Physicians for Human Rights

Dual Loyalties: The Challenges of Providing Professional Health Care to Immigration Detainees

March 2011

physiciansforhumanrights.org

PHR
Physicians for Human Rights

ABOUT PHYSICIANS FOR HUMAN RIGHTS

Physicians for Human Rights (PHR) is an independent, non-profit organization that uses medical and scientific expertise to investigate human rights violations and advocate for justice, accountability, and the health and dignity of all people. We are supported by the expertise and passion of health professionals and concerned citizens alike.

Since 1986, PHR has conducted investigations in more than 40 countries around the world, including Afghanistan, Congo, Rwanda, Sudan, the United States, the former Yugoslavia, and Zimbabwe. With the help of our supporters, we have worked to stop torture, disappearances, political killings, and denial of the right to health by governments and opposition groups; deaths, injuries, and trauma inflicted on civilians in armed conflict; suffering and deprivation caused by political differences or discrimination; mental and physical anguish inflicted on women by abuse; loss of life or limb from landmines and other indiscriminate weapons; harsh methods of incarceration and interrogation and torture in prisons and detention centers; and poor health stemming from vast inequalities in societies.

As one of the original steering committee members of the International Campaign to Ban Landmines, PHR shared the 1997 Nobel Peace Prize.

A. Frank Donaghue, Chief Executive Officer, PHR
Robert Lawrence, Chairman of the Board

2 Arrow Street | Suite 301
Cambridge, MA 02138 USA
1 617 301 4200

1156 15th Street, NW | Suite 1001
Washington, DC 20005 USA
1 202 728 5335

Physiciansforhumanrights.org
©2011, Physicians for Human Rights. All rights reserved.
Library of Congress Control Number: 2011925437
ISBN : 1-879707-61-6

Acknowledgments

This report was written by Christy Carnegie Fujio, JD, MA, Asylum Program Director at Physicians for Human Rights (PHR).

The report has benefited from review by Frank Davidoff, MD, Editor Emeritus of Annals of Internal Medicine and PHR Board member; Michele Heisler, MD, MPH, Associate Professor of Internal Medicine at the University of Michigan Medical School and PHR Board member; Vincent Iacopino, MD, PhD, Senior Medical Advisor at PHR; and Scott Allen, MD, Co-Director of the Center for Prisoner Health and Human Rights at Brown University and Medical Advisor to PHR.

Jennie Baldé and Kathleen Sullivan initiated development of the report and provided guidance on the report's structure and content. Attorneys Allen Jun and Lindsay Tunney of Ropes & Gray LLP provided extensive background research and materials, and attorney Jessica Chicco contributed to the early development of background narratives. PHR legal interns Neena Dhouni, Giovanni DiMaggio, and Vanessa Madge assisted with fact-checking and citation development. PHR legal and medical interns Linda Rigas, Alyssa Vangeli, Caitlin Reed, and Brian Mancke conducted legal and medical research and assisted with development of early outlines.

PHR wishes to thank Atlantic Philanthropies for their generous support of this project.

Physicians for Human Rights
Robert Lawrence, Chairman of the Board
A. Frank Donaghue, Executive Director

Table of Contents

Executive Summary 1

Recommendations 4

Introduction: Privileged Relationships and Accompanying Responsibility 5

Dual Loyalties Concept 5

Dual Loyalties in Immigration Detention 7

- Explicitly Conflicting Missions 7
- Isolation and Shortage of Health Professionals Working in Detention 7
- Muddled Accountability and Lack of Transparency 8
- Lack of Independent Oversight 9
- Insufficient Procedural Protections for Detainees 10
- Non-binding and Inconsistent Standards 11

Health Crisis in Detention 11

Medical Ethics, Human Rights Principles and Standards of Practice 14

- Bioethics 14
- Human Rights 15
- Standards of Practice 16

Clinical Independence 17

Inappropriate Use of Segregation to Treat Mental Health Issues 20

Non-Consensual Treatment of Detainees 26

Recommendations 29

Executive Summary

The US immigration system has been criticized for failing to meet the needs of the people it is intended to serve. The detention system, in particular, has drawn extensive attention in recent years from non-governmental organizations (NGOs), immigrant advocates, health organizations, and journalists who have been calling for detention center reform due to well documented reports of abuse, poor health care, sexual assaults, and deaths in detention facilities.[1] Approximately 400,000 people, including elderly, women, mentally ill, and disabled people, are detained each year[2] in restrictive conditions that have been designed for punitive purposes, even though most detainees have no violent criminal records.[3] Asylum seekers and other survivors of human rights violations often spend months and sometimes years in detention, waiting for their cases to wind their way through the adjudicatory system.[4] Immigration detention rates have grown dramatically in the last decade, rising from approximately 20,000 detention beds in 2002 to over 33,000 in 2009.[5] Within the network of approximately 250 detention locations, immigrants are often detained in harsh conditions meant to house convicted offenders.[6]

Thousands of asylum seekers – including virtually all those who present their claims upon arrival at an airport or other point of entry – are detained each year by Immigration Customs Enforcement (ICE), a federal agency under the umbrella of the Department of Homeland Security (DHS), while their cases are evaluated by US authorities. Guidelines published by the UN High Commissioner for Refugees (UNHCR) call the detention of asylum seekers "inherently undesirable" and state that there should be a presumption against detention, allowing it only in cases of necessity.[7] NGOs have reported on the broad scope of the mandatory detention provision of the Immigration and Nationality Act (INA), which results in the arguably unneces-

---

1 *See, e.g.,* Florida Immigrant Advocacy Center, Dying for Decent Care: Bad Medicine in Immigration Custody, (Feb. 2009), *available at http://www.fiacfla.org/reports/DyingForDecentCare.pdf;* Human Rights Watch, Detained and at Risk: Sexual Abuse and Harassment in United States Immigration Detention, (Aug. 25, 2010), *available at http://www.hrw.org/sites/default/files/reports/us0810webwcover.pdf* [hereinafter Detained and at Risk]; Human Rights Watch, Detained and Dismissed: Women's Struggle to Obtain Health Care in United States Immigration Detention, (March 2009), *available at http://www.hrw.org/sites/default/files/reports/wrd0309web_1.pdf* [hereinafter Detained and Dismissed]; Human Rights Watch & American Civil Liberties Union, Deportation by Default: Mental Disability, Unfair Hearings, and Indefinite Detention in the US Immigration System, (July 25, 2010), *available at http://www.hrw.org/sites/default/files/reports/usdeportation0710webwcover_1_0.pdf* [hereinafter Deportation by Default]; and Nina Bernstein, Ill and in Pain, Detainee Dies in U.S. Hands, New York Times, Aug. 12, 2008, at A1, *available at http://www.nytimes.com/2008/08/13/nyregion/13detain.html.*

2 Tyche Hendricks, *New Report Blasts US on Immigrant Detainees,* San Francisco Chronicle, 1 (Mar. 25, 2009), *http://articles.sfgate.com/2009-03-25/news/17213848_1_immigration-detainees-immigration-officials-immigration-detention* (last visited March 7, 2011); and Center for Constitutional Rights. *Rights Groups Call for Dignity, not Detention on One-Year Anniversary of Obama Administration's Detention Reform Announcement*, (Oct. 6, 2010), *http://ccrjustice.org/newsroom/press-releases/rights-groups-call-dignity,-not-detention-one-year-anniversary-of-obama-admi* (last visited March 7, 2011).

3 Deportation by Default, *supra* note 1 at 72.

4 Dora Schriro, U.S. Department of Homeland Security, *Immigration Detention Overview and Recommendations*, 6 (Oct. 06, 2009), *http://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf.*

5 Tom Barry, *County Jails Welcome Immigrants,* Detention Watch Network (May 27, 2008), *http://www.detentionwatchnetwork.org/node/1180* (last visited March 7, 2011); Human Rights First, *Human Rights First Urges Fulfillment of Detention Reform promises [Press Release],* (Oct. 6, 2010), *http://www.humanrightsfirst.org/media/asy/2010/alert/666/index.htm* (last visited March 7, 2011) [hereinafter *HRF Urges Fulfillment of Detention Reform Promises*]; and US Department of Homeland Security: Office of Inspector General, Detention and Removal of Illegal Alien, 9 (Apr. 14, 2006), *http://trac.syr.edu/immigration/library/P737.pdf.*

6 US Immigration & Customs Enforcement, *Detention Management, http://www.ice.gov/detention-management/* (last visited Jan. 5, 2011); Women's Commission for Refugee Women and Children, Behind Locked Doors: Abuse of Refugee Women at the Krome Detention Center, 3 (Oct. 2010), *http://repository.forcedmigration.org/pdf/?pid=fmo:2517;* and *HRF Urges Fulfillment of Detention Reform Promises*, *supra* note 5.

7 United Nations High Commissioner for Refugees, UNHCR Revised Guidelines on Applicable Criteria and Standards Relating to the Detention of Asylum Seekers, Introduction Nos. 1, 3 (Feb. 1999), *http://www.unhcr.org.au/pdfs/detentionguidelines.pdf.*

sary detention of non-violent immigrants with no criminal records and limited risk of flight.[8] Furthermore, the discretion accorded to ICE, under the guise of security-related grounds, allows for tremendous latitude in determining whether or not to subject a person to immigration detention.[9] Such procedural inconsistency is at odds with the International Covenant on Civil and Political Rights (ICCPR), to which the US is a party, which provides that no one should be subjected to arbitrary detention.[10]

On October 6, 2009, upon the release of an eye-opening report ("Immigration Detention Overview and Recommendations") by former Director of ICE's Office of Detention Policy and Planning, Dr. Dora Schriro, ICE promised to undertake major reforms of the US detention system.[11] To its credit, during the past few years ICE has introduced a number of new goals and procedures, including the establishment of new offices and positions, in order to take better care of detainees. As this report goes to press, ICE is poised to release the 2010 Performance Based National Detention Standards (PBNDS), but it is unclear whether or not these standards will survive the union approval process, and if so, where and when they would be implemented.

While ICE's efforts are commendable and clearly indicative of its desire to improve the system, marginal improvements in detention center standards cannot substitute for the major structural reform that is needed in order to provide for the health care needs of immigration detainees. Due to its emphasis on security and control, the health care management system utilized by the US immigration detention regime, executed by ICE and the ICE Health Service Corps (HSC) under the DHS umbrella, risks infringing upon the right of detainees to obtain adequate physical and psychological care while in detention. Over 100 detainees have died in US immigration detention since 2003[12], and thousands of others have been denied medicine, screening procedures, therapy and other medical care necessary to treat injuries, illness, and chronic conditions.[13] Further abuses suffered by detainees include neglect in isolation rooms for unduly long periods, denial of the right to refuse treatment, and forcible drugging with powerful psychotropic drugs in order to render them unconscious as they were deported from this country.[14] This ongoing lack of attention and care is inconsistent with US human rights obligations articulated in the ICCPR[15], as well as those under the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Protocol Relating to the Status of Refugees (Refugee

8 Human Rights Watch, Forced Apart (By the Numbers): Non-citizens Deported Mostly for Nonviolent Offenses, (Apr. 15, 2009), *http://www.hrw.org/sites/default/files/reports/us0409web_0.pdf*; Human Rights Watch, Costly and Unfair: Flaws in U.S Immigration Detention Policy, (May 6, 2010), *available at http://www.hrw.org/sites/default/files/reports/usimmigration0510webwcover.pdf*; 8 USC. § 1226(c) (2000) (codifying Immigration and Nationality Act § 236A Mandatory Detention provision).

9 Immigration and Nationality Act § 236A Mandatory Detention provision, 8 USC. § 1226(c) (2000).

10 International Covenant on Civil and Political Rights, art. 9(1), Dec. 16, 1966, 99 U.N.T.S. 171, *available at http://www2.ohchr.org/english/law/pdf/ccpr.pdf [hereinafter ICCPR].*

11 Schriro, *supra* note 4, at 6.

12 US Immigration & Customs Enforcement, List of Deaths in ICE Custody October 2003-February 24, 2011, (Feb. 24, 2011) *http://www.ice.gov/doclib/foia/reports/detaineedeaths2003-present.pdf* [hereinafter List of Deaths in ICE Custody].

13 Florida Immigrant Advocacy Center, *supra* note 1; Homer Venters, Dana Dasch-Goldberg, Andrew Rasmussen & Allen S. Keller, *Into the Abyss: Mortality and Morbidity Among Detained, Immigrants*, 31 Hum. Rts. Q. 474 (2009); Human Rights Watch, *Chronic Indifference: HIV/AIDs Services for Immigrants Detained by the United States*, 35 (Dec. 05, 2007), *available at http://www.hrw.org/sites/default/files/reports/us1207web.pdf* [hereinafter Chronic Indifference].

14 Texas Appleseed, Justice for Immigration's Hidden Population: Protecting the Rights of Persons with Mental Disabilities in the Immigration Court and Detention System, 21 (Mar. 2010), *available at http://oppenheimer.mcgill.ca/IMG/pdf/1269915942_Immigration_Detains_Booklet_ONLINE_REV.pdf*; Sandra Hernandez, *US Agents Forcibly Drug Immigrants to Deport: Two Los Angeles Detainees Recount Harrowing Stories of Involuntary Sedation*, L.A. Daily Journal, March 8, 2010, *http://standing-firm.com/2007/05/08/drugging-of-deportees-against-their-will/* (last visited March 8, 2011).

