

Forensic psychiatry ethics: expert and clinical practices and research on prisoners

Ética em psiquiatria forense: atividades pericial e clínica e pesquisa com prisioneiros

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Abstract

Objective: Review the most relevant ethical issues of the tripartite aspects on which forensic psychiatry is based: expert activity, treatment of the mentally ill in prisons, and research on prisoner subjects. **Results and Discussion:** The principles of General Medical Ethics and those of Forensic Medical Ethics are discriminated and confronted and the steps the psychiatrist should take both as an expert and as a clinician to follow the ethical principles of his profession are indicated. A succinct résumé of the research on prisoners is offered and the basic principles, which, if respected, would keep a balance between the need for carrying out research in prisional environments and the safeguard of prisoners' rights are suggested. **Conclusion:** It is fundamental for the forensic psychiatrist the knowledge and implementation of the ethical principles that govern his practice so that he will effectively respect the basic rights of the individuals he treats or researches with.

Descriptors: Forensic psychiatry; Ethics, research; Therapeutic human experimentation; Research subjects; Human Rights

Resumo

Objetivo: Revisar as questões éticas mais relevantes do tripé que compõe a base da prática psiquiátrica forense: a atividade pericial, o tratamento de doentes mentais nas prisões e a pesquisa com sujeitos prisioneiros. **Resultados e Discussão:** Distinguem-se e confrontam-se os princípios da Ética Médica Geral com os da Ética Médica Forense e indicam-se os cuidados que o psiquiatra, tanto na função de perito quanto na de clínico, deve tomar para que os preceitos morais de sua profissão sejam observados. Faz-se, também, breve apanhado histórico da pesquisa com prisioneiros e indicam-se princípios básicos que, se respeitados, possibilitariam um equilíbrio entre a necessidade de realização de pesquisa em ambientes prisionais e a proteção dos direitos dos detentos. **Conclusão:** É essencial ao psiquiatra forense o conhecimento e observância dos princípios éticos que regem sua prática para que possa efetivamente respeitar os direitos básicos das pessoas que avalia, trata ou pesquisa.

Descritores: Psiquiatria legal; Ética em pesquisa; Experimentação humana terapêutica; Sujeitos da pesquisa; Direitos Humanos

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Introduction

The interface between psychiatry and law is known as forensic psychiatry, and professionals who work in this field are known as forensic psychiatrists. Since the two disciplines are based on distinctly different principles and have divergent, if not opposing, objectives, it comes as no surprise that the field of forensic psychiatry is an environment in which significant ethical dilemmas are likely to arise.¹

In the present study, we examine some aspects of forensic psychiatry that create the potential for such dilemmas to appear: the practice itself, as well as the treatment of the mentally ill who are in the custody of the state, whether in psychiatric hospitals or in penitentiaries. The first is related to area of forensics itself, in which the physician plays a role defined by the judge in charge of the case or when he is hired by one of the interested parties. The second, in the penitentiary setting, is strictly of a therapeutic nature. Therefore, we can see that the forensic psychiatrist has a unique position in the practice of medicine: in the case of expert evaluation, the forensic psychiatrist cannot be absolutely certain that the medical intervention provides any benefit to the individual examined; in the case of the therapeutic approach, the physician-patient relationship established is, of necessity, triangular, since both parties are directly and equally linked to a third, the director of the prison.² Therefore, the forensic psychiatrist attempts to address the traditional principles of ethics in medicine and of ethics in forensic medicine, determining which should take precedence and when. Despite the fact that the forensic psychiatrist has "two masters", a unified system of ethics must be respected.¹

In the final part of this study, the delicate issue of medical research involving prison convicts will be addressed, including a brief history of the subject and outlining the ethical precautions that should be taken in this practice, since the human population affected constitutes an extremely vulnerable group.³⁻⁴

Ethics in providing expert opinions

The development of ethical reference points specific to the area of forensic psychiatry is a relatively recent phenomenon.⁵ Currently, some of the most well-respected authors agree that the principal allegiance of the forensic psychiatry expert must be to the judicial system.⁵⁻⁷ Other basic principles, such as veracity (in relation to the individual examined, as well as to the authority who requested the expert opinion) and respect for the individual (the form in which the evaluation is conducted), should also be considered.⁶ However, these principles should be balanced with other traditional medical ethics, such as that of non-maleficence, according to which a physician should be concerned with *primum non nocere* ("first, do not harm"). Under certain circumstances, this principle should prevail. One example of this is seen in countries that impose the death penalty. Since only prisoners that are considered mentally competent are executed, an expert opinion is called for whenever the mental state of the condemned is questioned. In such a case, the only medically ethical alternative available to a physician would be to refuse to perform the evaluation, since lying to save the life of the prisoner is also ethically unacceptable.

