Making standards work

an international handbook on good prison practice

Penal Reform International

PRISONERS' PHYSICAL AND MENTAL HEALTH

Opening statement

1. Physical and mental health of prisoners is the most vital as well as the most vulnerable aspect of life in prison.

   The **Universal declaration of Human Rights** states that:

   Article 3
   Everyone has the right to life, liberty and security of person and that:

   Article 5
   No one shall be subjected to torture or to cruel, inhuman and degrading treatment or punishment.

   The **Body of Principles (Principle 6),** the **International Covenant on Civil and Political Rights (Articles 6.1 and 7)** claim the same rights, as well as the **U.N. Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment** in its preamble. The **Body of Principles** moreover explains in a note added to **Article 6** "The term cruel, inhuman or degrading treatment or punishment should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental, including the holding of a detained or imprisoned person in conditions which deprive him, temporarily or permanently, of the use of any of his natural senses, such as sight of hearing, or of his awareness of place and the passing of time".

2. Health care consequently is of most prominent importance and prisoners' health has to be a priority of treatment in prison. The level of health care in prison and medication should be at least equivalent to that in the outside community. It is a consequence of the government's responsibility for people, deprived of their liberty and thus fully dependent on the state authority.

   According to **Rule 57** of the SMR referred to in **Section I**, **paragraph 22**, imprisonment is afflictive by its very nature and shall not be aggravated. The Rule states that deprivation of liberty implies deprivation of the right of self-determination. When that right has been lost not only in principle, but also is impeded in daily practice by the rules governing prison regime, it will be difficult for a prisoner to take measures which he or she would consider necessary or desirable for his or her health. It is then an obvious responsibility of the government to ensure prisoners' right to life, good health standards in prison and

to guarantee healthy living and working conditions, activities and treatment which do not harm health of prisoners, and efficient and sufficient medical and nursing provisions and procedures.

Health care for prisoners and detainees: a matter of priority

3. Too much emphasis can never be put on the fact that a fair trial, including a well-founded indictment, information about legal procedures and legal aid and about prison rules and facilities are essential preconditions to prisoners' mental as well as physical health. Moreover long prison sentences as such are damaging to a person's well-being. They should be imposed as sparingly as possible. Sentencing being beyond the competence of prison administrations, they nevertheless could contribute to shortening long imprisonment where appropriate and possible by making use or recommending to make use of release, parole, remission or grace. In general, seriously ill prisoners without a prospect of recovery should be released and outside care and housing with family, friends or appropriate bodies should be ensured.

4. SMR summarily mention health care for pre-trial prisoners (see **Rule 91**, **para. 22** of this Section). As has been pointed out in the opening chapter **"Where the Handbook starts from", para. 13**, the SMR should also be applied to people detained in remand centres, in police stations and other establishments. Therefore the rules about health and health care in prison and what they imply in practice, are to be followed at all places where people are detained.

5. Being imprisoned means being made powerless and dependent and often without knowledge of what will happen and how to get some hold of one's situation. It creates bitterness, aggressiveness, nervousness, stress. The frequency of visits to a doctor, excessive use of sleeping pills, tranquillizers, drugs, even efforts of suicide particularly during pre-trial detention prove it.

   Mental health affects physical health and vice versa. Therefore humane living conditions, psychologically and socially stimulating treatment of prisoners are also matters of health. Likewise confidence of prisoners in the health care of the prison is a remedial factor as such. This can only be obtained if it is known to everyone in prison that for a prison physician, nurse or health worker the patient always has to have and indeed has priority over order, discipline or any other interest of the prison.

Health care and health care functions

6. In order to ensure the physical and mental health of prisoners, the SMR contain rules which point at necessary provisions. Prisoners should be

informed properly about them and about procedures to make them obtainable, about the exact purpose of prescribed medicines and about the contents of their medical reports and files. There should be more openness towards prisoners about their personal state of health and about medical treatment.

Right to health

7. The SMR do not look at the well-being of prisoners from the viewpoint of the prisoners. Nor are they formulated as rights of prisoners. In contrast, the **Universal Declaration of Human Rights** refer to the physical and mental well-being of prisoners as a right where they declare that **'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family ...' (Article 25)**.

8. About restriction of these rights the **Declaration** provides, that:

   "In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society" (Article 29. 2).

   These restrictions in no way injure the right of health.

9. Both Rules mentioned in **paragraphs 7** and **8** speak about rights and thus imply a certain responsibility of prisoners for their own well-being. While deprived of some opportunities to take care of their own health, they are not deprived of their own responsibility to do so. Staff should remind prisoners of this and encourage them to exercise that responsibility, for example concerning taking exercise, washing and shaving, cleaning their teeth, smoking, keeping their living space clean. If prisoners do not accept responsibility for their state of well-being however, they should not be punished. They should be informed about health and hygiene risks, prevention of risks, first aid measures etc. Furthermore if prisoners behave irresponsibly so as to create a general health hazard to others, it may be necessary to impose measures of hygiene.

   However if there are no proper provisions and opportunities to actively care for their health and hygiene, nor for timely consultation of a physician or other health officer, prisoners cannot be held responsible.

10. SMR claim that the medical service in prison **'should be organized in close relationship to the general health administration of the community or nation'** (**Rule 22**).

Therefore access of medical provisions in the local community to the prison and prisoners requesting medical advice from or being treated by outside services should be permitted as much as reasonable. Prison doctors themselves in particular should not scruple to refer to outside medical services, nor consider this an insult of their professional skills.

Quality of medical services

11. It is often asked what the standard of health care should be. In many countries or parts of countries the medical services in the community leave much to be desired. Their actual availability may be insufficient; their accessibility, e.g. for financial reasons, may be bad. Should medical care in prisons then be better than in the outside community?

12. Neither the SMR nor any other international regulations give the impression that poor health care in prison is acceptable, if it is poor in the community. The government has full responsibility for imprisoned people, who are placed under its total authority. It is not tolerable for imprisonment to add sickness, physical or mental suffering to the punishment. Health is therefore a prime responsibility. That responsibility is even bigger, since the situation of imprisonment in itself to a greater or less extent is damaging to people's physical and mental health. Moreover and perhaps in contrast to the situation outside, but consistent with **Rule 57** (see **paragraph 2**), medical care has to be provided free of charge, as is required by **Principle 24** of the **Body of Principles** (see **paragraph. 31**).

Prisoners' health: a responsibility of all staff members

13. It can be concluded from the preceding rules, that the physical and mental health of prisoners is a responsibility not only of the government and the prison administration, nor of health officers only, but also of prison staff, managerial as well as executive staff and others engaged in treatment of prisoners. Every staff member in prison should ensure that these prisoners' rights and entitlements are enforced and he or she has to contribute to it.

    Mention has to be made of psychologists and social workers, who also have come to play an important role in matters of health, mental health in particular. Their profession and position in prison should be respected and supported similarly as those of health officials.