15 ICCPR, *supra* note 10, at arts. 7, 9-10.

Protocol).[16] As a signatory to the ICESCR and ratifying member of the ICCPR and the Refugee Protocol, the US is obligated to provide a certain standard of care to everyone, including non-citizens, within its borders.[17]

Furthermore, the health professionals who participate in the immigration detention system are bound by the same standards of conduct that apply to their treatment of patients in private clinics and hospitals: to treat their duty to patient as their first priority and to always act in the best interests of the patient. Fidelity to patients is the cornerstone of medical ethics considerations around the world, regardless of institutional setting.[18] However, health professionals' ability to maintain loyalty to their patients and to act in their best interests becomes severely compromised when the interests of their employer intrude upon or directly conflict with the needs of patients. This conundrum, most commonly called "dual loyalty," is especially pronounced in the US immigration detention setting, where health care is managed within the DHS system, and the health care professionals report either directly or indirectly to ICE or to HSC, another agency governed by DHS.[19] Operating within a law enforcement organization whose chief mission is to control and eventually remove undocumented immigrants from the US creates numerous loyalty conflicts for health practitioners torn between acting in their patients' best interests and serving the mission and needs of the US government.

Health professionals working in this setting frequently encounter scenarios that test their loyalties and constrain the amount and quality of care they are able to offer to patients. The conflicting loyalty problems inherent in the US immigration detention system are having a gradual but deleterious effect on both the human rights of detainees and on the morale of the health professionals working within its confines. Detainees are deprived of their right to the highest attainable standard of health because many clinicians are subordinating their needs to meet the security requirements of ICE. Additionally, clinicians' confidence and satisfaction in their work risks erosion as they feel forced to choose, repeatedly, between serving the best interests of their patients and serving the goals of ICE and DHS.

Fidelity to patients is the cornerstone of medical ethics considerations.

The fact is, however, that health professionals do not have a choice in determining their loyalties: medical ethics clearly state that they are unequivocally obligated to act in the best interests of their patients – always.[20] Therefore, it is incumbent upon DHS, ICE, the medical community as a whole, and all the policy makers who shape immigration detention policy, to restructure the system in ways that enhance clinical autonomy and allow health professionals to act in their patients' best interest without fear of reprisal. Governmental implementation of the following seven recommendations would positively affect both the detained immigrant population and the cohort of health professionals that serve them, by enhancing clinical independence, establishing transparency and accountability, providing procedural

16 Protocol Relating to the Status of Refugees, arts. 1-2, Oct. 4, 1967, 606 U.N.T.S. 267, *available at http://www2.ohchr.org/english/law/protocolrefugees.htm.*

17 International Covenant on Economic, Social and Cultural Rights, art. 12, Dec. 16, 1966, 993 U.N.T.S. 3, *available at http://www2.ohchr.org/english/law/pdf/cescr.pdf* [hereinafter ICESCR]; ICCPR, *supra* note 10, at arts. 7, 9-10; Protocol Relating to the Status of Refugees, *supra* note 16, at arts. 1-2.

18 British Medical Association, Providing Medical Care and Treatment to People Who are Detained: Guidance from the British Medical Association, 2-3 (Oct. 2007), *available at http://www.medicaljustice.org.uk/images/stories/reports/bmacaredetained2007.pdf.*

19 Health professionals in federally owned detention facilities report directly to HSC, but health professionals working in local or county jails report directly to local authorities. However, HSC is officially charged with overseeing medical care in the entire detention system, and takes an active role in approving, or more frequently; denying claims for medical care outside the detention facilities.

20 *Definition of the Hippocratic Oath,* MedicineNet.com, (Jul. 13, 2002), *http://www.medterms.com/script/main/art.asp?articlekey=20909* (last visited March 8, 2011).

protections to detainees, and supporting health professionals. Implementation will also help align immigration detention practices with US human rights obligations.

Recommendations

1. Require that health care professionals working in detention centers report to health organizations, such as the Department of Health and Human Services, so that they may maintain clinical independence. They should not report to the Department of Homeland Security or to for-profit private contractors;
2. Address chronic staffing shortages so that health professionals have adequate time to spend with each patient;
3. Ensure that lines of accountability are clear to health professionals, patients and security personnel;
4. Create an independent oversight organization to monitor provision of health care in all facilities that house immigration detainees, including tracking of health care metrics such as morbidity and mortality rates, immunization and preventive health utilization, and other standard measures of quality performance in health care settings;
5. Create an ombudsman office to which detainees may easily report grievances regarding access to medical care;
6. Make the Performance Based National Detentions Standards (PBNDS) legally enforceable in all facilities that house immigration detainees. Failure to adhere should result in contract cancellation;
7. Revise PBNDS so that they are based on an adminstrative model of temporary custody rather than the current penal, corrective, model.

Introduction: Privileged Relationships and Accompanying Responsibility

Inherent in the cultural norms, ethical considerations, and legal principles which govern the operation of Western society is the notion that certain relationships are sacrosanct and therefore deserving of special recognition, treatment, and protection under the law. Among these relationships are those between priest and confessor, lawyer and client, and doctor and patient. Society gives particular deference and respect to these relationships because doing so serves a variety of critical functions and supports values that its citizens hold dear. Because the right of confidentiality between parties in these privileged relationships is undeniable, the priest is able to give clear spiritual guidance to the confessor, the lawyer can fully protect the liberty interests of his client, and the doctor is able to provide informed care for the mental and physical well being of her patient. All parties benefit from the universal recognition (and accordant protection) of the unique positions priests, lawyers, and doctors stand in to advise and treat those under their care and influence.

However, because the priest, lawyer, and doctor stand in unique positions to advise and treat those under their sphere of influence, they are expected, by both society and the law, to adhere to a higher code of legal, moral, and ethical considerations than is expected from other professionals. Requirements governing the level of care provided by priests, lawyers and doctors are contained in various places, including black letter state law, professional codes and guidelines, human rights principles, and international treaties. Many of these requirements are considered to be so fundamental that they are universally recognized around the world, even in the most oppressive societies. One such fundamental requirement, embodied in multiple ethics codes and presented unequivocally in the World Medical Association (WMA) Declaration of Geneva, is the promise made by doctors that "the health of my patient shall be my first consideration" and to provide medical services in "full technical and moral independence."[21] Furthermore, the WMA International Code of Medical Ethics affirms that "a physician shall owe his patients complete loyalty and all the resources of his science."[22]

Dual Loyalties Concept

Although these principles are grounded in both ancient and modern texts across the globe, there is a growing recognition that doctors and other health professionals are too often placed in situations where it is difficult for them to fulfill loyalty obligations to their patients. Opposing and competing obligations to third parties, such as employers, governments, and insurers, often test the commitment that health professionals are required to give to their patients. Such conflicts have been identified as "dual loyalty" issues because the health professional is caught between two different players who often have different or discordant aims and objectives. In many cases, health professionals who succumb to the pressure to fulfill third party needs at the expense of their patients end up breaching the ethical obligations of their profession and violating the human rights of the very person who is entitled to the health professional's strongest loyalty. While the term "dual loyalty" may imply equivalence between a medical professional's loyalty to the patient and loyalty to third party interests, no such equivalence exists. Ethically, with very rare and well-circumscribed exceptions, a health professional is obligated to act in the interest of the patient above all other concerns.

---

21 World Medical Association, International Code of Medical Ethics (Oct. 1949), *http://www.wma.net/en/30publications/10policies/c8/index.html.* (last visited March 8, 2011)

22 *Id.*

While overall awareness of health and human rights issues is increasing among health professionals, there is a lack of formal training and guidance regarding identification and resolution of dual loyalty conflicts.[23] In 2002, PHR was at the forefront of the medical community in identifying the existence of dual loyalty issues and providing recommendations for change to mitigate related consequences when it participated in the International Dual Loyalty Working Group's report *Dual Loyalty and Human Rights in Health Professional Practice.*[24] Although health professionals' loyalty to patients should never be *prohibited* by ties to any third party, there exist a number of work environments in which health professionals' ability to give undivided loyalty to patients is *inhibited* to some degree, due to pressure from their employer or the government, concerns about security, demands to keep costs low, or any other third party objectives that cannot coexist symbiotically with the patients' best interests. Closed environments, such as prisons, jails, detention centers, mental health facilities and the military, are the most susceptible to breeding dual loyalty conflicts because security concerns tend to run high while transparency and monitoring mechanisms are generally lacking or altogether absent. Additionally, there is often ambiguity, sometimes deliberately, about the health professional's role in closed institutions.[25] Health professionals working in these environments often find it difficult to provide the best possible care for their patients because they may feel pressure to participate in institutional security, cost cutting, and helping to meet other institutional objectives.

Dual loyalty conflicts resulting from third party pressure may be *express* (e.g. a guard orders a doctor to send a detainee to a segregation unit to quiet him) or *implied* (the guard frequently reminds the doctors that placing detainees in segregation enhances safety), and they may be *real* (the guard is indeed putting pressure on the doctor), or *perceived* (the doctor feels that his colleagues want him to send "troublesome" detainees to segregation more often, even though the security team has not communicated with him at all). However, regardless of the form the pressure takes, and even if it is only perceived by the doctor, it still has the potential to interfere with his obligation to his patients. Dual loyalty conflicts frequently draw health professionals into a moral and ethical conflict, where they end up second-guessing what they know to be their primary duty: giving patients the best possible care.

In its 2002 publication, the International Dual Loyalty Working Group identified six different scenarios where health professionals could potentially violate patient human rights by subordinating his or her needs to the aims and objectives of a third party:

- Using medical skills or expertise on behalf of a third party to inflict pain or psychological harm on an individual when it is not a legitimate part of the medical treatment;
- Subordinating independent clinical judgment to suport conclusions favoring the third party;
- Limiting or denying medical treatment of an individual in order to facilitate policy objectives or practice of a third party;
- Sharing confidential patient information to third parties;
- Performing evaluations for third party purposes in a manner that results in human rights violations; and
- Staying silent as human rights abuses are committed against people under the care of health professions.[26]

23 Physicians for Human Rights & University of Cape Town, Health Sciences Faculty, Dual Loyalty & Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms, 15 (2002), *available at https://s3.amazonaws.com/PHR_Reports/report-2002-dualloyalty.pdf* [hereinafter Dual Loyalty & Human Rights in Health Professional Practice].

24 *Id.*

25 *Id.* at 23.

26 *Id.* at 23-24.

Detainees in the US immigration detention system are susceptible to suffering human rights violations under all of the scenarios described above. Numerous reports disseminated in recent years by NGOs, watchdog groups, journalists, and attorneys have focused on the role of DHS/ICE and other security personnel in violating the human rights of detainees, but documentation of health professionals' role in detainee deaths and other violations has been noticeably absent in the reporting. Given that health professionals staff all of the federal detention centers, and are at least on-call and visiting the remaining detention centers, it is striking that the profession is often overlooked when responsibility for the chronic health issues and death rates of people in detention is assessed. Even where health professionals have not actively and directly participated in human rights violations of detainees, their failure to report on such activities conducted by ICE or other security personnel renders them equally complicit on an ethical, if not legal, level in the suffering and deaths of many detainees over the years.

Dual Loyalties in Immigration Detention

Explicitly Conflicting Missions

Dual loyalty conflicts are prevalent in closed institutions, where the government has a role, security concerns are strong, transparency and accountability are lacking, employees are encouraged to keep costs low, and when the role of health professionals is ambiguous. Because all of these factors are inherent in the US immigration detention system, it is ripe for potential dual loyalty conflicts which test health professionals' resolve to serve their patients' best interests. Health professionals working in detention facilities run directly under DHS oversight, report to the federal agency charged with managing health care for detainees, the ICE Health Service Corps (HSC). Like ICE, HSC is a division of DHS, and therefore, has objectives that tend to focus on deportation and security, rather than on providing comprehensive health care to immigrants in detention. Review of the HSC mission statement clearly demonstrates that its mandate is prone to conflict with health professionals' obligation to provide their patients with the best possible care. The HSC website proudly proclaims: "We protect America by providing health care and public health services in support of immigration law enforcement."[27]

Reconciling the outcomes that are likely to flow from this security-focused mission statement with doctors' promise to give "…patients complete loyalty and all the resources of his science" is undoubtedly a complex task. The conflicts arising under these two statements are manifest, but they may be consolidated in this critical question: Can health professionals working for HSC, and alongside ICE officers responsible for maintaining security in immigration detention centers, serve patients' best interests, when the government-employer is primarily concerned with quick, secure, and efficient deportations of undocumented immigrants? If the answer is "no," then stakeholders, including the government, health professionals, and detainee advocates, must find ways to restructure the immigration detention system so that health professionals can fulfill their loyalty obligations to patients without fear of reprisals.

