainees for maltreatment. On the other hand, without the intervention of the health service, detainees unfit to withstand maltreatment might nevertheless be subjected to it. In the circumstances, it may be very difficult for the prison medical officer to form a judgement as to what course of action is in the best interests of a particular detainee. In reality, this is not a medical problem, but a matter for the conscience of society as a whole.

XVI. Biomedical experiments on prisoners

64. Reference has already been made to methods of restraint by treatments about which there are wide differences of opinion, and which must therefore be regarded as experimental and for this reason inappropriate for the treatment of prisoners. This is especially the case in that prisoners do not have access to a personal physician of their choice, while if they did have such access the chosen physician might be one of those opposed to the treatment. Aversion therapy, while not a form of restraint, must also be regarded as a procedure that is still in an experimental stage. It has been used, inter alia, for drug-dependent persons, sexual offenders, and obsessive gamblers whose weakness has caused them to come into conflict with the law. The subject may be asked to recount his misdeeds while an unpleasant stimulus, such as an electric shock, is applied or a drug, such as apomorphine, which produces severe nausea, may be administered.

65. The use of prisoner volunteers for non-therapeutic biomedical experiments, as of volunteers from other special segments of the population, such as students, has often been criticized.

"Critics maintain that in such groups there may be special incentives - such as the desire of students to find favour with professors or to avoid the appearance of being uncooperative - that invalidate consent. In the United States of America there has been widespread use of volunteers from among prison populations for the first clinical trials of new pharmaceutical preparations and other investigations. Prisons permitting this practice may have a detailed tariff of cash payments made for various interventions. In one case these range from 25 cents for a stool specimen to \$12 for a bone-marrow aspiration." 46/

66. Protagonists of the use of prisoner volunteers point to participation in experiments as a welcome relief from the monotonies of life in prison:

"To these inmates life is basically a bore, and one day is quite like another. The experiment breaks this boredom and as such is refreshing. It also introduces a note of excitement into prison life. Man in general needs some stimulation." 47/

Further:

"The volunteers were subjects of interest to the entire prison, not only to the other inmates, but also to employees of the prison at all levels.

46/ "Health Aspects of Human Rights in the Light of Scientific and Technological Developments". WHO report distributed to the Commission on Human Rights of the Economic and Social Council as document E/CN.4/1173, 18 February 1975.

47/ McDonald, J. C. "Why Prisoners Volunteer to be Experimental Subjects". J. Amer. Med. Ass., 1967, 202, 511-512.

People inquired of the experiment's progress, what was being required of the inmates as volunteers, and what was being learned. As they conversed, the volunteers found that they were no longer nonentities. Suddenly, they were important! They became, at least for a while, the elite of their own society."

67. Experiments upon prisoner volunteers are sometimes performed within the prison premises and sometimes in an ordinary hospital. In one university hospital a prisoner spent almost one year participating in studies on the effects of certain antivitamin on pantothenic acid metabolism. 48/ At this hospital prisoner volunteers were paid \$1 per day.

68. The field in which there has been the most extensive use of prisoner volunteers for experiments is that of clinical pharmacology. In the United States of America requirements for the introduction into medical practice of new pharmaceutical preparations are very stringent, and before clinical trials on patients may be undertaken a new drug must first have been tested on healthy human volunteers. 49/ Such a drug will have been subjected to exhaustive tests on animals resulting in a near certainty that it will be harmless to human beings, although it may be only after many millions of doses have been used clinically that undesirable side-effects may become apparent. Testifying before a United States Senate sub-committee in 1973, the President of the Pharmaceutical Manufacturers Association of the United States of America advanced two main justifications for this use of volunteer prisoners: (i) the subjects were "relatively homogeneous", and living in a constant environment as regards time, place, diet, and exercise; (ii) they were willing to volunteer for a far lower financial reward than would be the case with non-prisoners. The witness testified that "the most important factor behind prisoner participation is financial reward", and gave as additional reasons "to escape the tediousness of prison life; to be part of a commendable effort; to show themselves and others that they can do good and worthwhile things; to gain acknowledgement as individuals deserving respect; to show authorities that they are reforming". 50/

69. In 1973 the Department of Health, Education and Welfare of the United States of America drafted very full and objective general policy considerations to be taken into account in accepting the voluntary participation of prisoners in biomedical experimentation. These considerations were drafted against a background of some years of discussions of problems of human experimentation at several levels both by medical scientists and by groups concerned with human rights, and as such they deserve reproduction at some length:

48/ Hodges, R. E. and Bean, W. B. "The Use of Prisoners for Medical Research". J. Amer. Med. Ass., 1967, 202, 513-515.