14. Attention may be drawn to the **U.N. Code of Conduct for Law Enforcement Officials**. It states in **Article 6** that:

    "law enforcement officials shall ensure the full protection of health of persons in their custody and, in particular shall take immediate action to secure medical attention whenever required."

This code includes prison staff, and therefore the quoted **Article 6** should be applied conscientiously by prison staff as well. Every request of a prisoner to see a doctor should be taken very seriously, answered and agreed to promptly, unless if misuse is patent. In case of doubt a request should be granted. If afterwards willful misuse is established, appropriate disciplinary sanctions may be taken, but a new request to see a doctor should never be refused by referring to a former misuse.

15. Mention may be made of Amnesty International's publication of **'Ethical Codes and Declarations relevant to the Health Professions.'** It is a compilation of selected ethical texts and comprises of statements of international professional associations of physicians, psychiatrists, nurses and psychologists, for example.

Physician's functions: the patient is the priority

16. The SMR, analyzed closely, distinguish three functions and related duties of prison doctors;

    1. the doctor as a **private doctor** of a prisoner;
    2. the doctor as an **adviser to the prison director** for specific matters with respect to prisoners' treatment (e.g. prison labour, regime);
    3. the doctor as a **social health and hygiene officer**, supervising and reporting about the general situation of health and hygiene in the prison.

    Notwithstanding these distinctions, it should be abundantly clear, that doctors work in prison because they are doctors. They are to act like doctors, i.e. only in the interests of their prisoners/patients and without interference by others or other interests.

17. As a private doctor the prison doctor acts on request of a prisoner and on behalf of the prisoner's health. **Rules 22, 23, 25 (1) and 91** (see below) for example presuppose such function, where provisions are mentioned to ensure qualified medical care for prisoners. In **Rule 26** (see below) a general responsibility of a prison doctor is mentioned, namely that of a social health and hygiene officer. It is a preventive function, according to which a prison doctor has to see that prison conditions and provisions do not endanger prisoners' health. Other rules (see below) define a further function of a prison doctor. It is derived from the prison director's responsibility for the health of prisoners. This includes not only the arrangements for a well functioning medical service, but also the need to ensure that regime's provisions do not damage prisoners' health. To undertake that responsibility properly, a director may often ask a doctor's advice.

18. The SMR do not claim that the three medical functions should be fulfilled by different physicians, nor do they say the opposite. However desirable separate functions for separate doctors may be, it will not always be possible, so it is essential to be on the alert for conflicting situations which may arise. It should always be taken in mind however, that the first and most essential function of a doctor in prison is that of a private doctor, acting at the request and on behalf of the prisoner. Whatever further function the doctor may perform, it should never be to the detriment of the prisoner's health. For a prison doctor and any doctor the health interest of the patient comes first. The prisoner-patient has absolute priority.

19. A prison doctor's responsibility for his or her patients has a particular dimension, because a sound state of mind and physical health may improve prisoners' capacities to work at their rehabilitation. **Rule 62**, a guiding principle, is of particular relevance in this respect. It reads:

Rule 62
The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end.

Undesirable and bad prison conditions not only affect insane and mentally abnormal prisoners. They exert influence on all prisoners. Therefore **Rule 62** mentions an overall responsibility of the medical services of a prison. This principle, though explicitly addressed to prisoners under sentence, is as compelling with regard to all prisoners and detained persons.

Oath of Athens

20. The great resposibility of a prison doctor is clearly underscored by the **International Council of Prison Medical Services** in the so-called **Oath of Athens**, which is quoted here:

"We, the health professionals who are working in prison settings, meeting in Athens on September 10, 1979 hereby pledge, in keeping with the spirit of the Oath of Hippocrates, that we shall endeavour to provide the best possible health care for those who are incarcerated in prison for whatever reasons, without prejudice and within our respective professional ethics. We recognize the right of the incarcerated individuals to receive the best possible health care.

We undertake

1. **To abstain from authorising or approving any physical punishment.**

2. **To abstain from participating in any form of torture.**
3. **Not to engage any form of human experimentation amongst incarcerated individuals without their informed consent.**
4. **To respect the confidentiality of any information obtained in the course of our professional relationships with incarcerated patients.**
5. **That our medical judgements be based in the needs of our patients and take priority over any non-medical matters".**

21. In order to improve the effectiveness of the Oath of Athens, prison directors and prison physicians should ensure that the Oath of Athens is known to all health staff, regularly or incidentally engaged in health care of prisoners. Resources and procedures are needed to ensure prompt and adequate medical help and to publicize ethical codes for physicians and nurses.

    It should be a government's duty to provide health staff in prisons with information (names, addresses etc.) about bodies responsible for medical ethics.

Necessary provision of services

22. The following rules refer to necessary medical provisions as preconditions for effective medical service and health care:

    Rule 22 (1)
    At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.

    Rule 22 (2)
    Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitably trained officers.

    Rule 22(3)
    The services of a qualified dental officer shall be available to every prisoner.

23. It is obviously the first requirement of health care that a physician is available and accessible. It will not always be possible nor necessary -

depending on the size of prison - to have a physician available full time. But then it is the more necessary to ensure permanent links with outside health services of the community, as it is stated in **Rule 22 (1)**. The **U.N. Basic Principles for the Treatment of Prisoners** go as far as stating that:

"Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (Principle 9).

As far as untried prisoners are concerned **Rule 91** of the SMR requires:

Rule 91
An untried prisoner shall be allowed to be visited and treated by his own doctor or dentist if there is reasonable ground for his application and he is able to pay any expenses incurred.

24. **Principle 9** as well as **Rule 91** of the SMR, certainly is often not implemented because of its practical complications. Still the rules cannot be looked upon lightheartedly. Particularly because medical service in prison have always their limitations, structural and working relations with outside provisions are of major importance. Only then medical help in serious and emergency cases can be guaranteed. It happens, that prison directors and doctors do not pay sufficient attention to it. It certainly is a director's formal and initial responsibility. It is however, just as much a prison physician's duty to organize and maintain such links and to establish procedures and conditions to be observed. At the same time it is important to make sure, that 'red tape' should not obstruct a speedy transfer of patients to hospitals, nor a speedy visit to (out-patient) clinics.

Health officers

25. It is mentioned in **Rule 22 (2)**, that 'suitable' and 'trained' officers shall be present in a prison hospital unit. This obviously not only refers to qualified physicians, but also to qualified nurses. Qualified nurses should be present as much in prisons without a hospital unit, particularly if services of a physician are limited. They can fulfil an important role by compensating for a physician's restricted availability. In some countries in prisons even prison officers are trained to act as medical first aid officers, often referred to as health workers, to ensure that immediate help is available when necessary and that minor illnesses or wounds can be treated. (For some observations about nurses and health workers see below).

