

5 | The role of health professionals in segregation units: ethical, human rights and professional guidelines⁷⁰

5.1 Introduction: ethics as applied to prison medicine

Health professionals working in prisons and other places of detention face some particular challenges which stem from the inherent tension between the role of the prison as a place of punishment through deprivation of liberty, and their role as protectors and promoters of health (physical, mental and social). Firstly, they need to provide care in an environment which is geared towards security and all the physical arrangements – and institutional culture – that this entails. Their patients are held involuntarily in conditions which severely limit not only their freedom of movement, but the degree of control they have over most other aspects of their daily lives and activities. Other challenges include a high workload, often coupled with limited resources; work with populations with special needs and high prevalence of mental illness; dual obligations towards their patients and the prison's authorities; the competing demands of each and potential mistrust by both; poor training and, where they are employed exclusively by the prison, a degree of isolation from other members of their profession⁷¹.

The ethical challenges are especially acute when the question of the involvement of health personnel in disciplinary measures arises, and nowhere is this more contentious than in their role, if any, in segregation units⁷².

By asking a number of pertinent questions, the following section outlines the ethical and legal framework that guides the role of health personnel when confronted with the use of solitary confinement. Some of the potential dilemmas and conflicts identified below are not always easy to resolve in practice. Nonetheless, health professionals must always ensure that their conduct is not compromised by external and possibly spurious considerations. When faced with such dilemmas, advice and guidance should always be sought from senior health colleagues and from professional bodies.

5.2 Issues regarding prison medicine in solitary confinement units

What are 'dual loyalties' and where can health professionals seek support and advice?

A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her (WMA International Code of Medical Ethics, 1949).

A situation of dual loyalty arises when health professionals face *"simultaneous obligations, expressed or implied, to a patient and a third party"*⁷³. Health professionals working in prisons will almost inevitably face situations where they are asked or expected to suspend their clinical judgement in favour of other considerations or to contribute to processes and procedures that are not driven by therapeutic purposes. Codes of ethics make it clear that the duty owed to the patient takes precedence over any other obligation, and that health professionals must act in the best interest of their patients at all times. Many of the issues outlined in the following sections, such as whether to certify someone fit for punishment, or the right to access healthcare, are examples of such dual loyalties.

Clearly, as in any medical practice, there will be situations in which health professionals will have to judge whether their primary obligation to the care of the individual patient might have to be overridden in order to protect that individual, other prisoners, or staff. Again, their actions should be guided primarily by their function as health professionals, above that of their status as employees of a prison, police force or the military, but therein lies the very essence of "dual loyalties". Health professionals should strive to retain a professional independence, and thereby to retain the trust and confidence of their prisoner-patient.

Physicians seeking advice on ethical dilemmas can approach both their national medical association and the World Medical Association⁷⁴ (www.wma.net). Nursing professionals can approach their national nursing association as well as the International Council of Nurses, the body which provides ethical guidance to nurses (International Council of Nurses www.icn.ch).

Do health professionals have any role in certifying a prisoner 'fit' to undergo disciplinary measures, including solitary confinement?

In exactly the same manner as any health professional working in the community, the primary duty of the health professional working inside a prison is to protect, promote and improve the health of their patients. Naturally, when working in an environment whose over-arching aim is security, the health professional must follow the rules and procedures necessary for the safe and lawful running of the institution, but their role as health professionals must not be subordinated to this purpose. Their ethical duties remain the same as if they were working in the community but, as we shall see below, with the various constraints that working in a place of deprivation of liberty brings.

“Act only in the patient’s interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient” (World Medical Association International Code of Medical Ethics 1949, amended 1983).