Below is an outline of the ethical recommendations that an expert should follow in conducting an evaluation.

1. General medical ethics

Despite the fact that the primary allegiance of forensic psychiatrists is to the legal system, they are subject to all of the ethical mandates of medical practice, which do not conflict with the objectives of giving an expert opinion, since the role of physician is inseparable from that of medical expert.

Therefore, the forensic psychiatrist must always maintain a respectful attitude toward the individual evaluated, as well as toward colleagues who might be involved in the evaluation, abstaining from making any comments during the evaluation itself and reserving any observations for the official report. Likewise, experts should maintain their integrity and restrict their evaluations to what was actually observed and is necessary to report (*visum et repertum*). The forensic expert must base his conclusions on his own observations, and it is unacceptable to omit facts that might be considered prejudicial to any of the interested parties. These are the rules established in articles 119 and 121 of the Brazilian *Código de Ética Médica* (CEM, Code of Medical Ethics).⁸

Another relevant point is that professionals can accede to giving expert opinions only in areas in which they are qualified and have experience. That would be fraudulent and would be considered morally unacceptable conduct, despite the fact that the CEM does not explicitly address the issue. Therefore, "legal qualification" should be distinguished from "technical capacity", since only those psychiatrists who have the necessary experience in a given area can take on the task of giving expert opinions regarding controversies in that area.⁹ However, in some cases, there are no professionals meeting all of these criteria. In such cases, the report submitted should make it clear that, despite being duly licensed to practice psychiatry, the reporting professional has not had the necessary training or experience in the relevant area.⁹ This theme can be found in the Ethical Guidelines for the Practice of Forensic Psychiatry, published by the American Academy of Psychiatry and the Law (AAPL), which include the statement, in section V, that "expertise in the practice of forensic psychiatry should be claimed only in areas of actual knowledge, skills, training, and experience".¹⁰

2. Introduction of the expert

In accordance with the principles of veracity and honesty, it is fundamental that the professional is clearly introduced to the individual to be examined at their initial contact. To that end, a double introduction should be made.¹¹ The first should consist of a positive affirmation: "I am Dr. Smith, I am a psychiatrist, and I have been appointed by the judge to give an expert opinion in your case." The second should consist of a negative affirmation: "Although I am a doctor, I am not here as your doctor."

These precautions are taken in order to establish, from the outset, the rules governing the forensic expert-examinee. Since the social function of a doctor is known, intuitively, by everyone, it is important that the individual examined understand clearly that the forensic psychiatrist, at that moment, is not acting exclusively in accordance with the system of ethics that informs decisions made in the medical profession. If these precautions are taken and the individual still agrees to be evaluated, there will be no question regarding the willingness of the individual to co-operate in the process.

3. Knowledge of the goal of the interview

The next step is to certify that the individual examined has a clear idea of the objective of the interview and of its implications. This is also related to the observance of the principle of honesty. Therefore, experts should inform the individuals examined, in clear and accessible language, why the expert evaluation has been requested and what are the potential legal consequences. It is important that the experts not settle for laconic responses but stimulate the individuals to say, in their own words, exactly what they understood about the process that they are about to undergo, since only an individual who clearly understands a procedure can give valid consent to be submitted to that procedure.

4. Confidentiality

Experts should explain to the individuals examined that the information provided in the interview is not protected by doctor-patient privilege. Much to the contrary, if considered relevant, such information – even if intimate – must be included in the report that will be sent to the judicial authority, and the interested parties will have free access to its content, as well as to any notes taken or recordings made during the interviews. The professionals involved must also make it clear, however, that the lack of confidentiality related to the protagonists in the process (judge, attorneys and interested parties), as well as the fact that, as a rule, the process is public, does not release them from the responsibility to conduct themselves with discretion. In relation to outside parties, the physician should maintain the same level of discretion observed when such information is collected during the course of a clinical visit.

