

# MEDICAL ETHICAL GUIDE- LINES

Medical practice in respect  
of detained persons



Schweizerische Akademie der Medizinischen Wissenschaften  
Académie Suisse des Sciences Médicales  
Accademia Svizzera delle Scienze Mediche  
Swiss Academy of Medical Sciences

**Issued by**

Swiss Academy  
of Medical Sciences (SAMS)  
House of Academies  
Laupenstrasse 7, 3001 Bern  
Tel. +41 (0)31 306 92 70  
mail@samw.ch  
[www.samw.ch](http://www.samw.ch)

**Design**

Howald Fosco Biberstein, Basel

**Translation**

Jeff Acheson, Bottmingen

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Medical-ethical guidelines

# Medical practice in respect of detained persons

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The French text is the authentic version.

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These guidelines are an integral part of the Code  
of the Swiss Medical Association (FMH).

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## I. PREAMBLE

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The participation of physicians in police coercive measures, especially during the deportation of persons expelled from Switzerland, has raised numerous questions among the public. In response to the expectations of the various parties concerned, the Swiss Academy of Medical Sciences (SAMS) has drawn up guidelines for physicians who may be called on to serve in this highly sensitive area, where ethical boundaries can easily be overstepped. More generally, the provision of medical care for all persons in police custody or held in a penal institution<sup>1</sup> has also been considered.

The elaboration of such guidelines is complicated by the existence in Switzerland of a wide variety of criminal procedure codes and cantonal regimes for the execution of sentences. The situation becomes even more complex if the detained person<sup>2</sup> suffers from a mental disorder.

It should be noted that, unfortunately, there is a severe lack of appropriate institutions – as specified in the Swiss Criminal Code<sup>3</sup> – for the accommodation of such persons, as well as a lack of suitably trained medical (and social therapeutic) personnel.

Against this complex background, the SAMS is now issuing guidelines which, though largely based on international recommendations concerning health care for detained persons, make no claim to be exhaustive. In particular, they do not address the general question of coercive measures in psychiatry or of emergency measures in somatic medicine.

The SAMS is well aware that some elements of these guidelines primarily concern the administrative and executive authorities, and perhaps also legislators. Where this is the case, their applicability is limited and their main purpose is to make known the views of the medical profession.

1 For the purposes of these Guidelines, the term “institutions” covers facilities for custody and for execution of sentences, for execution of therapeutic measures, for pre-trial detention and for detention pending deportation.

2 For the purposes of these Guidelines, the term “detained persons” (as opposed to persons subject to protective placement in accordance with Art. 426 ff. Swiss Civil Code) refers to persons deprived of their liberty on the basis of a decision of the police or of a criminal (or military) court, or whose detention is ordered under the Federal Act on Coercive Measures in Foreign Nationals Law.

3 Article 59 of the Swiss Criminal Code deals with the care of offenders suffering from mental disorders.

## **II. GUIDELINES**

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### **1. General principles; conscientious objection**

The basic ethical and legal requirements governing medical practice, in particular those concerning patient consent and confidentiality, are also applicable to detained persons.

However, in this context, physicians often have to take into account requirements relating to security and discipline, even though their primary concern is always the patient's welfare and respect for the patient's dignity. A specific feature of medical practice in this setting is that the physician has obligations both to the detained patient and to the competent authorities,<sup>4</sup> and the interests and goals in question may sometimes diverge.

Given the physician's personal convictions, it may be difficult to reconcile these conflicting demands (either within a long-term contractual relationship or in individual interventions). The physician must then be able to act in accordance with the dictates of conscience and medical ethics and have the right to refuse to give an expert opinion or treat a detained person, except in an emergency.

### **2. Conditions for medical examinations**

To promote mutual trust, the physician should seek to maintain the usual framework and dignity characteristic of the physician-patient relationship.

A suitable room should be provided for medical examinations of detained persons. Examinations must take place out of the sight and hearing of third parties, unless otherwise requested by, or with the consent of, the physician.

<sup>4</sup> For the purposes of these Guidelines, the term "competent authorities" covers the authorities responsible for committal, the management of the institution for execution of sentences or therapeutic measures, or the judicial authorities.

### **3. Serving in an expert capacity**

Except in crisis or emergency situations, a physician cannot combine the roles of therapist and expert.

Before acting in the capacity of an expert, the physician must clearly inform the person to be examined that the results of the examination will not be subject to medical confidentiality.

### **4. Disciplinary measures**

If physicians are asked to assess a person's fitness to undergo sanctions, their opinion is only to be given after a disciplinary measure has been ordered. The medical assessment is thus the second step in the process and, if appropriate, takes the form of a veto based on purely medical criteria.