It is clear that for health staff to participate in any manner in disciplinary measures within a prison would, in the first place, be in direct contradiction with their fundamental role as healthcare providers. The primary duty of the physician and the nurse, wherever they work, is to the health of their patient (World Medical Association Declaration of Geneva 1949, amended 1994, and International Council of Nurses Code of Ethics for Nurses, adopted 1953 and revised 2005). Moreover, in order to establish and to maintain the professional relationship and confidence and trust with the prisoner-patient, the prison health staff cannot be seen to have any role in the prison administration, and in particular in disciplinary matters. Health care must be provided with “*full technical and moral independence*” and be based purely upon medical needs (World Medical Association International Code of Medical Ethics 1949, amended 1983, and International Council of Nurses Position Statement on Nurses’ Role in the Care of Prisoners and Detainees 1998, revised 2006).

“It is a contravention of medical ethics for health personnel, particularly physicians...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” (Principle 4 (b), United Nations Principles of Medical Ethics⁷⁵).

International standards of medical ethics thus clearly state that health professionals, particularly physicians, must neither certify someone “fit for punishment”, nor participate in any way in the administering of such punishment. When isolation is used for any purpose that is not purely medical (e.g. isolating a potentially infectious patient), health staff can have no part in the process of deciding on its application or its administration.

It has often been argued that the physician can have a protective role by examining the fitness of individuals to undergo certain punishments. Indeed, the UN Standard Minimum Rules, which date from the 1950s and from a more ‘paternalistic’ view of medical ethics state that “*Punishment by close confinement or reduction of diet shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it*” (Rule 32. (1)). Standards evolve over time, however, and this rule is now clearly at odds with contemporary standards of medical ethics (see above) as well as current standards of prison administration and treatment of prisoners which, obviously, would not allow a reduction in the basic nutrition of any prisoner as a punishment. Looking at the issue from another perspective, were the physician to decide that certain prisoners are not fit to undergo solitary confinement, those people may well be spared the punishment. But this also means that in other cases the physician is effectively authorising the punishment of placing another prisoner in solitary confinement. Not only are they certifying someone fit for punishment, but they are acquiescing in a punishment that is known to adversely affect mental and physical health.

But there is a more decisive argument. The Sourcebook has set out the substantial body of research that shows the deleterious effects of solitary confinement on the mental and physical health of individuals, even if only inflicted for relatively short periods. The fact that in several international prison standard instruments and in many national prison regulations particular attention is given to solitary confinement and to attempts to mitigate its negative effects by involving health staff in its application, is a clear indication that the potentially harmful consequences are known to those writing them. Put more simply, if solitary confinement is safe, why must a physician check that someone can withstand it, and why must they be required to monitor their physical and mental health on a daily basis? No other legal disciplinary measure requires so much medical oversight.

For these reasons, the World Health Organisation (WHO) recommends that *“doctors should not collude in moves to segregate or restrict the movement of prisoners except on purely medical grounds, and they should not certify a prisoner as being fit for disciplinary isolation or any other form of punishment”* (Health in Prisons, A WHO Guide to the essentials in prison health 2007:36). The official commentary on the revised European Prison Rules (EPR) similarly states that *“medical practitioners or qualified nurses should not be obliged to pronounce prisoners fit for punishment but may advise prison authorities of the risks that certain measures may pose to the health of prisoners”*⁷⁶.

Do health professionals have any role in monitoring the effects of a disciplinary punishment once it has started?

From the previous paragraphs it is clear that health staff have no role in prison discipline, and that this includes monitoring the health effects of a sanction once it is being carried out. If the health professional, of their own volition and following their medical judgement rather than as ‘standard procedure’, was to chart the appearance of negative health effects, and at a given point intervene to end a disciplinary sanction, then effectively they are acting as arbiter of how long particular individuals can withstand the punishment. Inevitably, they will then have to decide that some individuals must be removed from isolation, while others must remain isolated (while knowing that the latter may sooner or later develop psychological, psychiatric or physical disorders linked to the isolation).

Monitoring the potential health consequences must, however, be distinguished from the right of all prisoners, irrespective of their status, location, or behaviour, to access healthcare (this will be discussed in more detail in the following section). Again, herein lies one of the key tensions of dual loyalty, since there is clearly a fine line between monitoring the punishment and providing needed clinical attention and care.