5. Informed consent

The question of informed consent is another ethical issue that is relevant to the process of giving an expert opinion. It might be the most important issue in terms of the principle of respecting the individual. In order to scrutinize the psychic make-up of an individual, it is necessary to first obtain authorization from the individual in question. Otherwise, this would constitute an invasion of privacy. However, there are processes in which merely a judicial order is sufficient to allow an evaluation to be conducted in an ethically correct manner, even if the individual in question has not given consent. The best examples are expert opinions given in cases of criminal responsibility (insanity) and of assessment of competence. In these cases, the expert should advise the individual that the examination must be performed, since there is a judicial order to that effect, but that refusal to cooperate might have a negative effect on the medicolegal conclusions. Regarding risk assessments, a full and informed consent must always be obtained, as the examinee is the person most interested to clarify his personal condition.¹¹ When the individual examined has been declared mentally incompetent, informed consent must be obtained from the legal guardian or person who has the power of attorney.

In Brazil, as well as in other Latin American countries, there is a cultural background of paternalism, and less attention is therefore paid to the question of consent. In contrast, respect for individual autonomy takes center stage in Anglo-Saxon cultures. Therefore, in the former, special precautions should be taken regarding this ethical aspect, which is often neglected. In section III of the AAPL guidelines, it is stated that “at the outset of a face-to-face evaluation, notice should be given to the evaluatee of the nature and purpose of the evaluation and the limits of its confidentiality. The informed consent of the person undergoing the forensic evaluation should be obtained

when necessary and feasible. If the evaluatee is not competent to give consent, the examiner should follow the appropriate laws of the jurisdiction”.¹⁰

6. Impartiality

In the Brazilian court system, the expert, a person who has the full confidence of the magistrate presiding over the process, is charged with examining a question that is beyond the knowledge of a jurist. Therefore, the expert must be as neutral as the judge and is subjected to the same rules regarding impartiality (articles 134 and 135, as well as article 138, clause III, of the Civil Procedural Code).¹² It is understood that neutrality is as much an objective condition of having no conflict of interest in the case being judged as it is a subjective condition related to various question, especially those of a countertransference nature.

As a result of the requirement of impartiality, the report submitted by the expert will be clear and objective. However, objectivity can be seriously affected by sentiments that the behavior or history of the individual examined evokes in the examiner, as well as by the nature of the relationship established between the expert and the judge in charge of the case or between the expert and the attorneys for the interested parties. Therefore, forensic psychiatrists should be alert to early indications of factors that could compromise their objective status, such as intense identification with or rejection of the individual examined, as well as the revival of memories related to traumatic events experienced by the examiner. Impartiality can also be impaired if experts identify strongly with the figure of the magistrate and, rather than making an objective evaluation, “judge” the case and steer their conclusions toward the “impartial” verdict they proffer. This distortion can occur if the experts, as a result of their experience, are aware of the effects that their conclusions have on the judicial decision.¹¹

In article 118 of the CEM, physicians are obligated to “act with absolute objectivity when appointed to proffer an expert opinion or act as an auditor (...)”.⁸ Under Brazilian law, the rule of impartiality does not apply to the technical assistants to the interested parties. As indicated by their title, they “assist” the party throughout the process and do not have the status of expert. However, despite having a moral allegiance to one side in the case, technical assistants are still obligated to observe the principle of veracity and to remain objective.

In Anglo-Saxon cultures, such scenarios unfold differently, since the experts contracted by the interested parties have this status and are obligated to remain neutral. Accordingly, in section IV of the AAPL guidelines, it is stated that “when psychiatrists function as experts within the legal process, they should adhere to the principle of honesty and should strive for objectivity. Although they may be retained by one party to a civil or criminal matter, psychiatrists should adhere to these principles when conducting evaluations, applying clinical data to legal criteria, and expressing opinions.”¹⁰

7. Conflict between medical treatment and giving expert opinion

Finally, it must be borne in mind that there is a profound ethical incompatibility between medical treatment of a patient and giving an expert opinion regarding the same individual. The physician-patient relationship is a bilateral

one, in which the loyalty of the physician is to the patient alone. Therefore, all information furnished is covered by the mantle of confidentiality. However, when an expert opinion is requested, a triangular relationship is established among the expert, the judge and the individual examined, although the principal allegiance of the expert is to the judicial system. Therefore, situations can arise in which the expert must choose between being disloyal to the "patient", thereby breaking the rule of doctor-patient privilege, and being disloyal to the judge in charge of the case by not producing an objective and reliable report. In addition, we can presuppose that a pre-existing relationship between the expert and the patient is enough to impair the neutrality of said expert. In response to this problem, article 120 of the CEM states that physicians are prohibited from "giving an expert opinion regarding their own patients, members of their own family or any person with whom they have a relationship that might influence their opinion."⁸ However, it must be borne in mind that, according to the Brazilian law, no conflict exists between medical assistance and technical assistance during judicial process, since, although the party experts are expected to be honest and objective, they are not required to be neutral.

