

CEJA Report 4 – A-98 Court-Initiated Medical Treatments in Criminal Cases

INTRODUCTION

Frustrated with limited sentencing options and high rates of recidivism for sex offenders, some officials have sought additional approaches. Some states have instituted programs in which chemical castration is a condition of probation. Some judges have required Norplant implants as a condition of probation. In effect, competent convicts are told that they may obtain release from confinement conditional upon their agreeing to undergo court-specified medical treatment. If they decline the specified treatment, they remain in prison.

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Indisputably, convicted criminals have fewer rights and protections than other citizens have. However, being convicted of a crime does not deprive an offender of all protections under the law. Does offering a medical treatment as an alternative to imprisonment effectively deprive the convict of the right to refuse medical treatment – a right grounded in a long common-law tradition, as well as in state and federal constitutional law? With regard to judges' powers: Does tying medical treatment to a criminal sentence risk confusing treatment with punishment? Do judges have – or can they obtain from experts--enough technical understanding to recommend appropriate medical treatments? If the threat of imprisonment can sometimes invalidate a competent convict's consent, and if lack of judicial expertise sometimes results in inappropriate medical treatment, might good-faith errors slip toward court-ordered medical punishment? Does exercise of this new judicial power set up a slippery slope toward exploitation of vulnerable prisoners as "voluntary" subjects for experimentation?

Questions about prisoners' rights and the limits of judicial power and expertise are beyond the purview of this Council. However, physicians still have to face the further question whether professional ethics permit cooperation in administering and overseeing such medical treatments. The American Medical Association's Principles of Medical Ethics recognize that physicians have civic duties. However, medical ethics do not require the physician to carry out civic duties that contradict fundamental medical ethical principles, such as the duty to avoid doing harm. Physicians may have ethical obligations in some circumstances to refuse to participate in legal procedures.

This report will focus on the ethical status of court-initiated medical treatments in criminal cases, limited only to those that are medically appropriate. From the onset, the Council concurs with the House of Delegates Policy H-140.955, "Court-Ordered Castration," which reads, "The AMA opposes physician participation in castration and other surgical or medical treatments initiated solely for criminal punishment." The task of this report is to determine when it is ethically permissible for a physician to participate in legal court-initiated medical treatments in criminal cases.

EFFICACY OF PARTICULAR COURT-INITIATED MEDICAL TREATMENTS

Uncertainty exists as to whether or not treatments being ordered by the courts are efficacious in treating the motivation to commit crimes in the first place. There may be uncertainty as to whether the motivation can be ascribed to a medical condition. Surgical or chemical castration, a parole condition for male sex offenders, raises such skepticism.^{1,2,3} Before the court can initiate a medical treatment, the link between the criminal behavior and the medical condition, as well as the efficacy of a medical treatment in treating the condition should be established. A court should not mandate a therapy if it does not offer a direct

medical benefit for the condition from which the offender suffers. It would be unethical for physicians to follow through with a court-initiated medical procedure if no such benefit exists.

TREATMENT VS. PUNISHMENT: MEDICINE AS A MECHANISM FOR SOCIAL CONTROL

In light of the above discussion on efficacy, court-initiated medical treatments without proven therapeutic benefits with respect to the offender's condition appear to be mandated as a form of punishment and not treatment. For example, if the offender suffers from psychological problems, then a procedure that alters the offender's biological or hormonal make-up may not necessarily provide the appropriate form of therapy. Long-acting contraceptives mandated as therapy for women convicted of child abuse are questionable in this regard because the medication does nothing to treat the abuser's psychological abusive tendencies.⁴ Many professionals believe that acceptance of court-initiated medical treatments is the easy solution to a larger, and more difficult, problem. One opponent to castration wrote, "Castration would just be sidestepping the problem. [He] would still be a child molester. [He] would just be a child molester who was taking tablets."⁵ In order to consider a particular court-initiated treatment a treatment and not a punishment, it would have to effectively treat the disorder that motivates the patient to offend.