The revised version of the European Prison Rules (2006) states that solitary confinement should be an exceptional measure, and that even then it should only be applied for the shortest possible time (Rule 60.5). The Rules then require that medical staff should monitor prisoners in solitary confinement on a daily basis, and emphasise that if their mental or physical health is “seriously at risk”, this must be reported to the director⁷⁷. Similarly, the CPT in its early general reports foresaw a monitoring role for physicians (CPT 2nd General Report, CPT/Inf (92) 3 Para. 56).

However, in an often overlooked footnote contained in the revised European Prison Rules the government of Denmark objected to the proposed role of physicians in monitoring those in solitary confinement, on the basis that this could constitute certifying that the person is fit to continue the punishment of solitary confinement, which would be unethical. The objection could also have been made on the basis that this particular treatment may amount to a form of ill-treatment and not only would the participation of health staff be unethical, it would also be a contravention of international law. Addressing this ethical issue, the official commentary on the revised Rules stipulates that daily visits to isolated prisoners “*can in no way be considered as condoning or legitimising a decision to put or to keep a prisoner in solitary confinement*”.

What if the disciplinary measure actually or potentially inflicts injury?

It is self-evident that if acts of torture or other cruel, inhuman or degrading treatment are prohibited by international law, health professionals are also bound by such laws. Furthermore, their conduct is also constrained by international ethical standards which clearly prohibit not only active participation in interrogation, but also any other acts such as devising or planning methods of interrogation, particularly when the use of medical knowledge is solicited or when confidential medical information is misused against the patient⁷⁸. The World Medical Association’s Declaration of Tokyo states in its paragraph 3:

“When providing medical assistance to detainees or prisoners who are, or who could later be, under interrogation, physicians should be particularly careful to ensure the confidentiality of all personal medical information. A breach of the Geneva Conventions shall in any case be reported by the physician to relevant authorities. The physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals”.

Ethical standards also clearly dictate that if health professionals are aware or suspect that a criminal or other illegal act is planned or has taken place in a prison or other place of detention, they are obliged to report this act through the appropriate channels, and it is these authorities who will decide if there is criminal liability and what action is to be taken. Understandably, acting to report or denounce actions of colleagues (sometimes known as “whistle blowing”) is a very delicate issue, and in some States may even endanger the life of the person reporting such cases. In countries where there is a degree of impunity for particular authorities, then there may be separate channels established to allow confidential reporting of incidents. The World Medical Association has specifically stated that fellow professionals should provide support and protection to physicians who are either pressured to participate in acts of torture or other ill-treatment, as well as to those physicians who report and denounce such acts (WMA Declaration of Hamburg⁷⁹).

Thus, if the use of solitary confinement is considered to be inhuman or degrading treatment, and in some cases torture, then it would be contrary both to international law and to international standards of medical ethics for physicians and other health professionals to participate in the practice in any way, or to condone or acquiesce to its use. In those instances where the negative health effects of solitary confinement are deliberately used as a tool for interrogation purposes,

either to mentally or physically weaken the individual, or to instil disorientation, dependence, fear and so on, then this may amount to torture or to cruel, inhuman or degrading treatment, contrary to international law and standards of medical ethics. Health professionals involved in such acts will be culpable to the same degree that the prison or security forces are culpable. Similarly if a physician or any other health staff divulge confidential medical information on a patient primarily to serve the purposes of the interrogation, this would be unethical, and in those cases where the interrogation amounts to torture or other ill-treatment, this would amount to complicity in those acts or omissions.

Does a prisoner in solitary confinement lose the right to access healthcare?