Ethical treatment of prison convicts

The greatest hindrance to the ethical execution of therapeutic studies involving prison convicts is the inevitable question of "double agency", since the agent must be loyal to two distinct entities: the prisoner, who is actually just a patient in need of medical assistance; and the administration of the penitentiary, which employs the psychiatrist and is a political organ of the society in which the civilian physician lives.⁴

The question of multiple loyalties and the consequent multiple allegiances is a crucial point in the field of bioethics. Loyalty is a voluntary commitment to be faithful to a cause or a person, resulting from a sense of duty. Loyalty should not be confused with love, nor is it derived from the strict cognitive evaluation of a given situation. Loyalty implies a profound and complete commitment of all aspects of the individual – affective, rational, conscious and unconscious – to the determined entity.¹³ When these entities are in opposition, loyalties conflict, which can be manifested in diverse domains, most commonly those of confidentiality and patient autonomy.

1. Confidentiality

In the penitentiary setting, the rule of confidentiality, even in purely clinical activities, takes on different shades than when medicine is practiced outside the bounds of the judicial system. This difference in the general standard occurs as a result of various factors, the most relevant being as follows: 1) the aforementioned double agency of the physician, who must be loyal to the patient and the penitentiary administration alike; 2) the fact that crimes (past or future) are involved; and 3) the fact that the evaluation of the danger posed by the convict will potentially lead to continued incarceration, parole or the discontinuation of any extra security measures imposed.

The problems related to double agency can only be minimized by making it clear to the patient at the outset, in accordance with the principles of honesty and veracity, that the physician also has a duty to the penitentiary administration. By doing so, the physician can and should assure the ailing convict that facts regarding his or her personal profile will remain confidential as long as they do not affect prison security, that being the only case in which such confidentiality would be

broken. Otherwise, this conduct would constitute a betrayal of the duty the physician has to the patient. Possible motives for breaking doctor-patient privilege include plans to commit serious violations of prison rules (escape plans) and crimes (the murder of rivals or crimes ordered from within prison), which would have to be communicated to the superiors of the physician.

When such secrets are related to past crimes, the general rule regarding confidentiality should be observed: the physician should communicate to the authorities facts regarding "crime(s) that affect the public welfare and that come to light in the course of practicing medicine or other health care profession, as long as (...) communicating such knowledge does not expose the client to criminal prosecution".¹⁴ The most serious crimes are those that affect the public welfare, and they are prosecuted independently of the wishes and interest of the victim. Therefore, this is one of the instances in which the physician has the legal obligation to break doctor-patient privilege, as stated in article 102 of the CEM,⁸ since it does not expose the patient to criminal prosecution (it being understood that the patient was not the author of or an accomplice to the crime). Nevertheless, bearing in mind the particulars of the codes of conduct that are in force among the convicts themselves, the revelation of any such secrets must be accompanied by the appropriate security measures, such as maintaining the anonymity of the convict in question and, if necessary, removal of that convict from the general prison population.

One final confidentiality issue is related to the medical records of convicts, which should be freely examined during risk assessments. Therefore, despite the fact that the psychiatrist who provides clinical treatment is prohibited from participating (concurrently or after the fact) in the procedures employed to establish risk, which would prejudice the status of the prisoner, the observations of that psychiatrist will come to the attention of the expert. The only way in which this moral indiscretion can be ameliorated is, again, by clearly informing the patient that his or her medical chart could be examined at the time that a decision is being made regarding his or her imprisonment.¹⁵

2. Autonomy

In applying the principle of autonomy to prisoners, one must bear in mind a very special aspect: that they constitute a population deprived of its most valuable characteristic, physical freedom. This is currently a crucial problem, since the number of mentally ill individuals in penitentiaries is growing, which is as much due to the insecurities and stresses of incarceration as to social changes in the model of mental health care.¹⁶ The great majority of such individuals are mentally competent and therefore capable of making choices of an extremely personal nature, such as whether or not to receive medical treatment. The great dilemma that arises is, therefore, related to involuntary treatment.

In addressing this issue, one must draw a clear distinction between mentally ill patients being held for psychiatric treatment in forensic psychiatric hospitals (or, in their absence, hospitals that function as such) and those serving out their sentences in prison. In the former, involuntary treatment is imposed by the judicial system and is the primary objective of their criminal commitments. In such cases, there is therefore no other option. Of course, the treatment guidelines are the prerogative of the physician, who exercises professional autonomy and is not subject to any outside interference.

