

Review

Ethics of medical care for body packers (drug smugglers): untangling a web of fears and conflicts of interest

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أخلاقيات الرعاية الطبية لمبتلي اللفائف المخدرة لتهربها: تكشف شبكة من المخاوف وتضارب المصالح

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الخلاصة: يعتبر بلع مهربي المخدرات للنفائف، أي نقل الأدوية غير المشروعة في عبوات يتم بلعها أو إقحامها في أحد تجاويف الجسم، واحدة من الظواهر العالمية التي أصبحت تزداد انتشاراً. وتثير الرعاية الطبية لهؤلاء المرضى مشاكل طبية وأخلاقية صعبة. فبالرغم من تحليل الجوانب الطبية المتعلقة بمعالجة مبتلي اللفائف تحليلاً منهجياً، إلا أن القضايا الأخلاقية لم تحظ إلا بقدر ضئيل من اهتمام النشريات. فقد يكون المريض قيد التوقيف من قبل الشرطة أو قيد البحث عنه من قبل راعيه الإجرامي، وربما استدعى ذلك إجراء تحقيقات واتخاذ إجراءات طبية محفوفة بالمخاطر، مما قد يتنقص من إمكانية الحصول على موافقة صحيحة ومستنيرة من المريض المُحتَجَز. وبالإضافة إلى ذلك قد يخشى الأطباء دائرة الاتصالات الإجرامية للمريض. ويحلل هذا المقال تضارب المصالح الذي قد يواجهه الأطباء عند معالجة مبتلي اللفائف، ويقترح بعض المبادئ لتعزيز الدلائل الإرشادية المؤسسية المتبعة في معالجة هؤلاء المرضى.

ABSTRACT Body packing by drug smugglers—the transport of illicit drugs in packets swallowed or inserted into body cavities—is a global phenomenon and is becoming more prevalent. The medical care of these patients raises difficult medical and ethical problems. While the medical aspects of treating body packers have been systematically analysed, the ethical issues have received little attention in the literature. The patient may be under police custody or being sought by their criminal patron which may result in imposed interrogations and risky medical procedures. Obtaining informed valid consent for procedures from the patient-detainee may thus be compromised. In addition, physicians may be intimidated by the patient's criminal contacts. This article analyses the conflicts of interest that doctors may face when treating body packers, and proposes some principles to promote institutional guidelines for the treatment of these patients.

Éthique des soins médicaux aux passeurs de drogues *in corpore* : démêler l'écheveau des peurs et des conflits d'intérêts

RÉSUMÉ Le transport de drogues *in corpore* par les trafiquants, c'est-à-dire le convoyage de drogues illicites ingérées ou insérées dans des cavités corporelles sous forme de boulettes, est un phénomène mondial de plus en plus répandu. Les soins médicaux prodigués à ces patients soulèvent des questions éthiques et médicales difficiles. Si l'aspect médical du traitement des passeurs de drogues *in corpore* a été systématiquement analysé, les questions éthiques n'ont pas bénéficié de beaucoup d'attention dans la littérature scientifique. Le patient peut être sous surveillance policière ou recherché par le patron de son réseau criminel, ce qui peut entraîner des interrogatoires imposés et des procédures médicales risquées. Dans ces conditions, l'obtention d'un consentement valable et pris en connaissance de cause par le patient-détenu, en ce qui concerne les actes médicaux requis, peut être compromise. En outre, les médecins peuvent être victimes d'intimidations de la part des relations criminelles du patient. Le présent article analyse les conflits d'intérêts auxquels sont confrontés les médecins lors de la prise en charge d'un passeur de drogues *in corpore* et présente certains principes afin de favoriser l'élaboration de directives institutionnelles sur le traitement de ces patients.