26. To ensure that responsible action can be taken, a disciplined functioning of nurses and health workers as well as systematic oral and

written reporting to the prison physician is necessary . This also applies to distribution of medicines, prescribed by the prison doctor to prisoners. It applies even more to the preparation of medicines (i.e. mixing or diluting powders and liquid medicines; preparing portions for individual prisoners). These are tasks to be carried out by qualified nurses. Prepared medicines may be distributed by health workers and, only if it is unavoidable, by regular but instructed prison officers. In such cases strict instructions and procedures drawn up by the doctor are to be followed and reporting to the doctor about any irregularities in distributing them should be prescribed. Preparation of medicines however can never be left to insufficiently qualified staff.

Equipment

27. Next to sufficient and competent medical staff, medical services include good and well cared for medical equipment and treatment rooms. Rooms, medicine-cupboards and the like must be solidly locked and be accessible only by competent medical staff. Hygiene and safety also are their responsibility. Because of high temperatures in day-time in certain parts of the world, medicines are easily perishable, which requires adequate provisions to prevent it.

The physician as a private doctor of prisoners

28. The most general guideline for the prison doctor is **Rule 25 (1)**, which reads:

Rule 25 (1)
The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.

This rule undoubtedly implies three things: firstly that the medical officer is a qualified physician; secondly that the prison doctor has at his or her disposal a well equiped physician's surgery and treatment room with all normal facilities and an adequate range of medicines; thirdly that the doctor is in a position and prepared to treat prisoners on the same basis as other patients.

In other words prison doctors should not just prescribe sleeping pills and pain killers, but act and be able to act at a fully professional level. Prison doctors are often under pressure to prescribe various kinds of tranquillisers for prisoners without there being strict medical reasons for doing so. The prison doctor has a duty to prescribe such medicines only when they are medically indicated for individual patients. They should never be prescribed for other reasons or under other circumstances.

Rule 25 (1), seen in its context, also applies to the prison doctor's role as an adviser of the director. This combination is a difficult one, as is explained below. In particular see **paragraph 43**.

Prompt and proper medical examinations

29. It is for very good reasons that **Rule 25 (1)** emphasizes the prison doctor's personal responsibility to see daily all prisoners who complain of illness. Health of prisoners is generally more vulnerable than that of free citizens, due to the conditions of imprisonment, due to the behaviour of prisoners themselves, who may mutilate themselves, make suicidal efforts or who may be violated by one another. The emotional stress of imprisonment furthermore may result in physical illness. Illness however also may be pretended and health care misused. But it is only the doctor who can judge this. It should also be taken in mind, that faking illness may be a signal of a prisoner that something about his or her health and situation is wrong.

30. If a doctor is not available or immediately accessible at all times, the availability and accessibility of a qualified nurse is to be ensured for a first screening and first aid. It is also necessary to ensure that an outside doctor can and will be called in immediately in cases of emergency.

31. **Principle 24** of the **Body of Principles** requires that:

A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary. This care and treatment shall be provided free of charge.

This principle is not about the physician's duty to examine a prisoner after admission, but about the prisoner's right to be examined. He shall be offered an examination and treatment. This shall be free of charge.

32. To underline the importance of the subject and the central position of the prisoner in it, **Principle 25** and **26** of the **Body of Principles** state respectively:

Principle 25
A detained or imprisoned person or his counsel shall, subject only to reasonable conditions to ensure security and good order in the place of detention or imprisonment, have the right to request or petition a judicial or other authority for a second medical examination or opinion.

Principle 26
The fact that a detained or imprisoned person underwent a medical examination, the name of the physician and the results

of such an examination shall be duly recorded. Access to such records shall be ensured. Modalities therefore shall be in accordance with relevant rules of domestic law.

33. These rules are addressed to the prison authorities as much as to the prison physicians. Both of them however may have different views about what is '**necessary**' (**Principle 24**), what are '**reasonable conditions to ensure security and good order**' (**Principle 25**) and about '**access to reports**' (**Principle 26**). And their views may differ from the prisoner's opinion, who after all is the main subject. To comply with these Principles and to solve possible differences of opinion and interpretation, consequences have to be drawn as far as access to medical help is concerned (**paragraphs 35 and 36**), information about injuries (**paragraph 34**) and the competence of decision making bodies in case of disagreements (**paragraphs 86 and 87**).

Health officers should be informed about incidents

34. It is necessary that the doctor and the nurses are informed and take active steps to be informed about violence between prisoners as well as about use of violence, beatings, physical punishments etc. by members of staff. The prisoners concerned should be visited; immediate medical help should be provided; the director should be advised about the way of treatment of these prisoners. The same applies to suicidal efforts, self mutilation, hunger strike, sexual abuse etc. Wounds and marks of beatings, torture etc. must be investigated by a doctor, preferably an independent one. The doctor should be enabled to do this quietly, without official pressure. A 'second opinion', if required always should be allowed. It is the doctor's responsibility to report to an independent (judicial) body about torture practices and marks of physical violence by staff.

    The **Body of Principles**, which explicitly forbids any form of cruel and degrading treatment (see **paragraph 1**), emphasizes that it is a duty of officials and others to report any violation to superior or other authorities or organisations '**vested with reviewing or remedial powers**' (**Principle 7**).

Unhindered access to medical care

35. To ensure a fair, caring and prompt access to prison health services it is of high importance, that prison officers are instructed to take prisoners' complaints seriously, to allow them to see the medical service promptly, to develop a caring and attentive attitude, and not to judge for themselves whether a prisoner needs a doctor.

36. Requests for and access to medical help should not be thwarted by complicated forms to be filled in by prisoners. It is not acceptable that the doctor or at least the nurse would see the patient only one or more days after the complaint has been raised. Although access to medical

services should not be administratively complicated, it does not mean that no records of requests have to be taken. In matters of health misunderstandings must be prevented. Requests to see a doctor should be written down on a simple form or a special book, either by the staff or by the prisoner and signed by both. The doctor is responsible for keeping these forms or the book carefully.

The prison doctor should explain his or her position to the prisoner

37. Because the prison doctor mostly is acting in two functions, i.e. as a private doctor and as an adviser to the prison director, he has a strict obligation to make clear his position in advance and to explain where his obligation to confidentiality ends, about what he has to report and which matters only can be reported with the prisoner's consent.

The physician: adviser to the prison director

38. The second function of the prison doctor is being an adviser to the director in individual and corporate health matters. Given that health encompasses most aspects of prison life, this function should not be seen as assistance to the director for the sake of good order and safety. Although consideration of health issues may help to do so, the prison doctor should not be ordered to put his or her skills at the service of prison order and discipline. Certainly a prison doctor's function should not be combined with that of a forensic physician, acting for the sake of police investigation. This last task is not envisaged by the SMR, is not compatible with that of prisoners' private doctor and therefore combination of these functions is unacceptable.