No. It is a matter of international law that every person, including all prisoners (regardless of their location within a prison, and regardless of any disciplinary infraction they may have committed), retain the right to access and receive appropriate health care⁸⁰. This right places a positive duty on prison authorities and governments to provide prisoners with a level of healthcare equivalent to that provided in the community, and this obligation should be reflected in national legislation and national prison rules and regulations. In England and Wales, the principle of equivalence of care has been endorsed by Parliament and incorporated into the Prison Service's standards and guidelines⁸¹. This requirement excludes the right to choose one's own doctor (BMA 1992:177).

The ethical obligation to provide healthcare to prisoners on an equivalent level to that available in the local community is also clearly stated in several international instruments:

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained (Principle 1 of the UN Principles of Medical Ethics relevant to the Role of Health Personnel, 1982)

Thus anyone placed in solitary confinement, for however long, does not forfeit the right to request medical attention, to be seen without delay, and to receive treatment appropriate to the nature and gravity of the problem.

As in any other section of the prison, prison staff may alert the health staff to potential or actual health problems that the prisoner himself may not have noticed. In the first instance this should be done with the consent of the prisoner, who may not wish to see a member of the health staff, but if the staff consider that the condition may be a risk to the individual then they should alert the health staff. It is also recommended that, where they have concerns about a particular prisoner in solitary confinement, doctors visit that prisoner at their own initiative, even if the prisoner did not request this (WHO Health in Prisons, 2007:36). This is good practice, which is in line with principles of assertive community treatment outside the prison.

Finally, prisoners' right to health has been recognised as an integral part of wider public health promotion and protection in the community, because prisoners are a part of society, with the vast majority passing through prison for relatively short periods before returning to the community.

Health issues within prisons usually mirror and amplify health issues in the community, so ignoring prison health effectively means that community public health is not fully attended to. This is best summarised by the WHO, who have stated that “*prison health is public health*”⁸².

Do prisoners in segregation have the right to confidential medical examinations and confidentiality of their medical files?

Again, the health staff must at all times distinguish themselves from custodial staff and, while it is accepted that in a very few cases the health staff may need to take precautions against a potentially violent prisoner, medical examinations should be carried out in a manner which is respectful of the patient’s right to privacy and allows for confidentiality to be maintained. If a relationship of trust and confidence has been established between health staff and the prisoner from the outset, then excessive security measures are rarely warranted.

Particular challenges to the principle of medical confidentiality may arise in high security and segregation units because of their security arrangements, and because they house prisoners who are regarded as high risk. This may mean, for example, that all areas of the unit are covered by CCTV, limiting the availability of private spaces in which to conduct the examination. In some situations the custodial staff may insist that medical interviews with prisoners are conducted through a glass partition, or that the prisoner is handcuffed or otherwise physically restrained, or they may insist on remaining in close proximity whilst the medical examination takes place. The previous discussion on the duties of health staff to provide an equivalent level of healthcare within prisons and to follow the same ethical practice as they must outside the prison makes it clear that such security measures would interfere with the doctor-patient relationship. It should also be noted, however, that such security measures also interfere with proper clinical care. It is obvious that conducting any kind of medical interview or intervention through either a glass partition or through the viewing slot of a cell door is unacceptable clinical practice. There will of course be instances where an individual has a proven history of violence or threats, and consideration must naturally be given to the safety of health staff. But this must be done on a case by case basis, and not form a blanket policy for all consultations with the prison population.

Thus, a prisoner in solitary confinement should be seen in the prison health centre just like any other patient. The use of restraints during a medical consultation not only interferes with the clinical procedure but can damage the relationship between the prisoner-patient and the health staff, since the latter are seen as just another facet of the security system. The need for any extra security for a specific prisoner must be assessed, and periodically reassessed, on an individual basis, preferably by an interdisciplinary group comprising of health professionals, custodial staff and management, and using established risk assessment protocols. Where a serious threat of violence does exist, health and custodial staff should attempt de-escalation techniques first, and any additional security measures deemed necessary by custodial staff should be taken on the basis of proportionality and using the minimum means necessary. Further, more attention should be given to making the examination room safe and secure than to the ultimate measure of restraining the patient⁸³. If there is thought to be a significant risk, then some form of ‘panic button’ should be available in the room, and if prison staff insist on remaining close to the patient, they may remain in sight, but must be out of hearing distance of the consultation.