49/ United States. Code of Federal Regulations, Title 21, Parts 130 to 146 e, Washington, 1970.

50/ United States Congress. Senate Committee on Labour and Public Welfare. Subcommittee on Health. Quality of health care - human experimentation, 1973. Hearings ... Ninety-third Congress, First Session, Washington, 1973, pp. 846-883.

"Clinical research often requires the participation of normal volunteers; for example, in the early stages of drug or vaccine evaluation. Sometimes, the need for standardization of certain variables, or for monitoring responses over an extended period of time, requires that the subjects of research remain in a controlled environment for the duration of the project. Prisoners may be especially suitable subjects for such studies, since, unlike most adults, they can donate their time to research at virtually no cost to themselves. However, the special status of prisoners requires that they have special protection when they participate in research.

"While there is no legal or moral objection to the participation of normal volunteers in research, there are problems surrounding the participation of volunteers who are confined in an institution. Many aspects of institutional life may influence a decision to participate; the extent of that influence might amount to coercion, whether it is intended or not. Where there are no opportunities for productive activity, research projects might offer relief from boredom. Where there are no opportunities for earning money, research projects offer a source of income. Where living conditions are unsatisfactory, research projects might offer a respite in the form of good food, comfortable bedding, and medical attention. While this is not necessarily wrong, the inducement (compared to the deprivation) might cause prisoners to offer to participate in research which would expose them to risks of pain or incapacity which, under normal circumstances, they would refuse. In addition, there is always the possibility that the prisoner will expect participation in research to be viewed favourably, and to his advantage, by prison authorities (on whom his other few privileges depend) and by the parole board (on whom his eventual release depends). This is especially true when the research involves behaviour modification and may be termed 'therapeutic' with respect to the prisoner. In such instances, participation inevitably carries with it the hope that a successful result will increase the subject's chances for parole. Thus, the inducement involved in therapeutic research might be extremely difficult to resist; and for this reason, special protection is necessary for prisoners participating in research, whether or not the research is therapeutic. Many prisoners are strongly motivated to participate in research, and view as unfair suggestions that they be denied this opportunity. Unless society, through its judicial and legislative bodies, decides that such participation should be halted, it is essential to develop mechanisms to protect those who may participate, or who are now participating, from the coercive aspects of incarceration which diminish their capacity for voluntary consent." 51/

70. Unless all medical progress is to come to a standstill, any new drug or other treatment must be tried for the first time on a human being or group of human beings. In practice, individual idiosyncrasies would exclude reliance of a trial on one person, although it may be noted in passing that the first clinical trial of penicillin was in fact made on a single subject, although the reason for this was that the available supply of the antibiotic was then so minute that it even proved

51/ United States. Federal Register, 1973, 38, 31743.

insufficient to provoke more than a temporary remission of the subject's infection. ^{52/} The question arises, then: who shall be the group of persons upon whom a drug is tested for the first time, and shall they be sick persons in need of treatment or healthy volunteers? The collateral question arises whether persons who are ill and in need of medical treatment should be subjected to trials with a drug never before used on a human being that may conceivably have some unexpected side-effect detrimental to their health.

71. In most countries therapeutic trials of new drugs on sick persons are permitted subject to certain safeguards and administrative controls which differ considerably from one country to another. Where such trials may not be undertaken before there have been tests on an adequate sample of healthy human volunteers the question arises: what are to be the catchment areas for such volunteers? Medical and nursing students are a possible source of volunteers for relatively short-term experiments, although objections have been made to their use for this purpose. However, when an experiment must continue for weeks or months under fully controlled conditions neither students nor those in gainful employment have the necessary time at their disposal, and there remain as potential subjects the unemployed, old-age pensioners, and the prison population. All three social groups have in common that unlimited time is at their disposal and, often, that even a modest financial reward is an incentive to volunteer.