However, the physician must at least attempt to obtain the consent and co-operation of the patient in executing the treatment plan, as a sign that the patient is valued and respected. However, in relation to common criminals who present a mental disorder, the situation is different. When the primary pathology does not impede the prisoner from making a decision, such a decision should be rigorously respected, as if it came from a citizen who enjoyed full liberty. Involuntary treatment can only be given for pathologies that impair judgment or in cases in which the disorder puts the life of the patient in jeopardy, as stated in article 46 of the CEM.⁸ In such cases, since the individual is in the custody of the penitentiary administration, it is incumbent upon the administration to authorize the treatment.

3. Another crucial problem

Unfortunately, the ethical dilemmas related to the treatment of prisoners are not limited to issues of confidentiality and autonomy. Another serious problem that demands close attention from physicians who work in penitentiaries is that of "treatment" that has an objective other than therapy. Such physicians might be asked to perform interventions in certain prisoners as a means of disciplining, or even punishing, those prisoners. Situations such as these, in fact, do not, as in the previously mentioned situations, constitute a conflict between divergent duties, since the concept of discipline is foreign to the field of medicine, and there is no moral justification for co-operating with these practices. Therefore, acts of this nature are completely deplorable from an ethical standpoint, being proscribed, directly or indirectly, by all medical organizations in democratic countries.

The CEM⁸ states that "the purpose of the medical profession is to provide health care to human beings (...)" (in article 1), that "the full attention of physicians must be focused on human beings health (...)" (in article 2), that "a physician must have the utmost respect for human life, always attempting to benefit the patient. A physician must never use his skills to cause physical or moral suffering, to kill a human being or to allow or abet any attacks on human dignity or integrity (in article 6)."

Likewise, section 7 of the Declaration of Hawaii II states that "a psychiatrist must never (...) violate the dignity or human rights of any individual or group" and "must on no account utilize the tools of his profession, once the absence of psychiatric illness has been established".¹⁷ On the other hand, section 4 of the Declaration of Madrid states that "treatment must always be in the best interest of the patient".¹⁸ This is also the essence of the Oath of Athens, which was proffered by health care professionals working in prisons and in which they swore "to abstain from authorizing or approving any physical punishment" and that their medical judgments would be based on the needs of the patients, which would have "take priority over any non-medical matters".¹⁹

Although foreign to the Brazilian situation, another facet of psychiatric "treatment" with non-therapeutic objectives is that of prisoners on death row. In countries that impose the death penalty, the legislation typically stipulates that a prisoner must be mentally competent to understand the punishment that will be carried out. Therefore, psychosis can prevent the execution. Under these conditions, a forensic psychiatrist can be called upon to give an expert opinion regarding the mental competence of the condemned or, if it is obvious that the prisoner is mentally incompetent, to provide the treatment that will make the prisoner eligible for execution. The World

Psychiatric Association has made a formal pronouncement in the matter, declaring that the participation of psychiatrists in any activities related to the application of the death penalty is "a violation of professional ethics".

Ethics in research involving prisoners

1. Historical underpinnings

From the times of Ptolemy, in ancient Egypt, to the modern era, prisoners have been used as research subjects.²⁰ This is common practice in developed nations, which possess the technology to generate advances in scientific knowledge, although scientists in these countries occasionally attempt to avail themselves of the human resources found on poorer continents. In 1884, Louis Pasteur wrote to Emperor Dom Pedro II of Brazil, proposing to test his anti-rabies vaccine on prisoners condemned to death. Dr. Pasteur suggested explicitly that a type of risk contract be established, stating that "since men on death row fear only death", those that survived should have their lives spared. The Emperor refused the idea, but made a counterproposal to the effect that Pasteur should test a vaccine against yellow fever, which would have a much greater benefit for society.²¹ This response was quite characteristic of the prevailing ideology at that time, according to which the common good would justify performing experimentation on humans without the need to respect their autonomy.

This was the keynote of the thinking until the end of World War II, during which research on prisoners was widespread. Examples of such research are provided not only by the horrors perpetrated by the Nazi physicians in concentration camps and by Japanese researchers on the celebrated Manchurian Chinese Unit 731²² but also by the famous experiment conducted during that war, beyond the borders of the Third Reich, in the state of Illinois, in the United States, in which hundreds of detainees were inoculated with malaria in order to discover effective means of preventing and treating the disease that devastated the American troops operating in the Pacific theater.²³

