Dual Loyalty & Human Rights
In Health Professional Practice;
Proposed Guidelines & Institutional Mechanisms

A Project of the
International Dual Loyalty Working Group
A Collaborative Initiative of
Physicians for Human Rights
and the School of Public Health and Primary Health Care
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The Problem of Dual Loyalty and Human Rights

The problem of dual loyalty – simultaneous obligations, express or implied, to a patient and to a third party, often the state – continues to challenge health professionals. Health professional ethics have long stressed the need for loyalty to people in their care. In the modern world, however, health professionals are increasingly asked to weigh their devotion to patients against service to the objectives of government or other third parties. Dual loyalty poses particular challenges for health professionals throughout the world when the subordinating of the patient’s interests to state or other purposes risks violating the patient’s human rights. Efforts to bolster ethical codes to address these challenges have only marginally succeeded, as will be discussed in Chapter II.

The goals of this project are to identify the dimensions of dual loyalty and to propose guidelines and mechanisms for the prevention of complicity by health professionals in human rights violations. This introductory chapter defines what dual loyalty is, explains how professional ethics and human rights relate in solving dual loyalty problems, and explores the obligations of health professionals to respect human rights. These introductory comments provide the background for a description of the motivation for and scope of this project.

The Concept of Dual Loyalty

Since ancient times, many societies have held healthcare professionals to an ethic of undivided loyalty to the welfare of the patient. Current international codes of ethics generally mandate complete loyalty to patients. The World Medical Association (WMA) Declaration of Geneva, the modern equivalent of the Hippocratic Oath, asks physicians to pledge that “the health of my patient shall be my first consideration” and to provide medical services in “full technical and moral independence.” The WMA International Code of Medical Ethics states that “a physician shall owe his patients complete loyalty and all the resources of his science.”

In practice, however, health professionals often have obligations to other parties besides their patients – such as family members, employers, insurance companies and governments – that may conflict with undivided devotion to the patient. This phenomenon is dual loyalty, which may be defined as clinical role conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer or the state. The dual loyalty problem is usually understood in the context of a relationship with an individual patient. In many parts of the world, however, clinicians have responsibilities to communities of patients, for prevention, health education and clinical care. Dual loyalty conflicts can and do arise in these settings as well.

In cases where dual loyalty exists, elevating state over individual interests may nevertheless serve social purposes often accepted as justifiable. Evaluations for adjudicative purposes are a common example. A medical evaluation of an individual’s condition that is relevant to resolution of a lawsuit or a claim for disability benefits requires the health professional to express opinions about individuals that may result in their exclusion from desired benefits or their being deprived of a desired outcome. Such an evaluation is generally accepted as a justifiable departure from complete loyalty to the individual because of the overriding need for objective medical evidence to resolve the claim in a fair and just manner.
Such socially and legally accepted departures from undivided loyalty to the patient are not restricted to evaluations. For example, a health professional may be required to breach confidentiality in a relationship with a patient in order to protect third parties from harm or to notify a health authority of communicable diseases for health surveillance purposes. However, in all circumstances where departure from undivided loyalty takes place, what is critical to the moral acceptability of such departures is the fairness and transparency of the balancing of conflicting interests, and the way in which such balancing is, or is not, consistent with human rights.

**Dual Loyalty and Human Rights**

Dual loyalty becomes especially problematic when the health professional acts to support the interests of the state or other entity instead of those of the individual in a manner that violates the human rights of the individual. The most insidious human rights violations stemming from dual loyalty arise in health practice under a repressive government, where pervasive human rights abuses, combined with restrictions on freedom of expression, render it difficult both to resist state demands and to report abuses. In addition, closed institutions, such as jails, prisons, psychiatric facilities and the military, impose high demands for allegiance on health professionals even in the face of often-common human rights violations against individuals held there. But violations of human rights at the behest of the state by health professionals also take place in open societies, for example, in cases of institutionalized bias or discrimination against women, members of a particular ethnic or religious group, refugees and immigrants, or patients who are politically or socially stigmatized. Violations of people’s rights of access to health care may also arise from policies imposed by governments, or in health systems, including privately managed health systems, in which health professionals are called upon to withhold treatment from certain groups of people in discriminatory ways.

The problem is compounded when the health professional’s conduct is constrained by pressure to yield to other powerful interests, especially those of the state. The pressure may be a product of legal requirements, threats of professional or personal harm for non-compliance, the culture of the institution or society where the professional practices, or even the professional’s own sense of duty to the state. In repressive political regimes or in closed institutions like prisons and jails, the personal consequences can be quite severe.

