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January 28, 2008

Mr. John P. Torres
Director, Office of Detention and Removal Operations
Immigration and Customs Enforcement
U.S. Department of Homeland Security
425 I Street, NW
Washington, DC 20536

Don Wright, MD, MPH
Principle Deputy Assistant Secretary for Health
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Mr. Torres and Dr. Wright:

As physicians with expertise in prescription medications (including psychotropic drugs), medical ethics, correctional medicine, and human rights, we write to express the deep concern of Physicians for Human Rights over the Amended Medical Escort Policy of the office of Immigration and Customs Enforcement ("ICE"), dated January 9, 2008. This new policy formalizes ICE's widely reported practice of forcibly sedating asylum seekers and other immigration detainees with powerful psychotropic medication – with the aid of medical personnel – in order to render them compliant for deportation.

We are extremely troubled that ICE's Amended Policy fails to adopt the firmly established medical and legal standard governing forced sedation. This standard prohibits physicians 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. We emphatically urge ICE and the US Public Health Service ("USPHS") to adopt it and to ensure its enforcement.

According to recent Congressional testimony and public statements of ICE officials, ICE frequently has called on medical professionals, including USPHS personnel, to forcibly sedate detainees slated for deportation "solely to facilitate removal efforts"¹ and to "allow the United States to enforce its

immigration laws”¹ when a detainee’s resistance to deportation is deemed dangerous and when the forced drugging is supported by a court order. In her September 2007 testimony before the Senate Committee on Homeland Security and Governmental Affairs, ICE Assistant Secretary Julie Meyers disclosed that 56 immigration detainees were given psychotropic medication and other drugs to facilitate deportation between October 2006 and April 2007. She testified that 33 of these detainees (more than five per month) were drugged in the absence of a history of mental health problems, solely to enable deportation by quelling allegedly “combative” resistance to removal.² No medical diagnosis or therapeutic purpose has been required for forced sedation, and that remains the case under ICE’s Amended Policy.

The new policy, in fact, largely ratifies ICE’s past practice, allowing court-ordered forced sedation “to effectuate removal” when a detainee’s resistance is deemed “dangerous.” The Amended Policy also requires evidence from a medical doctor that the drug or drugs to be forcibly administered are “medically appropriate.”

While we welcome this recognition of medical concerns, the Amended Policy offers no criteria for the vague standard of “appropriateness,” providing far too little guidance and presenting far too great a risk that ICE’s sole interest in removal will subvert the physician’s obligation to the patient’s health. This risk is particularly grave in view of ICE’s stated commitment to enforcing deportation orders through involuntary sedation, the shocking frequency with which medical personnel already have forcibly sedated detainees to enforce removal orders without therapeutic purpose, and the fact that, by its terms, the Amended Policy does not apply to patients who *are* receiving medication as part of ongoing “therapeutic treatment.”

Years of medical and legal experience with forced sedation have produced the more exacting “therapeutic purpose” standard, and we urge ICE and the USPHS to use it. The standard 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 harm.³ 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*.”⁴

The US Supreme Court’s rulings on forced sedation are entirely consonant with medical ethics. The Court has held, under the Due Process Clause of the Constitution, that forcible

¹ Push to sedate resistant immigrant prompts bill, *Dallas Morning News*, November 2, 2007. Accessed November 14, 2007 at http://www.dallasnews.com/sharedcontent/dws/news/localnews/stories/DN-albaniadeport_02met.ART0.West.Edition1.41f1dfd.html.

² “ACLU seeks to stop drugging of deportees,” Associated Press, October 10, 2007, accessed November 29, 2007 at http://www.usatoday.com/news/nation/2007-10-10-3024431624_x.htm; “Lawsuit: ICE drugging detainees set for deportation,” CNN, October 24, 2007, accessed November 29, 2007 at <http://www.cnn.com/2007/US/10/12/doping.immigrants/index.html>.

³ See 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, adopted by United Nations General Assembly resolution 37/194, December 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*.”