39. A prison doctor's views are often asked with regard to punishment of prisoners, as mentioned in **Rule 32 (1)** and **(2)** (see **Section II**, **paragraphs 50-53**). This Rule is no longer consistent with viewpoints which have developed since SMR have been established. It is contrary to a doctor's profession and ethics to collaborate in the maltreatment of a person with the possibility of his or her mental or psychical health being affected, by certifying fitness to sustain certain punishments or other hardship. (On this matter see further **paragraphs 43-45**).

The doctor to report and retain confidentiality

40. Other Rules about a doctor's function are applicable to his or her being a private doctor as well as an adviser to the governor. They therefore have to be interpreted very conscientiously. These Rules are:

Rule 24
The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental

illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

Rule 25 (2)
The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any conditions of imprisonment.

Rule 32 (3)
The medical officer shall visit daily prisoners undergoing such punishments and shall advise the director if he considers the termination or alteration of the punishment necessary on grounds of physical or mental health.

41. A doctor examining a prisoner (**Rule 24**) and being obliged to report about it, may interfere with the prisoner's right of personal integrity and privacy. Such medical reports may also have disadvantageous consequences for the prisoner's situation in prison and thereby for his or her well-being or health.

42. Examining and reporting about it for instance may lead to allocating a prisoner to a hard work section or to excluding him or her from manual work at all. It may lead to segregation e.g. of HIV or AIDS patients, thus stigmatizing them. It may lead to punishment, isolation or solitary confinement, which may even cause physical or mental damage.

The medical officer and punishment

43. It is stated in the **UN Principles of Medical Ethics relevant to the role of Health Personnel, particularly Physicians, in the protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment, or Punishment, Principle 4(b)**, that:

It is a contravention of medical ethics for health personnel, particularly physicians:
(b) To certify, or to participate in the certification of the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.

44. What must be avoided at the very least is involvement of a prison doctor in security or disciplinary matters of whatever kind. A prison doctor, being appointed as a clinical doctor, is not and may not be seen as part of prison management. In a dualist function as mentioned, a prison doctor should be painfully aware of not creating the impression on prisoners by attitude, words or conduct, that he or she is at the side of prison management. The advisory function therefore should be restricted as much as possible if the prison doctor has to combine it with being the prisoner's private physician. The physician in the first place, as well as the prison director, should realize, that such a dualist function is difficult to handle and it may present serious conflicts of conscience to an ethically operating doctor.

45. It has to be emphasized that nurses often are put in the same delicate position as physicians. Because of their mostly being subordinate prison staff members, their professional independence should be ensured with even more carefulness.

    It should be mentioned that in special institutions, such as (psychiatric) hospitals, doctors may be managers. The potential conflicts between the management function and the clinical function in relation to the individual patient however should be recognized.

Medical experimentation and research

46. **Article 7** of the **International Covenant on Civil and Political Rights** declares, that:

    No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

    Agreement of prisoners to undergo medical experiments in exchange of, for example, shortening of imprisonment or financial reward, is interfering with his or her free consent. Such forms of manipulation are definitely in disagreement with **article 7**. **Principle 22** of the (more recent: 1988) **Body of Principles** in a way which is even more restrictive:

    No detained or imprisoned person shall, even with his consent, be subjected to any medical or scientific experimentation, which may be detrimental to his health.

    This principle does exclude categorically the prisoner's consent as an excuse for possibly damaging experimentation.

47. The 1964 **Helsinki Declaration** of the **World Medical Association**, reviewed in 1975, 1983 and 1989, has paid ample attention to this matter, clearly holding that the matter nowadays is of great significance. The Declaration therefore is very recommendable to prison doctors. It does not refer to experimentation in its strict sense, but to medical research. It states that 'Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.' It states further that '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.' The Declaration goes on saying, that 'If at all possible, consistent with patient's psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation.' The Declaration makes a 'fundamental distinction' between 'Clinical research in which the aim is essentially therapeutic for the patient and the clinical research, the essential object of which is purely scientific and without therapeutic value to the person subjected to the research.' About the latter the Declaration is very detailed. It states that '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.' Further 'The nature, the purpose and the risk of clinical research must be explained to the subject by the doctor'. And: 'Clinical research on a human being cannot be undertaken without his free consent after he has been informed.' This 'Consent should as a rule, be obtained in writing.' Furthermore the person involved 'should be in such a mental, physical and legal state as to be able te excercise fully his power of choice.' And: '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.' The last two statements obviously are of importance with respect to prisoners, in particular when rewards are offered to them in return to their consent.

Transmissible diseases, including HIV infection

48. Prisoners, who are HIV infected, suffer from AIDS, tuberculosis, hepatitis or other transmissible diseases, are often considered a risk to fellow prisoners and staff. Particularly HIV infection is felt a threat, because of it being often connected with drug use. Therefore, forced medical examination and blood testing sometimes is considered a solution. Also segregation in separate units and social isolation is practiced, although it may be discriminative (see **Section I**, **para. 11**). Measures taken are very different in different countries. Decisions about these matters cannot be based on irrational opinions of prisoners, staff or the general public. The basic starting points should be respect of a person's integrity and dignity and trust in a physician's medical judgement and obligation of confidentiality. The first

recommendable solution therefore is to inform prisoners as well as staff about these diseases, the real risks of infection and how to avoid them. Furthermore measures to reduce risks should be considered, like making condoms available and even syringes for drug users. However regrettable, sexual contacts among (male) prisoners and use of drugs to a smaller or larger degree are part of prison life. They are even to a certain extent effects of imprisonment. Such practices may be undesirable; certainly forced sexual contacts should be prevented and punished, either disciplinarily or by criminal law; against drug use should be fought sensibly and reasonably, but it is useless to close one's eyes to reality.

49. It is part of a prison doctor's role to take initiatives both with regard to these prison problems of growing urgency and with respect to people's privacy. The latter even more points in the direction of involvement of independent outside health services.

    The complex problem as such requires special attention to the training of health staff and to a careful study of their codes of ethics, mentioned in **para. 15** of this Section. In particular clear principles should be adopted on questions of confidentiality in relation to HIV infection.

50. However there may be extreme situations, which may allow for segregation of these prisoners and even to medical tests under well formulated and very restrictive conditions. Decisions like these should never be left to a prison doctor or governor. They should be taken on the basis of specific legal regulations by politically responsible authorities and after broad expert consultations.

Suicide

51. In prison self-mutilation and suicidal efforts occur. They happen generally because of mental, psychic, social or cultural problems. Therefore they should be dealt with carefully, sensitively and individually, certainly not routinely or disciplinarily. Despair about the future, the social situation in prison (e.g. sexual harassment), racial problems, different cultural backgrounds, isolation from family and friends (e.g. with foreigners or imprisonment in very distant and unfamiliar places), many personal reasons can explain such behaviour. Often the measure taken to prevent a prisoner harming him- or herself is isolation. However, isolation is the opposite of what is needed. Care and contact by trusted staff or fellow-prisoners should be the first response.