The General Medical Council's (UK) Good Medical Practice Guidelines (2006) require doctors to respect the patient's right to dignity and confidentiality and the expectation is that prisoners will be examined without restraints and without the presence of prison officers unless there is a high risk of violence. Where such high risk is present, the patient's privacy, dignity and confidentiality should be maintained as much as possible (British Medical Association (BMA) Ethical Guidance, 2004). Practice shows that the circumstances in which doctors need to compromise on privacy and confidentiality are very few, and this should be a guiding principle when accepting restrictions on clinical practice. Ultimately doctors operate professional judgement and have to balance the needs of their patients against the needs for security and safety. Experience shows that the latter rarely needs to override the former.

Once a medical examination is conducted and medical notes are made, health professionals have a duty to hold information on their patients in confidence.

A physician shall respect a patient's right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality (World Medical Association International Code of Medical Ethics, 1949).

This requirement is central to the doctor-patient relationship, and without the assurance of confidentiality, patients may be reluctant to give information to their health-care providers. Establishing trust and a good doctor-patient relationship in the prison setting is potentially even more difficult than it is outside the prison, as medical staff may be identified by prisoners as being part of the prison's authorities. Further, medical staff may face pressures to disclose information to non-medical prison staff who mistakenly feel that they have a right to know such information for their own protection. Good practice guidelines make it clear that any disclosure of confidential information must adhere to established principles of medical ethics, and doctors making such disclosure must always be prepared to justify their decision in accordance with these principles⁸⁴. As stated in the International Code of Ethics, there will of course be situations in which the health professional may judge that a real and imminent threat exists, either to the patient himself or to other prisoners or staff, and which may necessitate disclosing limited medical information to assist in protecting the patient or others. This would be the case, for example, if a patient is judged to have suicidal ideas which they could act upon. The doctor may then judge that they must disclose some information for the patient to be put on "suicide watch". In cases where the health professional feels that a prisoner threatened harm against another prisoner or staff, in a way which suggested a very real risk of the threat being carried out, then they must consider reporting such a threat in order to protect the potential victim.

5.3 Case law regarding the provision of medical care in prison

Failure to provide adequate medical care in prisons not only raises ethical issues, but may also breach prisoners' human rights under international law. In examining the question of access to appropriate medical care in prisons and detention centres, some of the following principles have been established.

- Prison authorities have an obligation to protect the health of persons deprived of liberty (*Hurtado v Switzerland* 1994 Series A. No. 280 par. 79) and are required to provide medical assistance and treatment to those held in their custody (*Aers v Belgium* 1998, Reports 1998-V).
- This obligation is not dependent on the prisoner's behaviour: "It must be stressed in this respect that the applicant's alleged rude behaviour towards medical staff and, indeed, any violation of prison rules and discipline by a detainee, can in no circumstances warrant a refusal to provide medical assistance" (*Iorgov v. Bulgaria*, 2004 par. 85).
- Failure to provide appropriate medical care to a prisoner who clearly needs it may amount to inhuman or degrading treatment in breach of Article 3 of the ECHR (*Beceiev and Sorban v. Moldova*, 2005; *McGlinchey v. UK*, Application 50390/99 ECHR 2003-V).
- An increased standard of vigilance is required where a vulnerable person, for example a mentally ill prisoner, is involved, taking into account their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by their conditions of detention (*Herczegfalvy v. Austria*, 1993 15 EHRR 437).

Case study: the death of Mark Keenan⁸⁵

Mark Keenan was 28 years old when he died from asphyxia caused by hanging in his cell at Exeter prison. His medical history included symptoms of paranoia, aggression, violence and deliberate self-harm. He was previously diagnosed as suffering from paranoid schizophrenia and, from the age of 21, was intermittently treated with anti-psychotic medication.