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II. Dual Loyalty and Human Rights: The Dimensions of the Problem

- **Overview**
- (A) Using medical skills or expertise on behalf of the state to inflict pain or physical or psychological harm on an individual that is not a legitimate part of medical treatment
  - Participating in torture and punishment
  - Participation of health professionals in administration of the death penalty
  - Participation in forced abortion, sterilization and contraception and other violations of reproductive health rights relating to bodily integrity
  - Degrading Physical Examinations that Violate Human Rights
  - Female Genital Mutilation
  - Use of chemical and physical restraints and intrusive examinations to enhance security interests of a prison, detention center, or other institution
- (B) Subordinating independent medical judgment, in therapeutic or evaluative settings, to support medical conclusions favorable to the state
- (C) Limiting or denying medical treatment or information related to treatment to an individual to effectuate policy of the state in a manner that violates the patient’s human rights
  - Denial of or restrictions on care based on gender, ethnic or racial discrimination, sexual orientation or immigration status
  - Denial of care for political reasons and during armed conflicts
  - Denial of appropriate care to prisoners, detainees, and institutionalized people
  - Withholding information about health or health services
  - The special problem of hunger strikers
  - Denial of care because of inequities in health care in society
- (D) Disclosing confidential patient information to state authorities or powerful non-state actor
- (E) Performing evaluations for legal or administrative purposes in a manner that implicate human rights
- (F) Remaining silent in the face of human rights abuses committed against individuals and groups in the care of health professionals
- **Conclusion**

**Overview**

Dual loyalty conflicts in health practice give rise to human rights violations in all societies. They do so particularly in societies that lack freedom of expression and association, where state officials demand that health professionals contribute to the suppression of dissent. But human rights violations stemming from dual loyalty take place even in the most open and free societies. They occur most frequently in closed settings like prisons and detention facilities, where there is often deliberate ambiguity about the health professional’s role in the institution, and in settings where individuals who are otherwise subjected to social or legalized discrimination seek health care.
The circumstances of dual loyalty conflicts are grouped into three categories: to further public health objectives, to serve non-medical ends such as state security or religious or cultural values, and to evaluate individuals for social purposes ranging from receipt of public benefits to determination of criminal responsibility.58 These categories clarify the justifications and indeed the origins of demands for lending clinical expertise to state or other third-party purposes.

From a health practice point of view, however, the problem of dual loyalty and human rights may best be illustrated by the types of conduct by health professionals that may violate the human rights of patients. This chapter thus provides examples grouped by clinical practices that violate human rights at the behest of or to support the state or other third party,59 rather than by the type of justification. The examples are not meant to be exhaustive but illustrative, as an aid to understanding the problem and pointing to solutions.

The types of dual loyalty practices that violate human rights are as follows:

(A) Using medical skills or expertise on behalf of the state or other third party to inflict pain or physical or psychological harm on an individual that is not a legitimate part of medical treatment.

(B) Subordinating independent judgment, whether in evaluative or treatment settings, to support conclusions favoring the state or other third party.

(C) Limiting or denying medical treatment or information related to treatment of an individual in order to effectuate policy or practice of the state or other third party.

(D) Disclosing confidential patient information to state authorities or other third parties in circumstances that violate human rights.

(E) Performing evaluations for state or private purposes in a manner that facilitates violations of human rights.

(F) Remaining silent in the face of human rights abuses committed against individuals in the care of health professionals.

In each situation, the chapter discusses which human rights are infringed and identifies guidelines that international medical and nursing organizations have issued to address them. It addresses ambiguities and gaps in the codes of conduct and, where relevant, the reasons why even explicit guidelines for conduct have not been effective in preventing the health professional from becoming embroiled, often reluctantly or unwittingly, in human rights violations against patients. In some cases, health professionals are following legal requirements, in others, adhering to cultural practices.