72. The case of prisoner volunteers is often treated as if it were unique, but it is submitted that there is no essential difference in their motivation and that of other special social groups. What is unique in the case of prisoner volunteers is the strength of the incentive to interrupt the misery and monotony of prison life, to enjoy greater amenities, to gain some sort of social approbation, and, in some cases, to escape from humiliating treatment from fellow-prisoners or custodial staff. With the reservation that no experiments involving a foreseeable risk to life or of irreparable damage to health should be performed on any human being, it may be concluded that outright condemnation of the participation of prisoners in any biomedical experiments is unrealistic, and fails to take into account not only the limitations of the catchment areas for volunteers for any but very short-term experiments but also the material and moral benefits that may accrue to a prisoner from such participation.

XVII. Provisions relating to health in the Standard Minimum Rules for the treatment of prisoners

73. Rules 22-26 of the Standard Minimum Rules have the subheading "Medical services". However, there are many other rules that have an important bearing on health, most of them being de facto specifications, often not quantitative, of health requirements. Specifically, these are rules 10, 11, 12, 13, 15, 17 (1) (2), 20, 21, 32, 33 (b) (c), 43 (2) (4), 44 (1), 45 (2), 49 (1), 52 (1) (2), 53 (3), 62, 66 (2), 71 (2), 74 (2), 82, 83, 91.

^{52/} Abraham, E. P., Chain, E., Fletcher, C. M., Florey, H. W., Gardner, A. D., Heatley, N. G. and Jennings, M. A. "Further observations on penicillin". Lancet, 1941, 2, 177-188.

74. It would seem to be desirable that all rules touching the health of prisoners should be brought together in an organized and codified form to constitute what might be regarded as or called a "Health Charter for Prisoners" (hereafter called the "Health Charter").

75. This would not necessarily imply a recasting of the present Standard Minimum Rules. The "Health Charter" could be appended to the Standard Minimum Rules for the guidance of those particularly concerned with the health protection of prisoners, or it could be issued as a separate document.

76. The question arises whether the "Health Charter" should consist merely of a restructuring of the existing rules relevant to health and medical care, or whether each rule should be critically examined with a view to suggesting amendments, amplifications, or possibly additional provisions.

77. If it be accepted that it is desirable that there should be a "Health Charter", perhaps amplifying or amending those of the Standard Minimum Rules that relate to the health of prisoners or detainees, the Director-General of WHO would consider the extent to which he could assist in the drafting of such a charter, which would not be mandatory but would be offered as a desirable objective.

XVIII. Concluding remarks

78. In this document an attempt has been made to outline the various situations in which the health of prisoners and detainees may be involved, the implications for prison health services of some of these situations, and the extent to which the World Health Organization is involved in relevant ethical considerations. The document represents an approach by the World Health Organization to problems of the health protection of prisoners and detainees. Any further study of these problems arising from discussions at the Fifth United Nations Congress on the Prevention of Crime and the Treatment of Offenders would imply consideration of the whole subject by the governing bodies of WHO.

Annex I

DRAFT DECLARATION OF TOKYO OF THE WORLD MEDICAL ASSOCIATION

GUIDELINES FOR MEDICAL DOCTORS

Concerning Torture and Other Cruel, Inhuman or Degrading Treatment
or Punishment in relation to Detention and Imprisonment

Statement approved by the Council of the World Medical Association, March 1975.
(This Statement is being recommended by the Council to the Twenty-ninth World
Medical Assembly, Tokyo, October 1975, for adoption as the Declaration of Tokyo.)

PREAMBLE

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

DECLARATION

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.
2. For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.
3. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.
4. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.
5. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible.
6. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he shall not be fed artificially. The

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decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

7. The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctors to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

8. The doctor shall in all circumstances be bound to alleviate the distress of his fellow men, and no motive - whether personal, collective or political - shall prevail against this higher purpose.

Annex II

DECLARATIONS OF GENEVA AND OF HELSINKI
OF THE WORLD MEDICAL ASSOCIATION

DECLARATION OF GENEVA

At the time of being admitted as a member of the medical profession:

I solemnly pledge myself to consecrate my life to the service of humanity.

I will give to my teachers the respect and gratitude which is their due;

I will practise my profession with conscience and dignity;

The health of my patient will be my first consideration;

I will respect the secrets which are confided in me, even after the patient has died;

I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;

My colleagues will be my brothers;

I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I make these promises solemnly, freely and upon my honour.

The text of the International Code of Medical Ethics is as follows:

Duties of doctors in general

A doctor must always maintain the highest standards of professional conduct.

A doctor must practise his profession uninfluenced by motives of profit.