Facts of the case

On April 1st 1993 Mark Keenan was convicted of an assault on his girlfriend and sentenced to four months imprisonment. He was admitted to Exeter prison where he was initially placed at the prison's health centre for observation and assessment. When it was suggested on April 14th that he could be moved to an ordinary location at the prison, he barricaded himself at the health centre in protest. On April 16th he was discharged to ordinary location but was returned to the health centre the following evening after his cell-mate reported that he had made a noose from his bed sheet. He was placed in an unfurnished cell and placed on a 15 minute watch. On April 26th there was another attempt to return him to ordinary location, but he was again returned to the medical centre the following day. On April 29th he was assessed by the prison's visiting psychiatrist who prescribed a change in his medication, and recommended that he should not associate with other prisoners until his panic subsided. The following day the possibility of movement to ordinary location was raised again. Mark Keenan said that he did not feel fit for the move. In the course of the day his mental state deteriorated, with evidence of aggression and paranoia. The doctor, who

had no psychiatric training, considered that this might be because of the change in his medication, and prescribed a return to his previous medication. At 6 pm that day Mark Keenan assaulted two hospital officers and was placed in an unfurnished cell and put on a 15 minute watch. On May 1st the prison's senior medical officer, who had six months training in psychiatry, certified him fit for adjudication in respect of the assault, and fit for segregation. Whilst in the segregation wing, Mark Keenan appeared agitated and distressed and was threatening to harm himself. He was transferred again to an unfurnished cell in the hospital wing where he continued to appear agitated and was aggressive towards staff.

On May 3rd his medical notes recorded that Mark Keenan's attitude was 'very much better', and that he had requested to be returned to the segregation unit. Back at the segregation unit, it was noted that he seemed better but still needed watching. It was further noted that he stated that he felt that he was about to 'go off on one'. The medical notes from that evening recorded that he was being troublesome and given extra medication. There were no further entries in his medical notes until his suicide on May 15th, although entries in the segregation unit's log indicated that he was 'acting very strangely'. On May 14th, nine days before his expected release date and two weeks following the event, adjudication in respect of his assault on the officers took place and he was awarded 28 additional days in prison, and seven days in punitive segregation. The following morning he was seen by the chaplain, the doctor, and visited by a friend. They all later recalled that he seemed calm if unhappy about his punishment. At 18:35 that evening Mark Keenan was found dead in his cell. There was indication that sometime prior to hanging himself he pressed the panic button in his cell.

The court's findings

Assessing whether Mark Keenan's treatment violated Article 3 of the ECHR, the Court found that it had, and was particularly critical of the level and standard of medical care he received: *"the Court is struck by the lack of medical notes concerning Mark Keenan, who was an identifiable suicide risk and undergoing the additional stresses that could be foreseen from segregation ... the lack of effective monitoring of Mark Keenan's condition and the lack of informed psychiatric input into his assessment and treatment disclose significant defects in the medical care provided to a mentally ill person known to be a suicide risk. The belated imposition on him ... of a serious disciplinary punishment... which may well have threatened his physical and moral resistance, is not compatible with the standard of treatment required in respect of a mentally ill person"*(at pars. 113-115).

Key points

- Health staff must not participate in disciplinary procedures in any way, particularly in certifying prisoners fit to withstand procedures, including solitary confinement.
- Where the use of solitary confinement is abusive and may amount to torture or other forms of ill-treatment, health staff have a duty to report and denounce such acts to the appropriate authorities and professional bodies.
- Prisoners in solitary confinement, just like other prisoners, have the right to an equivalent level of medical care to that available outside the prison
- The providers of medical care in prison are bound by the usual established principles of medical ethics, in particular the confidentiality of medical information.
- It is the duty of medical personnel to familiarise themselves with these principles