Isolation and Shortage of Health Professionals Working in Detention

The problem of medical staffing shortages in detention facilities has been well documented by NGOs, independents journalists, and former detention center staff. At a 2008 Hearing on Problems with Immigration Detainees Medical Care, Zoe Lofgren, Chairwoman of Subcom-

27 US Department of Homeland Security, *ICE Health Service Corps,* http://www.inshealth.org/ (last visited Jan. 5, 2011).

mittee on Immigration, Citizenship, Refugees, Border Security, and International Law, affirmed that "Documents tell us that employees widely complained of severe staffing shortages of medical personnel. ICE tells us they are addressing these shortages now, but the documents indicate they ignored these warnings for years, failing to adequately address these shortages even as they ramped up enforcement and brought detention beds on line."[28] As the number of detention beds increased 78 percent between 2005 and 2009, detention facilities across the country have struggled to fill open medical positions.[29] In its *Careless Detention: Medical Care in Immigrant Prisons* series[30] in May of 2008, the *Washington Post* published a number of original documents on its website, including a resignation letter from a registered nurse, in which she details the myriad problems related to medical staff shortcomings at the Eloy Detention Center in Arizona.[31] The medical situation is described as "total disorganization," with a "severe nursing shortage on nights and weekends, and a pharmacy that was unstaffed and containing only "minimal stock" of drugs on weekends.[32] Furthermore, there was only one pharmacist and assistant employed by the facility; together they had to manage over 4,000 prescriptions per month - an "impossible task" according to the nurse's letter.[33] The letter additionally alleged that the medical director of the facility was wont to change or stop stable psychiatric patients' medications solely for cost-effectiveness, resulting in "unmanageable behavior and suicide attempts."[34]

The circumstances described in the resignation letter illustrate some of the clinical and ethical crises occurring at detention centers in the US. Health professionals are working in extremely difficult, short-staffed workplaces, where the primary concern of cost-cutting often supplants health professionals' duty to patients. This situation is exacerbated by the fact that most detention centers are located in rural areas, often far from major cities, producing even more dramatic feelings of geographic as well as professional isolation. This can result in compromised medical ethics and high staff burnout and turnover, which ultimately propagates human rights violations and chronic illness of detainees.

Muddled Accountability and Lack of Transparency

Dr. Dora Schriro, former Director of ICE's Office of Detention Policy and Planning, observes in her October 2009 *Immigration Detention Overview and Recommendations* report that, "Accountability is the keystone to detention reform. Accountability encompasses government oversight, transparency, and a commitment to continuous improvement."[35] In her recommendations for medical care, Dr. Schriro suggested that, "ICE may benefit from forming an office designated to assume accountability and authority for the integrated delivery of medical service system-wide."[36]

28 *Problems with Immigration Detainee Medical Care: Hearing Before the Subcomm. on Immigration, Citizenship, Refugees, Border Security and International Law of the Comm. on the Judiciary,* 110th Cong. 2 (2d Sess. 2008) (statement of Hon. Zoe Lofgren, Chairwoman, Subcomm. on Immigration, Citizenship, Refugees, Border Security, and International Law), *available at http://judiciary.house.gov/hearings/printers/110th/42722.PDF.*

29 Human Rights First, U.S. Detention of Asylum Seekers: Seeking Protection, Finding Prison, 52 (June 2009), *available at http://www.humanrightsfirst.org/wp-content/uploads/pdf/090429-RP-hrf-asylum-detention-report.pdf.*

30 Dana Priest & Amy Goldstein, *Careless Detention: Medical Care in Immigrant Prisons, Washington Post, http://media.washingtonpost.com/wp-srv/nation/specials/immigration/* (last visited Jan. 5, 2011).

31 Patricia O'Brien, *Careless Detention: Documents, Day 2: Letter from Two Nurses, Washington Post,* July 11, 2007, *http://media.washingtonpost.com/wp-srv/nation/specials/immigration/documents/day2_nurses_ltr.pdf.*

32 *Id.*

33 *Id.*

34 *Id*.

35 Schriro, *supra* note 4 at 28.

36 *Id.,* at 26.

Likewise, Dr. Susan McNamara, who spent four days assessing provision of health care at the Willacy Detention Facility in February of 2010, points to the lack of accountability among detention center medical staff, and cites it as one of the key problematic issues.[37] Chains of command do exist in detention centers; the problem is that multiple chains of command of doctors, nursing staff, corrections personnel, and ICE staff exist side-by-side without integration. Each professional classification has its own management structure, but when issues arise, a void of accountability is revealed. Dr. McNamara has witnessed the confusion and resulting poor health care that occur in the absence of an integrated accountability structure: "Nobody knows who is in charge…nobody knows who HSC reports to… there is no clear chain of command so when something goes wrong or when you want to implement change in the detention medical field it is extraordinarily difficult."[38]

The absence of a transparent, integrated accountability structure to provide health care in detention facilities not only creates a vacuum of professional responsibility and critical lack of care for patients, it exacerbates and increases the number of dual loyalty conflicts that health professionals face. Multiple chains of command are headed by different people, each with their own goals and priorities – they are unlikely to completely align with the heads of the other chains. This is a particular problem regarding security staff vis-a-vis doctors – as explained above, their missions are completely different and often difficult to reconcile. Additionally, Dr. McNamara observed that information is often not shared across chains of command. For example, ICE routinely fails to inform medical staff when they send someone to segregation.[39] This failure to communicate puts segregated detainees at risk for a variety of negative health outcomes – even death – especially if they already suffer from chronic illness or mental disabilities.[40] Under this confused and disintegrated management structure, it is not clear with whom health professionals should consult when dual loyalty conflicts arise, so many become further isolated and end up making unethical choices about patient care.

Lack of Independent Oversight

As explained above**,** HSC staff reports to DHS, an organization focused primarily on deportation and security, not providing comprehensive health care to immigrants in detention. This arrangement creates the conditions for dual loyalty conflicts because many health professionals feel pressure to subordinate patient care to security and deportation aims. In closed institutions, it is often easier for them to disregard their ethical obligations to their patients than to challenge the objectives and directives from DHS. Inspections through DHS' Office of Inspector General (OIG) and through the US General Accountability Office (GAO) occur at some intervals, but these are an inadequate substitute for a regular program of oversight run by a completely independent organization, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or National Commission on Correctional Health Care (NCCHC). In the absence of a full-time, independent oversight organization to monitor and provide corrective action when needed, it becomes easier for health professionals to sacrifice duty to patient in favor of compliance with DHS objectives.

---

37 Telephone interview with Dr. Susan McNamara, Physicians for Human Rights (September 20, 2010).

38 *Id.*

39 *Id.*

40 Nina Bernstein, *Officials Hid Truth of Immigrant Deaths in Jail, New York Times,* Jan. 9, 2011, at A1, *available at http://www.nytimes.com/2010/01/10/us/10detain.html?_r=1&ref=incustody_deaths;* Rob Harris, *What Really Happened to Boubacar Bah?, New York Times,* Jan. 9, 2011, *http://video.nytimes.com/video/2010/01/09/nyregion/1247466467222/what-really-happened-to-boubacar-bah.html* (last visited Jan. 5, 2011).

Insufficient Procedural Protections for Detainees

The lack of clear and meaningful procedures for detainees to file grievances regarding the timely access to essential medical care in detention serves to insulate delinquent health professionals from repercussions regarding their failure to adhere to ethical codes, and it prevents policy makers from learning about and rectifying systemic deficiencies and human rights violations. Although ICE's 2008 PBNDS and Grievance System[41] guidelines contain a number of provisions that would indicate the existence of procedures whereby detainees could report problems, their practical usefulness is extremely limited. Technically, all detainees have the right to file general as well as medical grievances, but they must first be reported to staff inside the detention facility. Appeals also proceed within the same facility, first to a grievance officer or detainee grievance committee, and then to the facility administrator or designee if the individual facility allows for more than one appeal (facilities are only required to provide one appeal opportunity).[42] Detainees are not afforded an opportunity to address their grievances with someone outside of the DHS system itself, or even outside the facility in which they live. Furthermore, medical grievances are sent only to medical staff, again, within the same facility: "Grievance forms concerning medical care shall be delivered directly to medical staff designated to receive and respond to medical grievances at the facility. Designated medical staff shall act on the grievance within five working days of receipt and provide the detainee a written response of the decision and the rationale."[43]

The power imbalance within detention facilities is a formidable barrier to detainees. According to the Grievance System document, detainees are not supposed to suffer any negative consequences for filing a grievance, ("Staff shall not harass, discipline, punish, or otherwise retaliate against a detainee who files a complaint or grievance or who contacts the Inspector General or the Office for Civil Rights and Civil Liberties."[44]), but no penalties or other language meant to deter staff from retaliating is included in the system. In 2003, the American Bar Association (ABA) conducted a review of a California detention facility and found that "it was not entirely clear what is done to protect the claimant" against reprisal for filing a grievance.[45] The ABA also concluded that despite the alleged existence of an AT&T Language Line for translation, there did not seem to be a "formal procedure for offering translation assistance to an inmate seeking to file a grievance" and that the "forms necessary to file a formal grievance are currently available only in English, though...translation help was available if requested."[46]

Detainees who want to file "external" complaints are technically able to do so with the DHS OIG, but as explained above, DHS is the umbrella department overseeing ICE and HSC and also charged with deporting people from the US, so its objectivity is questionable. Furthermore, a 2008 GAO Report assessing ICE's adherence to medical standards in detention facilities found that "the OIG complaint hotline 1-800 number was blocked or otherwise restricted at 12 [out of 23] facilities we tested."[47]

---

41 US Immigration & Customs Enforcement, ICE/DRO Detention Standard: Grievance System, (Dec. 2, 2008), *http://www.ice.gov/doclib/dro/detention-standards/pdf/grievance_system.pdf* [hereinafter ICE/DRO Detention Standard: Grievance System].

42 *Id.* at 4.

43 *Id.* at 5.

44 *Id.* at 9.

45 Memorandum from American Bar Association Delegation to Oakland City Jail to Anthony S. Tangeman, Deputy Executive Commissioner Office of Detention and Removal, 8 (Sept. 19, 2003), *http://www.ice.gov/doclib/foia/dfra/2003/oaklandcityjailoaklandcajuly312003.pdf.*

46 *Id.*

47 US General Accountability Office, Alien Detention Standards, Observations on the Adherence to ICE's Medical Standards in Detention Facilities, (Jun. 4, 2008), *http://www.gao.gov/new.items/d08869t.pdf.*

Establishment of an independent ombudsman's office to which detainees could easily report grievances regarding medical care is critically important to ensuring that accountability is placed squarely at health professionals' feet where it belongs. Such an office must be separate from all agencies within the DHS umbrella so that detainees can file complaints without fear of reprisals, and so that policy makers are able to obtain unbiased reports regarding the quality of health care provision in detention facilities. These grievance reports must be used to evaluate and address deficiencies regarding the provision of health care in immigration detention facilities.

Non-binding and Inconsistent Standards

The lack of uniform and legally enforceable standards contributes to the problem of dual loyalty conflicts by insulating health professionals from legal responsibility when patient care is sub-standard. There are currently no legally binding standards governing health care provision in immigration detention facilities, and as a result, standards of care and available services vary greatly among the approximately 250 facilities that house immigration detainees. Several sets of standards exist, including the 2000 National Detention Standards (NDS) and the 2008 PBNDS (and the soon-to-be released 2010 PBNDS), but these are neither regulations nor statutes, and therefore, essentially constitute non-binding guidance for minimum standard of care – they carry no force of law and no legal action by detainees may be initiated under them. Furthermore, although ICE requires that its federal facilities, as well as many of the contract facilities, comply[48] with the 2008 PBNDS, adherence to national standards is not part of the contract language for many of the Intergovernmental Service Agreement (IGSA) facilities because the contracts were signed by the US Marshal Service prior to the creation of ICE.[49] Finally, while HSC provides medical care to detainees in the federal facilities, routine health care provision for most everyone else in the detention system is handled at the local level, where revenue generation and cost cutting are the primary motivators for prison and jail administrators.[50] Although health professionals are always obligated to put loyalty to their patients ahead of other concerns, the absence of legally binding standards of care allows them to place institutional objectives ahead of patient concerns because there are no personal or professional consequences for doing so.

Health Crisis in Detention

Every night, ICE detains approximately 33,000 people in approximately 250 facilities throughout the US and its territories.[51] This network of federally owned and operated detention centers, privately owned contract detention facilities, as well as locally owned and operated jails, is difficult to navigate, oversee, and manage. In these facilities, immigration detainees are frequently

48 "Compliance" is required at the federal facilities, but there is no indication of what sanctions or repercussions will affect non-complying facilities.

49 Schriro, *supra* note 4 at 10.

50 Leslie Berestein, *Detention Dollars: Tougher Immigration Laws Turn the Ailing Private Prison Sector into a Revenue Market, San Diego Union-Tribune*, May 4, 2008, *http://www.signonsandiego.com/uniontrib/20080504/news_lz1b4dollars.html* (last visited March 8, 2011); Detention Watch Network, *The Money Trail,* (2008), *http://www.detentionwatchnetwork.org/node/2393* (last visited Jan. 5, 2011); Tanya Golash-Boza, *The Immigration Industrial Complex: Why We Enforce Immigration Policies Destined to Fail,* 3 Soc. Compass 295, 301-302 (2009); Anna Gorman, *Cities and Counties Rely on US Immigrant Detention Fees, LA Times*, March 17, 2009, *http://articles.latimes.com/2009/mar/17/local/me-immigjail17* (last visited March 8, 2011); Suzanne Kirchhoff, Congressional Research Service, Economic Impacts of Prison Growth, 12-13, 22-32 (Apr. 13, 2010), *http://www.fas.org/sgp/crs/misc/R41177.pdf;* Kameelah Rasheed, *Silence Broken: Cities Profiting from Immigrant Detention,* Wiretap Magazine, Mar. 27, 2009, *http://www.wiretapmag.org/immigration/44084/* (last visited March 8, 2011); Margaret Talbot, *The Lost Children,* New Yorker, Mar. 3, 2008, *http://www.newyorker.com/reporting/2008/03/03/080303fa_fact_talbot?printable=true¤tPage=1* (last visited March 8, 2011).