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Denial of appropriate care to prisoners, detainees, and institutionalized people

Individuals have a right to appropriate clinical care as part of the right to the highest attainable standard of health. In prison and detention settings, UN Guidelines require no differentiation in medical care from that available to the civilian population, 167 and direct that health care services must be provided at no cost. UN Principles of Medical Ethics state, "Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have the 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." 168 Detailed requirements for examinations, access to health personnel and even second opinions, and complaint procedures are designed to assure adequate health services for prisoners. For psychiatric patients, the UN General Assembly demands that facilities for people with mental illness receive "the same level of resources as any other health facility," including sufficient staff, equipment, professional care and treatment. 169

As noted in the discussions of torture and security practices, the disparity between clearly established human rights and ethical obligations on the one hand, and day to day health conditions and practices on the other, is nowhere clearer than in detention facilities, prisons and psychiatric institutions. Even in the absence of intentional abuse, human rights violations are pervasive. Throughout the world, poor health conditions, inadequate nutrition and lack of access to health services lead to rates of morbidity and mortality that are far higher in prisons, detention facilities, and psychiatric and mental retardation facilities than in civilian populations. Health professionals working in these institutions generally do not have the resources or the authority to provide adequate medical care, much less to provide care equivalent to standards in the larger society. The health consequences for inmates are enormous. Tuberculosis, AIDS and mental illness in prisons are common, yet in many countries treatment is rarely adequate or appropriate. Even in non-repressive, non-conflict-ridden industrialized countries, health professionals often cannot provide appropriate medical care, principally because they are not provided the resources to provide it or because prison authorities impede their ability to provide the care. In some places, too, the commercialization of prison care has made health professionals more accountable to the firm running the institution than to the inmate-patient.

Like health professionals who work in settings where discrimination is common, prisons and detention center health professionals often try to accommodate their medical skills to the limitations imposed on them. They often need to adjust standards of practice to institutional constraints. Health professionals outside the institutions rarely evince interest in what goes on inside them, so clinicians working inside prisons and detention facilities receive neither scrutiny nor support from colleagues in civilian practice or from institutions whose mission it is to uphold practice standards. Moreover, many health professionals working in this environment are subject to employment arrangements that formally subordinate them to officials responsible for institutional operation, thus compromising their ability to exercise independent judgment. In other cases, they become part of an institutional culture that subordinates patient interests to the financial, political, or administrative agendas of the institution.

When ethical guidelines are brought to their attention, health professionals working in these environments often find them meaningless in the world in which they practice. Formal mechanisms for seeking improvements in care or protection of the human rights of their patients are few, and speaking out to improve health care or to change abusive conditions may jeopardize their employment. Improved guidelines for conduct, greater professional training and support, and major changes in structural relationships between health professionals and authorities in these institutions is required.

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IV. Proposed Guidelines for Practice in Difficult Settings

- (A) Prison, Detention and Other Custodial Settings
- (B) Health Care for Refugees and Immigrants
- (C) Health Professionals in the Workplace
- (D) Health Professionals Engaged in Forensic Evaluations
- (E) Military Health Professionals

A) Guidelines for Prison, Detention and Other Custodial Settings

Preamble

The problem of dual loyalty and human rights is particularly challenging for health professionals who are responsible for providing health care services to prisoners. On the one hand, such professionals are subject to professional ethics and mores governing their conduct; on the other, they work within institutions primarily concerned with state and/or public security. It is inevitable that these dual obligations will at times seem to be, or actually will be, opposed to each other.

Health professionals working in prisons often willingly and knowingly comply with policies that violate one or more aspects of medical ethics, and may even participate in drawing up separate codes of ‘medical ethics’ specifically for use in such institutions. Others may be unsure of how to cope with situations where their ethical responsibility to the patient seems to be in conflict with state or prison policies and practices. They tend to be passive participants in unethical practices, rather than willing perpetrators of ethical violations.

In some situations, subordination of patient interests to the requirements of the state undeniably serves legitimate purposes. For example, a prison health professional who becomes aware of sexual or other abuse among prisoners themselves may in certain cases have to intervene and breach confidentiality in order to protect others from harm. Under some circumstances, particularly when public health is at risk, a health professional may have to consider betraying confidentiality for the wider public interest, for example, in combating contagious diseases. More frequently, however, elevating the interests of the state over those of the patient leads to violations of that patient’s human rights. As noted above, in Chile, as well as in other South American countries, physicians participated in torture under orders from the military; in South Africa, as well as in many other countries, prison health professionals routinely failed to record or report torture and abuse of political detainees.

Numerous international codes and declarations address (directly and indirectly) the responsibilities and obligations of prison health professionals. The fact that such health professionals still find themselves facing apparently irresolvable ethical dilemmas, or even acting unethically, indicates the complexity of these situations, for which existing codes may be inadequate or incomplete. This set of guidelines intends to reinforce the principles already stated in existing codes and declarations, while
specifically addressing the dual loyalty concerns experienced by health professionals working in prisons and other closed institutions.