    Besides, prevention of suicide and self-harm is of utmost importance. Death or serious injury of someone in custody can be damaging to staff and prisoner morale. Training staff (including specialists) about reasons

for suicide attempts, identifying symptoms, establishing strategies to support those who appear vulnerable and prescribing record-keeping procedures are essential. There should be clear operational instructions about what to do to prevent suicide and self-harm attempts.

52. All staff are responsible for these issues. Although medical staff should be informed in every case, appropriate help may be found from, for example, a chaplain, a social worker, or another prisoner. Many of the problems that lead to suicide attempts are not resolvable at all, e.g. someone's husband abandoning them. What needs to happen is that unconditional support should be offered to such prisoners immediately. It may become necessary to supervise them closely and to take items away from them that they could hurt themselves with. It is true that in nearly every case prisoners who are offered support and who recognise that staff and fellow prisoners are concerned about them become more able to cope with their situation. Outside organizations who care for the suicidal in the community may be keen to extend their work into the prison.

Refusal to eat

53. A distinction has to be made between a refusal to eat as a protest, as a sympton of mental disturbance or a free choice to end life. A refusal to eat is frequently a protest, not a suicide-attempt. Where this is the case, it is not a medical problem in the first place, but a political or social problem. It is of prime importance to realize this. Examining a prisoner who is on hunger strike and reporting about his or her condition may lead to forced feeding. It may even lead to ordering the doctor himself to administer liquid food against the will of the prisoner, thus annulling a prisoner's protest and allowing them ignore it. This definitely is unjust. As it is stated in the **World Medical Association's Declaration on Hunger-Strikes**. "…. **It is the duty of the doctor to respect the autonomy which the patient has over his person."** The W.M.A.'s Declaration recognizes the doctor's conflict to both respect the patient's autonomy, and act in what is perceived to be the patient's best interest. The Declaration, however, states, that, if a doctor **'agrees to attend to a hunger-striker, that person becomes the doctor's patient',** with all inherent implications, **'including consent and responsibility.'** Further the Declaration states: **"The ultimate decision on intervention or non-intervention should be left with the individual doctor without the intervention of third parties whose primary interest is not the patient's welfare**."

54. Prisoners who refuse food may be disturbed, or may be trying to draw attention to their plight, or pursuade someone to take or not take certain actions. Sometimes there is no logical connection between not eating and the desired effect. For example, a prisoner who refuses to

eat because he wishes the court to make a different decision is unlikely to be succesful. Staff and friends of the prisoner should point this out. If sensible approaches fail, his condition should be monitored by a doctor who should advice him of the health risks involved. If necessary the prisoner should be moved to a hospital. Clear guidelines on treatment and resuscitation should be established.

55. Prison policy should be in accordance with the following principles, formulated in the **Tokyo (1975) and Malta (1992) Declaration** of the **World Medical Association** concerning a refusal to eat:

There is a moral obligation on every human being to respect the sanctity of life. This is especially evident in the case of a doctor who exercises his skills to save life and also acts in the best interests of his patients (beneficence).

It is the duty of the doctor to respect the autonomy which the patient has over his person. A doctor requires informed consent from his patients before applying any of his skills to assist them, unless emergency circumstances have risen in which case the doctor has to act in what is perceived to be the patient's best interests.

Furthermore they declare:

The ultimate decision on intervention or non-intervention should be left with the individual doctor without the intervention of third parties whose primary interest is not the patient's welfare

From the guidelines the following may be mentioned:

- **Doctors or other health care personnel may not apply undue pressure of any sort on the hunger-striker to suspend the strike;**
- **The hunger-striker must be professionally informed by the doctor of the clinical consequences of a hunger strike;**
- **Any treatment administered to the patient must be with his approval;**
- **The doctor should ascertain on a daily basis whether or not the patient wishes to continue with his hunger strike.**

Extreme illness and death

56. Another problem is connected with a prisoner's state of terminal or severely incapacitating illness, or with a prisoner being in an extremely bad physical or mental condition without any perspective to improvement. Such prisoners of course cannot be neglected nor given up, although much care is needed. The obvious solution is to end or suspend imprisonment and hand the medical care over to the

appropriate community health services. According to **Rule 25 (2)**, quoted earlier, and as far as confidentiality permits, the doctor anyway should recommend the most preferable medical solution to the director.

57. Because of the complicated position of a prison doctor careful action is needed in the case of a death. It goes without saying that death in prison, regardless of its cause, has to be verified and investigated immediately by a doctor. It is desirable to have it done by an independent physician, not connected with the prison system or the ministry in charge. This should be done at any rate, if relatives of the deceased so request. Extreme caution in these matters is required, regardless of whether there is or could be a link between the imprisonment and the death, or that any suspicion of such a link might arise.

58. In all these cases a prison doctor, acting as the prisoner's private physician and as the director's adviser as well, must act with great subtlety and be extremely candid towards his or her patients about this dualist position and the consequences of it. It applies also to the prison director and other staff.

The physician: a health and hygiene officer

59. The prison physician's general health and hygiene function should not be attributed exclusively to the prison doctor, although in a way it is connected with his or her function as a private doctor of prisoners and as an adviser to the director. Since prisoners live in a closed area and under restricted conditions their health situation is defined largely by this situation. Knowing the physical and mental complaints of the patients, the prison doctor is able to point at matters, which are critical to the health and hygiene situation in prison. Moreover imprisonment itself affects the health of prisoners. Therefore the prison doctor should advise about improvements of the prison regime, prison rules and methods of work, as far as they are related to health and hygiene, as is stated in the following **Rule 26**.

A medical officer's duty to inspect and report about health in prison

60. **Rule 26 (1)**
The medical officer shall regularly inspect and advise the director upon:

(a) The quantity, quality, preparation and service of food;
(b) The hygiene and cleanliness of the institution and the prisoners;
(c) The sanitation, heating, lighting and ventilation of the institution;

(d) The suitability and cleanliness of the prisoners' clothing and bedding;
(e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.

Rule 26 (2)
The director shall take into consideration the reports and advice that the medical officer submits according to rules 25 (2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority.

61. Daily exercise in the open air, as is stated in **Rule 21** (see **Section VI**, **para. 122**) and safety at prison work, as required in **Rule 74** (see **Section VI**, **paras 101-103**) should also be paid attention to by the prison doctor, although certainly not exclusively or even in the first place by him or her.

62. A doctor is not an expert in all matters mentioned in **para. 60**. Specialist services, as far as they are available in the community, or volunteers, specialized in some of these matters, should be involved, if possible, in monitoring the health and hygiene situations in prison, including those which are mentioned in the next few paragraphs.