51 Schriro, *supra* note 4 at 6. As of Sept 1, 2009, this report pegged the number at 31,075, and subsequent indicators point to an increasing number of detained persons.

mixed in with the criminal inmates, including violent offenders, regardless of the fact that immigration detainees are held for administrative, not punitive, infractions.

The average length of detention is currently 30 days but varies significantly depending upon whether the detainee is seeking relief from deportation or whether he is waiting for formal ICE-administered removal from the US.[52] The detainee's country of origin or intended receiving country also impacts the length of detained time, as each detainee's removal from the US must be negotiated and arranged with the receiving country. Although some detainees are released (either within the US or returned to their countries) within days, the majority are held for weeks and months awaiting resolution on their cases.[53] Many detainees are already suffering from chronic health conditions before entering the detention system because they tend to be poor, living on the margins of society, and without reliable access to health care. Many more have suffered physical and psychological trauma in their countries or on the journey to the US. When these detainees spend significant periods in detention, receiving sub-standard medical care and/or having difficulty accessing necessary physical and mental health services, their health can deteriorate quickly and substantially, and often irreversibly. Between October 2003 and October 2010, 113 people have died in ICE custody.[54]

When these detainees spend significant periods in detention, receiving sub-standard medical care and/or having difficulty accessing necessary physical and mental health services, their health can deteriorate quickly and substantially, and often irreversibly.

While most of these deaths may have occurred naturally and unavoidably, the allegations of mistreatment, sexual assault, prolonged isolation, forced drugging, and other cruelties reported by NGOs and journalists should not be ignored.[55] The number of stories recounting detainees' denial of proper medical attention for mental illness, cancer, diabetes, and even AIDS, demonstrates that access to medical services appears to be uneven across detention facilities. Several lawsuits have been filed by aggrieved relatives, the ACLU, and other NGOs seeking to ensure that current and future detainees are afforded better and timely medical care than those who have suffered and died in the recent past.[56] Tracking statistics, investigating individual cases, and apportioning blame for the number of deaths in detention has become such a hot topic, the *New York Times* even has a webpage, "In-Custody Deaths," dedicated to statistics and stories documenting the tragedies that have occurred in the US detention system.[57] While there are undoubtedly a number of factors – pre-existing chronic conditions, torture-related trauma, lack of long-term access to health care – contributing to the high death rate of detainees in ICE custody, it is ultimately up to the health professionals working with detainees to monitor their care and to sound the alarm when they are prevented from fulfilling their obligation to provide the best care possible to their patients. Health professionals working in detention centers are frequently bogged down by institutional practices and complications, including dual loyalty conflicts, but existence of these obstacles cannot excuse the failure to protect their patients' best interests.

52 *Id.*

53 *Id.*

54 List of Deaths in ICE Custody, *supra* note 12.

55 Detained and at Risk, *supra* note 1; Florida Immigrant Advocacy Center, *supra* note 1; Hernandez, *supra* note 14.

56 American Civil Liberties Union, *ACLU Sues ICE Over Grossly Deficient Health Care: Inadequate Medical Care Causes Great Physical Suffering and Risk of "Premature Death,"* (Jun. 13, 2007), *http://www.aclusandiego.org/news_item.php?article_id=000256* (last visited March 8, 2011); American Civil Liberties Union, *Rhode Island ACLU Files Lawsuit on Behalf of Family of Wyatt Center Detainee who Died in Custody; Suit Alleges Hiu Lui Ng was Subjected to "Cruel, Inhumane, Malicious and Sadistic Behavior,"* (Feb. 9, 2009), *http://www.riaclu.org/News/Releases/20090209.htm* (last visited March 8, 2011).

57 *Times Topics: In-Custody deaths,* New York Times, *http://topics.nytimes.com/top/reference/timestopics/subjects/i/immigration_detention_us/incustody_deaths/index.html* (last visited Jan. 5, 2011).

*While in detention, **Francisco Castaneda**,[58] an immigrant from El Salvador, sought medical help for an extremely painful and bleeding lesion on the foreskin of his penis. Medical personnel who examined Francisco recognized the need for an immediate biopsy to diagnose penile cancer, but their recommendation was denied by HSC officials who deemed biopsy to be an elective procedure. As Francisco's condition worsened, he was given clean underwear and sheets because of the copious bleeding, and he was treated with antibiotics and ibuprofen, but he still did not receive the desperately needed biopsy. Eleven months later, after a tumor developed near the base of his penis, HSC finally approved and scheduled a biopsy for Francisco. A couple of days before the appointment, however, ICE suddenly freed Francisco from detention – thereby releasing the federal government from financial responsibility for the medical care and treatment that he required. Emergency room doctors confirmed that Francisco had invasive squamous cell carcinoma – cancer – and advised amputation of his penis. Following removal of his penis, Francisco endured chemotherapy, but it was too late to save his life. He died one year later of penile cancer that should have been diagnosed and treated two years earlier.*[59]

***Maria Inamagua Merchan**, a 30-year-old woman from Ecuador, suffered from persistent headaches for more than a month in detention. She was given Tylenol by medical staff, but received no other treatment or screening. Eventually, she fell from a bunk bed, and after several hours she was taken to the local hospital, where physicians diagnosed neurocysticercosis, an infection of the brain by larvae of the pork tapeworm.*[60] *Maria died shortly thereafter, and ICE was doubly criticized for failing to respond quickly enough to the head trauma, and also for failing to recognize the signs of neurocysticercosis, which is common among Latin American immigrants.*

***Hui Lui Ng**, a 34-year-old computer engineer married to a US citizen wife and father of two US citizen children, was taken into ICE custody during his final green card interview for allegedly overstaying a visa many years earlier. Ng was repeatedly transferred among jails and detention centers as his case was pending. During this time he experienced excruciating back pain and was too weak to walk, but security personnel denied his requests for a wheelchair and failed to take him to critical medical appointments for MRI or CT scans. When Hui eventually died in ICE custody, the medical examiner found a fractured spine and a body completely overcome with undiagnosed and untreated cancer.*[61]

***Joseph Nosius Dantica,** an 81-year-old from Haiti, was arrested and sent to the Krome Detention Center in Miami when he requested asylum. Joseph's medications for high blood pressure and inflamed prostate were immediately taken by detention center staff, and his requests for replacements were ignored. On the day of his asylum hearing, he became ill, appearing to have a seizure. According to his niece, "...vomit shot out of his mouth, his nose, as well as the tracheotomy hole he had in his neck as a result of the throat cancer operation. The vomit was spread all over his face, from his forehead to his chin, down to the front of his dark blue Krome-issued overall." When a medic and nurse arrived 15 minutes later, he was accused of faking illness. Later that morning, as Joseph's condition deteriorated, he was transported to a hospital, where he continued to suffer from acute abdominal pain, nausea, loss of appetite, weakness, and profuse sweating. Finally, after more than 20 hours with no food and only sugarless IV fluids, Joseph was found to be hypoglycemic, with below-normal sugar level. By 8:46pm, he was pronounced dead.*[62]

58 All full names appearing in case studies in this report represent real people whose stories are part of the public record. Because their case details are readily available in both print and online media, we have opted to include them without de-identification.

59 Adam Liptak, *Justices Agree on Detainee Death*, New York Times, May 3, 2010, at A20, *available at http://www.nytimes.com/2010/05/04/us/04scotus.html;* Amy Goldstein & Dana Priest, *E-mails Show Attempt to 'Patch Up' a Case of Medical Negligence,* Washington Post, May 11, 2008, at A9, *available at http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d1sidebar.html.* Francisco's family was subsequently awarded $1.73 million by the Los Angeles Superior Court, who blamed the state prison for Francisco's death. Associated Press, *Court: $1.73M Award for Man Denied Care in Custody,* USA Today, Nov. 11, 2010, *http://www.usatoday.com/news/nation/2010-11-11-award-for-man-denied-custody-care_N.htm* (last visited March 8, 2011).

60 Nina Bernstein, *Federal Report Recommends Improvements in Reporting Deaths of Immigrant Detainees,* New York Times, Jul. 3, 2008, *http://www.nytimes.com/2008/07/03/us/03detain.html?partner=rssnyt&emc=rss* (last visited March 8, 2011).

61 *Id.*

62 Edwidge Danticat, *Less than Human, The Progressive* (Dec. 2007), *http://www.progressive.org/danticat1207.html.* (last visited March 8, 2011).

Medical Ethics, Human Rights Principles and Standards of Practice

Numerous medical ethics codes, human rights principles, and standards of practice have been designed to support and guide the work undertaken by health professionals treating detainees, yet many health professionals have only cursory knowledge of them.[63] Developing an understanding and becoming conversant in these codes, principles and guidelines is critical to health professionals' ability to navigate thorny dual loyalty problems.

Bioethics[64]

Consideration of bioethics allows health professionals to analyze different courses of action when morally complex or ambiguous situations arise. Various schools of philosophical thought apply to different subsets of bio-research issues, but medical ethicists have identified a set of four ethical principles that are said to "encompass most if not all of the moral issues in health care."[65] By considering the following four choices and balancing them in context with other factors, health professionals are meant to be able to solve complex bioethical dilemmas arising in clinical care:

- Respect for the decision-making ability of autonomous persons;
- The duty to maximize benefit to the person or people in care;
- The mandate to avoid the causation of harm; and
- Fairness in deciding competing claims, often to resources, but also to human rights and laws or social policy.[66]

However, the International Dual Loyalty Working Group notes that while these four ethical principles are generally consistent with a human rights framework, they do not require adherence to human rights standards; rather, bioethics treats compliance with human rights norms as one of many competing obligations which should be fulfilled.[67] Furthermore, because the four principles are not arranged in any sort of hierarchy, it is up to the health professional to assign appropriate weight to each of them depending upon the context of his dilemma. Given that all humans bring different experiences, morality, and background to the decision-making process, there is a high probability that health professionals evaluating the exact same conflict using only ethics principles may differ significantly. While disagreements about moral choices are not inherently negative, health professionals often need further direction for solving dual loyalty conflicts when human rights violations are at issue. Therefore the principles encompassed in the UN human rights framework also must be considered by clinicians dealing with dual loyalty issues.[68] Indeed, most of the modern medical ethics codes have incorporated values from the international human rights framework, and many professional associations have developed and promulgated their ethical principles based on human rights norms.[69]

63 Dual Loyalty & Human Rights in Health Professional Practice, *supra* note 23, at 4.

64 Bioethics is the field of study concerned with the ethical, moral, and philosophical implications of medical procedures, treatment, research, technologies, advances, and practices.

65 Dual Loyalty & Human Rights in Health Professional Practice, *supra* note 23, at 8 (citing Tom Beauchamp & James Childress, *Principles of Biomedical Ethics,* (4th ed. 1994); Ranaan Gillon, *Preface: Medical Ethics and the Four Principles,* in Ranaan Gillon & Ann Lloyd, *Principles of Health Care Ethics*, xxi (1994)).

66 Dual Loyalty & Human Rights in Health Professional Practice, *supra* note 23, at 8.

67 *Id.* at 10.

68 *Id.*

69 *Id.* at 14. Amnesty International has compiled an excellent volume, "Codes of Ethics and Declarations Relevant to the Health Professions", which contains numerous codes, declarations, and statements meant to guide health professionals through the ethical dilemmas they face in the course of their work. Amnesty International, Codes of Ethics and Declarations Relevant to the Health Professions (5th ed. 2009) [hereinafter Code of Ethics and Declarations Relevant to the Health Professions].

Human Rights

The two primary human right treaties in existence today, the International Covenant on Civil and Political Rights (ICCPR)[70] and the International Covenant on Economic, Social and Cultural Rights (ICESCR),[71] provide strong support and guidance for health professionals seeking resolution of dual loyalty issues. Both treaties are part of the International Bill of Human Rights, established by the United Nations in the wake of World War II, and they aim to operationalize the aspirations spelled out in the Universal Declaration of Human Rights, specifically, that "all human beings are born free and equal in dignity and right."[72]

The ICCPR, a multilateral treaty adopted by the UN General Assembly in 1966 and entered into force in 1976, has been ratified by 165 countries including the US. The ICCPR codifies the civil and political rights of individuals, including the rights to life, freedom of religion, freedom of speech, freedom of assembly, electoral rights, and rights to due process and a fair trial. Certain rights protected in the ICCPR, including the right to be free from torture and cruel, inhuman or degrading treatment can never be derogated.[73] Additionally, the Convention Against Torture and other Cruel, Inhuman and Degrading Punishment and Treatment, adopted by the General Assembly in 1975 and ratified by the US in 1988, sets out standards of conduct for states and monitoring mechanisms for the UN to ensure compliance.