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Introduction

Body packing—the transport of illicit drugs concealed as packets swallowed or inserted into body cavities—is increasingly common in the international narcotics trade. This risky practice represents a medical emergency that not only threatens the body packer's life, but also raises difficult ethical issues. While the clinical and forensic aspects of body packing have been thoroughly discussed [1,2], we have found no equivalent analysis of the ethical questions that emerge. The illegal nature of the patients' problem and the inevitable involvement of law enforcement agents put at risk the rights of patients and the ethical duties of their attending doctors. Although there are no published studies on this phenomenon, there is a consistent body of anecdotal evidence that suggests that these problems are a particular concern in low-income, underdeveloped countries, where law enforcement agencies may operate under different codes of conduct.

In this article, we explore the ethical conflicts that emerge in the medical care of body packers. We will first briefly describe the medical and non-medical events seen when such patients are admitted to hospital, including the role of law enforcement agents and the risk of threats from the body packers' own contacts. We will then analyse the dual loyalties and conflicts of interest that doctors face in these cases, and will propose some principles and practical guidelines that we believe should contribute to creating a pressure-free environment where doctors can focus on the patient's rights and quality of care. It should be made clear that the prevalence and the seriousness of the problems described here vary widely among different countries and regions. Nevertheless, any hospital in the world could find itself dealing with this by-product of the global drugs trade.

Body packing

Body packers may come to the emergency room with symptoms of intestinal obstruction, acute intoxication by drug leakage, or both [3]. These life-threatening, and in the case of cocaine packets, highly lethal, events have become somewhat less common today than they were in the past, since drug packing methods seem to have become less dangerous [4,5]. This might explain the growing involvement of women and children in the practice [1,6,7].

What doctors commonly encounter today is a young, asymptomatic, uncommunicative and frightened individual, who is brought to hospital by law-enforcement officers suspecting a case of body packing. Occasionally, terrified patients refer themselves to hospital alone. In either case, the patient may show mild abdominal distention and a tender mass on deep palpation. X-rays may show multiple oblong nuggets from radiolucent to radiopaque, depending on the substance and on the packing method, scattered throughout the abdomen [4]. Normally, the person admits to having ingested between 50 and 100 packets of a drug [1], stays in observation for a day after the cargo has passed, and is subsequently discharged. Throughout this time, the patient is likely to be under police custody [2], which often results in imposed interrogations and fast evacuation of the cargo being carried. This is mostly to further the criminal prosecution agenda. In the case of self-referred packers, their criminal patron may wish to locate them in the hospital to prevent any information leakage or to recover the highly valuable cargo [8].

These undesirable situations need to be avoided for the sake of all concerned: doctors, nurses and the patient, as well as other patients in the hospital. It may be detrimental to the patient's care to have the police, much less any suspicious visitors, present in the wards. In this

climate of rush and pressure, medical procedures may be performed more in the interest of speeding the process up, rather than protecting the best interests of the patient. Informed consent may receive very little attention. In the following section we will discuss informed consent, dual loyalty and other conflicts of interest in the medical care of body packers.

The ethical issues

Informed consent

Informed consent to diagnostic and treatment interventions is perhaps the first victim of the hectic environment that surrounds the care of body packers. It is tempting to argue that consent is not necessary in these cases, since body packers' judgement is too impaired by their fear of the law, of their patrons and accomplices, or of dying from drug intoxication. It would be no less tempting to state that refusing treatment brings no possible medical, legal or goal-related advantage to these patients, making the rejection of treatment too irrational to be respected. We do not agree. We believe, instead, that body packers' judgement, except in the case of drug intoxication from package rupture, should not be considered more impaired than that of any other patient, and that these patients retain their full right to informed consent and refusal. This includes the right to make unwise medical decisions. This is particularly true when some of the medical procedures are not necessarily in the patient's best clinical interest, but rather represent decisions made by doctors under pressures from criminal investigation officers.

As Milgram's experiments showed in 1963, obedience to a legitimate authority tends to be high among "ordinary people, simply doing their jobs", to the point that "without any particular hostility on their part, they can become agents" of processes that compromise a person's rights and physical integrity [9].

