Medicolegal issues surrounding body packers, pushers and stuffers

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Body packing, pushing and stuffing are methods by which individuals conceal illicit drugs for the purposes of transporting them across borders or evading police discovery. Body packers swallow drugs in rubber or latex packets for trafficking; body pushers insert drug packets into their rectum or vagina, and body stuffers swallow wrapped or unwrapped drugs to dispose of the evidence when fearing apprehension by the authorities.1

Individuals who swallow or insert illegal substances can present to the ED in a number of ways. They might self-present with acute symptoms of drug toxicity and either withhold or disclose a history of body packing, pushing or stuffing. Police might have witnessed the individual ingesting an unknown substance in the course of an arrest, or the individual might have been detained by federal police at border control sites under suspicion of drug trafficking, before being taken to an ED for investigation. These patients represent a challenging cohort of individuals for ED staff, with each scenario raising complex ethical and medicolegal questions.

The article in this issue by Mitra et al.2 highlights some of the difficulties faced by ED staff in managing cases that involve body packing. The article explores the issues of confidentiality and privacy in determining whether or not to report a suspected case of body packing to the police, and presents an argument for national guidelines surrounding mandatory reporting for medical practitioners in cases where a patient has used, or possesses, illicit drugs.

There are currently few circumstances in which the ethical and legal responsibilities of medical practitioners are completely clear-cut in the provision of medical care. In most Australian jurisdictions, mandatory reporting is only stipulated for notifiable infectious diseases, impaired medical colleagues, and cases of suspected child abuse. Yet, on a day-to-day basis, medical practitioners are called on to make significant decisions in many other common scenarios where their ethical and legal responsibilities are ill-defined. The decisions that are made at the time, with little opportunity for reflection or consultation, might unwittingly lead to legal ramifications for both the practitioner and the patient. Despite this, medical practitioners receive little training in the field of law as it pertains to medical practice. Legislation varies between States, and there is often ambiguity surrounding the interpretation and application of specific provisions. Navigating through privacy laws and legislation covering health and criminal issues can be a daunting and indescribable process.

The question of whether to report a patient who presents with concealed illicit substances is but one aspect of a much wider debate regarding duty of care, and reporting to police in cases of body packing, pushing or stuffing. Related issues include the appropriateness of acting on police requests for medical investigations, the retrieval of the drugs for evidence, and the factors surrounding patient safety and discharge planning for persons in custody.

Safety and reporting

Where the patient is believed to be concealing a traffickable quantity of drugs thereby posing a substantial risk to themselves or others, disclosure to the police is arguably justified. Where the patient appears acutely unwell, medical investigations and interventions are undeniably warranted. However, what if the safety benefits to the individual and the community become less clear? Consider the case of a body pusher or stuffer who self-presents – should those individuals also be reported to...
police? The quantities of drugs involved are likely to be on a much smaller scale, but have nonetheless been illegally obtained and concealed.

Medical investigation and intervention

What if if the police request a radiological investigation to confirm the presence of drug packets in an individual who is otherwise well and does not display any overt signs of drug toxicity? Would a medical indication for investigation exist? What if a patient refuses medical investigation? Would the threshold to investigate be altered by the availability of an imaging modality that purportedly resulted in a much lower level of radiation exposure? What if the police request an invasive examination or bowel evacuation of the suspected drug packages? Who is responsible for retrieving the evacuated packets? What if a patient refuses this?

ED environment

There are resource pressures and interpersonal factors that can influence on decision making in the ED. How long should a patient suspected of concealing illicit drugs be observed in an ED? What resources are available to hospitals and police for the adequate supervision of such patients? What if the ED was overcrowded with high-acuity patients, or the suspected body packer was a belligerent and violent individual? Would the decision to investigate or report to police be tipped in favour of expediting their discharge from the department?

There are, unfortunately, few simple answers. There is no gold standard for detecting concealed drugs, nor is there a universally accepted medical approach to suspected cases of body packing, pushing and stuffing. Some EDs have developed their own protocols for the management of these patients, but the ethical and legal issues involved prove challenging for even the most experienced medical practitioners. Therefore, in managing patients with suspected drug concealment, medical practitioners must have a clear understanding of the medical risks of concealment, the ethical principles involved, the personnel and facilities required to manage these patients in their locality, and the specific laws that govern the actions taken by police, medical practitioners and hospitals in their State.