The indignation over the behavior of the defeated nations led to the establishment of the Nuremberg Code. However, that was not the first effort made to limit research involving human subjects. Previously, on March 2, 1900, the American senator Jacob Gallinger introduced legislation designed to regulate this practice. Because it was a very advanced piece of legislation, requiring that there must be a previous scientific basis for any research conducted, that the project design be submitted to an independent committee, that vulnerable groups be excluded from use as research subjects, and that all participating subjects give informed consent, it was not passed.²⁴ During the same period, research conducted on non-volunteer human subjects by the illustrious professor of venereology, Albert Neisser, who injected uncontaminated prostitutes with serum collected from patients with syphilis in attempts to develop a syphilis vaccine, caused such an outcry that, in 1901, the German Ministry of Health responded by devising the first set of standards regulating research conducted on human subjects, in which the need full disclosure and prior consent of subjects was predominant. Years later (in 1931), the German Ministry of the Interior established strict guidelines to limit experimentation on human subjects, emphasizing the importance of respect for the demonstration of willingness on the part of potential subjects and not making any exceptions in the case of prisoners held by the state.²²

Ironically, these rules were not revoked by the Nazi regime and were still in full effect during World War II.

In the post-war era, under the influence of the Nuremberg Code, attempts were made to establish rules governing research conducted on human subjects in general and to determine their applicability to prisoners. Therefore, based on the general principles put forth by the American Medical Association – which basically consisted of the need to obtain subject consent, to have performed previous experiments on animals and to provide medical protection during the course of the study – a committee appointed by the governor of Illinois found that the medical experiments conducted in that state were carried out fully within the bounds of the ethical principles established. This proclamation strengthened the tendency to use prisoners as research subjects, a practice that took on alarming proportions in the United States. It is estimated that, by the end of the 1960s, approximately 90% of all phase I trials of new drugs were conducted in prisons.²⁵

Actually, from the time of the Nuremberg trials until the 1970s, there was a great bias in the ethical approach to this issue, since the researchers limited their observation of subject willingness to merely formal aspects (if the prisoner was mentally competent, had been informed of the study design and had not been explicitly coerced into making the decision). However, these parameters proved highly unsatisfactory, as was demonstrated in the now famous cases of testicular irradiation in the states of Oregon and Washington, since they did not include one fundamental factor: even if a prisoner is mentally competent, he is an individual deprived of his liberty and subjected to an environment in which the values of the common man are easily subverted. Therefore, prisoners constitute a vulnerable population that is deserving of special measures of protection.²⁶

Due to the extent of the abuses, some authors have used expressions such as “human guinea pig”²⁵ and “cheaper than chimpanzees”²⁷ in denouncing the conditions under which experiments on prisoners were carried out. It therefore comes as no surprise that a total ban on this type of research has been proposed.²⁸ It became evident that new rules were needed, and such rules were laid out in various documents disseminated internationally by a number of organizations. The first was authored by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, a commission created by the American Congress, according to which, the incarceration of prisoners used as research subjects must be under liberal conditions, such that they can exercise their free will to the fullest extent possible.²⁹ Later, the Council for International Organizations of Medical Sciences stated that a prisoner suffering from, or at risk for, a serious disease cannot be denied access to experimental therapies based on the condition of vulnerability. This statement sought to prevent excessive enforcement of protective measures from doing harm to those that such measures were designed to protect.³⁰ More recently, the United Nations, in its Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment, established that “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.”³¹

2. Current situation and recommendations

In the last two decades, the situation has changed substantially. The number of studies involving prisoners has declined considerably. The phase I trials of new drugs are

preferentially conducted on “free” individuals of low socioeconomic status. However, the essence of the problem has yet to resolve. There are still no clear definitions regarding which parameters should be used to regulate studies involving prisoners. Merely invoking traditional variables, such as mental competence and the absence of coercion, is insufficient. At the least, it is fundamental to prevent the “buying” of subject compliance with research, which, in a prison setting, can consist of unimaginably minimal recompense (better nutrition, transfer to another cell block, etc.) or even explicit, self-evident advantages (free medical care, actual payment or a reduced sentence).²

It should also be considered that the vulnerability of the prison population in relation to research is attributable to limited free will, and to the degree to which prisoners are effectively at liberty to give informed consent. In addition, mentally ill prisoners are doubly vulnerable, due as much to their status as prisoners, which affects their willingness, as to the condition of mental illness, which can impair their competence.³²

The prevalence of certain pathologies, such as infectious diseases (AIDS in particular) and psychiatric disorders (chemical abuse/dependence, depression, suicidal tendencies, etc.), is especially high in prison populations.³³⁻³⁵ Therefore, participation in research studies can provide direct, immediate benefits (receiving treatment for a certain condition) or indirect benefits (establishing the category or nature of a medical problem). It is also possible that prisoners can benefit by perceiving that they are contributing to the common good, thereby making them feel as though they are still useful members of society.³⁶

