Australian Asylum Law: Advocacy in Medicine

Andrew Hawkins

ABSTRACT

In the United States since the 1970s, formal ethical guidelines make it a professional obligation for healthcare institutions to protect the human rights of patients. The legal system in Australia currently lacks these safeguards. The concern of this paper will be to define these professional responsibilities with respect to medical ethics in an effort to understand public policy and its direct effects on human health.

Keywords: bioethics, autonomy, confidentiality, human rights, policy

INTRODUCTION

The International Bioethics Retreat, hosted by Cambridge University Press, brings together the leading bioethics experts for a three-day discussion of the most pertinent issues in healthcare, technology, and public policy. There, I had the pleasure of meeting Dr. Deborah Zion, an associate professor at Victoria University and Clinical Ethics Professor at Deakin Medical School, whose primary focus in the past decade has been assuring human rights for asylum seekers and government accountability in Australia.

In the United States since the 1970s, formal ethical guidelines make it a professional obligation for healthcare institutions to protect the human rights of patients. The legal system in Australia currently lacks these safeguards. From a policy standpoint, asylum law raises issues concerning medical ethics and the limits of professional obligation. Zion argues that it is "an intrinsic conflict between the desire to provide appropriate care, and the compromising of this by supporting a pathological system."[1] The concern of this paper will be to define these professional responsibilities in an effort to understand public policy and its direct effects on human health. Certainly, this will broaden the scope of our current understanding of bioethics with regard to the patient-physician relationship. The traditional concept of bioethics, which stems from the "Georgetown Mantra" in Tom Beauchamp and James Childress's *Principles of Biomedical Ethics*, is that patient autonomy and confidentiality are to be respected throughout the healthcare process.[2] It is quite evident, however, that this argument is limited to the legal structures present in the United States. A novel concept that bypasses this constraint is *relational autonomy*, the idea that autonomy is socially dependent and that relevant contexts such as political structures are what allow for the exercise of this right. Indeed that is why an analysis of policy history is so pertinent.

An adequate rendering of how human rights are either supported or neglected in legal structures is necessary to guide reform. Bioethics cannot truly exist in isolation from questions of social justice. Severe deprivation of human rights is linked to poor health outcomes. Recent asylum-seeker research has suggested an association between time in detention and mental health. In three US states, 70 percent of detainees reported

© 2015 Andrew Hawkins. This is an open access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction, provided the original author and source are credited.

that their mental health had worsened in detention with a significant correlation between length of time in detention and levels of anxiety, depression, and post-traumatic stress disorder.[3] How does an understanding of an inherent relationship between policy and health outcomes shape the responsibilities of healthcare providers for these vulnerable populations? Professional obligations must be expanded into the realm of advocacy.

I. LEGAL AND POLICY HISTORY

Those seeking asylum from violence or persecution from countries beset by sectarian conflict and persecution such as Afghanistan, Iraq, Iran, and Myanmar are imperiled by Australia's immigration policy. Migrants are labeled "unauthorized boat arrivals" by Australian media, and politicians campaign on narrow slogans (i.e. "stop the boats)."[4] Both contribute to a culture of prejudice. Violation of human rights, arbitrary incarceration, and reported harm to health in relation to this policy is deeply rooted in Australia's political past. Under Australia's Migration Act, which was adopted in 1992 by the Australian Labor Party government, any "unlawful non-citizen[1] is to be detained, regardless of circumstances, until they are granted a visa or leave the country."[5]