Food and hygiene

63. An area of high importance and which requires expert monitoring and supervision is food, water and sanitation. Extensive attention is paid to this subject matter in **Section II**. As has been emphasized in that section, a matter of priority is good quality of drinking water and sufficient access to it. The same applies to hygienic sanitary facilities. In many countries they are below reasonable and humane standards. Especially provisions in prison cells often are horrible. Air sometimes may be polluted by use of oil, paint, other chemicals, or by smut. Clean and sufficient fresh air and ventilation are among the basic necessities of good health and hygiene.

64. Inspection of food and meals in prison is extremely important, though often not done regularly, frequently and in a qualified way. Inspection is not only needed of the prepared food, its preparation and the hygiene situation in the kitchen. Inspection is needed as much with regard to the distribution of the meals: Is hot food still hot when the prisoners get it? Are portions sufficiently big? Are ways of distribution and eating facilities hygienic? Special attention is to be given to the

quantity and quality of meals for young prisoners, sick prisoners and those who have to work hard.

65. The quality of food requires sound and expert supervision. The main components of food should be present in adequate qualities and adapted to climate; variation of menus is needed; account has to be taken of special diets for prisoners on religious or medical grounds; particular care should be paid to the diets of pregnant women, young mothers and their babies. These requirements are high. Even if local situations in the community with respect to food leave much to be desired, it is a governmental responsibility, that people in its care, who in fact are unable to care for themselves, are fed well and that health is ensured.

Outside monitoring

66. Instead of the prison doctor, a medical inspector of community health services could act in this function. In many countries moreover, outside bodies of volunteers, so-called supervisory bodies or boards of visitors, inspect aspects of the general health and hygiene situation and the well-being of prisoners in general. It should be given attention that the medical or related professions are represented in these bodies for matters of health and hygiene. (Inspection is extensively discussed in **Section IX**).

Position of nurses

67. The Statement of the **International Council of Nurses** (Singapore 1975) about the role of the nurse in the care of detainees and prisoners refers to the **ICN Code for Nurses**, which reads:

> **The fundamental responsibility of the nurse is fourfold: to promote health, to prevent illness, to restore health and to alleviate suffering ...**
>
> The statement concludes among other matters:
>
> **Therefore be it resolved that ICN condemns the use of all such procedures harmful to the mental and physical health of prisoners and detainees; and further it be resolved that nurses having knowledge of physical or mental ill-treatment of detainees and prisoners take appropriate action including reporting the matter to appropriate national and/or international bodies ...**

68. Nurses have a crucial function to perform in prison. At the same time generally their degree of professional independence is less than that of prison physicians. Certainly they are seen as less independent by

prisoners. Nurses may also contribute to this situation by creating an impression of being more concerned with discipline and the smooth running of the prison than with the prisoners' health.

69. Although nurses are not explicitly mentioned in the SMR, it is obvious that they are implicit in what the SMR call 'medical services'. These services cannot function adequately without doctors' assistants. Their function however is often even more delicate than that of doctors. They share with the doctors confidential information, they assist and in minor matters even may replace the doctor and therefore they have to develop a relation of trust with prisoners.

Supervision of nurses

70. Practice in some countries does not always provide protection in accordance with the **ICN Code for Nurses**. The 'medical profession's secret' is not always considered to be applicable to nurse's profession. One reason is the different levels of qualifications of nurses. Another reason is that in prisons nurses, being mostly part of the executive prison staff, are subordinate to the prison director.

    Moreover in some countries there are no nurses in prisons. Some nursing or assisting tasks are fulfilled by ordinary prison officers.

    To act responsibly it is necessary for prison directors, leading staff and physicians, to fully respect international and national codes of ethics of nurses and other health workers and to inform them about their position in this respect. Furthermore they should ensure that nurses and health workers are not charged with tasks for which they are not qualified and about which appeals to ethical codes will not be recognized.

71. In order to avoid conflicts of conscience with nurses, they should be managed and supervised by the prison doctor, who is responsible for their work.

Nurses' status

72. It is consistent with nurses being part of medical services, that they have access to the same complaints procedures as doctors and for similar reasons. Furthermore they are bound by the right as well as the duty of medical confidentiality in the same way as doctors are. The **ICN Code for Nurses** should be respected by the nurses themselves as well as by leading prison staff. It presents guidelines as to their role in the care of detainees and prisoners and in safeguarding human rights. The **ICN** (Brasilia 1983) stated in this respect:

    Nurses have individual responsibility but often they can be more effective if they approach human rights issues as a group. The national nurses associations need to ensure that this structure

provides a realistic mechanism through which nurses can seek confidential advice, counsel, support and assistance in dealing with these difficult situations.

Nurses' professional skills

73. It should be a responsibility of the prison doctor to see to it, that the nurses are trained well, that they keep up with their medical expertise and that they are informed about frequent occurrence of diseases, symptoms of new or seasonal diseases and about how to prevent or in minor cases how to treat them. Special attention should be paid to identifying symptoms of AIDS, drug addiction and other transmissible diseases and how to handle them.

74. Nurses not only should be well trained as far as their medical profession is concerned, but also with respect to the way of dealing with patients. An authoritarian or patronizing way of handling prisoners, or behaviour which suggests that it is a favour to the prisoner and a privilege to be given attention, are not ways to gain a prisoner's confidence. This applies to doctors and generally to prison staff as well.

Role of health workers

75. Health workers can play a valuable role in prisons, provided that they are trained well and function under full and sufficiently intensive supervision of the prison doctor, possibly assisted by a fully qualified nurse. Their main tasks can be:
    - providing simple first aid;
    - recognizing situations which have to be referred to a professional medical officer - doctor or nurse - and acting accordingly;
    - identifying stress caused by or connected with imprisonment and reporting about it to the responsible medical officer;
    - identifying symptoms of drug addiction, abstinence of drug use, AIDS, other transmissible diseases and reporting about it as well.

76. Health workers could ensure full time availability of initial medical care. Health workers then, as a strict condition, must be well-trained and well-supervised. In prisons where regular prison officers have been trained up to a level indicated in **paragraph 78**, health workers may not be necessary. If however health workers are appointed, ordinary prison officers should not be charged with health workers' tasks.

The health officer subject to conflicts of interests

77. Since prison doctors' - and nurses' - first responsibility lies with the patients and their personal autonomy, it is of utmost importance for

them to make that clear to their patients and thus create a basis of trust with prisoners. On the part of the director it is of prime importance to respect that relation of confidentiality between doctor or nurse and prisoner, asking a doctor's advice only when urgently needed and discussing beforehand about the desirability of medical advice and its possible consequences.