### **5. Equivalence of care**

Detained persons are entitled to receive care equivalent to that provided for the general population.

### **6. Coercive measures ordered by the police or prison authorities**

If physicians are asked to inform the competent authorities about the potential risks and consequences for the health of a detained person of a coercive measure (e.g. eviction, deportation) already ordered by the authorities, they must exercise the utmost care, seeking to obtain, as far as possible, all the relevant information on the medical history of the person concerned. In particular, they are to take into account the intended means of transport, the expected duration of the transfer, and any security and restraint measures likely to be applied.

They must always request a medical escort if this is necessitated by the detained person's physical or mental condition, or if the nature of the restraint or security measures to be applied is likely to pose a risk to the person's health.

If physicians are called on to attend a detained person to whom a coercive measure is to be applied, they are to adopt a neutral and professional attitude and inform the detained person that they are at his/her disposal and that no medical procedure will be undertaken without his/her consent (with the exception of the emergency situations described in Section 7).

Physicians who are convinced that the means to be employed for a coercive measure (e.g. gagging, close and prolonged restraint, cuffing of feet and hands behind the back) pose an immediate and serious risk to the patient's health must notify the competent authorities without delay that, unless the means envisaged are dispensed with, they cannot assume medical responsibility and will therefore refuse to provide any further assistance.

## **7. Consent to medical treatment and compulsory treatment**

As in any other medical situation, physicians acting in the capacity of an expert or therapist may only carry out a diagnostic or therapeutic measure after obtaining the informed consent of the detained person.

Medication, in particular psychotropic drugs, may therefore only be administered to detained persons with their consent and for strictly medical reasons.

In emergency situations – under the same conditions as are applicable for non-detained persons – physicians may forgo obtaining informed consent if, owing to a major mental disorder, the patient lacks mental capacity and there is an immediate risk of the patient endangering him/herself or others (cumulative conditions). In such cases, physicians are to ensure that the patient receives appropriate short- and long-term medical care (in particular, temporary admission to a psychiatric clinic if, for example, a deportation order cannot be carried out for medical reasons).

Physical restraint on medical grounds is only to be contemplated for a few hours at most. In all such cases, the responsible physician must check whether the measures are correctly applied and remain justified, reassessing the situation at regular intervals.

## **8. Infectious diseases**

In a case of infectious disease, the detained person's autonomy and freedom of movement is only to be restricted according to the same criteria as are applicable for other population groups living in crowded conditions (e.g. military units, holiday camps).

## **9. Hunger strike**

In the event of a hunger strike, physicians must objectively and repeatedly inform the detained person about the potential risks of long-term fasting.

If it has been confirmed by an external physician that the detained person has full mental capacity, the decision to go on hunger strike is to be medically respected, even if it poses a substantial health risk.

If the hunger striker lapses into a coma, physicians are to proceed in accordance with their conscience and professional ethics unless the person concerned has left explicit instructions to be followed in the event of a life-threatening loss of consciousness.

Physicians confronted with a hunger strike are to maintain a strictly neutral attitude towards the various parties involved and ensure that medical decisions are not instrumentalised.

Despite the expressed refusal of food, physicians are to ensure that food is offered to the hunger striker every day.

## **10. Confidentiality**

Medical confidentiality is to be maintained under the same legal provisions as are applicable for persons at liberty (Art. 321 Swiss Criminal Code). In particular, patients' medical records are to be kept by the physicians responsible for their care. The conditions for examinations specified in Section 2 are applicable.

However, given the lack of privacy characteristic of prison life, possibly lasting for several years, and/or the fact that prison or police personnel frequently serve as guarantors or even assistants in the care of prisoners, the exchange of medical information between healthcare and security personnel may be unavoidable.

In such cases, physicians must endeavour, with the detained person's consent, to answer any legitimate queries on the part of prison or police personnel.

In cases where the detained person opposes disclosure and this could pose a risk to security or to third parties, physicians may ask the competent authority to release them from their duty of confidentiality if they consider it their duty to inform third parties, and in particular the managers or security personnel responsible (Art. 321, para. 2 Swiss Criminal Code). In such cases, the patient is to be informed that a release from confidentiality has been requested.

In exceptional cases, if the life or physical integrity of a third party is seriously and acutely endangered, physicians may themselves decide to breach confidentiality and directly inform the competent authorities or the third party at risk.

## **11. Reporting of suspected abuse**

Any signs of physical violence discovered in the course of a medical examination of a detained person are to be duly documented.

In their reports, physicians are to distinguish clearly between the patient's allegations (account of the circumstances which led to the lesions) and (subjective) complaints and the (objective) clinical and paraclinical findings (extent, location and appearance of lesions, X-rays, laboratory findings, etc.). If their training and/or experience permit them to do so, physicians should indicate whether the patient's allegations are consistent with the medical findings (e.g. the alleged date of injuries and the colour of bruises).