The present crisis stems from strict immigration policy forwarded by former Prime Minister John Howard after his administration responded to popular xenophobic sentiments in 2001.[6] Commonly known as the "Pacific Solution," the introduced regulations excised offshore detention centers on the islands of Manus, Papua New Guinea (PNG), and Nauru from the Australian migration zone. All those landing on Australia proper would be sent to these centers for "offshore processing" so that no individual would gain an advantage over those already waiting in the camps. Asylum seekers could be deprived of work, access to health care, and the ability to apply for their families to join them in detention because their location was not within Australian territory. These regulations successfully evaded an international obligation to the United Nations Convention Relating to the Status of Refugees and facilitated the violation of many of its precepts against maltreatment, including mandatory detention, detention of children, and indefinite detention.[7] That is, asylum seekers have the option to leave detention centers and must be processed in a timely manner. In 2008, the detention centers in Nauru and PNG were closed following a report released by the UN Arbitrary Detention group that cited inhumane conditions.[8]Prime Minister Tony Abbott (of the Liberal Party), facing political pressure to avoid "softness" on "illegal maritime arrivals," reopened these detention centers in 2013, after which all asylum operations were placed under military control.

II. UNCERTAINTY, NEGLECT, AND HEALTH OUTCOMES

A 2013 report released by Amnesty International detailed the conditions at offshore detention centers visited by researchers.[9] It noted that detainees are housed in a "hodgepodge of World War II-era buildings and newer units, many of which are assembled from converted shipping containers. These accommodations offer almost no natural light, fresh air, or personal space." Other flagrant abuses include isolation of detainees from family and friends due to lack of access to phones and internet, families queued in the sun for hours at the Nauru facility for meals, and excessive use of force in a manner described as "prison-like." A nurse named "Elizabeth" (changed for privacy) described conditions at the Curtin detention center as follows:

There was nowhere that you could ever not be viewed by guards, where you could get privacy, where you could ever sit quietly, where you could have a private conversation with somebody (or where you could have a row with somebody). For a family not to be able to have a good argument, for a parent not to be able to talk to a child, to discipline a child, or have anything for intimacy... There was nothing. Even as a nurse there was nowhere where I could sit and have a chat to a patient. There was nowhere I could sit with a group of women and just have a chat, where people weren't watching and listening.

According to asylum seekers, the most damaging effect of internment is the uncertainty about how long they will remain in detention, whether they will be resettled in Papua New Guinea instead of Australia, and if they can safeguard their families' well-being. These are the same individuals who have escaped torture and ill treatment prior to attempting their journey to Australia who are now subjected to additional psychological distress. In August

2014, 190 experts signed a "j'accuse" statement citing "clear evidence that it [current asylum policy] causes psychiatric disorders, self-harm and suicide."[10] Furthermore, it states that the current policy violates the rights of children by "exposing them to violence, trauma and to poor medical and psycho-social care, with no access to independent monitoring." The evidence is clear that the "inherently toxic" conditions in these detentions centers are harmful to detainees' physical and mental health. [11] The bottom line, according to Dr. Zion, is: "if a person has not committed a crime, it is a serious violation of basic human rights to incarcerate them…it's a human rights abuse to incarcerate someone who is seeking to be protected."[12]

According to Dr. Peter Young, the former Director of Mental Health at the International Health and Medical Services, a third of asylum seekers are identified as having a significant mental disorder; whether those diagnoses originate from treatment while in detention cannot be confirmed. Psychiatric mitigation and treatment are often unsuccessful because the causes of disorder are from the environment rather than the individual. A study published in 2009 that analyzed the detention health database held by the Australian Department of Immigration and Citizenship found a correlation between incidence rate of mental health problems and reason for, and time in, detention.[13]Researchers, however, have not gained sufficient access to gather longitudinal data to confirm these assertions.