There are a number of significant healthcare issues specific to ED presentations with drug concealment. The drugs might have been wrapped in cellophane, aluminium foil, plastic bags, or paper of variable strength and quality; often an ingestion is suspected but not witnessed; the type of drug, dose and purity is frequently unknown; patients might present with confounding clinical effects of co-ingested drugs, and there might be a prolonged time interval between concealment and onset of symptoms, making it difficult to differentiate between false claims and delayed symptomatology. In general, the more spontaneous the ingestion, the less secure the packaging and potentially greater risk to the patient of drug toxicity.

Complications of body packing

Complications of body packing include intestinal obstruction from pellet obturation, as well as the toxic risks associated with the specific types of drugs used. Leakage of stimulant substances, such as cocaine, cause acute arrhythmias, myocardial infarction and stroke, and opiate compounds, such as heroin, result in respiratory depression and coma. Acute rupture of the packages leading to inadvertent severe toxicity and potentially death from the concentrated doses of drug might also occur. Risk factors for the development of complications include improvised packaging, large total quantity of drug, high number of packets (>50), large size of packets, delayed passage of packets (>48 h), previous abdominal surgery and concomitant drug use (e.g. constipating agents).  

Ethical concepts

The foremost ethical concepts that apply to dealing with patients suspected of concealing drugs are duty of care, confidentiality and consent. Medical practitioners have an ethical and legal duty of care to their patients. Within the framework of this duty exist the prima facie principles of autonomy, beneficence and non-maleficence. In the past, it was perhaps easier to assert that all body concealers required admission to hospital for removal of drug packages to ensure that their safety and best interests were upheld. The health consequences of failure to remove the packages were severe and medical necessity justified the treatment. In recent times though, more sophisticated methods of packaging drugs for intestinal concealment have been used, and the likelihood of leakage or rupture has fallen significantly. As a result, there has been increasing recognition that asymptomatic patients can for the most part be managed conservatively. Examination of orifices for drug packets
constitutes an intimate examination and might cause considerable distress for the patient and the practitioner. Clinical investigation of suspected body concealers requires exposure to radiation, and treatment alternatives centre on the use of gastrointestinal therapies that are not without their own risks of side-effects. Additionally, the benefits of using stool softeners and motility agents remain unclear. However, a review of the problem of drug concealment conducted in the UK found that there was a medical complication rate of less than 5% in drug traffickers. This creates a disparity between the medical purpose for hospital care and the police motivation where the focus is on obtaining legal proof of drug concealment.

Legislation covering drug trafficking and forensic procedures exists under various guises across the Australian states, but the principles are similar for all. In Victoria, the legal provisions covering possession and trafficking of illicit substances, and the medical and forensic examinations of suspects are Section 71AC of the Drugs, Poisons and Controlled Substances Act (VIC) 1981. A person who, without being authorised by or licensed under this Act or the regulations to do so, possesses a substance, material, document containing instructions relating to the preparation, cultivation or manufacture of a drug of dependence or equipment with the intention of using the substance, material, document or equipment for the purpose of trafficking in a drug of dependence is guilty of an indictable offence.

and Section 464R of The Crimes Act (VIC) 1958:

A forensic procedure may be conducted on a suspect if the suspect gives his or her informed consent; or the Magistrates’ Court makes an order.

**Informed consent and confidentiality**

The doctrine of informed consent is underpinned by fundamental moral values of ensuring patient well-being and patient autonomy. The elements that render a patient’s consent (or refusal of treatment) as legally or ethically valid are competence, voluntariness, relevance and specificity. These features hold true irrespective of whether the need for consent relates to a clinical investigation, a medical or surgical treatment, or to the disclosure of information about a patient to a third party.