COURT-INITIATED TREATMENT FOR SUBSTANCE ABUSE DISORDERS

Court-initiated treatment for substance disorders is different from other types of court initiated treatments in one regard. Even without a court mandate the majority of substance abusers seek treatment involuntarily to a certain extent. Pressure to seek alcohol- or drug-related treatment can come from some other outside authority, such as a parent, spouse, welfare worker, or employer. Therefore, regardless of court action, some degree of coercion to seek treatment exists for all but a small minority of these patients.⁶ When the courts do mandate treatment for substance abuse disorders, some patients recognize their alcohol- or drug-related problems and willingly accept treatment as a means to deal with their interpersonal problems. Treatment, in these cases, is still considered involuntary because it is initiated by the court rather than independently sought out. Some patients with alcohol dependence or other substance abuse disorders are reluctant to undergo court-ordered treatment because they deny drug or alcohol abuse and, therefore, deny that abuse causes their problems. Patients of this sort feel that their referral for treatment is a violation of their privacy, a further humiliation to the previous arrest and, ultimately, a form of punishment.⁷ However, there is a suggested need for, and possible benefit from, treatment for alcohol- or drug-related abuse in involuntary cases. These types of cases do not need the same kinds of safeguards, such as mandatory second opinions, as do criminal cases involving court-initiated in-patient hospitalization, surgery, or pharmacological treatments.

ETHICAL IMPLICATIONS OF PHYSICIAN PARTICIPATION

Implementation of Diagnosis and Treatment

It is outside the jurisdiction of the Council to determine if the courts have the authority to mandate medical procedures. That decision must be left up to the individual states. However, should a state enact laws that permit court-ordered medical treatments, ethical safeguards should be in place to guide the proper implementation of such procedures. First, while the court has the authority to identify criminal behavior, the court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. In accordance with ethical practice, physicians should treat patients based on sound medical diagnoses, not court-defined behaviors. In order to ensure that patients are being treated for

medical diagnoses and not court-identified behaviors, a specific diagnosis must be made independently on each patient. To avoid any conflict of interest, the diagnosis should not be made solely by the physician who will do the treatment.⁸ For cases involving court-ordered in-patient therapy, surgical interventions, or pharmacological treatment, the diagnosis can be made initially by the physician who will do the treatment, but must then be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations. A national specialty society or national medical society should approve pre-established scientifically valid treatments for medically determined diagnoses. Such pre-established acceptable treatments should then be applied on a case-by-case basis.

Given the potential ethical conflicts involved, no physician, even if employed by the state, can be compelled to provide a court-ordered medical treatment if such activity is contrary to the physician's personal beliefs. Physicians who would prefer not to be involved with the court-ordered treatment should be excused or permitted to transfer care of the patient to another physician.⁹

TENET OF INFORMED CONSENT

Informed consent refers to the fundamental right to control decisions regarding one's own body. This right is established for individuals of adult years and sound mind.¹⁰ Individuals with known mental disorders typically do not consider themselves to be ill even though their behavior conflicts with society and could potentially result in criminal punishment.¹¹ It is therefore not clear then how informed consent can be given by persons who do not believe they are ill. This discussion will deal only with those offenders who are determined to be competent to give informed consent.

A decision is considered involuntary when some element is involved that prevents an individual from acting freely. Informed consent is by definition voluntary. However, one can imagine a case that is not free of coercion but is nonetheless voluntary. "Coercion is established by demonstrating that duress induced individuals to give their consent where they would not have otherwise done so."¹² This topic is usually discussed in the context of financially coercive elements. For example, is it voluntary refusal when a patient forgoes medical treatment because the medications are too expensive? Few would argue that any decision the patient in this scenario makes is involuntary, or even irrational. The difficulty of a choice does not necessarily remove the voluntariness of consent. A choice is not to be considered coerced simply because the decision-maker would rather not make the choice at all.

Due to the nature of their circumstances, criminals fall into a class of individuals who are regarded as vulnerable and should therefore be given special ethical considerations. Criminals should not be automatically denied access to treatments that show promise of therapeutic benefit simply because of a presumption that the circumstances make their consent invalid.¹³ The task for physicians is to determine which coercive factors render the consent involuntary. Individuals will undoubtedly weigh risks and benefits differently. In the context of court-initiated medical treatments, the offender is likely to have a desire for freedom that weighs heavily in favor of giving consent. Even in the face of all the information regarding the risks and benefits of a medical procedure, the decision to undergo a medical procedure so as to avoid a lengthy incarceration seems neither irrational nor involuntary. Therefore, it is possible to give voluntary consent under certain coercive circumstances.