To achieve an equilibrium between the need to conduct research in prison settings and the protection of the rights of prisoners, the following basic principles have been proposed:¹⁻²

1) Incentives to participate should be avoided

Appropriate medical precautions should be taken and adequate nutrition should be made available to persons deprived of their liberty and submitted directly to the power of the State, so that such basic necessities cannot be used as incentives to participate in research projects. Nor should reduced sentences and visitation privileges be used as incentives. Payments, if made, should be limited to what is normally paid to other prisoners for their labors within the prison.

2) Therapeutic research should be distinguished from non-therapeutic research

It is necessary to draw a distinction between therapeutic and non-therapeutic research so that, in the former, no prisoner is deprived of the potential benefit resulting from recruitment as a research subject. As for non-therapeutic research on prisoners, the most prudent course of action would be to ban this practice entirely or to carefully regulate and allow it under special circumstances. In the latter case, in addition to precautions against inappropriate recruitment, several variables must be considered. These include the level of security of the prison, the potential future benefit to similarly vulnerable populations and the federal legislation regarding competence in the country in question.

3) Pro-active role of Ethics in Research Committees

In Brazil, since the passage of Resolution CNS No. 196/96,³⁷ the ethics involved in the design and execution of research projects have been quite rigorously monitored. The Institutional Review Boards, in Brazil called Ethics in Research Committees (ERCs) are composed of persons from diverse sectors of society

and are total independent in their deliberations. Therefore, penitentiaries should be encouraged to form their own ERCs, which would meet in a locale outside the prison system. At least one member of the committee should be a former prisoner.

Bearing in mind the vulnerability of prisoners, deprived of a portion of their autonomy and free will, as well as the fact that they live in an environment that fosters abuse, the ERC should carefully evaluate the following aspects: the scientific validity of the project submitted; the qualifications of the researchers; the estimated risks; the cost-benefit ratio; the rules governing the recruitment of subjects; the guarantee of confidentiality; the safeguards against the release of confidential data; and any potential conflicts of interest among the researchers. In addition, the ERC should be pro-active in monitoring the execution of the project, not limiting itself to the bureaucratic examination of periodic reports regarding the progress of the study but also making unannounced on-site inspections.

Conclusion

Knowledge of and observance of the ethical principles that govern forensic practice are essential to physicians who give expert opinions regarding individuals involved in civil or criminal trials, as well as to those who treat individuals deprived of their freedom. Adhering to these principles is the only way to ensure that the basic rights of all citizens are respected. However, the practice of carrying out biomedical research in prisons is a public health necessity, since only through knowledge of this situation can we intervene in an efficacious manner and provide benefits to the prison population. However, the advancement of science through research on prisoners must be accompanied by the strict observance of universal ethical principles in order to avoid imposing on this highly vulnerable population an onus greater than their sentence.