78. If for special reasons, for example at the intake of prisoners, it is necessary to have them examined, doctors always are to inform a prisoner what a specific examination is about and what it is for. It contributes to a trustworthy relationship. If possible however, doctors should leave prisoners a choice and a responsibility, so that they can decide for themselves to allow the examination or not. If prisoners refuse to be examined, it may be necessary to take measures in proportion to health risks, which are suspected by the doctor. However, prisoners should not be punished for it. It would be an interference with their right to personal integrity.

79. Carefulness of health and medical care of prisoners should be ensured by national guidelines, including check lists of diseases, physical and mental complaints which the prison physician has to observe. Files of patients should be composed in conformity with these guidelines.

Principle 26 of the **Body of Principles**, quoted in **para. 32**, clearly underlines these requirements, where it states that **'the results of such an examination shall be duly recorded'**, and that, **'access to such records shall be ensured'**.

Patients and representatives designated by them, do have the right to know the contents of their files and reports and to read them. If a prisoner is transferred to another prison, it is the physician's responsibility, that prisoners' medical files are handed to the physician of the other prison, while respecting the prisoner's privacy. If desirable from a medical point of view, the prison doctor should advise a prisoner at his or her release from prison, whether certain medical information should be passed on to the prisoner's outside personal physician.

Measures should be taken, to ensure, that the confidentiality of medical records and the patients' rights of access to them are respected after release.

80. Doctors too should not report to the governor without informing the prisoners concerned about the reports' content. As has been said earlier, international rules have defined that prisoners are entitled to know what is in the reports. It would be preferable for a doctor to leave it to the prisoner to inform the governor about the outcome of an examination or not.

81. In fact there are only a few situations, where the doctor has to inform the governor, i.e. when the interest of the prison community or the community outside is at serious risk. These situations are hardly different from those, where a doctor in the community has to report to public authorities about patients causing health risks. In most other situations it can be left to the prisoner to report about his or her health situation, when he or she thinks it necessary. A prisoner should allow the prison director or the responsible staff member to have that information checked with the doctor. In case prisoners do not wish to reply to reasonable and purposeful questions of a competent staff member about their health conditions, the taking of regime measures mostly will suffice. These measures however should never be of a disciplinary nature, in order not to devalue the prisoners' rights in this highly private and vital area of personal life.

Right of prisoners to complain about health care

82. **Rule 36 (1)** of the SMR reads:

Every prisoner shall have the opportunity each week day to make requests or complaints to the director of the institution or the officer authorized to represent him.

The same is established in **Principle 33** of the **Body of Principles**. It is therefore important that complaints procedures are developed. Obviously this general Principle also refers to complaints about health care. Complaints procedures should include provisions about involvement of independent health (complaints) bodies, who are competent in matters of medical care. These bodies should be competent to review decisions, to order second opinions or treatment by another physician, to advice authorities about necessary improvements of health services and access procedures and about measures to be taken to ensure professional quality and conduct of health personnel. (About complaints see also **Section II**).

83. Complaints procedures must be known to prisoners to be effective. It inspires confidence if written as well as oral information is given at admission of the prison by a nurse, or by an intake officer together with further information about prison rules and facilities.

84. Independent health authorities furthermore should be involved in monitoring the health care situations in prisons and the application of the standards of medical ethics issues in general.

85. Besides, where such vital interest as health is at stake, access of prisoners to the civil judge and to a disciplinary body of the official professional organization of physicians or nurses should be made possible.

Health officers' appeal procedures

86. The responsibility of a prison doctor and prison health officers in general for prisoners' health and his or her way of performing it, may give rise to problems between the doctor and the prison director. Conflicts also could arise about a doctor, charged with the dual or triple function mentioned before, not acting properly according to a director's opinion. The first way to solve their problem of course is by sensibly and frankly discussing them between each other. That however may not always work. In that case, precisely because of the doctor's delicate and mostly multi-functional position, as well as because of his or her medical expertise, such conflicts need involvement of an independent body, acceptable to both parties and competent in both areas.

87. Formal procedures about how to deal with such matters are needed. It is not only in the interest of doctors and directors, but also of prisoners. It stengthens confidence that health care is considered of great value and problems are dealt with impartially. It is strongly recommended to create also complaints procedures for doctors and health officers in general. Their prescriptions about treatment of patients, or their advices with respect to their advisory and social hygienic functions, may not always be followed at the detriment of individual or general health situations. If such provisions do not exist, the functions of health officers become enfeebled.

88. Since health matters are so crucial in prison, general supervision of the medical practice and the health situation is needed. The attention paid to health care in prisons in international legal instruments are compelling reasons to introduce independent and qualified bodies to ensure regular oversight of medical practice, of effectiveness of links with outside health services and of sufficient resources.

Specific health care for some groups of prisoners

89. **Principle 5 (2)** of the **Body of Principles** in particular stresses that:

> **Measures applied under the law and designed solely to protect the rights and special status of women, especially pregnant women and nursing mothers, children and juveniles, aged, sick or handicapped persons shall not be deemed to be discriminatory. The need for, and the application of, such measures shall always be subject to review by a judicial or other authority.**

Health provisions for female prisoners (and their babies)

90. The SMR have emphasized the urgent need of special provisions for pregnant women and mothers with babies.

Rule 23 (1)
In women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the institution. If a child is born in prison, this fact shall not be mentioned in the birth certificate.

Rule 23 (2)
Where nursing infants are allowed to remain in the institution with their mothers, provision shall be made for a nursery staffed by qualified persons, where the infants shall be placed when they are not in the care of their mothers.

91. Although in different countries different viewpoints are held about the best solutions with respect to imprisoned mothers, some very basic provisions should be guaranteed. The recommendations of the Human Rights Watch Global Report on Prisons (New York, 1993) deserve to be quoted:
    - Female inmates should be given sanitary napkins or substitutes and have daily access to showers or their equivalent during menstruation;
    - work and educational opportunities should be available on an equal basis to both men and women;
    - where visits to female inmates are severely limited because of the long distances relatives must travel, the authorities must make efforts to compensate (by subsidizing relatives' travel or through some other system);
    - pregnant prisoners should be given regular pre-natal checkups and an adequate diet;
    - nursing mothers should get an adequate diet;
    - efforts should be made to facilitate mothers' contacts with their children and their right to direct their upbringing.

92. Prisons for women are not, or are poorly, differentiated nearly everywhere. As a result the amount of security is mostly high, certainly far higher than what is generally necessary for women. Prison work for women is little and uninteresting. Prisons are built for men and often hardly adapted to the special needs of women. In some countries not even their vital needs with respect to menstruation, pregnancy and motherhood, are met as is indicated in the afore- mentioned Human Rights Watch Global Report on Prisons. These conditions affect adversely women's health situation and their state of mind. Moreover, women in prison may be vulnerable to abuse, including rape, by some prison staff.

    Prison doctors and nurses, therefore, should pay explicit attention to women, their conditions and their complaints. Gynaecological care for female prisoners should be guaranteed.