Given these considerations, in cases involving court-initiated in-patient therapy, surgical interventions, or pharmacological treatment, both the physician who will perform the treatment and an independent physician or a panel of physicians not responsible to the state

should conclude, in good conscience and to the best of their professional judgment, that the consent was given voluntarily to the extent possible, recognizing the element of coercion that is inevitably present. This requirement does not apply to cases of court-initiated counseling or referrals for psychiatric evaluations.

CONCLUSION

It is controversial whether prescriptions from the court can ever be appropriate. The question at hand, however, is how physicians are to respond to such court-initiated medical treatments. This report offers three conclusions. First, research must demonstrate the efficacy of court-initiated medical treatments. It is questionable whether such procedures have a direct beneficial medical affect on the psychological problems from which the offensive tendencies stem. The physician must be certain that the court-initiated medical treatment is the appropriate treatment for the problem at hand.¹⁴ Second, implementation of a court-initiated medical procedure must incorporate the appropriate roles of the court, the national medical or specialty society, the physician who will do the treatment and an independent physician or a panel of physicians not responsible to the state. Third, in order for any patient to give informed consent the physician must disclose all information necessary for the patient to evaluate the options and risks associated with each option. The consent does not have to be given under circumstances free of coercive elements, but the physician must be certain to his or her best professional ability that the consent is not itself coerced. In cases involving court-ordered in-patient therapy, surgical interventions, or pharmacological treatment an independent physician or a panel of physicians not responsible to the state should confirm this conclusion.

If the physician cannot secure adherence to these criteria, then he or she may be liable for medical malpractice or charges of battery. However, in ethical terms, the detriment such a practice could do to the integrity of the medical profession is much graver. "Physicians in the future will have to be very careful not to become the agents of social control of the state rather than providers of treatment."¹⁵

RECOMMENDATIONS

To safeguard the ethical participation of physicians in court-initiated medical treatments in criminal cases, the Council recommends the following and that the remainder of this Report be filed:

1. House of Delegates Policy H-140.955, "Court-Ordered Castration," should be reaffirmed. This policy states, "The AMA opposes physician participation in castration and other surgical or medical treatments initiated solely for criminal punishment."
2. Physicians can ethically participate in court-initiated medical treatments only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
3. While the court has the authority to identify criminal behavior, the court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered.
4. In accordance with ethical practice, physicians should treat patients based on sound medical diagnoses, not court defined behaviors. This is particularly important where the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment. In these cases diagnosis can be made initially by the physician who will do the treatment, but must then be confirmed by an independent physician or a panel of physicians not responsible

to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.

5. A national specialty society or national medical society should approve pre-established scientifically valid treatments for medically determined diagnoses. Such pre-established acceptable treatments should then be applied on a case by case basis.

6. The physician who will perform the treatment must be able to conclude, in good conscience and to the best of his or her professional judgment, that the informed consent was given voluntarily to the extent possible, recognizing the element of coercion that is inevitably present. In cases involving in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that the informed consent was given in accordance with these guidelines.

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8. This provision has also been used as a safeguard in guiding physician participation in state execution. A physician who treats an incompetent prisoner should not offer witness testimony that the prisoner is now competent to be executed. In: Council on Ethical and Judicial Affairs, American Medical Association. Opinion 2.06, “Capital Punishment.” *Code of Medical Ethics: Current Opinions with Annotations.* Chicago, Ill: American Medical Association. 1996.
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14. For example, patients for which the therapy is contraindicated should not be considered for the treatment. In the case of chemical castration, “The exclusion criteria were a

history of malignancy, cardiovascular disease, deep vein thrombosis and embolism, chronic liver disease, diabetes mellitus, chronic alcoholism, active psychosis, severe chronic depression, sickle cell anemia, or organic brain disease. Patients on medication were excluded. Physical examination and hematological and biochemical tests were used to exclude active medical illness..." In: Bradford JM., et. al., Double-Blind Placebo Crossover Study of Cyproterone Acetate in the Treatment of Paraphilias. *Arch Sex Behav.* 1993;22:383-402.

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