The ICESCR, also a multilateral treaty adopted by the UN General Assembly in 1966 and entered into force in 1976, complements the rights articulated and protected by the ICCPR. While the ICCPR focuses on the protection of civil and political rights, the ICESCR focuses on the need to work toward granting economic, social, and cultural rights, including labor rights and rights to health, education, and an adequate standard of living, to all people. Specifically, Article 12 of the ICESCR recognizes that "Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."[74] Furthermore, General Comment No. 14 of the UN Committee on Economic, Social, and Cultural Rights[75] provides that states should not engage in "…denying or limiting access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive curative, and palliative health services…".[76] More specifically, they are entitled to a standard of medical care that is at least equivalent to that which is provided in the broader community, if not higher, considering that detainees are forced into a position by society in which they're incapable of providing for themselves. The right to health applies to all immigration detainees regardless of their citizenship, criminal record, or health needs.[77]

Thorough understanding of the human rights principles promulgated and enforced by the UN can assist health professionals in analyzing and resolving dual loyalty conflicts by referencing a universally applicable set of moral principles agreed to by a majority of countries.[78] The

70 ICCPR, *supra* note 10.

71 ICESCR, *supra* note 17.

72 Universal Declaration of Human Rights, art. 1, Dec. 10 1948, G.A. Res. 217A (III), *available at* http://www.un.org/en/documents/udhr/.

73 Amnesty International, *Fair Trials Manual: 31.3 Rights That May Never be Restricted,* http://www.amnestyusa.org/fair-trials/manual/311-derogation/page.do?id=1104735 (last visited Jan. 5, 2011).

74 ICESCR, *supra* note 17, at art. 12.

75 General Comment No. 14, published in 2000, is meant to clarify many of the substantive issues involved in implementation of the ICESCR by state parties.

76 U.N. Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, U.N. Doc. E/CN. 12/2000/4 (Aug. 11, 2000), *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.

77 ICESCR *supra* note 17, at art. 12; ICCPR, *supra* note 10; Protocol Relating to the Status of Refugees, *supra* note 16.

78 Dual Loyalty & Human Rights in Health Professional Practice, *supra* note 23, at 7

International Dual Loyalty Working Group noted that "For health professionals, a human rights framework provides a steady moral compass, a blueprint of a just and human social order that at its core articulates the principles of the dignity and equality of every human being."[79] This Group went on to affirm that consideration of the human rights principles enshrined in the ICCPR, ICESCR, and other related treaties and conventions should be a requirement for health professionals attempting to resolve dual loyalty conflicts.[80]

Standards of Practice

Currently, the immigration detention system operates under a patchwork of various standards of practice, including the outdated 2000 National Detention Standards (NDS), which were created under the old Immigration and Naturalization Service (INS) and are neither legally binding nor enforceable except by ICE through contract enforcement actions with the post-2003 IGSAs. According to DHS, "The standards established consistency of program operations and management expectations, accountability for non-compliance, and a culture of professionalism. They were based on policy and procedures and focus solely on what was to be done."[81] ICE has spent significant time reviewing the old standards and redrafting them into a performance-based, rather than procedure-based, format, called Performance Based National Detention Standards (PBNDS). The first set of PBNDS was due to be implemented in 2008, but delays ensued, and now ICE is finalizing the 2010 PBNDS, which will contain 41 standards, including new critical provisions regarding Sexual Abuse and Assault Prevention and Intervention, and Staff Training. PBNDS are representative of DHS/ICE's motivation to improve the care of detainees, but various delays, including ICE's determination to get Enforcement and Removal Operations' (ERO) union approval of them, has severely undermined the implementation process. Timeline for release of the final 2010 PBNDS is still uncertain as this publication goes to press, and queries to ICE personnel generally yield vague answers assuring that implementation will occur in the coming months.

The immigration detention system operates under a patchwork of various standards of practice.

Beyond the NDS and PBNDS, health professionals can also refer to national industry standards promulgated by the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC), with some significant caveats. While implementation of these standards is certainly better than operating in the absence of any standards, there are problems with applying them in the immigration detention system. First and foremost, the immigration detainee population is being held for administrative, not punitive, reasons, so the security concerns inherent in correctional institution standards are not as relevant in immigration detention settings. Immigration detainees should be granted significantly more freedom than convicted criminals. Implementation of any corrections-based standards in this population should be strictly considered as the floor – that is, the very least acceptable of care to which they are entitled - and every effort should be made to provide better care and more autonomy to them. Furthermore, implementation of either ACA or NCCHC standards is problematic even in the correctional system for which they were designed because, like the 2000 NDS, they focus on procedure rather than performance, meaning that compliance does not necessarily result in improved health care.[82]

79 *Id.*

80 *Id.*

81 US Immigration & Customs Enforcement, *Fact Sheet: ICE Performance Based National Detention Standards,* (Nov. 20, 2008), *http://www.ice.gov/news/library/factsheets/facilities-pbnds.htm* (last visited March 8, 2011).

82 Melvin Delgado & Denise Humm-Delgado, Health and Health Care in the Nation's Prisons, 175 (2009).

Clearly, the absence of uniform, legally enforceable standards of care is a significant shortcoming in the immigration detention system that needs to be addressed by policymakers as soon as possible. The standards described above serve a limited role in guiding health professionals as they evaluate dual loyalty conflicts and strive to provide the best care possible for their patients, but the current state of ill-fitting and non-binding standards is too diffuse to be of any real value. There is too much room for health professionals and others involved in immigration detention to choose to follow the standards that match their own organizational and personal priorities. For health professionals determined to serve their patients, however, the standards described above may provide some justification for following certain courses of action in support of patients, at least until appropriate and enforceable standards are implemented uniformly at all detention facilities.

Clinical Independence

Health professionals working in detention settings must address numerous dual loyalty issues, yet the overarching problem facing these clinicians is the inability to operate with complete clinical independence. Several factors inhibit detention center-based health professionals' ability to treat their patients with clinical independence, but the key obstacle is that their employers are generally focused on security and deportation (in the case of DHS/ICE/HSC) or profitability (in the case of county jails and private contract facilities) when it comes to housing immigration detainees, rather than on the provision of comprehensive health care to a vulnerable population. In short, the goals of the health professionals working in detention centers rarely align with the goals of their employers, and in fact, they are generally discordant.

The overarching problem facing these clinicians is the inability to operate with complete clinical independence.

Recall that HSC's mission statement – HSC being the employer of health professionals working in federal detention centers – promises to "...protect America by providing health care and public health services in support of immigration law enforcement." This security-based declaration which, in effect, promises to support ICE in its arrest and deportation functions, cannot be easily reconciled with health professionals' obligation to act in the best interest of patients at all times. The standard of care resulting from adherence to the HSC mission statement has negatively impacted the health of immigration detainees, especially those with chronic conditions or mental illness, because the model is "emphasis on care to enable deportation."[83] And once deportation of a patient is effected, whatever medical problems he had in detention disappear as far as HSC is concerned.[84] Efficiency principles held by DHS and private contractors running prisons for profit support the goal of keeping detainees just healthy enough that they can be deported to their countries of origin. Furthermore, supplying detainees with anything beyond the most essential health needs is anathema to some who believe that undocumented immigrants do not deserve improved living conditions at detention centers.[85]

The Swiss model of prison health care is instructive on this point – having started with a firm belief in the premise that prisoners have the same right to quality health care access as the rest of the population, the Swiss have created a system based on the four pillars identified in a Council of Europe Recommendation on Health Care in Prisons: equivalence, confidentiality,

83 Texas Appleseed, *supra* note 14 at 38.

84 Venters et al., *supra* note 13, at 495.

85 *US Sen. Grassley: Illegal Immigration Oversight,* Iowa Politics.com, (June 14, 2010), *http://www.iowapolitics.com/index.iml?Article=199708* (last visited Jan. 4, 2011).

informed consent, and independence.[86] Independence, in this case, refers to the total separation of powers between the health care providers working in Swiss prisons and the prison administration system.[87] All health care professionals working in prison and detention settings in Switzerland report to university hospitals which operate under the Department of Health.[88] University-trained physicians and nurses rotate in and out of this dynamic system, which allows clinicians to treat patients with clinical autonomy.[89] They need not concern themselves with how their employer might react to clinical decisions, because their employer is a hospital, and therefore, also obligated to treat patients as their first priority. Health professionals have observed that this separation of powers between clinicians and penal administration has been central to addressing the health needs of detainees.[90] Additionally, the rotating system of health professionals in the Swiss model helps to prevent the type of burnout and chronic understaffing that plague the US immigration detention system. Dual loyalty conflicts are far less likely to arise within this system because health and penal powers are separated, prisons are fully staffed with independent clinicians, and the rotating staff of fresh clinicians is able to put forth its best efforts at caring for patients.

In contrast, the US immigration detention system, where all principal players including medical staff are overseen by DHS, is much more prone to developing dual loyalty conflicts. Over-medication, under-medication, use of solitary confinement as a replacement for mental health care, and use of shackles during medical exams are a few examples of how the lack of clinical independence affects detainees.[91] Health professionals too frequently sacrifice the needs of their patients in order to satisfy DHS/ICE deportation and security-related goals. There are several reasons why this occurs - complacency, fear of job loss, cynicism, burnout – but none is impossible to overcome if the right mechanisms and resources are introduced to support health professionals and to induce compliance with their ethical obligations.

Fostering independence of the clinicians working in detention centers is critical. Multiple NGO reports have identified the need for clinical independence as a requirement for detention center health care to improve.[92] There are several ways in which this goal might be realized, but the most important component of change is that the employment relationships of the health professionals working in immigration detention must be re-structured so that they are not reporting directly to an agency which is also responsible for security and deportation.[93] In practice, this means that health professionals working in federal detention centers would not report to HSC, which is under the umbrella of DHS, but rather, would report to an independent agency concerned with health issues, such as the Department of Health and Human Services (HHS).[94] Such a reporting structure would help to ensure that clinicians are fully engaged in working for an employer whose mandate (health care) aligns with their responsibility to put their patients' needs first. Health professionals working under an independent agency would feel secure knowing that their decisions regarding the best care for their patients would not be counter-

86 Louis Loutan, Slim Slama & Hans Wolff, *Right to Health in Prisons: Implications in a Borderless World, in* 3 Realizing the Right to Health 185, 190 (Andrew Clapman & Mary Robinson eds., 2009), *available at* *http://www.swisshumanrightsbook.com/SHRB/shrb_03_files/11_453_Slam_Wolff_Loutan.pdf.*

87 *Id.* at 188.

88 *Id.* at 189.

89 *Id.*

90 *Id.* at 188.

91 Texas Appleseed, *supra* note 14, at 38.

92 Venters et al., *supra* note 13; Texas Appleseed, *supra* note 14, at 28-29; Slama et al., *supra* note 86.

93 Dual Loyalty & Human Rights in Health Professional Practice, *supra* note 23, at 104.

94 In fact, DIHS was originally housed under HHS until 2007, when the decision was made to move it under DHS. US Immigration & Customs Enforcement, Fact Sheet: ERO - Detainee Health Care - FY2010, (2010), *http://www.ice.gov/doclib/news/library/factsheets/pdf/ihs-fy10.pdf.*

manded in the name of security. Furthermore, they would also feel freer to report human rights violations and other concerns regarding the care of patients. Given that in detention and prison situations the most likely violators of human rights are security personnel, it is necessary to divide the lines of accountability so that health professionals and security staff are not reporting to the same agency. The current situation, wherein ICE (security and deportation) and HSC (health services) both report to DHS, is a significant obstacle to ensuring clinical independence of health professionals.

Employment relationships should be restructured in all immigration detention settings to ensure that health professionals are not reporting to agencies or administrators whose mandates focus on security, deportation, or profitability, but achieving this goal is admittedly difficult given the immense scope of the current immigration detention infrastructure. In fact, implementation of many suggested improvements to the system is continually postponed because the prospect of introducing change to a network of 250 facilities is daunting. Yet, improvements to the system cannot be postponed in perpetuity. Goals and eventual requirements regarding the restructuring of employment relationships for health professionals must be included in all contracts with private and county-run prison and jail facilities. Failure to achieve division of accountability lines for security staff and health professionals should result in contract termination for the facility. Cash is the primary motivating force for many of the detention facility administrators,[95] and if they know that they risk losing profitable government contracts, they will undoubtedly find a way to restructure employment relationships so that the health professionals can operate with clinical independence.

In addition to restructuring employment relationships and lines of accountability, job descriptions and employment agreements for health professionals must include explicit obligations to respect human rights and to report ethical and human rights violations to the proper authorities.[96] Under the status quo, most health professionals working in detention are at least vaguely aware of their ethical and human rights obligations to patients, but failure to report human rights violations results in few or no consequences to them. There is no urgency, other than moral imperative, for health professionals to take the trouble to report potential and real violations of human rights. Conversely, reporting on the shortcomings of ICE staff and/or the detention system in general is perceived to be extremely risky for health professionals who fear demotion or termination of job. This risk paradigm needs to be shifted so that health professionals not only feel obligated to report potential human rights violations, but additionally feel confident and secure in their decision to raise their voices in the face of abuse.

In 2002, the International Dual Loyalty Working Group promulgated a set of guidelines specially tailored to the responsibilities of health professionals working in prison, detention and other custodial settings.[97] Many of these guidelines are directly applicable to immigration detention settings and should be incorporated into job descriptions, employment agreements, practice manuals, and any other documentation regarding health professionals' employment in immigration detention settings:

- The health professional should act in the best interests of his patient at all times.
- 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 actually custodial setting.

95 Berestein, *supra* note 50; Detention Watch Network, *supra* note 50; Golash-Boza, *supra* note 50, at 7-8; Gorman, *supra* note 50, at 1-3; Kirchhoff, *supra* note 50, at 12-13, 22-23; Rasheed, *supra* note 50; Talbot, *supra* note 50, at 1

96 Dual Loyalty & Human Rights in Health Professional Practice, *supra* note 23, at 105.

97 *Id.* at 69.