The Dual Loyalty Working Group has thus attempted to address the almost inevitable ethical conflict that will confront prison health professionals, by developing guidelines that build on and add to existing codes, and by suggesting ways in which institutional support mechanisms can be strengthened.

**Scope and context**
The following guidelines apply to health professionals who are responsible for providing health care services to persons in custody, whatever their legal situation — whether they are awaiting trial or already sentenced, detainees being held without charge or in any other form of custody. The rules apply wherever the health professional is called upon to provide medical treatment or any other form of medical expertise, whether that be in a prison itself, a police station, a holding cell, a health care facility or any other place where people are held in custody.

**Guidelines**
In addition to being required to adhere to the principles outlined in relevant World Medical Association, World Health Organization, United Nations, and other guidelines, health professionals who are responsible for providing health care services to those in custody should follow the following guidelines.

1. **The health professional should act in the best interests of his or her patient at all times.**

   **Commentary:** While this precept may seem to conflict with others, it is the basis for medical ethics outlined in such documents as the World Medical Association’s Declaration of Geneva and International Code of Medical Ethics, as well as other declarations such as the Malta Declaration on Hunger Strikes. It must continue to be the primary goal of health professionals caring for prisoners, even in situations of dual loyalty. Acting in the best interests of patients does not necessarily preclude taking steps to prevent harms to, or violations of the rights of other parties, where the health professional has information that could prevent such harms. However, the Guideline does imply that actions that are not in the interest of the patient should be considered only within a framework of exceptions described in General Guideline 7.

2. **The health professional is responsible for ensuring physical and mental health care (preventive and promotive) and treatment, including specialized care when necessary; ensuring follow-up care; and facilitating continuity of care—both inside and outside of the actual custodial setting—of convicted prisoners, prisoners awaiting trial, and detainees who are held without charge/trial.**

   **Commentary:** Health professionals face an ethical conflict when they are called upon to limit or deny care to prisoners, as well as when they are called upon to engage in or passively accept practices that harm the physical and mental health of the patient. This guideline makes clear the responsibility of the health professional to provide care, regardless of outside pressures, and to advocate for the health interests of the patient. This guideline goes beyond Principle 1 laid out in the UN Principles of Medical Ethics Relevant to the Role of Health Personnel in the Protection
of Prisoners, which states that health personnel have a duty to "provide [prisoners] with protection of their physical and mental health and treatment of disease of the same quality and standard...afforded to those who are not imprisoned or detained." It is recognized that not all health professionals will be able to ensure follow-up and continuity of care outside the custodial setting, but to the extent they can, they should.

3. The health professional must be ensured, and must insist on, unhindered access to all those in custody.

Commentary: Health professionals may unknowingly deny care to prisoners when custodial officials deny them access to prisoners, often to manipulate which prisoners get care. This practice may be undertaken for a variety of reasons, including corruption, harassment or enforced discrimination. This guideline makes clear the health professional's responsibility to ensure his or her duties are not neglected or impeded because of the actions of prison officials.

4. The health professional should examine a detained or imprisoned person as soon as possible after incarceration, and thereafter should provide medical care and treatment to such persons whenever necessary, and consistent with the principle of informed consent for such treatment.

Commentary: This guideline, building on Guideline 3, ensures that health professionals are able to provide care to all prisoners within the custodial setting, especially ones who may have experienced abuse. This guideline reinforces Principle 24 of the UN Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment. Furthermore, even though incarcerated, prisoners do not lose their right as patients to be consulted on any treatments they receive consistent with the principle of informed consent.

5. The health professional must regularly inspect and report on sanitary, living and general health conditions to the custodial authority and an independent medical authority; and should, when necessary, advocate for better custodial conditions with custodial authorities and/or an independent medical authority.

Commentary: Health professionals in prison settings face an ethical conflict when their duty is to protect the health of the prisoners, yet the material and/or psychological living conditions of those prisoners, whether through lack of resources or deliberate neglect on the part of prison authorities, make that impossible. In such cases, health professionals can uphold the best interests of their patients by reporting on sanitary and living conditions. This guideline is more specific than those of other medical codes, which do not address the responsibility of health professionals to monitor living conditions in prisons.

6. The health professional should report to the custodial authorities and, where appropriate, to an independent medical authority any situation in which he or she becomes aware of allegations or evidence that those in custody are being subjected to torture or cruel, inhuman or degrading treatment. The health professional must, however, weigh this action against any reprisal or further punishment to the prisoner that may result. When
appropriate, the health professional should gain the consent of the prisoner before making such a report.