Confidentiality can be defined as a branch or subset of informational privacy. It prevents re-disclosure of information that was originally disclosed during the course of a confidential doctor–patient relationship. It is an implied professional responsibility that has been echoed throughout the ages, from the Hippocratic Oath, to the current Australian Medical Association Code of Ethics. Nevertheless, the concepts of confidentiality and consent are not absolute, and there are certain situations where professional duties might conflict with, and even override confidentiality. One such example is the duty to obey the law. In the situation of a body concealer in police custody presenting to an ED, legal exceptions to confidentiality and consent might arise in the form of a court order. Body concealers who have the capacity to consent have the right to refuse examinations and investigations. In those circumstances, a court order might be obtained by police to legally enforce the requirement for an examination and collection of forensic evidence. Court orders as described in Section 464 of the Crimes Act 1958 (VIC) compel suspects to have the listed procedure performed, but they do not compel the ED doctor to carry out the procedures for the police. They simply permit such procedures to be undertaken in the absence of consent without fear of legal recourse. Hence, medical practitioners should reflect further on their individual professional stance and consider the request within the ethical context of their duty of care to their patient. This illustrates the underlying conflict for ED staff between the obligation to respect the patient’s confidentiality and autonomy, and the responsibility to assist police in a law enforcement activity.

The British Medical Association and the Faculty of Forensic Medicine released a document in 2007 that outlined the guidelines for practice for doctors asked to perform intimate body searches. The consensus opinion was that ‘detained individuals who are capable of considering the issues and reaching a decision should always be invited to give consent irrespective of the fact that, in certain circumstances, consent is not a legal requirement . . . and no medical practitioner should take part in an intimate body search without that subject’s consent’.13

**Custodial setting constraints**

Emergency department staff should be aware of the availability (or lack thereof) of resources outside a hospital for the supervision and management of body packers, pushers and stuffers. There are a number of constraints in a custodial setting that limit the options for housing persons suspected of concealing drugs. The repercussions of a suspect becoming unwell while
in police custody precludes the option of detaining them in a police station or custody centre. If the person has not yet been remanded, they might not be eligible for a prison medical ward. Dedicated forensic medical facilities that can accommodate persons in custody are not available in Australia. In cases where internal drug concealment is suspected, immediate hospitalisation without attending a custody suite is essential. Concerns might follow a witnessed event, such as hand to the mouth, or if objects are seen in or around the mouth, or an admission by a detainee, or empty packages are found. In those situations, an acute medical assessment should take precedence over law enforcement procedures. Once assessed in hospital, a patient safety-based approach to discharge planning would suggest that if the drugs were wrapped in paper or single cellophane or cling film and the patient is asymptomatic at 6 h, they should be fit to be detainted in police custody. If the drugs were wrapped in condoms or double thickness membranes, or the type of packaging is unknown, then longer periods of observation in hospital of at least 24 h should be considered.

Within Australia, there is little commentary in the medical literature that addresses the medical care of persons in custody, or the relationship between ED healthcare provision, forensic examinations and law enforcement. Similarly, there is a scarcity of resources and options specifically designed for the medical management of body packers, pushers and stuffers, where forensic evidence can be collected in a safe and secure environment. Until the time that specific protocols and facilities are developed, persons suspected of concealing illicit drugs will continue to present to EDs for investigation and treatment. The principles of management for medical practitioners should be to respect and communicate their medical and ethical duties at all times, to both the patient and the attending law enforcement officers, and endeavour to be vigilant and prepared in the event that a complication does occur.

Back to the question of whether to report a body packer who self-presents to an ED. Mitra et al. refer to published opinion that many health professionals would argue physician–patient confidentiality should not be breached solely on the amount of illicit drugs involved. A physician who fails to inform police of a suspected crime by a patient might be found guilty of concealing a crime or other similar offence, yet there is no Victorian statute or provision that requires individuals to report suspected crime.

Introducing nationally consistent legislation

The concept of introducing nationally consistent legislation for reporting might be useful for clear cases of body packing in the setting of drug trafficking. However, there will remain a significant proportion of drug-related hospital presentations that will not fit easily within such a protocol. When faced with the seemingly opposing medical and legal objectives of care in an ED, there will continue to be questions regarding a medical practitioner’s responsibilities and duties in the management of body packers, pushers and stuffers. As such, each patient should be assessed on an individual basis with reference to the medical, ethical and legal aspects of that case.

Competing interests

None declared.

References