This information is to be forwarded without delay to the authorities responsible for supervising the police and the prison administration. The detained person is entitled to obtain a copy of the medical report in question at any time.

If the detained person formally objects to the forwarding of this information, the physician should weigh up the opposing interests and, if appropriate, proceed as described in Section 10.

## **12. Independence of physicians**

Irrespective of their conditions of employment (status of civil servant, public employee or private contractor), physicians must always be completely independent of police or prison authorities. Their clinical decisions and any assessments of the health of detained persons are to be based solely on strictly medical criteria.

In order to guarantee the independence of physicians practising in a police or prison setting, direct hierarchical or even contractual relationships with the management of the institution are to be avoided in future.

Nursing staff may only receive medical instructions from the attending physician.

## **13. Training**

In future, it must be ensured that any health professionals working regularly with detained persons receive appropriate training. This should cover the objectives and functioning of the various penal institutions and the management of situations with a potential for risks or violence. Knowledge of ethnosociocultural factors is also required.

### **III. APPENDIX**

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**Personnes retenues en vertu de législations relatives à l'entrée et au séjour des étrangers.**

7<sup>e</sup> rapport général d'activités du CPT couvrant la période du 1<sup>er</sup> janvier au 31 décembre 1996; CPT; Conseil de l'Europe; août 97.

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**Madrid Declaration on Ethical Standards for Psychiatric Practice.**

World Psychiatric Association; approved by the general assembly on august 25, 1996.

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**Déclaration de Tokyo de l'Association Médicale Mondiale.**

Directives à l'intention des médecins en ce qui concerne la torture et autres peines ou traitements cruels, inhumains ou dégradants en relation avec la détention ou l'emprisonnement,  
Adoptée par la 29<sup>e</sup> Assemblée Médicale Mondiale; Tokyo, Octobre 1975.

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**Déclaration de Malte de l'Association Médicale Mondiale sur les Grévistes de la Faim.**

Adoptée par la 43<sup>e</sup> Assemblée Médicale Mondiale; Malte, Novembre 1991.

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**Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and other Communicable Diseases; World Medical Association.**

Adopted: October 2000.

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## **Guidance on implementation of the Guidelines in practice**

### **A. Introduction**

In 2010, the medical care of a prisoner on hunger strike, a related Federal Supreme Court ruling<sup>5</sup> and the involvement of physicians in forced deportations were widely covered in the media and also aroused debate among the medical profession.<sup>6</sup> Against this background, the Swiss Academy of Medical Sciences (SAMS) decided to review the currency and practicability of its medical-ethical guidelines on medical practice in respect of detained persons, originally issued in 2002. This task was undertaken by a working group established by the Central Ethics Committee of the SAMS (CEC). In the light of the working group's report, the CEC concluded that the guidelines – prepared on the basis of internationally recognised agreements – remain valid. However, the experience of physicians working in prison medicine indicates that the ethical principles laid down in the guidelines have yet to be fully implemented within the system for execution of sentences and therapeutic measures, and that clarification is required in certain areas. For this reason, the CEC adopted an Appendix to the medical-ethical guidelines on medical practice in respect of detained persons, providing guidance on their implementation. As nursing staff are mentioned only incidentally in the 2002 guidelines, their role is described in more detail in this Appendix.

### **B. Authority of SAMS guidelines**

The Federal Supreme Court ruling referred to above provoked a legal debate on the weight to be attached to the medical-ethical guidelines of the SAMS. Can prison physicians invoke the guidelines if they are requested to act in a way which contravenes the principles of their code of professional ethics, or are they always bound by the instructions of prison management or the judicial authorities?

5 The Federal Supreme Court ruling of 26 August 2010 on the case of B. Rappaz.

6 Cf. Swiss Medical Association (FMH), Swiss Professional Association for Nurses (SBK), Swiss Academy of Medical Sciences (SAMS), Central Ethics Committee of the SAMS (CEC), Conference of Swiss Prison Physicians (KSG), Swiss Prison Health Services Forum and 74 individual co-signatories. Hungerstreik im Gefängnis – Zum Entscheid des Bundesgerichts vom 26. August 2010/A propos de l'arrêt du tribunal fédéral du 26 août 2010: Grèves de la faim en prison. SAEZ/BMS 2010; 91(39): 1518–20.

Like any other SAMS guidelines, the guidelines on medical practice in respect of detained persons are designed to provide guidance for physicians and other health professionals in their daily work. They do not have the force of law, but they may assume a binding character by virtue of a contract or through membership of a professional association.<sup>7</sup> But even outside this framework, the guidelines have a certain legal authority. For example, in Federal Supreme Court case law, they are accorded the value of rules of medical practice. They may be invoked by a judge in assessing the degree of care exercised by a physician in a particular case. Under liability regulations, the guidelines thus serve as a reference for assessing whether physicians have breached their duties by failing to comply with professional standards.