Notes

- 70 This chapter was co-authored with Jonathan Beynon, MD, Medical Co-ordinator for Health in Detention, International Committee of the Red Cross. Thanks are also due to Julian Sheather of the Medical Ethics Department of the British Medical Association for his insightful comments on a draft of this chapter. The points of view expressed here represent the personal opinions of the authors, and do not necessarily represent the position of their organizations
- 71 For further discussion see: British Medical Association (2001) *The Medical Professions & Human Rights: Handbook for a changing Agenda*, Zed Books, London & New York, particularly chapter 5.
- 72 This chapter does not aim to address the range of issues of medical ethics as applied in places of deprivation of liberty, but focuses on the conflicts and issues related to the use of solitary confinement.
- 73 *Dual Loyalty & Human Rights in Health Profession Practice*, Physicians for Human Rights and the School of Public Health and Primary Health Care, University of Cape Town, 2002:l
- 74 The World Medical Association (WMA) formed in 1948 in direct response to the horrors perpetrated by the Nazi regime, and in particular by the direct participation of Nazi doctors in many of the atrocities, has as one of its principal aims the adoption and promotion of international standards of medical ethics. The WMA Declaration of Geneva is a modern version of the Hippocratic Oath, the pledge of service to mankind implicit in the work of all physicians.
- 75 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. Adopted by General Assembly resolution 37/194, 18 December 1982.
- 76 Commentary to Recommendation REC(2006)2 of the Committee of Ministers to Member States on the European Prison Rules, Commentary on Rule 43.
- 77 European Prison Rules. Council of Europe Committee of Ministers Recommendation Rec (2006)2. Rule 43.2: *The medical practitioner or a qualified nurse reporting to such a medical practitioner shall pay particular attention to the health of prisoners held under conditions of solitary confinement, shall visit such prisoners daily, and shall provide them with prompt medical assistance and treatment at the request of such prisoners or the prison staff.* And Rule 43.3: *The medical practitioner shall report to the director whenever it is considered that a prisoner's physical or mental health is being put seriously at risk by continued imprisonment or by any condition of imprisonment, including conditions of solitary confinement.*
- 78 World Medical Association, Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment, Adopted by the 29th World Medical Assembly Tokyo, Japan, October 1975 and revised 2006 (Known in abbreviated form as the Declaration of Tokyo). Article 1: *"The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures..."*. Also: International Council of Nurses, Position Statement on Torture, Death Penalty and Participation by Nurses in Executions, 1998
- 79 Declaration of Hamburg. World Medical Association. Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment Adopted by the 49th WMA General Assembly Hamburg, Germany, November 1997
- 80 The right to health in international human rights law is stipulated in the International Covenant on Economic, Social and Cultural Rights, and detailed in General Comment No.14 of the Committee on Economic Social and Cultural Rights ('The right to the highest attainable standard of health' (11 August 2000) UN Doc E/C.12/2000/4 par. 1). See also Rule 22 of the UN Standard Minimum Rules and Rule 40 of the European Prison Rules.
- 81 Prison Service Order 3200; PSI 5/2003. See also: Joint Parliamentary Committee on Human Rights (2004), Third Report Session 2004-05, HL 15/I/HC 137-I; All Parliamentary Group on Prison Health (2006), The Mental Health Problem in UK HM Prisons.
- 82 World Health Organization Europe, The Moscow Declaration: Prison Health as part of Public Health, 24 March 2003
- 83 The use of restraints for medical purposes, for example with an acutely psychotically disturbed patient, is governed more by clinical judgement for protecting the individual patient or others than purely on the grounds of security or prison management.
- 84 For further guidance see: General Medical Council, Good Practice Guidance on Confidentiality: Protecting and Providing Information, April 2004; British Medical Association Medical Ethics Today, 2004; Royal College of Psychiatrists, Good Psychiatric Practice: Confidentiality and Information Sharing, CR 133, 2006
- 85 *Keenan v. The United Kingdom*, Application No. 27229/95, ECtHR Judgement of 3 April, 2001.