Objective information regarding the effects of detention is needed to challenge government claims about safety but the data collection itself produces ethical concerns. Issues of medical ethics and patient rights in refugee research abound. Jacobsen and Landau argue that research into asylum seekers and other populations is only justifiable if the results obtained contribute to an abatement of their suffering.[14] Zion acknowledged that the process of rigorous data collection in coercive settings might pose a threat to detainee informed consent. These studies are often conducted by social workers who are also intimately involved in the provision of services that refugees rely upon. Individuals and families in detention centers must provide informed consent without coercion or while under duress—a difficult ethical dilemma to avoid when subjects are incarcerated. One key study conducted by Zachary Steel elucidated psychiatric status of asylum seeker families in Australia's remote facilities.[15] The group supported the objectivity of the patient's response by conducting interviews independent of the private corrections company through the detainee's legal worker. Detainees provide information to researchers in anticipation of it being used to improve their situation. However, patient advocacy is often not the purpose of these observational refugee studies and participants feel that their information is treated like a commodity. A refugee explains: "We are really fed up with people just coming and stealing our stories, taking our photos and we never get anything back, not even a copy of the report. Nothing ever changes".[16]. How can research be structured as a reciprocal relationship where information gained by researchers is equally balanced by the potential benefits for participants? The utilitarian point of view that patients suffer risks for the benefit of future patients, which is associated with the biomedical model does not promote social justice in detention centers. A suitable alternative known as the participatory, relational model recognizes that capacity for consent is affected by social context and seeks to provide tangible benefits for partipants.[17]

III. ETHICS OF REFUGEE RESEARCH

There are issues linked to vulnerability and exploitation in researching the health conditions of asylum seekers. This returns to the classic concept of informed consent and whether basic rights in such a deprived environment can be upheld. Deborah Zion argues that autonomy requires rationality and freedom for its exercise, both of which are often absent in protracted displacement situations.[18] The solution may necessitate a redefinition of the clinical contract that extends beyond "do no harm" to a position of patient advocacy. Doctors serving asylum seekers in remote detention centers where public disclosure is limited are a critical source of unbiased information concerning detainee safety. Zion argues that a less formalized research practice that involves gathering information from advocates and medical and nonmedical professionals can mediate the issues of false hope and the powerful incentive to participate while in detention.[19] When a patient's illness is derived from an

unhealthy environment enforced by political factors, it is the duty of the clinician to advocate against maltreatment. An expansion of physician duties is the next logical step.

The Australian Border Force Act, enacted on July 1st, 2015, makes it an offense for an "entrusted person to make a record of or disclose protected information."[20]A violation can result in up to two years of imprisonment and the burden of proof rests upon Border Force health workers to prove that the disclosure was necessary to prevent a threat to the health of an individual. This legislation prohibits healthcare workers who treat asylum seekers from providing essential information due to fear of retribution and counteracts the alterative research techniques previously described. Despite possible conviction, a group of forty current and former workers at Australia's detention centers on Nauru and Manus Island challenged Tony Abbott and Peter Dutton to prosecute them under new secrecy laws.[21] The immigration situation in Australia is at a serious crossroads that requires an increase in the public's political awareness. That is why it is critical to discuss the conditions that asylum seekers face and support repeal of legislation that prevents healthcare professionals from assuming advocacy roles.

CONCLUSION

A coherent resolution to the problem in Australia requires further discussion that would be far too extensive for the purposes of this article. However, the United States must acknowledge the mistakes made in public policy in Australia and take steps to avoid a similar tragic situation. There exists growing xenophobic sentiments in the United States, as evidenced by current Republican presidential candidate Donald Trump's recent remark, "When Mexico sends its people, they're not sending their best...They're bringing drugs. They're bringing crime. They're rapists."[22]While the United States has a slightly less harsh immigration policy than Australia's, this type of rhetoric can engender such governmental injustice. Since 2014, the Obama administration has supported the expansion of family detention centers on the US border with Mexico as a deterrent for asylum seekers. A private corrections company, Corrections Corporation of America, managed a 2,400-bed facility in Dilley, Texas—unnervingly similar to offshore detention centers in Australia. Human Rights Watch documented that "indefinite detention of asylum-seeking mothers and their children in the United States takes a severe psychological toll".[23] On July 24th, 2015, however, a United States District Court ruled that the US government may not detain children and their parent(s), and mothers and children who are not deemed a security risk are to be released. Fortunately, the ideological interests supporting an immigration detention regime were stopped in this case.