The following practices are deemed unethical:

(a) Any self advertisement except such as is expressly authorized by the national code of medical ethics.

(b) Collaborate in any form of medical service in which the doctor does not have professional independence.

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(c) Receiving any money in connexion with services rendered to a patient other than a proper professional fee, even with the knowledge of the patient.

Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest.

A doctor is advised to use great caution in divulging discoveries or new techniques of treatment.

A doctor should certify or testify only to that which he has personally verified.

Duties of doctors to the sick

A doctor must always bear in mind the obligation of preserving human life.

A doctor owes to his patient complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond his capacity he should summon another doctor who has the necessary ability.

A doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him.

A doctor must give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

Duties of doctors to each other

A doctor ought to behave to his colleagues as he would have them behave to him.

A doctor must not entice patients from his colleagues.

A doctor must observe the principles of "The Declaration of Geneva" approved by the World Medical Association.

DECLARATION OF HELSINKI

It is the mission of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfilment of this mission.

The Declaration of Geneva of the World Medical Association binds the doctor with the words, "The health of my patient will be my first consideration"; and the International Code of Medical Ethics which declares that "Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest".

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to each doctor in clinical research. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil, and ethical responsibilities under the laws of their own countries.

In the field of clinical research a fundamental distinction must be recognized between clinical research in which the aim is essentially therapeutic for a patient, and clinical research the essential object of which is purely scientific and without therapeutic value to the person subjected to the research.

I. Basic principles

1. Clinical research must conform to the moral and scientific principles that justify medical research, and should be based on laboratory and animal experiments or other scientifically established facts.

2. Clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man.

3. Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

4. Every clinical research project should be preceded by careful assessment of inherent risks in comparison to foreseeable benefits to the subject or to others.

5. Special caution should be exercised by the doctor in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedure.

II. Clinical research combined with professional care

1. In the treatment of the sick person the doctor must be free to use a new therapeutic measure if in his judgement it offers hope of saving life, re-establishing health, or alleviating suffering.

If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In case of legal incapacity* consent should also be procured from the legal guardian; in case of physical incapacity the permission of the legal guardian replaces that of the patient.

2. The doctor can combine clinical research with professional care, the

* Note: The phrase "legal incapacity" means incapacity to give consent freely.

objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.

III. Non-therapeutic clinical research

1. In the purely scientific application of clinical research carried out on a human being it is the duty of the doctor to remain the protector of the life and health of that person on whom clinical research is being carried out.

2. The nature, the purpose, and the risk of clinical research must be explained to the subject by the doctor.

3a. Clinical research on a human being cannot be undertaken without his free consent, after he has been fully informed; if he is legally incompetent the consent of the legal guardian should be procured.

3b. The subject of clinical research should be in such a mental, physical, and legal state as to be able to exercise fully his power of choice.

3c. Consent should as a rule be obtained in writing. However, the responsibility for clinical research always remains with the research worker; it never falls on the subject, even after consent is obtained.

4a. The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator.

4b. At any time during the course of clinical research the subject or his guardian should be free to withdraw permission for research to be continued. The investigator or the investigating team should discontinue the research if in his or their judgement it may, if continued, be harmful to the individual.

Annex III

EXTRACT FROM A STATEMENT BY THE INTERNATIONAL COUNCIL
ON ALCOHOL AND ADDICTIONS (MAY 1975)

The treatment of individuals addicted to chemical substances

In that it is widely recognized that it is in the best interest of both the sovereign State and the individual for persons addicted to chemical substances to be dealt with as public health problems rather than as ordinary criminal offenders, differential processes and procedures shall be established distinguishing between individuals manifesting symptoms of their addiction (in the instance of alcoholism, intoxication) and ordinary criminal offenders. While it may be necessary from time to time for the sovereign State to intervene to prevent the social contagion of widespread harmful, nonmedical usage of chemical substances through the restriction of the freedom of addicted individuals, such intervention shall be for the medical and social rehabilitation of the individual and not considered as a punitive action by the State.

In view of the need to differentiate between individuals addicted to chemical substances and ordinary criminal offenders, the International Council on Alcohol and Addictions calls for the removal from the penal codes of all laws which prescribe penal sanctions for individuals whose sole offence is addiction to a chemical substance and the transferring of jurisdiction of these individuals from penal authorities to medical and health authorities in the State.

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