References

- Arboleda-Flórez J. Forensic psychiatry: two masters, one ethics. *Die Psychiatrie*. 2005;2:153-7.
- Taborda JG, Arboleda-Flórez J. Forensic medicine in the next century: some ethical challenges. *Int J Offender Ther Comp Criminol*. 1999;43(2):188-201.
- Verdun-Jones SN, Weisstub DN, Arboleda-Flórez J. Prisoners as subjects of biomedical experimentation: Examining the arguments for and against a total ban. In: Weisstub DN. *Research on Human Subjects*. Oxford: Elsevier Science (Pergamon); 1998. p. 328-54.
- Arboleda-Flórez J, Taborda JGV. Princípios éticos aplicáveis na prática da psiquiatria forense. In: Taborda JGV, Chalub M, Abdalla-Filho E. *Psiquiatria Forense*. Porto Alegre: Artmed; 2004.
- Weinstock R, Gold LH. Ethics in forensic psychiatry. In: Simon RI, Gold LH. *Textbook of Forensic Psychiatry*. Washington, DC: American Psychiatric Publishing; 2004.
- Appelbaum PS. A theory of ethics for forensic psychiatry. *J Am Acad Psychiatry Law*. 1997;25(3):233-47.
- Weinstock R. A theory of ethics for forensic psychiatry. *J Am Acad Psychiatry Law*. 1998;26(1):151-6.
- Conselho Federal de Medicina. Resolução Nº 1.246/88 (Código de Ética Médica). *Diário Oficial da União*, 26 jan 1988.
- Miranda-Sá Jr LS, Bayardo E, Bayardo G. Ética na perícia psiquiátrica. In: Moraes T. *Ética e Psiquiatria Forense*. Rio de Janeiro: IPUB-CUCA; 2001.
- American Academy of Psychiatry and the Law. Ethical Guidelines for the Practice of Forensic Psychiatry. Atlanta: Semiannual Meeting; 2005.
- Taborda JGV. Exame pericial psiquiátrico. In: Taborda JGV, Chalub M, Abdalla-Filho E. *Psiquiatria Forense*. Porto Alegre: Artmed; 2004.
- Brasil. Lei Nº 5.869/73 (Código de Processo Civil). *Diário Oficial da União*, 17 jan 1973.
- Dwyer J. Conflicting loyalties in the practice of psychiatry: some philosophical reflections. In: Simon RI. *Review of Clinical Psychiatry and the Law*. Washington, DC: American Psychiatric Press; 1992.
- Brasil. Decreto-lei Nº 3.688/41 (Lei das Contravenções Penais). *Diário Oficial da União*, 31 dez 1941.
- Kantor JE. Psychiatric ethics in the correctional setting. In: Rosner R. *Principles and Practice of Forensic Psychiatry*. 2nd ed. London: Arnold; 2003.
- Butler T, Andrews G, Allnutt S, Sakashita C, Smith NE, Basson J. Mental disorders in Australian prisoners: a comparison with a community sample. *Aust N Z J Psychiatry*. 2006;40(3):272-6.
- World Psychiatric Association. Declaration of Hawaii II. Viena: 7th World Congress of Psychiatry; 1983.
- World Psychiatric Association. Declaration of Madrid. Madri: 10th World Congress of Psychiatry; 1996.
- International Council of Prison Medical Services. Oath of Athens. Atenas: Inaugural Meeting; 1979.
- Arboleda-Florez J. The ethics of biomedical research on prisoners. *Curr Opin Psychiatry*. 2005; 18(5):514-517.
- Vieira S, Hossne WS. Experimentação em seres humanos. São Paulo: Moderna; 1987.
- Capron AM. Human experimentation. In: Veatch RM. *Medical Ethics*. Boston: Jones and Bartlett; 1997.
- Rothman DJ. Strangers at the Bedside: a History of How Law and Bioethics Transformed Medical Decision Making. New York: Basic Books; 1991.
- Lederer SE. Subjected to Science: Human Experimentation in America Before the Second World War. Baltimore: John Hopkins Press; 1995.
- Adams A, Cowan G. The human guinea pig: how we test new drugs. *World*, 5 dec 1971.
- Arboleda-Florez J. Ethical issues regarding research on prisoners. *Int J Offender Ther Comp Criminol*. 1991;35(1):1-5.
- Mitford J. Kind and Usual Punishment: the Prison Business. New York: Alfred A. Knopf; 1973.
- McCarthy CM. Experimentation on prisoners. *N England J Criminal Civil Commit*. 1989;15:55-8.
- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Report and Recommendations: Research Involving Prisoners. Washington: DHEW; 1976.
- Council for International Organizations of Medical Sciences. International Ethical Guidelines for Biomedical Research Involving Humans Subjects. Geneva: WHO; 1993.
- United Nations. Resolution 43/173. Body of principles for the protection of all persons under any form of detention or imprisonment. General Assembly, New York, December 9; 1988.
- Roberts LW, Roberts B. Psychiatric research ethics: an overview of evolving guidelines and current ethical dilemmas in the study of mental illness. *Biol Psychiatry*. 1999;46(8):1025-38.
- Tye CS, Mullen PE. Mental disorders in female prisoners. *Aust N Z J Psychiatry*. 2006;40(3):266-71.
- Fotiadou M, Livaditis M, Manou I, Kaniotou E, Xenitidis K. Prevalence of mental disorders and deliberate self-harm in Greek male prisoners. *Int J Law Psychiatry*. 2006;29(1):68-73.
- Remartinez EJ, Planelles Ramos MV, Garcia Guerrero J. Tendencia de la tasa de mortalidad en una prisión española (1994-2004). *Rev Esp Salud Publica*. 2005;79(6):673-82.
- Roberts LW. Informed consent and capacity for voluntarism. *Am J Psychiatry*. 2002;159(5):705-12.
- Conselho Nacional de Saúde. Resolução Nº 196/96 (Diretrizes e Normas Regulamentadoras de Pesquisas Envolvendo Seres Humanos). *Diário Oficial da União*, 16 out 1996.