- The health professional must insist on unhindered access to all those in custody.
- The health professional should have the unquestionable right to make independent clinical and ethical judgments without outside interference.
- The health professional should not perform medical duties or engage in medical interventions for security purposes.[98]

These guidelines serve to re-affirm the obligations that health professionals working in detention settings are bound to uphold. They echo and complement ethical norms from the WMA and other international bodies, so the fundamental concepts should be familiar to all health professionals. However, as discussed above, health professionals working for an agency charged with security and deportation goals often face challenges in trying to adhere to these guidelines. Thus, a two-prong strategy of restructuring employment relationships to better support health professionals working in detention settings, while also holding the health professionals accountable for human rights violations occurring under their watch, can achieve a level of clinical independence which will allow for better care of immigrants in detention.

Inappropriate Use of Segregation to Treat Mental Health Issues

Dual loyalty conflicts frequently arise in regard to treatment of detainees with mental disorders due to time management issues, cost cutting mandates, and security concerns. Even where treatment by mental health professionals would yield tangible positive improvements for detainees, it may not be provided by health professionals who feel over-worked and unmotivated to spend extra time with patients who need it. Sometimes, it seems easier to put detainees who do not conform to behavioral regulations into segregated areas where they cannot infringe on the health professionals' and security staff's time.

Several prominent NGO reports note that while ICE fails to maintain meaningful statistics on physical and mental health issues, at least fifteen percent of immigration detainees are estimated to have a mental disorder, including a range of conditions such as schizophrenia, bipolar disorder, and intellectual disabilities.[99] Additionally, research conducted around the world has shown that asylum seekers and displaced persons suffer high rates of pre-migration trauma which results in post-migration mental health problems, including anxiety, depression, and post-traumatic stress disorder.[100] PHR reported clinically significant levels of anxiety (77%), depression (86%), and PTSD (50%) among the group of seventy detained asylum seekers it evaluated as part of its groundbreaking 2003 study, *From Persecutions to Prison: The Health Consequences of Detention on Asylum Seekers*.[101] Asylum seekers, refugees, and other displaced persons suffer mental health difficulties at rates higher than the general population for a number of reasons related to pre-migration experiences, exposure to various dangers during escape and transit, and post-migration stressors,

Asylum seekers, refugees, and other displaced persons suffer mental health difficulties at rates higher than the general population.

98 Dual Loyalty & Human Rights in Health Professional Practice, *supra* note 23, at 71-75.

99 *See* Texas Appleseed, *supra* note 14, at 11; *and* Deportation by Default, *supra* note 1, at 6.

100 Katy Robjant, Rita Hassan & Cornelius Katona, *Mental Health Implications of Detaining Asylum Seekers: Systemic Review*, 194 Brit J. of Psychiatry 306 (2009); Derrick Silove, Zachary Steel & Charles Watters, *Policies of Deterrence and the Mental Health of Asylum Seekers,* 284(5) J. Am. Med. Ass'n 605 (2000).

101 Physicians for Human Rights & Bellevue/NYU Program for Survivors of Torture, From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers 57 (2003) [hereinafter From Persecution to Prison].

including unemployment, denial of work authorization, separation from family, loneliness, discrimination, difficult legal processes, fear of repatriation, and poverty, among others.[102]

Many of these people are overlooked, ignored, or inadequately treated as health professionals working in the immigration detention system struggle to provide medical services to their growing caseload. Several recent reports by NGOs[103] have documented the flaws that exist in ICE protocol and practice for treating mentally disabled people in immigration detention, but human rights violations continue to occur to this vulnerable, hidden population for two principle reasons: 1) most detention center staff are inadequately trained to deal with people with mental disabilities,[104] and 2) many of these detainees are generally unable or afraid to advocate for themselves. A well-known metaphor posits that "the squeaky wheel gets the grease," but immigration detainees are well aware that "the squeaky wheel" in detention is far more likely to get segregation[105] as a punishment than to receive positive attention from security or medical staff.[106] Detainees who complain or act out due to mental conditions beyond their control are frequently sent to segregation units or held down in restraints because staff is unable or unwilling to help them control their behavior.[107] Even those on suicide watch are routinely assigned to segregation in place of receiving necessary psychiatric care.[108] In many cases, security or even medical staff send mentally disabled people to solitary confinement for prolonged periods of time, where they remain without access to mental health professionals or even to other detainees. In these stark conditions, detainees' mental health often degenerates even further because they are starved for human interaction. In his *New Yorker* article "*Hellhole*," which contemplates whether or not solitary confinement constitutes torture, Dr. Atul Gawande observed that "[o]ne of the paradoxes of solitary confinement is that, as starved as people become for companionship, the experience typically leaves them unfit for social interaction."[109]

The Texas Appleseed report quotes a detention center nurse who admits, "When they are crazy and cannot be managed they go to 'seg' [segregation] when there is not room for them in the short stay unit."[110] The same report also provides insight from a former detainee who was held in a Texas detention center for nine months, spending more than half of those in solitary confinement."When they put you in 'el pozo' [the hole or solitary confinement] you only have a little space. You have a toilet and a little space where you can sleep. And there is a little place where they put the food, but they throw it without caring. If you don't take it rapidly, they throw it, whether it is hot or cold. They don't care. They throw it as if you were an animal. It makes you lose control mentally. That is why I did not come out so well, mentally. I would lose my mind – I would lose my mind severely. I even wanted to commit suicide." [111]

---

102 Silove et al., *supra* note 100, at 606.

103 Texas Appleseed, *supra* note 14; Florida Immigrant Advocacy Center, *supra* note 1; Deportation by Default, *supra* note 1.

104 Texas Appleseed, *supra* note 14, at 21.

105 There is a great deal of variance in the terminology dealing with this issue. Clinicians and security staff use the terms "segregation", "isolation", "seclusion", and "solitary confinement" to describe the situation where a detainee is placed alone in a small cell for 23 hours per day, separated from other people, and frequently in the dark. This scenario may be distinguished from "administrative segregation" (when detainees may be temporarily separated to prevent them from collaborating) or "medical isolation" (when a detainee is physically separated from the rest of the population because he has a contagious disease, but is kept in a glass-walled room so that he can continue to have human interaction).

106 Florida Immigrant Advocacy Center, *supra* note 1, at 23.

107 Texas Appleseed, *supra* note 14, at 21.

108 Schriro, *supra* note 4, at 26.

109 Atul Gawande, *Hellhole: The United States Holds Tens of Thousands of Inmates in Long-Term Solitary Confinement. Is This Torture?* New Yorker (Mar. 30, 2009), *http://www.newyorker.com/reporting/2009/03/30/090330fa_fact_gawande.* (last visited March 8, 2011).

110 Texas Appleseed, *supra* note 14, at 21.

111 *Id.* at 22.

Although the "they" referred to in the foregoing quote almost certainly refers to non-medical detention center staff, the role of health professionals in allowing the continued placement of mentally ill people in isolated cells must not be overlooked. Health professionals should always try to implement the least restrictive measures necessary to control a patient's behavior,[112] and assignment to a segregation unit is not appropriate in the absence of a therapeutic goal (related to time spent in segregation) for the patient. This is one of many areas, however, where health professionals may feel competing demands upon their loyalty – as discussed above, security concerns and pressure to keep costs low render placement of mentally ill people in segregation units as a viable option to some health professionals who are eager to implement quick "solutions" for time-consuming or difficult cases. An Australian report on the legal and ethical aspects of seclusion as a treatment option observes that placement of mentally ill patients in seclusion may be viewed as "an anachronistic and punitive form of ward management."[113] And indeed, reports from NGOs have affirmed that use of segregation in order to control challenging patients occurs far too frequently in understaffed and undertrained detention centers across the country.

PHR's observation that segregation has been used as a punitive measure for detainees with mental health issue has been echoed by numerous NGO and advocacy groups.[114] Not only have detainees who have requested mental health services been placed in segregation units, but so have those who have asked about detainee rights and become verbally argumentative.[115] This punitive use of segregation creates a significant disincentive for detainees to seek help for mental health issues, and it widens the chasm between the patients and health professionals working in detention settings. Furthermore, it effectively

Terminology

There is a pronounced lack of uniformity regarding terminology to describe different types of segregation in custodial settings. These are the most common usages:

Medical Isolation: *When a contagious patient is placed in a glass-walled unit to protect other detainees and staff from illness, but can see, hear, and interact with other people.*

Isolation: *A generic word to describe being placed alone, separate from the rest of the detention center population. Often occurs in a tiny, dark room and is used as a punishment and/or to hold those suffering from mental illness. Generally, only one hour per day may be spent outside the isolation room.*

Administrative Segregation: *When a detainee is separated from the rest of the detention population for a short period, perhaps upon arrival when arrangements are being made and/or to prevent detainees from colluding on stories. The dimensions and features of the room vary greatly across facilities, but the setting and restrictions are not meant to be punitive.*

Punitive Segregation: *When a detainee is separated from the rest of the detention population for some period of time because he has somehow "misbehaved." Often occurs in a tiny, dark room and is used as a punishment and/or to hold those suffering from mental illness. Generally, only one hour per day may be spent outside the isolation room.*

Solitary Confinement: *A generic word to describe being placed alone, separate from the rest of the detention center population. Often occurs in a tiny, dark room and is impliedly punitive in nature. Often used to hold those suffering from mental illness. Generally, only one hour per day may be spent outside the isolation room.*

---

112 World Health Organization, Mental Health Care Law: Ten Basic Principles, no. 4 (1996) *in* Code of Ethics and Declarations Relevant to the Health Professions, *supra* note 69, at 272-79 [hereinafter Mental Health Care Law: Ten Basic Principles].

113 E.C. Muir-Cochrane & C.A. Holmes, *Legal and Ethical Aspects of Seclusion: An Australian Perspective,* 8(6) J. Psychiatric Mental Health Nursing 501 (2001).

114 From Persecution to Prison, *supra* note 101; Florida Immigrant Advocacy Center, *supra* note 1, at 24.

115 Venters et al., *supra* note 13, at 487.

silences any questions or concerns that detainees might wish to raise in regard to their human rights. Even more serious, however, is that the use of segregation on people who have suffered torture and other grave human rights abuses exacerbates the mental anguish they already feel. PHR and other NGOs have extensively documented the fact that torture survivors and other asylum seekers experience high levels of stress, depression, and other mental health issues.[116] Much of their anguish relates back to the human rights abuses, including placement in solitary confinement, suffered in their country of origin. Therefore, reintroduction of this harmful method of control, this time at the hands of US detention center staff, frequently re-awakens their trauma and serves to greatly worsen their mental health issues.[117]

Indeed, compelling research and analysis has been done on the topic of solitary confinement, specifically, as to whether or not it constitutes torture in and of itself, regardless of whether or not the detainee was mentally ill to begin when entering the facility.[118] Although both psychiatrists and prison experts have comprehensively documented and acknowledged the detrimental effects of solitary confinement on prisoners and the negative health outcomes that result, prisons and detention centers around the world continue to use solitary confinement as a means of control.[119] Peter Scharff Smith summarized the effects of solitary confinement this way: "Solitary confinement – regardless of specific conditions and regardless of space and time – causes serious health problems for a significant number of inmates. The central harmful feature is that it reduces social contact to an absolute minimum: a level of social and psychological stimulus that many individuals will experience as insufficient to remain reasonably healthy and relatively well-functioning."[120]

In preparation for writing his March 2009 article "*Hellhole*" for *The New Yorker*, Dr. Atul Gawande interviewed several people who endured custody in isolation, including Senator John McCain, journalist former hostage Terry Anderson, and a prisoner from a state penitentiary, Bobby Dellelo. Although these men entered solitary confinement in good mental health, they all suffered significant psychological trauma, and upon their release had great difficulty re-entering society. Senator McCain, who suffered repeated beatings and interrogations during his time as a prisoner of war in Vietnam wrote: "It's an awful thing, solitary…[i]t crushes your spirit and weakens your resistance more effectively than any other form of mistreatment."[121] Likewise, Terry Anderson wrote of the "…formless, gray-black misery" that gradually overtook him, and how he became neurotically possessive of the few things he had. Finally, "…he snapped. He walked over to a wall and began beating his forehead against it, dozens of times. His head was smashed and bleeding before the guards were able to stop him."[122] Anderson eventually recovered, but another hostage he had met, Frank Reed, had to be admitted to a psychiatric hospital once he was freed because the solitary confinement had made him semi-catatonic.[123]

116 From Persecution to Prison, *supra* note 101, at 57; Robjant et al., *supra* note 100, at 306; Silove et al., *supra* note 100, at 607.

117 Venters et al, *supra* note 13, at 487.

118 Hérnan Reyes, *The Worst Scars are in the Mind: Psychological Torture,* 89(867) Int'l Rev. Red Cross 591, 591, 598 (Sept. 2007), *available at http://www.icrc.org/eng/assets/files/other/irrc-867-reyes.pdf;* Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in US Prisons: A Challenge for Medical Ethics,* 38 J. Am. Acad. Psychiatry Law 104, 105 (2010), *available at http://www.jaapl.org/cgi/reprint/38/1/104.pdf.*

119 Peter Scharff Smith, *Solitary Confinement: An Introduction to the Istanbul Statement on the Use and Effects of Solitary Confinement,* 18(1) Torture 63 (Nov.1, 2008), *available at http://www.humanrights.dk/files/pdf/Engelsk/International/Solitary_confinement.pdf.*

120 *Id.* at 61-62.