Doctors thus may be caught amid different loyalties and conflicting interests.

Dual loyalty and conflict of interest

Interrogation of any detainee, hospitalized or not, is aimed at administering justice and preventing further harm or danger to self or others [10]. In the case of a body packer, interrogation *per se* can have harmful clinical consequences [11], and yet the intimidating presence of the police can push doctors to make concessions to the law enforcement agenda. For instance, enemas and other methods to speed up the evacuation of the cargo, much desired by the law enforcement officers, are not the optimum treatment [2,12], and may increase the risk of packet rupture. When treating body packers, serving the patient-suspect may imply hampering the law; but the unchecked service to the law may harm the patient. This dual loyalty is the doctor's true dilemma.

The international dual loyalty working group of Physicians for Human Rights characterized this dilemma as the conflict between professional duties to a patient versus the expressed or implied, real or perceived, obligations to the interests of a third party such as an employer, insurer or the state [13]. In a wide variety of contexts and clinical settings, health professionals are pressured by influential third parties to subordinate patients' rights to their demands.

Bloche sees loyalty conflicts arising when 3 different type of goals are pursued: (a) furthering public health, as when reporting a communicable disease; (b) serving non-medical ends, such as state security, as when collaborating with the law; and (c) evaluating individuals for social purposes, such as receiving public benefits, evaluating requests for asylum, determining criminal responsibility, joining the army or transporting dangerous merchandise [14].

No doctor-patient relationship occurs in complete isolation. There are always third parties with some kind of interest to be served, from the need to make time for the next patient in the waiting room, to supporting the health system's cost-control policies. However, doctors' primary loyalty should be reserved for their patients. Sometimes doctors have no reason to refuse serving their secondary allegiance, e.g. if a patient asks the physician to forge information to support a fraudulent insurance claim [6]. It is also widely accepted that higher social purposes can legitimately be the first priority served by doctors [15]. Examples of that would be reporting fraud against the health care system, as well as health conditions that interfere with transport safety (driving, flying a plane, operating a train or controlling air traffic) [15]. More importantly, secondary loyalties are legally binding in many circumstances [16].

Serious conflict arises, however, when doctors—whose primary role is, or is perceived by the patient to be, providing clinical care—are pressed to subordinate their patient's interests to those of a third party, to the point of violating the patient's rights [17]. As a matter of principle, no social purpose should make this permissible. The situation is complex, however, in the case of body packers.

Doctors who deal with body packers are trapped in a web of conflicting loyalties and fear. On the one hand, body packers are brought to hospital to receive care; on the other hand, the law demands cooperation with investigations into the suspected drug trafficker. Doctors may feel intimidated by the presence of police but at the same time may fear that the suspect, or his criminal patrons, will seek revenge if the doctors cooperate with the law [14]. Doctors and hospital administrators may want to spare other patients and their families the uncomfortable presence of the police in the wards. The thought of having the patient's patrons or an accomplice

obtaining entry to the wards is especially alarming. It thus becomes convenient for everyone but the patient to expedite the patient's medical care in this situation. In addition, doctors in some cases may feel scrutinized by colleagues and staff over their commitment to support the legal processes.

Treating body packers: some general principles

Health institutions often have no explicit, well-developed guidelines for doctors dealing with patient-suspects in general, much less with body packers in particular [15]. In the case of police inquiries regarding confidential patient information, Health Information Privacy regulations that govern the ethical conduct of physicians in a professional environment do not have clearcut guidelines either [14,18]. Physicians are left with no clear guidance to deal with the potential interference of law enforcement agencies in medical treatment. Even in the case of a body packer seeking help on their own, physicians in most health care centres around the world would be left to their own judgement as to whether to alert law enforcement officials or not [14].