This explains the significance of the rules set out in SAMS guidelines. The guidelines on medical practice in respect of detained persons (first adopted in 2002) provide a readily comprehensible summary of the basic rights applicable in prison medicine and thus offer guidance for practitioners.

For example, the principle of equivalence of medical care for people in and outside of prison (specified in Section 5 of the Guidelines) is explicitly recognised in rulings of the European Court of Human Rights and in the legal practice of cantons such as Valais or Geneva. Likewise, the requirement that physicians should be able to choose and carry out treatments independently (Section 12) is based on fundamental principles of patient law and professional duties. It should also be noted that Articles 56ff. of the Swiss Criminal Code specify the conditions under which a court may decide, on the basis of an expert assessment, to order a therapeutic measure rather than imposing a penalty if an offender suffers from a mental disorder. It is also stipulated that the court is to seek the opinion of a medical expert in determining the nature of the measure and how it may be implemented at a suitable institution. At each stage, the criminal law defines the respective responsibilities of the judge and the physician, guaranteeing the latter's independence (cf. Section D.). A judge relying on a physician's assessment thus accepts the rules and conditions of medical practice.

<sup>7</sup> From a On being incorporated into the Code of the Swiss Medical Association (FMH), SAMS guidelines become binding for all members of the FMH.

### C. Implementation of the right to equivalent care → [Section 5](#).

The right to receive equivalent care is a central principle of prison medicine. Apart from a restriction of the right to a free choice of physician, detained persons have the same health-related rights as any other patient. Not only prison managers but also physicians and nurses involved in the delivery of care must seek to ensure that this right is respected.

The right to equivalent care encompasses not only access to preventive, diagnostic, therapeutic and nursing measures, but also the basic rules governing the physician-patient relationship, such as the right to self-determination, information and the maintenance of confidentiality. Physicians and nurses working in prison medicine are bound by professional confidentiality as specified in Article 321 of the Swiss Criminal Code and may only disclose information concerning their patients to the limited extent permissible by law (cf. Section 10).

It is therefore problematic if, for lack of resources, medication is dispensed by security personnel. The dispensing of medication by persons other than authorised medical personnel not only compromises professional confidentiality but also contravenes the Therapeutic Products Act. In this Act, the groups entitled to dispense medicinal products are precisely defined, with no exceptions specified for prisons – namely, pharmacists and other medical professionals (i.e. physicians, dentists, veterinary surgeons and chiropractors) and all other duly trained (medical) personnel under the supervision of a member of the above-mentioned professions and with the authorisation of the competent cantonal health authorities (i.e. normally the Cantonal Pharmacist).

Given the realities of medical care in Swiss prisons, it is essential to seek solutions which permit appropriate delivery of care, with acceptable delegation practices, while at the same time complying with legal requirements. If medicinal products are to be dispensed by non-authorised personnel, the following conditions should therefore be fulfilled:

1. The medicinal product has been prescribed by a physician.
2. It has been delivered to the institution by a public pharmacy, and medicinal products kept at the institution are under the supervision and control of an authorised pharmacist.
3. As far as possible, medicinal products are to be dispensed in a form which allows confidentiality to be maintained (pill dispensers/boxes).
4. The warden merely ensures that the pill dispensers are correctly distributed. If in doubt, he must contact the pharmacist or physician responsible and follow their instructions.

#### D. Responsibilities of physicians at therapeutic institutions → [Section 6](#).

Provision of care for detained persons undergoing court-ordered therapeutic measures (Art. 63 and 59 Swiss Criminal Code) is one of the central tasks of prison medicine. A court order for execution of a therapeutic measure is based on a psychiatric expert assessment; the measure ordered must be appropriate, reasonable and capable of being implemented (Art. 56 Swiss Criminal Code). The judgement will often include a more or less detailed description of the recommended therapeutic setting, usually formulated by the psychiatrist who conducts the assessment. The question thus arises of how much leeway is available to physicians responsible for providing court-ordered care at a therapeutic institution.

#### Acceptance of therapeutic assignments

Physicians should only accept a therapeutic assignment if they have the skills required to fulfil the defined objectives. For example, they may only undertake psychotherapeutic treatment if they have the specific expertise required to treat the detained person; otherwise they must decline the assignment.

