

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(A-23)

Introduced by: Medical Student Section

Subject: AMA Study of Chemical Castration in Incarceration

Referred to: Reference Committee E

1 Whereas, Chemical castration is defined as the use of pharmacologic agents, including anti-
2 antagonists and gonadotropin-releasing hormone agonists, to reduce serum testosterone
3 levels and quell libido in individuals diagnosed with a paraphilic disorder and other individuals
4 who commit sexual offenses, in an effort to reduce the occurrence of sexual offenses^{1,2}; and
5

6 Whereas, 4,984 people are currently incarcerated for sexual offenses in federal prisons^{3,4};
7 and
8

9 Whereas, Several states have passed or debated statutes requiring chemical castration for
10 individuals who commit sexual offenses as a sentence and/or as a requirement for parole,
11 most recently Alabama in 2019, where offenders are required to pay for their own treatment,
12 and in Tennessee in 2020^{1,5-8}; and
13

14 Whereas, Diagnostic and Statistical Manual of Mental Disorders (DSM)-V defines “paraphilic
15 disorder” as “recurrent and intense sexual arousal over a period of at least 6 months with
16 nonconsenting victims through voyeurism, exhibitionism, frotteurism, sexual sadism, and
17 pedophilia” and estimated lifetime prevalences are 12% for males and 4% for females⁹; and
18

19 Whereas, Chemical castration can be traced to the 1900s eugenics movement where people
20 with developmental delays and psychiatric diagnoses were forcibly sterilized, including up to
21 60,000 incarcerated women diagnosed with and intellectual disability¹; and
22

23 Whereas, Chemical castration via injection with Depo-Provera (medroxyprogesterone
24 acetate) and surgical sterilization have historically disproportionately targeted Black
25 individuals in the United States, including the deceptive, experimental testing of Depo-
26 Provera as a method of birth control on young Black females in the 1960s^{10,11}; and
27

28 Whereas, The current method of chemical castration for incarcerated males who committed
29 sex offenses in several states, including California and Florida, is via injection with Depo-
30 Provera, although no medication, including Depo-Provera, is currently FDA-approved for
31 chemical castration¹²; and
32

33 Whereas, Limited evidence exists for the effectiveness of chemical castration, with several
34 studies noting that chemical castration does not address the core psychological impulses
35 relating to sexually aberrant behavior^{12,13}; and
36

37 Whereas, When chemical castration is a requirement for parole, judges, not medical doctors,
38 are charged with deciding whether or not a prisoner receives chemical castration therapy,
39 suggesting that chemical castration constitutes punishment instead of rehabilitative therapy¹²;
40 and

1 Whereas, The Association for the Treatment of Sexual Abusers (ATSA) published a 2012
2 statement on the use of chemical castration for individuals with paraphilic disorders and
3 individuals who commit sexual offenses, concluding that chemical castration may be effective
4 for certain patients when combined with other non-pharmacologic interventions such as
5 psychotherapy¹⁴; and
6

7 Whereas, The issue of chemical castration is rife with ethical quandaries and valid arguments
8 may exist both in support of and in opposition to this practice¹⁵; and
9

10 Whereas, In situations where chemical castration is a requirement for parole, some may
11 argue that this requirement unjustly coerces an individual to agree to a medical procedure,
12 while others may argue that if chemical castration was not required, an individual may never
13 be allowed the possibility of parole at all and may remain incarcerated¹⁵; and
14

15 Whereas, Scientific research, medical information, and expert opinions from physicians on
16 the issue of chemical castration for individuals who commit sexual offenses, especially in the
17 last 5 years, are difficult to find most likely since the population affected by chemical
18 castration have not been the subject of much retrospective research; and
19

20 Whereas, The American Psychiatric Association raised concerns in July 2021 about the use
21 of chemical castration as a condition for parole, citing ethical concerns over the minimal to
22 absent involvement of physicians and calling the “court-driven, one-size-fits-all approach to
23 anti-androgen treatment inconsistent with contemporary medical practice”¹⁶; and
24

25 Whereas, Our American Medical Association previously adopted Policy 140.955, “Court-
26 Ordered Castration,” which stated that “The AMA opposes physician participation in
27 castration and other surgical or medical treatments initiated solely for criminal punishment,”
28 but this policy was later rescinded due to being considered duplicative of Code of Medical
29 Ethics Opinion 9.7.2, “Court-Initiated Medical Treatment in Criminal Cases”¹⁷⁻¹⁸; and
30

31 Whereas, While the AMA Code of Medical Ethics Opinion 9.7.2 states that “physicians who
32 provide care under court order should: (a) Participate only if the procedure being mandated is
33 therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a
34 mechanism of social control,” the morality of chemical castration under this Code is unclear,
35 including its use as efficacious treatment, as a mechanism for social control, as a tool for
36 public safety, and as an alternative to incarceration^{1,5-8,15,18}; therefore be it
37

38 RESOLVED, That our American Medical Association study the use of chemical castration in
39 the treatment of incarcerated individuals with paraphilic disorders and for other individuals
40 who commit sexual offenses, including ethical concerns over coercion in its use as an
41 alternative to incarceration and in probation and parole proceedings. (Directive to Take
42 Action)
43