121 Gawande, *supra* note 109.

122 *Id.*

123 *Id.*

Gawande's article further noted that in addition to psychological impact, people placed in solitary confinement actually experience physical trauma as well. "EEG studies going back to the nineteen-sixties have shown diffuse slowing of brain waves in prisoners after a week or more of solitary confinement. In 1992, fifty-seven prisoners of war, released after an average of six months in detention camps in the former Yugoslavia, were examined using EEG-like tests. The recordings revealed brain abnormalities months afterward; the most severe were found in prisoners who had endured either head trauma sufficient to render them unconscious or, yes, solitary confinement. Without sustained social interaction, the human brain may become as impaired as one that has incurred a traumatic injury."[124] Gawande unequivocally concludes that "[w]hether in Walpole [state prison] or Beirut or Hanoi, all human beings experience isolation as torture."[125]

Jesus Manuel Galindo *died in solitary confinement in 2008 after suffering a seizure. Jesus was placed in solitary in a for-profit West Texas prison after complaining about the facility's failure to provide him with medication to control his epileptic seizures. The ACLU has filed a lawsuit on behalf of Jesus' survivors, alleging that prison officials ignored pleas from Jesus, his family, and fellow inmates to move Jesus out of solitary and to provide proper medical care for him.*[126]

Arrested for driving without a license, 17-year-old ***Arturo Chavez*** *was initially hospitalized for treatment of injuries suffered at the hands of police, then he was placed in solitary confinement in the Galveston County Jail while his immigration case was pending. Jail officials were warned that Arturo was depressed and might try to harm himself, but placed him in solitary confinement anyway, "a very psychologically debilitating situation, especially for a minor." Arturo was later found dead in hic cell, hanging from a blanket tied to the shower nozzle. The coroner ruled the death a suicide.*[127]

Guido Newbrough *was held in immigration detention for nine months while his case was pending. During that time a virulent staph infection took hold of his system, causing intense pain in his stomach and back. While Guido's pleas to see a doctor went unanswered, his symptoms worsened dramatically until he was "sobbing throughout the night." When Guido began pounding on a door in desperation and shouting for help, guards accused him of faking his illness and dragged him, shouting, into an isolation cell. By the time Guido was transported to the hospital, his heart had begun to fail and he was likely suffering from multiple organ failure, which may have been treatable by antibiotics. Two hours after Guido's family arrived at the hospital, his heart stopped. Detention health care expert Dr. Homer D. Venters, who was called in by Guido's family to review the autopsy report, observed that the errors in the care of Mr. Guido Newbrough were threefold. "First, Mr. Newbrough's medical complaints were apparently ignored. Second, Mr. Newbrough was placed in a disciplinary setting while ill and despite having voiced medical complaints. Third, Mr. Newbrough was not adequately (if at all) medically monitored.*[128]

James L*, who suffers from both HIV/AIDS and mental illness, was transferred among several detention centers, and he finally ended up in the segregation unit of an Alabama correctional facility for more than six weeks. The jail officials justified the isolation by stating that it was due to a sore on James' leg, but James remained in isolation even after the sore had healed for reasons he could not understand. James was severely depressed and so upset by the continued isolation such that he declared, "I feel like hanging myself in my cell." James received medications for both HIV/AIDS symptoms and for his mental health issues, but when he asked to see a counselor, he was told that one comes monthly.*[129]

124 *Id.*

125 *Id.*

126 Complaint, *Galindo v. Reeves County*, No. 10-CV-454 (W.D. Tex. Dec. 7, 2010), *available at* http://aclutx.org/documents/galindo.pdf.

127 Mark Collette, *Family of Dead Inmate Sues, Galveston County Daily News*, Aug. 14, 2008, http://galvestondailynews.com/story.lasso?ewcd=8c084dae9132369e (last visited March 8, 2011).

128 Nina Bernstein, *Another Jail Death, and Mounting Questions,* New York Times, Jan. 27, 2009, at A14, *available at* http://www.nytimes.com/2009/01/28/us/28detain.html; Homer Venters, *Review of Autopsy and Other Information Concerning the Death of Guido R. Newbrough,* New York Times, Jan. 28, 2009, http://graphics8.nytimes.com/packages/pdf/nyregion/2009/20090128_AUTOPSY_2.pdf.

129 Chronic Indifference, *supra* note 13, at 35.

__Isaias Vasquez__ had a long record of mental illness, including schizophrenia, but medical staff in the ICE facility where he was held doubted his symptoms. They accused him of faking his illness and punished him for protesting a lack of medication and for other behaviors related to his illness. Isaias was subsequently transferred to another ICE facility, much further away from his wife. Isaias' mental and physical health continued to deteriorate – he was characterized by his wife as "frail and undernourished" as well as "unstable and disoriented." Isaias reported that both medicine and food were insufficient and that he was being placed in segregation as punishment. He began to undertake extremely anti-social behavior such as smearing feces and spitting in his cell. In response, medical staff cut off all his psychotropic medication and put him back in solitary confinement.[130]

Given the growing acceptance around the world that solitary confinement for prolonged periods of time results unequivocally in diminished mental health of the subject, use of segregation as a means of punishment or "treatment" in immigration detention settings, where a large percentage of people is vulnerable to mental trauma, is unacceptable. Numerous ethical codes strongly discourage use of it, especially for mentally ill detainees, unless there is a determined medical necessity or therapeutic goal for its use; such cases are rare, and segregation is generally considered to be "a mechanism of containment and isolation rather than a therapeutic tool in itself."[131] Furthermore, even if segregation must be used for a few very extreme situations, limitations on its use are required by ethical guidelines. Above all, patients must always be treated with dignity and respect for their rights and autonomy.[132] Patients must also be treated "in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's heath needs and the need to protect the physical safety of others."[133] Physical or chemical restraints should be used only for short duration when there is immediate threat of harm to self or others and no other means available to mitigate the risk.[134] Health professionals must not participate in punishment, security operations, or any activities that do not have a therapeutic goal for the patient, nor may they facilitate the practice of torture or cruel, inhuman or degrading treatment.[135] Furthermore, health professionals must report instances of torture, or cruel, inhuman or degrading treatment, unless there is risk of reprisal or further punishment to the detainee; in such cases, health professionals should obtain consent of the prisoner before making such a report.[136]

Non-Consensual Treatment of Detainees

"As a rule, medical treatment shall not be administered against a detainee's will."

This simple and direct statement taken verbatim from ICE's 2008 PBNDS Operations Manual[137] articulates a principle that most Americans take for granted: **no one should be forced to undergo medical treatment without giving informed consent.** Unfortunately, research and anecdotal evidence demonstrate that this basic and unequivocal principal is often ignored in immigration detention settings. Several stories recently reported in the media shed light on the involuntary medical treatment of

"As a rule, medical treatment shall not be administered against a detainee's will."

130 Florida Immigrant Advocacy Center, *supra* note 1, at 56.

131 Muir-Cochrane & Holmes, *supra* note 113, at 505.

132 Mental Health Care Law: Ten Basic Principles, *supra* note 112, at no. 4.

133 *Id.*

134 *Id.*

135 Dual Loyalty & Human Rights in Health Professional Practice, *supra* note 23, at 73-75.

136 *Id.* at 72.

137 ICE/DRO Detention Standard: Grievance System, *supra* note 41, at 19.

immigrants being held in US detention.[138] Numerous reports cite cases where detainees were forced to take medications, most often psychotropic drugs and other sedatives, to make them easier to manage in detention and easier to transport for deportation. Administration of drugs without first obtaining informed consent of the patient constitutes "nonconsensual treatment," and is not only in direct violation of ICE's own regulations,[139] but also of international human rights norms[140] and medical ethics codes.[141]

Amina Mudey *escaped from Somalia following the murders of her father, two brothers, and sister. Her family was part of a minor clan in a society where clan size and relationships can mean the difference between life and death. Amina endured the deaths of the male members of her family, but after her sister was gang-raped and murdered by men from another clan, her mother decided to sell the family house in order to buy a ticket for Amina to come to America. Amina spent five months in the Elizabeth, NJ detention center while her political asylum case was pending. During that time, she suffered from panic attacks. Her condition was misdiagnosed, due in large part to communication difficulties in the absence of an interpreter, and she was given the potent anti-psychotic drug Risperdal, which caused her to suffer serious side effects, including dizziness, confusion, imbalance, drooling, lactation, and a shaking similar to that induced by Parkinson's disease.*

Amina had no opportunity to communicate with a doctor through a Somali interpreter, and the immigration center medical staff failed to monitor or even recognize the side effects of the drug. The doctors continually increased her dosage, which only heightened the dramatic and negative side effects she was already suffering. Amina's attorney became concerned and enlisted the help of two doctors from outside the detention system to examine Amina. These doctors immediately recognized her symptoms as the side effects of an anti-psychotic drug, and they wrote extensive letters to the detention center staff outlining their professional credentials, explaining their diagnosis of Amina's condition, and suggesting that use of the anti-psychotic drug be discontinued. The detention center doctors refused to heed the letters, however, and they continued to insist that Amina continue taking the drug despite her protests that she did not want to take it any longer. Amina's health continued to deteriorate until she was finally granted political asylum and freed from detention.[142]

The tenet of informed consent is among the most fundamental in the provision of healthcare in the US and around the world. Both in theory and in law, no competent person is to be subjected to any medical treatment without his full understanding and consent. This principle can be found

138 *In re* Soliman, 134 F. Supp. 2d 1238 (N.D. Ala. 2001), *vacated as moot*, 296 F.3d 1237 (11th Cir. 2002); Hernandez, *supra* note 14; *Careless Detention: Amina Mudey's Story,* Washington Post, May 12, 2008, *http://www.washingtonpost.com/wp-dyn/content/video/2008/05/12/VI2008051202381.html* (last visited March 8, 2011) [hereinafter *Careless Detention: Amina Mudey's Story*]; Amy Goldstein & Dana Priest, *Some Detainees are Drugged for Deportation,* Washington Post, May, 14, 2008, at A1, *available at http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d4p1.html*; Diane Solís, *Immigration Officials Curtail Sedation of Deportees after Criticism, Lawsuits,* Dallas Morning News, Dec. 29, 2008, *http://www.cis.org/griffith/morningnews122908* (last visited March 8, 2011).

139 US Immigrations & Customs Enforcement, Operations Manual ICE Performance Based National Detention Standards (PBNDS), Part 4 Care, 21 Hunger Strikes, V.C.5 (Dec. 2, 2008), *http://www.hsdl.org* (search "PBNDS" in search bar; then follow "Open Resource [pdf]" hyperlink).

140 International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, art. 25, Dec. 13, 2006, G.A. Res. 61/106, *available at http://www2.ohchr.org/english/law/disabilities-convention.htm* [hereinafter Convention on the Rights of Persons with Disabilities].

141 American Medical Association, *Code of Medical Ethics: Opinion 8.08 - Informed Consent, (Nov. 2006), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.shtml* (last visited March 8, 2011) [hereinafter *Code of Medical Ethics: Informed Consent*]; World Medical Association, *Medical Ethics Manual, 44-45 (*2d ed. 2009), *available at http://www.wma.net/en/30publications/30ethicsmanual/pdf/ethics_manual_en.pdf* [hereinafter Medical Ethics Manual].

142 *Careless Detention: Amina Mudey's Story, supra* note 138.

in medical organizations' rules, ethics guidelines, and international human rights instruments.[143] The presentation of information to patients in a language they understand is a key component of informed consent. Although ICE formally recognizes the import of this principle in the 2008 PBNDS, a significant gap exists between policy and practice. ICE's general guidelines require that informed consent be obtained for the provision of health care services and that consent forms "shall either be in a language understood by the detainee or translation assistance shall be provided and documented on the form."[144] ICE regulations also state that "involuntary treatment is a decision made only by medical staff under strict legal restrictions."[145] And yet, stories of competent individuals being forced to take medications are compelling.

*One woman, **Itzya N.,** details her experience during "pill call" at a detention facility:*

*[S]ome women reported that they did not have the option to refuse medication when the staff came through to distribute it at "pill call." Itzya N. recalled, "I started to stick the pills under my tongue ... because I didn't want to take the pills. But some nurses look under your tongue." **Serafina D.** reported that the facility would not permit her to stop taking anti-seizure medication, even after tests confirmed her ailments were not seizure-related: "They just kept giving it to me... They said since I was under their rules, if I didn't want to take it, I still have to take it... Medicine would make me tired and drowsy. My body was feeling heavy, my eyes were heavy. I felt drugged up."*[146]

Hunger strikes by immigration detainees pose a unique challenge to health professionals working in detention. The difficulty of reconciling the obligation to provide care for patients alongside the obligation to refrain from forcibly administering food, liquids, or drugs cannot be underestimated. Detainees commence hunger strikes for a number of reasons: to protest poor conditions in detention, to attract attention to their cases, to fight impending deportation, or simply because they have given up on life in detention and want to die.