Before they accept an assignment, physicians must be aware of what it entails both for them personally and for the patient. In particular, they must ascertain whether the patient is prepared to release them from their duty of confidentiality so that they can furnish the competent authorities with the information required to monitor the progress of the therapeutic measure. Ideally, the arrangements for the conduct of treatment in this context (release from duty of confidentiality, etc.) should be settled in advance.

## **Assessment of the patient and of therapeutic options**

The physician should take a careful history, evaluate the therapeutic options, draw up a treatment plan, discuss this with the patient and obtain the patient's consent. The choice of an appropriate treatment is based solely on medical considerations – i.e. it is a purely medical decision. In this situation, conflicts may well arise. For example, if the patient wishes to be treated with antilibidinal medication in order to secure his release, the physician is only to support this request if the treatment is medically advisable. Pharmacotherapy must be effective, and there must be no contraindications. The fact that therapeutic options are already described in the judgement does not absolve the physician from the responsibility of complying with the ethical principles applicable to any treatment.

It is important to bear in mind that a therapeutic measure merely sets the framework for the implementation of a court order. Within this framework, however, physicians remain fully entitled to conduct treatment solely on the basis of their medical assessment of the situation. They are accountable to the judicial authorities for the way in which they have carried out (or failed to carry out) the assignment entrusted to them; it should not be forgotten that their obligations relate to the means employed, not the results achieved.

## **E. Application of compulsory treatment measures → [Section 7](#).**

Compulsory treatment measures can take different forms. They may involve restrictions on freedom of movement, sedation or pharmacotherapy – usually with psychotropic agents – applied without the patient's consent. Compulsory treatment is only to be carried out in the emergency situations specified in Section 7, according to the same criteria as are applicable for non-detained persons. It must always be medically indicated and prescribed by a physician. The measures applied must be appropriate and reasonable, and the patient's dignity is to be respected. It is the physician's responsibility to establish the indication and to ensure that the measures are legally justified. Compulsory treatment must not be carried out by physicians or nurses on the instructions of the authorities.

Since compulsory measures may be traumatic not only for patients but also for the care team, the decision – wherever possible – should be discussed and supported by all members of the team (physicians, nurses and security personnel).

## F. Procedure for hunger strikes → [Section 9](#).

Physicians and nurses working in prisons are frequently confronted with inmates on hunger strike. A hunger strike is to be understood as an act – frequently a final act – of protest by a person who feels powerless to make his or her voice heard in any other way. Hunger strikers do not wish to die; first and foremost, they want their demands to receive attention. They know that a fatal outcome is possible if the situation escalates into an irresolvable conflict.

In order to determine the appropriate procedure, it is important to distinguish various types of situation in which artificial nutrition (tube feeding or infusions) may be contemplated for a hunger striker:

1. The detained person has mental capacity and refuses artificial nutrition, but the situation is not immediately life-threatening. Forced feeding in such circumstances has been declared to be torture by the European Court of Human Rights.
2. The detained person has mental capacity and refuses artificial nutrition, and continuation of the hunger strike would be life-threatening.
3. The detained person has lost mental capacity as a result of the hunger strike, refusal of artificial nutrition is documented in a valid advance directive, and forgoing such nutrition would be immediately life-threatening.
4. The detained person has lost mental capacity (as a result of the hunger strike or for other reasons), there is no valid advance directive rejecting artificial nutrition in this situation, and forgoing such nutrition would be immediately life-threatening.

According to the SAMS Guidelines, artificial nutrition is only medically indicated in the fourth type of situation, and it can generally be undertaken without the use of force. In the other types of situation described, it would not be in accordance with the Guidelines or the rules of medical practice.

The responsibilities of physicians confronted with a hunger strike are described in Section 9 of the SAMS Guidelines.

In addition, the following recommendations should be noted:

- The detained person on hunger strike is to be medically assessed as rapidly as possible (within 24 hours). It must be established whether fluids are being refused as well as food. In addition, comorbid conditions (e.g. diabetes, mental disorders or renal insufficiency) should be investigated. Subsequently, the patient's condition is to be assessed by a health professional on a daily basis.
- The hunger striker must be informed of the physical and mental effects of fasting. Risks and precautions (fluid intake, vitamin and electrolyte replacement) are to be discussed, as well as the risks associated with resumption of nutrition (refeeding syndrome) (cf. Section 9).
- The hunger striker must be offered food every day (cf. Section 9).
- Since treatment is always based on trust, it is important for roles to be clearly defined and for the hunger striker to be assured that the physician and nurses are acting independently of non-medical authorities. Assurances should also be given that the physician and nursing staff respect the SAMS guidelines on caring for detained persons, especially with regard to the maintenance of confidentiality and the patient's right to self-determination and physical integrity.
- It must be ascertained that the detained person's decision to go on hunger strike was made voluntarily, with no pressure from third parties.
- Mental capacity must be evaluated regularly (at least once a week), if necessary by independent experts.
- When hospitalisation is contemplated – if not earlier – attention is to be drawn to the possibility of preparing an advance directive.