Commentary: This guideline builds on current principles barring complicity in torture outlined in the UN Principles of Medical Ethics and the WMA’s Declaration of Tokyo, but goes further by calling on health professionals to report the abuses they may witness. When there is potential for reprisal, however, health professionals must take care to report only to those who will not misuse the information. Bearing in mind Guideline 1, they should take into account the need to protect the safety of the patient. This guideline requires that there be strong institutional mechanisms to support the health professional who blows the whistle, including an independent medical authority and a supportive national medical association.

7. The health professional should certify only that which he or she has personally verified; should not falsify evidence and should ensure that complete and accurate medical records are kept for all patients.

Commentary: Health professionals are often called upon by the state, or another powerful third party, to omit, falsify, or disguise crucial information in medical records. The WMA International Code of Medical Ethics holds that health professionals should certify only what they have personally verified, but it and others do not address the specific problem of omitting or falsifying information for the benefit of a party that does not have the best interest of the patient in mind. This guideline goes further than existing codes in addressing this omission brought on by dual obligations. The guideline requires strong institutional mechanisms to support the health professional who maintains complete and accurate records as well as to support his or her patients.

8. The health professional should abstain from participating, actively or passively, in any form of torture.

Commentary: This guideline is basic to medical ethics and is supported by international human rights covenants, as well as by the WMA Declaration of Tokyo and by the UN International Code of Medical Ethics. A health professional passively participates by permitting his or her clinical findings or treatment to be used by authorities to aid the process of torture.

9. The health professional should not provide any means or knowledge to facilitate the practice of torture or cruel, inhuman, or degrading treatment or punishment; should not authorize, approve, or participate in punishment of any form, in any way, including being present when such procedures are being used or threatened.

Commentary: Health professionals, while they may not participate directly in torture or punishment, may be called upon to participate indirectly, by providing instruments to facilitate torture, by using medical knowledge to monitor torture, or by authorizing punishment. This indirect participation includes examinations to declare an individual “fit” for caning, shackles, solitary confinement or any other type of abuse, and dietary restrictions. It also includes being present while the punishment is being administered, for example, observing caning, or examining a patient in solitary confinement to declare him or her “fit” for continuation of the punishment. This guideline does not prevent a health professional from providing
necessary medical care to an individual in solitary confinement; nor does it prevent a health professional from intervening to seek removal of a prisoner from solitary confinement on medical grounds.

10. The health professional should not participate in capital punishment in any way, or during any step of the process. This includes an examination immediately prior to execution and one conducted after the execution has been carried out.

Commentary: Health professional participation in capital punishment continues to occur, despite the World Medical Association’s resolution prohibiting physician participation and the many codes that prohibit physician involvement in other cruel, inhuman, and degrading treatment. Health professionals are called upon to participate in a range of activities – from preparing intravenous lines for lethal injection to certifying the death of executed prisoners. This guideline goes beyond existing codes to hold that health professionals should not participate in any part of the process, including the certification of death. We are aware, however, that in some countries, prisoners facing execution may prefer to have death certified by a health professional to ensure, for example, that organs for donation are not removed prior to death or that the individual is not buried alive. In these situations, the health professional should obtain explicit informed consent from the prisoner who is to be executed, stipulating that he or she wishes that health professional to certify death. Strong institutional mechanisms are needed to support health professionals in these positions, as many countries’ laws require that health professionals do participate.

11. The health professional should respect medical confidentiality; should insist on being able to perform medical duties in the privacy of the consultation, with no custodial staff within earshot; should divulge information strictly on a need-to-know basis, when it is imperative to protect the health of others.

Commentary: Confidentiality is a cornerstone of medical ethics and is upheld in the WMA’s Declaration of Geneva, among other codes. Yet health professionals are often called upon to divulge patients’ confidential medical information to authorities, or may perform examinations with authorities present, constraining the extent to which a patient can speak openly with the healthcare provider. When the health of other prisoners is at stake, however, the health professional has an obligation to balance their needs with the confidentiality due the patient, for instance, in circumstances of contagious disease or prisoner-to-prisoner abuse. When confidentiality in such circumstances is breached, care should be taken not to disclose any information beyond that which is needed for the asserted purpose. Such balancing of cases should be openly discussed with peer supervisors from medical authorities/bodies outside of the custodial setting in order to guard against abuses.

12. The health professional should have the unquestionable right to make independent clinical and ethical judgements without untoward outside interference.