Treatment of drug addicts

93. A matter of growing concern in prisons is the treatment of drug addiction. The SMR do not explicitly mention the need for drug treatment, because it is a rather recent phenomenon. Moreover in free society consensus of treatment methods does not exist. It should be considered a prudent line of conduct not to have one physician decide all by him- or herself about treatment of a particular prisoner or of prisoners in general. Consultation of colleagues or experts in this area and/or decisions on the basis of recent and well documentated reports, should be obligatory. Agreement of the respective prisoner, who has to be well informed, is absolutely necessary. National guidelines therefore should be strived at. They should include rules about use of drugs on order of a doctor. This is still forbidden in some countries, but at least for reasons of medical treatment it should be permitted.

    Guidelines are necessary concerning procedures for medically supervised detoxification, so that the risk is avoided that some prisoners are forced to withdraw from drugs without medication or support. For persistent drug addiction and HIV infection, see **paragraph 48**.

Care for mentally ill and unbalanced prisoners

94. Assuring a sufficient degree of well-being of prisoners is particularly difficult as well as important as far as insane and mentally abnormal prisoners are concerned and prisoners under serious psychological stress. **Rules 82 and 83** of the SMR deal with this matter. They read as follows:

    Rule 82 (1)
    Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible.

    Rule 82 (2)
    Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management.

    Rule 82 (3)
    During their stay in a prison, such prisoners shall be placed under the special supervision of a medical officer.

    Rule 82 (4)
    The medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment.

    Rule 83
    It is desirable that steps should be taken, by arrangement with

the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric after-care.

95. The amount of prisoners in need of psychiatric care is rising in many countries. One reason often is that psychiatric institutions and services in the community are overburdened with patients. Therefore, psychiatric patients who have committed offenses are often not admitted. Mentally disturbed and insane persons, however are not seldom neglected and abandoned in prison. Long term prisoners may develop mental and psychic disturbances by imprisonment itself and by being cut off from their families. Mental problems also arise and may become chronic in big prisons, where there is much overcrowding; where there are few activities; where prisoners have to stay a long time in their cells in daytime; where the prison population is undifferentiated; where criminal subcultures have developed and brute domination by prisoners occurs. These situations often coincide with and are aggravated by unsufficient staff to control the prison, let alone that staff have sufficient personal contact with prisoners; that they know who are in need of specialist help and that they can exert a relaxing influence on the prison climate. Moreover cultural differences may pose special hardship and emotional confusion to foreigners and members of minority groups.

    These reasons underline the necessity for prison staff to pay special attention to prisoners in psychic or mental trouble and to try and ease their situation individually. It is obviously an even bigger responsibility for medical and psychological staff.

96. To comply with **Rules 82 and 83** (**paragraph 94**), a relaxed atmosphere is the basic requirement. It is characterized by caring attitudes of staff, by an organization which enables staff to know prisoners and report their needs, and by procedures ensuring that prisoners' requests and prison officers' reports (oral and written ones) are taken seriously and dealt with promptly. Only in such situations, is it possible to detect prisoners in need of psychiatric care in the first place. Only then may it be possible to try and have them allocated, according to degree of urgency, to psychiatric institutions or to provide them with all adequate help which is available in prison and possibly after release.

97. In order to guarantee proper and adequate attention and treatment it is of special importance to keep records of mentally disturbed prisoners, or those who show abnormal conduct. Prison doctors or psychologists should be charged with instructing prison staff members to report regularly about these prisoners' behaviour.

    In (sections of) prisons for these categories of prisoners, reporting

systems and regular evaluation of reports have to be developed. Special emphasis should be put on qualified staff. It should be emphasized that even in psychiatric hospitals for prisoners practices are not always in conformity with these Rules. It frequently happens that patients are forgotten for a long time.

Prisoners under sentence of death

98. It is mentioned in the initial chapter about 'Where the Handbook starts from', that the SMR and other international rules about treatment of prisoners do not exclude from application people sentenced to death. The United Nations and other international and national organizations strive for the abolition of the death penalty. In spite of all reasonable objections however the death penalty still exists in many countries.

99. The UN General Assembly resolution 2857, dated 20 December 1971, affirmed that "in order fully to guarantee the right to life, provided for in **Article 3** of the **Universal Declaration of Human Rights**, the main objective being pursued is that of progressively restricting the number of offenses for which capital punishment may be imposed, with a view to the desirability of abolishing this punishment in all countries."

    The UN Economic and Social Council adopted resolution 1989/64, in which it declared itself "Alarmed at the continued occurence of practices incompatible with the safeguards guaranteeing protection of the rights of those facing the death penalty". It recommended that "member states take steps to implement the safeguards and strengthen further the protection of the rights of those facing the death penalty, where applicable, by:

    (a) Affording special protection to persons facing charges for which the death penalty is provided by allowing time and facilities for the preparation of their defence, including the adequate assistance of counsel at every stage of the proceedings, above and beyond the protection afforded in non-capital cases;
    (b) Providing for mandatory appeals or review with provisions for clemency or pardon in all cases of capital offence;
    (c) Establishing a maximum age beyond which a person may not be sentenced to death or executed;
    (d) Eliminating the death penalty for persons suffering from mental retardation or extremely limited mental competence, whether at the stage of sentence or execution."

Resolution on physician participation in capital punishment

100. As a consequence of the death penalty and of states' provisional decisions not to execute the death penalty, the situation of prisoners on death row requires urgent and intense attention. Conditions are usually far worse than those of other prisoners, because of increased

isolation, even for long and indeterminate periods of time - and lack of privacy -, inactivity and bad basic physical provisions. These conditions gravely damage death sentenced prisoners' mental, spiritual and physical health. Everything has to be done to ensure that at least humane living conditions, activities and communication facilities are provided, as well as professional psychiatric help. Conditions of prisoners on death row at the very least should not be worse than those of other prisoners.

101. In the context of health care, the role of health officials with respect to the execution of death penalties is to be considered. SMR do not deal with this matter. Reference may be made however to **para. 43** of this Section and to other international instruments. The **World Medical Association** on this matter has adopted in 1981 the following **Resolution on Physician Participation in Capital Punishment**:

"it is unethical for physicians to participate in capital punishment, although this does not preclude physicians certifying death".

The Secretary-general of the **World Medical Association** issued the following press release in September 1981 with the endorsement of the Assembly:

The first capital punishment by intravenous injection of lethal dose of drugs was decided to be carried out next week by the court of the State of Oklahoma, USA.

Regardless of the method of capital punishment a State imposes, no physician should be required to be an active participant. Physicians are dedicated to preserving life.

Acting as an executioner is not the practice of medicine and physician services are not required to carry out capital punishment even if the methodology utilizes pharmacological agents for equipment that might otherwise be used in the practice of medicine.

A physician's only role would be to certify death once the State had carried out the capital punishment.