## **G. Responsibilities with regard to deportation** → [Section 6.](#)

The principle of equivalence of care is also applicable during detention pending deportation. This entails a responsibility to conduct examinations and provide treatment in accordance with the rules of medical practice (cf. Section 2). The SAMS Guidelines also specify in detail the responsibilities of physicians with regard to deportations (cf. Section 6). In particular, it is stated that physicians cannot assume medical responsibility and must refuse to provide any further assistance if they are convinced that the means to be employed pose an immediate and serious risk to the patient's health.

Persons resisting deportation may still be restrained with plastic cable ties ("Level IV deportation"). Since 1 January 2011, monitoring of deportation by an independent observer has been required under the Return Directive.<sup>8</sup> In addition, care of the detained person is to be provided by a medical escort – a physician (trained in emergency medicine) and possibly a paramedic. However, the restraints employed make clinical assessment difficult. In many cases, the situation is further complicated by a lack of adequate medical records or examinations, since only emergency measures are covered for persons detained pending deportation. The determination of a deportee's fitness for transport and medical care during deportation are responsibilities which have to be discharged in accordance with the rules of medical practice. In circumstances that impede or preclude medical assessment and treatment, physicians have a moral and legal obligation to refuse to participate in a deportation.

### **Medical examination during pre-deportation detention**

The person to be deported must be informed about the forced return sufficiently early to allow a medical examination to be performed if he/she so requests, or if such an examination is indicated on the basis of evident signs of health problems.<sup>9</sup> If the findings of any medical examination, or other medical information from the physician-patient relationship, are communicated to third parties without the patient's consent – in particular, to cantonal authorities, to the State Secretariat for Migration (SEM), or to physicians accompanying the returnee on the flight (accompanying physicians), this represents a breach of medical confidentiality.

<sup>8</sup> Return Directive (Directive 2008/115/EC).

<sup>9</sup> Under Art. 27 para. 3 of the Use of Force Act (SR 364), the persons concerned are to be medically examined before transport is commenced if (a) they so request or (b) signs of health problems are evident.

Persons in pre-deportation detention are generally to be regarded as at-risk patients. It is therefore very important that any information which may be relevant for their health on the flight should be known. The prison physician (or attending physician) does not, however, decide whether a patient is fit for transport, but merely assesses whether contraindications exist (as specified in the list of contraindications<sup>10</sup>). The physician informs the returnee about the importance of passing on this information and encourages him/her to make it available to the accompanying physician. If the returnee agrees, any contraindications known to the physician are recorded in the «Medical Report in Cases of Return/Enforcement of Removal Orders»<sup>11</sup>, which the physician then passes on to the enforcement authorities in a sealed envelope. The latter immediately forward the envelope to the organisation responsible for providing the medical escort. If a patient does not consent to the medical information being communicated, the physician must explain the possible consequences to the patient. In this case, the authorities are merely notified that the patient refuses to have the medical information passed on; this is to be documented in the patient's medical records. At the same time, however, the physician must consider whether the resulting danger to the patient is sufficiently serious to justify the competent authorities in releasing him/her from the duty to maintain confidentiality and, if appropriate, take the necessary steps. In exceptional cases, if there is an immediate risk to the life or physical integrity of the patient or third parties, the physician may independently decide to depart from the duty of confidentiality and inform the competent authorities.

### **Medical examination performed by accompanying physicians**

Physicians accompanying forced returns assume an expert function. Accompanying physicians must have sufficient time for appropriate history-taking, and they may, if necessary, request additional medical investigations and examinations. They determine the conditions under which their duties are performed: during the medical examination, the patient should be released from restraints and spit hoods should also be removed. The examination facilities must be designed so as to permit confidentiality. If necessary, a translator must be called in.

Before the examination, at least the following administrative information must be made available by the enforcement authorities:

- sex;
- age;
- time of last meal;
- hunger strike (current or up to 6 months previously).<sup>12</sup>

10 Available (in German/French) at: [www.sams.ch](http://www.sams.ch) → Ethics → Medical care in the penal system.

11 Available at: [www.sams.ch](http://www.sams.ch) → Ethics → Medical care in the penal system.

12 Information relating to a hunger strike is not covered by medical confidentiality, as it is of an administrative nature. Such information must always be passed on, i.e. even in cases where the person concerned has not released the prison physician from the duty of confidentiality.

With the patient's consent, the accompanying physician inspects the «Medical Report in Cases of Return/Enforcement of Removal Orders» and, if necessary, consults the previous attending (prison) physician. Particularly problematic are situations in which returnees refuse to communicate and the accompanying physician is restricted to clinical impressions. Having performed the medical examination, the accompanying physician decides whether or not the returnee is fit for flight.