Commentary: Health professionals in prison settings are often called upon to subordinate their sound medical judgment in order to support conclusions or outcomes favorable to the state. This includes situations of falsifying or omitting information, but it also includes recommending treatment or action that is not in the
best interest of the patient, for example, allowing an ill patient to be transferred when the transfer will lead to further harm, or not hospitalizing an ill patient because authorities believe he is a security threat. Existing codes call for complete clinical independence. This guideline reinforces those codes and further requires that health professionals actively insist on and be granted this right. There may, however, be situations where legitimate restrictions are put on the health professional’s independent judgment. For instance, a physician may be asked to prescribe medication from an essential drug list, with medicines not on the list requiring particular motivation. In such instances, the physician may legitimately accept the restriction, if it is indeed for the greater benefit of the larger community— as long as that restriction does not bring harm or untoward consequences to the patient.

13. The health professional should not perform any medical duties on shackled or blindfolded patients, inside or outside the custodial setting. The only exception should be in circumstances where, in the health professional’s judgment, some form of restraint is necessary for the safety of the individual, the health professional and/or others, and treatment cannot be delayed until a time when the individual no longer poses a danger. In such circumstances, the health professional may allow the minimum restraint necessary to ensure safety.

Commentary: Health professionals in prisons are often expected to ignore or passively accept the physical restraints imposed on their patients. Many codes outline the duty of health professionals not to participate in any form of restraint except when medically determined to be necessary for the health of the patient and others (UN Principles of Medical Ethics, UN Minimum Rules for the Treatment of Prisoners, UN Principles for the Protection of Persons with Mental Illness). This Guideline goes beyond the others by permitting only a narrow exception, that health professionals should not treat a patient in restraints unless an urgent situation requires immediate action that cannot be performed safely without restraints — and even then with the minimum possible restraints.

14. The health professional should not perform medical duties or engage in medical interventions for security purposes.

Commentary: Health professionals should never engage in medical interventions that are not in the individual’s therapeutic interests, even when requested to do so by authorities for security purposes. Principle 3 of the UN Principles of Medical Ethics states that the purpose of the professional relationship must be “solely to evaluate, protect or improve ... physical and mental health [of prisoners and detainees].” For individuals in psychiatric hospitals, the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care state that medication “shall only be used for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others.”

15. The health professional should not participate in police acts like body searches or the imposition of physical restraints unless there is a specific medical indication for doing so or, in the case of body searches, unless the individual in custody specifically requests that the health professional participate. In such cases, the health professional will ascertain that informed consent has been freely given, and will ensure that the prisoner
understands that the health professional's role becomes one of medical examiner rather than that of clinical health professional.

Commentary: This guideline follows from Guideline 14. The World Medical Association's Statement on Body Searches holds that health professionals should participate in body cavity searches as they have the medical knowledge and skills to ensure that the prisoner is not harmed. The BMA and others, however, assert that such participation makes the doctor a wielder of force, which contravenes basic medical ethics. The British Medical Association holds that only if the doctor can ascertain true informed consent should he or she perform the search. This guideline goes beyond the WMA Statement and the BMA policy to say that the prisoner must request the participation of the health professional. Any breach of confidentiality will concern only the search and no other confidential medical information that the prisoner may confide to the health professional.

16. The health professional should, if prepared to treat a hunger striker, respect the rights and freedom of choice of a detained hunger striker regarding medical intervention and intravenous feeding without the intervention of a third party whose primary interest may not be the patient's welfare.

Commentary: Health professionals treating detained hunger strikers are challenged to uphold the sanctity of life while respecting the rights and choices of their patients. The WMA Declaration of Malta addresses this issue far more thoroughly than it is within the scope of this document to do. For the purpose of guidance in cases involving dual loyalty, where authorities may pressure health professionals to force feed hunger strikers, the health professional must not submit to the wishes of a third party whose primary interest may not be the patient's welfare.

17. The health professional should not engage or participate in any form of human experimentation amongst prisoners, unless the research will provide significant health and other benefits for prisoners and facilitate promotion of their human rights.

Commentary: The Working Group is aware that this is a controversial issue and that some existing guidelines do allow for research on prisoners, provided that voluntary informed consent is given. It is the view of the Working Group that true "voluntary informed consent" is almost impossible to obtain in the prison setting, because of the various overt and covert factors which govern the relationship between prisoner, prison staff and health professional. There may however, be some particular circumstances when research with prisoners may provide significant health and other benefits and facilitate promotion of their human rights. The Group acknowledges, moreover, that research issues are not strictly part of its mandate; it would thus welcome further discussion with and guidance from those directly involved in the ethics of research.

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