⁴ AMA Code of Medical Ethics, E-2.065, “Court-initiated medical treatments in criminal cases.” (Emphasis added.)

administration of antipsychotic drugs to a person held in custody must be “in the inmate’s medical interest,” based on a medical determination that any danger posed by the inmate to self or others is the result of “serious mental illness,” and the treatment for that illness is necessary to prevent harm.⁵

These ethical and legal principles are central to the National Commission on Correctional Health Care (“NCCCHC”) standard on “Emergency Psychotropic Medication.” That guideline, which applies to ICE detention facilities,⁶ prohibits forced medication of those in custody “simply to control behavior,” permitting it only in emergencies, to prevent harm “when an inmate is dangerous to self or others *due to a medical or mental illness.*”⁷ Therapeutic purpose is also reflected in ICE’s own Detention Standards on the Use of Force, which provide that “[m]edication shall not be used to subdue an uncooperative detainee for staff convenience. Medication must be prescribed and administered by licensed medical personnel *for medical purposes only.*”⁸

By failing to define the term, “medically appropriate,” however, while simultaneously encouraging forced sedation for deportation purposes, the Amended Policy permits, and may even promote, involuntary medication without “sound medical diagnoses” of “medical or mental illness,” or therapeutic purpose. This violation of medical ethics, NCCCHC and ICE standards, and the requirements of due process is especially likely in the context of removal, where distraught detainees’ agitation and resistance often arise from genuine fear of imminent harm upon return to a home country and extreme anxiety over separation from family and loved ones. These reactions themselves do not indicate an underlying psychopathology amenable to psychotropic medication.⁹

Yet, under the Amended Policy, powerful psychotropic drugs may nonetheless be deemed “medically appropriate” simply because they effectively curb resistant behavior, not because the detainee suffers from an illness for which the drugs are “therapeutically efficacious.” As a result, the Amended Policy creates the substantial risk that a physician’s fundamental role as healer will become secondary to a role as deportation officer.

The policy also promotes bad medical practice. Psychotropic medications, particularly anti-psychotic drugs, are powerful agents that can cause harmful side-effects, especially if they are administered to patients for whom they are not medically indicated. The published medical records of one detainee, for example, show that he was given repeated and substantial doses of the anti-psychotic drug Haldol (haloperidol), along with large doses of

⁵ *Washington v. Harper* 494 U.S. 210, 221-22, 227 (1990). See also, *id.*, at 231 (“[W]e conclude that an inmate’s interests are adequately protected, and perhaps better served, by allowing the decision to medicate be made by medical professionals rather than a judge.”).

⁶ ICE [formerly INS] Detention Standard: Medical Care, sec. I, p.1: “Medical facilities in service processing centers and contract detention facilities will maintain current accreditation by the National Commission on Correctional Health Care.”

⁷ *Standards for Health Services in Prisons*, National Commission on Correctional Health Care, 2003, standard P-I-02, “Emergency Psychotropic Medication,” p. 127.

⁸ ICE [formerly INS] Detention Standard: Use of Force, sec. III.B.8, p.5 (accessed December 5, 2007 at <http://www.ice.gov/doclib/partners/dro/opsmanual/useoffor.pdf>). (Emphasis added.)

⁹ Indeed, resistance under such circumstances may be an appropriate, even normal, response to a reasonably perceived threat to well-being and safety.

the sedative Lorazepam, and Cogentin – the latter apparently to prevent side effects caused by the Haldol.

Each of these drugs can give rise to harmful side-effects that can be life threatening or severely incapacitating. It is common medical practice to closely monitor the first-time administration of such potent agents, as patients can suffer cardiac, respiratory, and neurological effects that require immediate medical attention, particularly in cases of over-sedation. By failing to make therapeutic benefit (including compliance with established protocols), the sole purpose for psychotropic medication, the Amended Policy fails to provide adequate protection against these health risks.

Finally, the Amended Policy undermines the paramount ethical principle of informed consent to medical treatment. Even when medical treatment is ordered by a court, a physician “must be able to conclude, in good conscience and to the best of his or her professional judgment, that the [patient’s] informed consent was given voluntarily, to the extent possible, *recognizing the element of coercion that is inevitably present.*”⁴⁵ By ICE’s own account, the very purpose of forced sedation is entirely coercive, making it impossible for any participating physician to conclude that consent was voluntarily given.

Because the vague “medically appropriate” standard for forced sedation fails to ensure compliance with sound medical practice, correctional health standards, medical ethics, and the law, we urge ICE and the USPHS to expressly adopt the explicit and established standard: involuntary sedation may be used only for therapeutic purposes, to prevent harm when a detainee poses a danger to self or others due to a diagnosed medical or mental illness. We urge ICE and the USPHS to explicitly prohibit forced sedation for any other purpose.

If you have any questions or would like to speak further about this recommendation, we would be happy to meet with you to discuss it.

Sincerely,

A handwritten signature in black ink that reads "Robert S. Lawrence". The signature is written in a cursive style and is positioned to the left of a vertical red line.

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