The accompanying physician is responsible for assessing fitness for transport and for medical supervision and care of the returnee during the flight. The accompanying physician may recommend medication to prevent thrombosis. Involuntary treatment is not permissible. The accompanying physician does not assume responsibility for medical aftercare of the returnee, but may request that important medication (e.g. antihypertensives, antidepressants, antibiotics, antiviral drugs) be made available for a transitional period of several days.

The accompanying physician can refuse to serve as a medical escort if a contraindication for transport exists or if the prerequisites for an appropriate assessment are not met.

## H. Medical management of suspected persons with body packs

### General principles

#### Separation of the roles of expert and therapist

In connection with suspected persons with body packs, physicians may serve in the role of a therapist or in that of an expert (in a law enforcement procedure or under the Customs Act). Physicians who conduct a radiological investigation in a case of suspected body packing serve as a medical expert vis-à-vis security personnel and the judicial authorities. Physicians and other health professionals who monitor the patient until the packages are eliminated have a therapeutic role. Except in emergency situations, a physician cannot simultaneously serve as expert and therapist. This means that the physician who carries out the radiological investigation in a case of suspected body packing cannot subsequently be responsible for medical surveillance of the patient.

#### Equivalence of care

A person in whom body packing is suspected and/or confirmed is entitled to receive medical care and treatment equivalent to that provided for the general population.

## No coercive measures

The person concerned is to be informed of, and must consent to, any medical interventions. If the person refuses to undergo radiological screening, continuous surveillance for the elimination of possible body packages must take place in a medical setting.

## Investigation of suspected body packing (expert role)

The physician may only carry out measures requested by the competent customs or law enforcement authorities if they are proportionate. The implementation of coercive measures is not part of the physician's expert role. If a physical examination has been specifically ordered by the competent customs or law enforcement authorities, an executive physician will decide whether or not the expert role can be assumed. In the event of a positive decision, the following principles are applicable.

### Diagnostic assessment

- To investigate suspected body packing, a diagnostic assessment is performed. The radiological expert communicates the results to the security personnel and/or judicial authorities.
- As an alternative to imaging procedures, medical surveillance is possible. The use of special body pack toilets is recommended (e.g. the "WC trieurs" available at the university hospitals in Geneva and Bern, or at the provisional police detention centre in Zurich).
- If the person with suspected body packs refuses to undergo radiological screening, it is disproportionate to use compulsion. The performance of a radiological investigation under anaesthesia without the consent of the person concerned is also disproportionate and is therefore not permissible.
- The method of choice is low-dose computed tomography (CT) without a contrast agent. CT provides information on the number and location of body packages.
- In women, a pregnancy test must be carried out prior to imaging.
- Abdominal ultrasound represents an alternative for women who are pregnant. However, this procedure is less reliable.
- Urinary drug testing is of little value because its reliability is variable (sensitivity and specificity 37–50%) and it yields false-positive results in drug users. In addition, it is not suitable for detecting rupture of a package.

If suspected body packing is confirmed, the person concerned must receive medical care.

## Medical surveillance and care in the presence of body packages (therapeutic role)

Rupture of a body package is associated with a high risk of death. To ensure timely detection of rupture, medical surveillance must take place in a hospital. It must be carried out in accordance with the following principles:

- Continuous surveillance must be assured round the clock. Vital signs must be checked every 2–4 hours. This also includes neurological assessment (pupils, Glasgow Coma Scale).
- When the first body package is eliminated, its contents should be analysed and the results reported immediately to the attending physician. Possible complications can thus be treated rapidly and specifically.
- In patients with capacity, the physician and other health professionals must not carry out any coercive measures; this also applies if the person concerned is in police custody.

## Case history

It is essential that the following information should be obtained:

- *Details of body packing:* number of packages, type of packaging (industrial or home made), substance transported, time since ingestion, use of antispasmodics or constipating agents.
- *Risk factors:* gastrointestinal symptoms, fragments of packaging in stool, previous abdominal surgery.
- *Mental state, especially suicidality:* context of detention, risk of autoaggressive behaviour, evaluation of specific vulnerability (drug dependence with risk of re-ingestion of package contents, psychosis, fragile mental health).

A thorough clinical examination is to be performed in order to identify risk factors:

- *Signs of acute poisoning:* miosis/mydriasis, agitation, somnolence, tachypnoea, bradypnoea.
  - *Signs of gastrointestinal complications:* ileus, pain, peritoneal irritation.
  - *Signs of gynaecological complications (with intravaginal packages):* bacterial infection (vaginitis/salpingitis).
- **CAUTION:** Examination of the body cavity (vagina or rectum) is to be avoided, as it involves a risk of damage to drug packages.