In the absence of well-structured decision-making strategies for doctors and hospitals, it is no surprise if there are violations of patients' rights and avoidable adverse medical outcomes [15]. We would like to put forward some principles of practice that could form the basis for discussing institutional guidelines on the care of body packers.

Body packing and the doctor-patient relationship

The doctor-patient relationship in the context of body packing should be indistinguishable from any other clinical

relationship, because it is, with very few nuances, a clinical relationship, and so are its goals, conditions and rules of consent and confidentiality.

As a general principle, the examination and treatment of body packers should serve the best medical interest of the patient, which in this case mainly consists of preventing complications, such as intestinal obstruction, perforation, peritonitis or drug packet rupture and subsequent overdose. The demands from third parties should not result in invasive examinations or accelerating the evacuation of the cargo, even if the patient consents, since this may only increase the risk of packet burst. Doctors should focus instead on what is medically indicated, namely, to monitor the patient in an intensive care unit and wait for the spontaneous passage of drug packets [1,18].

Informed consent is not always a legal requirement in these cases. Nevertheless, doctors should respect body packers' moral right to informed consent when the suspect is able to make decisions. Even if there are reasons to believe that the web of misinformation, pressures and fear in which the patient-suspect is caught hampers the process of obtaining a valid consent, doctors should guarantee that all possible elements of the informed consent process are evoked [19].

Physicians are thus responsible for giving body packers well-explained, accurate and complete information. This should include explaining to the patient that in some circumstances, refusal to give consent may result in the search being carried out by a police officer rather than by a medical practitioner, and making the patient fully aware of the deadly risks of drug packets and the need to know their exact location to anticipate and prevent their splitting. Body packers should also be informed of the risks associated with the search itself, and that, due to the police involvement, the confidentiality of personal medical information might not be kept.

Consent is imperative prior to any form of examination. It should be obtained only after the patient-suspect has understood all the information and clarified his/her doubts. However, in the circumstances of detention, free consent can easily be compromised by pressures on the patient, such as a lack of privacy during an interview, by a patient's misinformed expectations, such as the hope of being released sooner in exchange for consent, or by the patient's fear that refusal would be considered a tacit confession of guilt. Guaranteeing a pressure-free environment and explaining to the patient-suspect the repercussions of consent are professional duties in these circumstances. However, preserving the physical integrity of those who could be harmed by a violent patient, and/or the integrity of the patient-suspect him/herself can of course justify non-consensual emergency medical interventions [14].

Physicians are usually asked to cooperate with the police, but this may imply breaching confidentiality in some cases. Confidentiality can be legitimately broken to avoid clear and immediate risk of harm to others that cannot be stopped by other means [15]. However, this is an exception, and when dealing with body packers, doctors can hardly take the role of police informants without betraying the basic ethics of the patient-doctor relationship.

Treating body packers: drafting guidelines

In the stressful dynamic of treating body packers, doctors might be affected by the perspective of a third party, losing sight of professional duties towards the patient-suspect. Other times, in siding with the weaker party, they may over-sympathize with their patient-suspect, putting themselves or others at risk, or jeopardizing the legal investigation.

The International Dual Loyalty Working Group has proposed some

guidelines to help physicians and institutions find their way through the maze of doubts, pressures and mixed feelings faced when dealing with patient-detainees. The recommendations include training doctors in human rights, helping them identify loyalty issues, and encouraging the exercise of clinical judgement independent of any other interest or consideration [17]. The guidelines state that military physicians' duty to care for enemy combatants "must supersede any blanket notion of loyalty, obligation, allegiance or patriotism" [13]. We do not see why it should be otherwise for body packers. The working group recommended that health care institutions keep the health profession independent of state pressures or influence, protecting health professionals from third party hostility, and increasing a proper understanding of the doctor's role among law enforcement agents and hospital administrators [17]. The working group's recommendations, along with some advice found in the literature, are a useful guide. In this paper, however, we would like to propose more specific measures that would help enact these recommendations. We believe that all conflicts of values, views and dual loyalties at the body packer's bedside are the result of third party pressures on doctors. In the context of these pressures and in seeking to shield doctors from them, we propose the following:

- To channel all police requests related to body-packer patients through the hospital's office of the director, or the office of the legal advisor, and prohibit doctors from interacting directly with law enforcement agents. The police role on the ward should be limited to the body packer's custody, in addition to the protection of other patients, doctors and health personnel.
- To keep all information regarding physicians' involvement and cooperation with police/state authorities or feedback on the way a physician has dealt with a body packer out of the physicians' individual, hospital

or any other records. Removing the threat of being labelled as uncooperative would minimize any need for physicians to consider their own self-protection.

The successful implementation of these two measures needs to be supported by the strengthening of at least two basic general strategies that might too often be taken for granted. They are:

- Having detailed and strictly implemented institutional guidelines for dealing with both detained and self-referred body packers, so that doctors do not find themselves pressured to implement their own rules. This would help prevent any disparity and inconsistencies in the way body packers are managed as patients, in legal and clinical terms, concerning their consent and treatment. It is easier for physicians to resist pressures when they are simply abiding by the rules and there is no margin for autonomous actions.
- Last, but not least, having in place a clear plan for high-security measures to be automatically triggered at the doctor's request if a suspected body packer is admitted to hospital. This would allow any unwelcome visitors related to the body packer's illicit trade to be dealt with in a safe manner.

Conclusion

Body packing is a growing global phenomenon that many hospitals may be forced to deal with sooner or later. Body packers are not a comfortable or desired presence in the hospital. They elicit fear, they invite police presence to the wards and they give rise to conflicting loyalties. Doctors may try to ameliorate the situation by yielding to their fears and to the pressures of law-enforcement authorities. However, a doctor's primary loyalty is to the body packer as a patient, and no secondary loyalty should supersede this.

Body packers as patients deserve the same respect as any other patient, and doctors would betray their professional duties if they primarily tended to interests other than those of the body packer. This implies that standards of care and confidentiality, together with the process of information and consent, should be indistinguishable from those received by all other patients in the same clinical settings. Nevertheless, doctors should be aware of when, by exception, it is morally valid to deviate from the general rules, particularly regarding matters of confidentiality.

Institutions do not usually have a specific set of guidelines to deal with body packers. There are some recommendations at the international level,

but they tend to be too general or too difficult to enact because they require the action of the state. Hospitals can, nevertheless, implement relatively simple strategies to help doctors deal in a fair and ethical way with body packers in clinical settings.

A stronger corpus of evidence on how ethics and patients' rights can be compromised in the case of body packers is still needed. We hope this article will encourage further research in this field. Systematic collection of data would raise awareness and may eventually foster higher standards of concern for patients' rights, independent of their legal predicament.

The adoption of these and other strategies should be preceded by an in-depth discussion among doctors, health care personnel and administrators to make explicit the different needs of the parties involved. We believe that this article provides a comprehensive starting point for that discussion.

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The Alcohol, Smoking and Substance involvement Screening Test (ASSIST): manual for use in primary care

The above-mentioned manual introduces ASSIST and describes how to use it in health care settings – particularly community-based primary health care settings – to identify people who are using substances and assess the health risks associated with substance use, so that a brief discussion or a referral to specialist centre can be provided as appropriate.

The ASSIST package is the result of more than 10-years work by WHO and an international group of researchers in the framework of the WHO ASSIST project. It is WHO's response to the growing demand for guidance on how to best manage problems of substance use in non-specialist health care settings. This approach is quick and easy to learn and is useful for all substances including alcohol and tobacco, and drugs such as cannabis, amphetamine-type stimulants, cocaine and opioids. Its effectiveness has been demonstrated in different cultural settings and it is set to become a keystone in the health care response to substance use.

Further information about the work of WHO in the area of substance abuse can be found at: http://www.who.int/substance_abuse/en/