Fiscal Note: Modest - between \$1,000 - \$5,000

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REFERENCES

1. Scott CL, Holmberg T. Castration of Sex Offenders: Prisoners' Rights Versus Public Safety. *J Am Acad Psychiatry Law*. 2003; 31:502-509. <http://jaapl.org/content/jaapl/31/4/502.full.pdf>
2. Thibaut F, De La Barra F, Gordon H, Cosyns P, Bradford JM. The World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for the biological treatment of paraphilias. *The World Journal of Biological Psychiatry*. 2010; 11(4):604-655. DOI: 10.3109/15622971003671628
3. Federal Bureau of Prisons. Statistics: Total Federal Inmates. United States Federal Bureau of Prisons. Last Updated 9 September 2021. Accessed September 15, 2021. https://www.bop.gov/about/statistics/population_statistics.jsp
4. United States Sentencing Commission. Mandatory Minimum Penalties for Federal Sex Offenses. United States Sentencing Commission. 2016. Accessed September 15, 2021. <https://www.ussc.gov/research/research-reports/mandatory-minimum-penalties-federal-sex-offenses>
5. Norman-Eady S. Castration of Sex Offenders. Hartford, CT: Connecticut General Assembly (CGA), Legislative Commissioners' Office (LCO), Office of Legislative Research (OLR); 2006. <https://www.cga.ct.gov/2006/rpt/2006-r-0183.htm>. Accessed August 27, 2020.
6. Blinder A. What to Know About the Alabama Chemical Castration Law. *The New York Times*. <https://www.nytimes.com/2019/06/11/us/politics/chemical-castration.html>. Published June 11, 2019. Accessed August 27, 2020.
7. Iati M. Alabama Approves 'Chemical Castration' Bill for Some Sex Offenders. <https://www.washingtonpost.com/health/2019/06/11/alabama-chemical-castration-bill/>. Published June 11, 2019. Accessed August 27, 2020.
8. Ebert J. Republican Lawmaker Files Bill to Chemically Castrate Convicted Sex Offenders. <https://www.tennessean.com/story/news/politics/2020/01/03/tennessee-republican-lawmaker-files-bill-chemically-castrate-sex-offenders/2803880001>. Published January 3, 2020. Accessed August 27, 2020.
9. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. 5th ed. Washington DC: American Psychiatric Association. 2013:685-705.
10. Washington H. Chapter 8: The Black Stork. In: *Medical Apartheid*. Anchor Books; 2006:189-215.
11. Davis, A. Racism, Birth Control and Reproductive Rights. In: *Women, Race and Class*. London: The Women's Press; 1982:202-271.
12. Shipley SL, Arrigo BA. Chapter 12: Family/Community Issues in Corrections/Correctional Psychology. Introduction to Forensic Psychology 3rd ed. Academic Press; 2012: 551-613. ISBN 9780123821690. <https://doi.org/10.1016/B978-0-12-382169-0.00012-8>.
13. North A. "Alabama's law forcing sex offenders to get chemically castrated, explained." *Vox*. Published June 11, 2019. <https://www.vox.com/identities/2019/6/11/18661514/alabama-chemical-castration-bill-kay-ivey-effects>. Accessed September 20, 2020.
14. Pharmacological Interventions. Association for the Treatment of Sexual Abusers (ATSA). <https://www.atsa.com/pharmacological-interventions-0>. Published August 2012. Accessed August 27, 2020.
15. Douglas T, Bonte P, Focquaert F, Devolder K, Sterckx S. Coercion, incarceration, and chemical castration: An argument from autonomy. *J Bioeth Ing*. 2013;10(3):393-405. doi: 10.1007/s11673-013-9465-4
16. American Psychiatric Association. Position Statement on Orchiectomy or Treatment with Anti-Androgen Medications as a Condition of Release from Incarceration. APA. 2021. Accessed September 15, 2021. <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Orchiectomy-Anti-Androgen-Medication-Incarceration-Release-Condition.pdf>
17. American Medical Association. Proceedings of the House of Delegates, 147th Annual Meeting, June 14-18, 1998. http://ama.nmtvault.com/jsp/PSImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00002%2F00000008&pg_seq=286. Accessed August 24, 2021.
18. American Medical Association. Proceedings of the House of Delegates, 157th Annual Meeting, June 14-17, 2008. https://ama.nmtvault.com/jsp/PSImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00005%2F00000010&pg_seq=273. Accessed August 24, 2021.

RELEVANT AMA POLICY

Court-Initiated Medical Treatment in Criminal Cases, E-9.7.2

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments.

Individual physicians who provide care under court order should:

- (a) Participate 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.
- (b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must 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.

(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.

(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

Issued: 2016

Informed Consent, E-2.1.1

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

(i) the diagnosis (when known);

(ii) the nature and purpose of recommended interventions;

(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

Issued: 2016

Patient-Physician Relationships, E-1.1.1

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.

(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.

(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

Issued: 2016

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Citation: Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12; Modified: CSAPH Rep. 1, A-22;

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