## Management of asymptomatic patients

- Medical surveillance must be assured until the last package has been eliminated spontaneously.
- Laxatives should be used with caution, as there is a risk of packages bursting. With the requisite care, they may be administered for medical reasons, but not in order to expedite the expulsion of packages.  
The following may be used: osmotic laxatives (macrogol, Klean-Prep, etc.), 1.5–2 L by mouth/nasogastric tube; or contact laxatives (sodium picosulfate) in the usual dosage.  
→ **CAUTION:** There is an absolute contraindication to the use of oil-based laxatives, as these can increase the porosity of packages.
- After three bowel movements without packages and/or after elimination of the number of packages reported to have been swallowed, a confirmatory radiological investigation (low-dose CT) should be performed.
- If packages are not, or not completely, eliminated spontaneously, a surgical intervention is indicated at the latest after 5–7 days.

## Management of symptomatic patients (body packer syndrome)

In cases of acute intoxication, if the patient is sufficiently stable, emergency surgery (laparotomy) is indicated; the patient should subsequently be transferred to intensive care.

Intoxication should be treated as follows<sup>13</sup>, in consultation with the head of the emergency/intensive care unit responsible:

- *Opioid toxicity:* airway protection, administration of naloxone to maintain adequate spontaneous respiration:
  - with spontaneous respiration: 0.04–0.05 mg IV with subsequent dose titration;
  - with apnoea: 0.2–1 mg IV with subsequent dose titration.
- *Sympathomimetic toxicity (cocaine):*
  - with agitation: lorazepam 1 mg IV or midazolam 5–10 mg IV every 3–5 minutes;
  - with hypertension: lorazepam 1 mg IV or midazolam 5–10 mg IV every 3–5 minutes or phentolamine 1–5 mg IV every 5–15 minutes;  
→ **CAUTION:** Beta-blockers are contraindicated;
  - with myocardial ischaemia: lorazepam or midazolam (as above), acetylsalicylic acid 100 mg per os, nitroglycerin 0.4 mg sublingually;
  - with torsades de pointes due to prolonged QT interval: magnesium IV.

13 As of October 2018.

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Adopted 1989.

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## **Information on the elaboration of these guidelines**

### **Mandate**

On 3 December 1999 the Central Ethics Committee of the SAMS appointed a sub-committee to draw up guidelines on medical practice in respect of detained persons.

### **Responsible sub-committee**

Dr Jean-Pierre Restellini, Geneva, Chair  
Dr Daphné Berner-Chervet, Neuchâtel  
Police Commissioner Peter Grüttner, Zurich  
Professor Olivier Guillod, Neuchâtel  
Dr Joseph Osterwalder, St. Gallen  
Dr Fritz Ramseier, Königsfelden  
Dr Ursula Steiner-König, Lyss  
André Vallotton, Lausanne  
Professor Michel Vallotton, Geneva, CEC President  
Dominique Nickel, Basel, ex officio

### **Consultation**

On 29 November 2001 the Senate of the SAMS approved a draft version of these guidelines, to be submitted for consultation.

### **Approval**

The final version of these guidelines was approved by the Senate of the SAMS on 28 November 2002.

### **Implementation of the Guidelines**

The appended "Guidance on implementation of the Guidelines in practice" was approved by the Central Ethics Committee of the SAMS on 20 January 2012. This Appendix was prepared by a working group chaired by Professor Christian Kind, with the following members:

Dr Bidisha Chatterjee, Dr Monique Gauthey, Professor Bruno Gravier, Professor Samia Hurst, Dr Fritz Ramseier, lic. iur. Michelle Salathé, Anna Schneider Grünenfelder, Professor Dominique Sprumont, Marianne Wälti-Bolliger, Dr Hans Wolff.

### **Adaptations**

In 2012, these Guidelines were revised to reflect the legal situation in Switzerland as of 1 January 2013 (Swiss Civil Code; Adult Protection Law, Law of Persons and Law of Children, Art. 360 ff.; Amendment dated 19 December 2008).

**Appendix lit. G** was amended with the approval of the Senate of the SAMS on 19 May 2015. Editorial revisions were made with effect from 1 January 2017.

**Appendix lit. H** was amended with approval by the Senate of SAMS on 29 November 2018. Authors of Appendix H: Prof. Dr iur. Regina Aebi-Müller, Dr med. André Juillerat, lic. iur. Michelle Salathé MAE, Dr med. Nguyen-Toan Tran, Prof. Dr med. Hans Wolff. Appendix H is supported by the Conference of Swiss Prison Physicians (KSG) (resolution of 30 August 2018).