*Egyptian immigrant **Nabil Ahmen Soliman** was so aggrieved at being force-fed intravenous fluids in immigration detention that he sought an injunction, based on constitutional rights to free expression and bodily privacy, to prevent officials from force-feeding him through tubes. "[M]edical personnel initially inserted a large tube into his nose, which did not fit. The medical personnel then attempted to insert smaller and smaller tubes until Soliman's nose began bleeding internally. The doctor ordered that Soliman be injected with an anesthetic, and a gastric tube inserted through his mouth."[147] Soliman's case made it to the 11th Circuit, but by that time Soliman had already been deported back to his native Egypt. The Court declined to make a substantive ruling on the case because the original controversy had become moot.*[148]

143 World Psychiatric Association, *Declaration of Hawaii,* (1977), http://www.codex.uu.se/texts/hawaii.html (last visited March 9, 2011); Joint Commission on Accreditation of Healthcare Organizations, Comprehensive Accreditation Manual for Ambulatory Care: Ethics, Rights, and Responsibilities, Standard RI.01.03.01, 62 (Jan. 2008), http://www.marylandpatientsafety.org/html/collaboratives/condition_h/toolkit/documents/Implementation_Planning_Tools/ARoadmapforHospitals_PtCentered.pdf; American Nurses Association, *Ethics and Human Rights: Nursing and the Patient Self-Determination Acts,* (Nov. 1991), http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/ANAPositionStatements/EthicsandHumanRights.aspx (last visited March 9, 2011); Convention on the Rights of Persons with Disabilities, *supra* note 140; Code of Medical Ethics: Informed Consent, *supra* note 141; *Medical Ethics Manual, supra* note 141.

144 ICE/DRO Detention Standard: Grievance System, *supra* note 41, at 19.

145 *Id.*

146 Detained and Dismissed, *supra* note 1, at 34..

147 *In re* Soliman, 134 F. Supp. 2d 1238 (N.D. Ala. 2001), *vacated as moot,* 296 F.3d 1237 (11th Cir. 2002).

148 *Id.;* Nina Siegal, *After 2 Years in Deportation Fight, a Hunger Strike,* New York Times, Jan. 31, 2000, http://www.nytimes.com/2000/01/31/nyregion/after-2-years-in-deportation-fight-a-hunger-strike.html (last visited March 9, 2011).

Perhaps the most well-documented form of nonconsensual treatment suffered by immigration detainees is the forcible drugging of people who are about to be deported in order to make them submissive and easier to transport. Until recently, it was common practice for ICE officers to order forced sedation of detainees who resisted moving peaceably towards their deportation. The role of health professionals in this practice has been controversial: while ICE argues that sedating agitated people actually enhances their safety because they are less likely to become involved in a physical altercation with ICE or other security officers charged with effecting deportation, others see the participation of health professionals in forced drugging as a severe ethical breach. In effect, the health professional's role as healer becomes secondary to a role as a deportation officer.

Medical guidelines and ethics codes are unequivocally clear on this point: health professionals should be involved only in beneficial drug therapy and only with the patient's informed consent. Erik Roske, a forensic psychiatrist and expert on treating mentally ill people in prisons, asserts: "In my opinion that [forced sedation prior to deportation] is completely inappropriate. Every correctional standard guideline says these drugs are to be used for medical reasons, not for restraints...They [psychotropic drugs such as Haldol] could have potentially very damaging side effects. These aren't drugs that most general practitioners prescribe. An emergency-room doctor may use the combination if someone comes in out of control, or for someone in intensive care."[149]

ICE's practice of forcibly drugging detainees has been extensively documented by both NGOs and journalists.[150] *The Washington Post* identified more than 250 cases between 2003 and 2008 in which the government administered strong psychotropic drugs to people without medical reason, in order to keep them sedated for their deportation trip home.[151] Documents obtained by the *Post* refer to the "pre-flight cocktail" which is so powerful that wheelchairs are often required to transport people onto their planes after they have been given the drugs. The same article includes notes from a medical file documenting the horrific and cruel process used to administer the drugs: "In a Chicago holding cell early one evening in February 2006, five guards piled on top of a 49-year-old man who was angry he was going back to Ecuador... As they pinned him down so the nurse could punch a needle through his coveralls into his right buttock, one officer stood over him menacingly and taunted, 'Nighty-night.'"[152]

Following extensive media coverage in 2007-2008 of its involuntary drugging practices, ICE amended its policies and has reportedly curtailed use of psychotropic medications in deportation for all but medically necessary cases, such as when the patient has schizophrenia or other severe mental illness. Nevertheless, PHR and other immigrant rights advocates remain troubled that ICE's amended policy still fails to adopt the firmly established medical and legal standard governing forced sedation. This standard prohibits health professionals from forcibly administering psychotropic drugs to control a patient's allegedly dangerous behavior, unless the medication has a therapeutic purpose for the treatment of a diagnosed mental illness. This requirement is clearly delineated in medical ethics, correctional practice standards, and the law. Years of medical and legal experience with forced sedation have produced the more exacting "therapeutic purpose" standard, which is rooted in the physician's essential role as healer – in the obligation to promote and improve a patient's physical and mental health, and to do no

149 Hernandez, *supra* note 14.

150 *Id.;* Goldstein & Priest, *supra* note 138 at A1; Solís, *supra* note 138.

151 Goldstein & Priest, *supra* 138 at A1.

152 *Id.*

harm.[153] The American Medical Association's Code of Ethics, therefore, permits court-ordered forcible treatment only if it is "therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control."[154]

Health professionals should be involved only in beneficial drug therapy and only with the patient's informed consent.

Given ICE's reticence to adhere to medical ethics, correctional practice standards, and legal requirements governing forced medication of detainees, it is up to health professionals to ensure that this practice is permanently abandoned. In light of ICE's strong interest and pressure to execute efficient management and deportation of immigrants, the problems surrounding forced drugging constitute a significant dual loyalty issue for health professionals. However, as outlined above, resolution of this issue should be crystal clear: health professionals should be involved only in beneficial drug therapy and only with the patient's informed consent. Any deviation from this course constitutes a grave ethical breach and health professionals involved in these practices should face professional sanction.

Recommendations

The US immigration detention system detains approximately 400,000 people per year, more than 33,000 on any given night, housed in approximately 250 facilities across the US. The scale and breadth of detention operations has deterred ICE from enacting reform despite the fact that NGOs, immigrant advocates, health organizations, and journalists have been calling for detention center overhaul for years. Well-documented reports of abuse, poor access to health care, sexual assaults, and deaths (113 in the past seven years) in detention facilities, led even former Director of ICE's Office of Detention Policy and Planning, Dr. Dora Schriro, to acknowledge that ICE needs to implement significant changes to its system, including the way it manages health care for detainees.

Provision of health care in the detention system suffers from six critical problems: conflicting missions of the agencies handling health care, inadequate staffing, muddled accountability, inadequate independent oversight, insufficient procedural protections for detainees, and lack of legally enforceable standards. As a result, detainees suffer an inordinately high number of negative health outcomes, and health professionals working in detention centers are forced to handle dual loyalty conflicts on a regular basis. It is extremely difficult for health professionals to adequately and ethically provide health care to their patients when they are employed by the law enforcement organization that is tasked with efficiently controlling and deporting their patient population. The dual loyalty problems inherent in the US immigration detention system are having a gradual but devastating effect on both the human rights of detainees and on the morale of the health professionals working within its confines.

The bottom line is that health professionals do not have a choice: **they are unequivocally obligated to act in the best interests of their patients.** Therefore, it is incumbent upon DHS/ICE, the medical community as a whole, and the policy makers who shape immigration detention

153 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, G.A. Res. 37/149 (Dec. 18, 1982) ("It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners and detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.") *available at* *http://www2.ohchr.org/english/law/medicalethics.htm.*

154 American Medical Association, *Code of Medical Ethics, E-2.065: Court-Initiated Medical Treatments in Criminal Cases,* (June 1998), *http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2065.shtml* (last visited March 9, 2011).

policy to restructure the system in ways that enhance clinical autonomy and allow health professionals to act in their patients' best interest without fear of reprisal. Implementation of the following seven recommendations will have dramatic positive effects on both the detained immigrant population and the cohort of health professionals that serve them by enhancing clinical independence, establishing transparency and accountability, providing procedural protections to detainees, and supporting health professionals:

1. **Require that health care professionals working in detention centers report to health organizations, such as the Department of Health and Human Services, so that they may maintain clinical independence. They should not report to the Department of Homeland Security or to for-profit private contractors.**
   a. DHS and ICE cannot be expected to extend an adequate level of care and consideration to a population it intends to deport as efficiently and rapidly as possible. Removal of health services from the DHS/ICE management portfolio would release health practitioners from many of the dual loyalty conflicts inherent in working for the gatekeeper of the detention system.
   b. Hold health professionals accountable for human rights violations occurring under their watch. Incorporate guidelines specific to the responsibilities of health professionals working in detention setting into job descriptions, employment agreements, and practice manuals.
2. **Address chronic staffing shortages so that health professionals have adequate time to spend with each patient.**
   a. Hire adequate, qualified health care staff on all levels, from nurses to doctors to pharmacists. Ensure that a sufficient number of health care professionals are available to consult with and care for mentally ill detainees.
   b. Consider adopting a rotating staff model including residents and other young doctors who are fresh and eager for clinical experience who could work alongside and learn from experienced health professionals.
   c. Move detention center facilities closer to urban centers so that it is easier to find and maintain qualified health care staff.
   d. Ensure that qualified interpreters are available to assist with communication between detainees and health care professionals.
3. **Ensure that lines of accountability are clear to health professionals, patients and security personnel.**
   a. Eliminate or integrate multiple chains of command so that everyone knows who is in charge and who is authorized to make critical decisions regarding health care.
   b. Ensure that patients, security staff and health professionals are all aware of the chain of accountability, as well as sanctions that will occur if health professionals fail to act in their patients' best interests.
   c. Ensure that security and health professional staff know to what extent they need to share information about patient care, so that patients may be protected without violating their privacy rights.
4. **Create an independent oversight organization to monitor provision of health care in all facilities that house immigration detainees.**
   a. Create a new organization to oversee health care operations at all detention facilities, or co-opt an existing one, such as the Joint Commission on Accreditation of

Healthcare Organizations or the National Commission on Correctional Health Care. This organization must be tasked with handling ongoing oversight, including regular inspections and monitoring. It might also house the ombudsman office, or at least work in close coordination with it, so that ethical and human rights violations are not overlooked.

b. This organization must be completely separate from any agencies which report to ICE/DHS so that it may act freely without fear of undue influence.

5. **Create an ombudsman office to which detainees may easily report grievances regarding access to medical care.**
   a. This office must be completely severed from ICE/DHS, and it must be easily accessible to all detainees in languages that they can understand. Confidentiality must be guaranteed so that detainees may make complaints without fear of reprisals.
   b. Additionally, the ombudsman office should allow for reporting of potential and real human rights violations which may stem from dual loyalty conflicts. This office should work in conjunction with an independent monitoring body, and should operate with the goal of providing clear advice to health professionals dealing with dual loyalty conflicts.
   c. Ensure that grievance reports are used to assess and improve provision of health care in the detention system.
6. **Make the Performance Based National Detentions Standards legally enforceable in all facilities that house immigration detainees. Failure to adhere should result in contract cancellation.**
   a. ICE needs to ensure that the 2010 PBNDS are implemented at every single one of the 250 detention facilities.
   b. Standards must clearly identify a person or chain of command responsible for ensuring compliance, and they must be publicized to all detention center staff.
7. **Revise PBNDS so that they are based on an adminstrative model of temporary custody rather than the current penal, corrective, model.**

The medical community as a whole also has a responsibility to find ways to support and educate health professionals working in the detention system, as well as to raise awareness regarding systemic challenges to provision of quality health care in detention, including dual loyalty conflicts. Professional medical associations should educate and support health professionals by taking the following actions: issue ongoing standards, guidance and education to health professionals regarding the problem of dual loyalties; establish an independent body and/or system of peer review and mentoring to provide support and advice to health professionals dealing with specific dual loyalty issues; establish professional disciplinary mechanisms to address human rights violations that result from health professionals subordinating patients' needs to 3rd party interests; and offer free continuing education opportunities focusing on ethical and human rights issues that frequently arise in detention.[155]

Finally, the ultimate responsibility for handling dual loyalty conflicts appropriately must lie with the health professionals themselves. Most health professionals should know the requisite guidelines by heart, but those who do not must re-educate themselves regarding medical ethics, human rights principles, and other relevant standards of practice. Ignorance is no excuse for violating a patient's rights, nor is the compulsion to act in ICE's interests over

155 Dual Loyalty & Human Rights in Health Professional Practice, *supra* note 23, at 106-114.

the patient's interests. Health professionals must abide by the following general guidelines to ensure that they manage dual loyalty conflicts so that neither patient health nor health professional ethics are compromised:

- Act in the patient's best interest.
- Obtain informed consent before treating patients.
- Review the basic medical ethics guidelines, as well as those that pertain to vulnerable populations, including mentally ill and prisoners or detainees, and adhere to them.
- Report ethical and human rights violations immediately.
- Refuse to participate in any security-focused or non-therapeutic activities (use of restraints, forced medication, segregation, etc.) related to detainees.

Health professionals are the guardians charged with ensuring that their patients receive the best care possible, and they are expected, by both society and the law, to adhere to a high code of legal, moral, and ethical considerations. The current immigration detention system presents numerous challenges, but none is insurmountable. Health professionals, both inside and outside the detention system, must work together with the policymakers to restructure and develop systems that meet the health needs of detainees and allow themselves to operate within ethical guidelines.

design: Envision | envision.us

2 Arrow Street | Suite 301
Cambridge, MA 02138 USA
1 617 301 4200

1156 15th Street, NW | Suite 1001
Washington, DC 20005 USA
1 202 728 5335

physiciansforhumanrights.org