The specifics of the immigration policies in both Australia and the United States are important to an ethical discussion of our treatment of these vulnerable individuals. Although these are unseemly, complicated issues, it is essential for those in the medical field to be engaged in them. According to the American Public Health Association, "Public health should advocate and work for the empowerment of disenfranchised community members."[24] Thus, the dissemination of crucial information and publicly denouncing harmful rhetoric are important responsibilities for the medical community. Physicians must be prepared to deal with a greater scope of practice and must adopt an activist stance besides providing individual care. This may be the only means of improving the health of vulnerable populations.

---

[1] Person who is not an Australian citizen and does not have permission to be in the county

[1] Zion, D. (2004) Caring for detained asylum seekers, human rights and bioethics. *Australian and New Zealand Journal of Public Health.* Vol. 28 No. 6

[2] Beauchamp T, Childress J. (1989) Principles of Biomedical Ethics, *Oxford University Press.* 3rd edition

[3] Acer, E., & Chicco, J. (2009). *US Detention of Asylum Seekers: Seeking Protection, Finding Prison*. Human Rights First.

[4] Price, M. E. (2009). *Rethinking asylum: history, purpose, and limits* (pp. 157-8). Cambridge University Press.

[5] Migration Act 1958.https://www.comlaw.gov.au/Details/C2012C00331

[6] Magner, Tara. (2004) Less than pacific solution for asylum seekers in Australia. Int'l J. Refugee L. 15, 53

[7]Convention and Protocol Relating to the Status of Refugees http://www.unhcr.org/3b66c2aa10.html

[8] A more comprehensive timeline of the history of Australia's Refugee and Humanitarian Program can be found here:http://www.asrc.org.au/resources/statistics/detention-and-refugee-statistics/ .

[9] This is Breaking People. Human Rights Violations at Australia's Asylm Seeker Processing Centre on Manus Island (2013). Amnesty International.http://www.amnesty.org.au/images/uploads/about/Amnesty_International_Manus_Island_report.pdf

[10]J'Accuse Statement: Convened by *Professor Louise Newman AM.*https://d68ej2dhhub09.cloudfront.net/825-J'accuse_Open_Letter.pdf

[11] Marr, David. Laughland, Oliver. Australia's detention regime sets out to make asylum seekers suffer, says chief immigration psychiatrist. *The Guardian.*http://www.theguardian.com/world/2014/aug/05/-sp-australias-detention regime-sets-out-to-make-asylum-seekers-suffer-says-chief-immigration-psychiatrist

[12] Interview with Deborah Zion, an academic from the International School of Public Health at Monash University, Melbourne, about Australia's treatment of refugees and asylum seekers.https://www.youtube.com/watch?v=Ysks5vJRfSo

[13] Green, J. P., & Eagar, K. (2010). The health of people in Australian immigration detention centres. *Med J Aust*,*192*(2), 65-70.

[14] Jacobsen, K. and Landau, L. B. (2003) 'The dual imperative in refugee research: Some methodological and ethical considerations in research on forced migration',Disasters, 27(3), pp. 185–206.

[15] Steel X. Momartin S. et al. (2004) Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. Aust N Z J Public Health 28:527-536

[16] Pittaway, E. Brtolomei, L. (2003). Women at risk field research report: Thailand. *Centre for Refugee Research,* University of New South Wales.

[17] Hugman, R., Pittaway, E., & Bartolomei, L. (2011). When 'do no harm'is not enough: The ethics of research with refugees and other vulnerable groups. *British Journal of Social Work*, *41*(7), 1271-1287.

[18] Zion, D. (2005). Does autonomy require freedom? The importance of options in international HIV/AIDS research. *Health Care Analysis*, *13*(3), 189-202.

[19] Zion, D. (2004). Caring for detained asylum seekers, human rights and bioethics. *Australian and New Zealand journal of public health*, *28*(6), 510-512.

[20]http://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r5408

[21] Open letter on the Border Force Act: 'We challenge the department to prosecute'. *The Gurdian*. June 30 2015. http://www.theguardian.com/australia-news/2015/jul/01/open-letter-on-the-border-force-act-we-challenge-the-department-to-prosecute

[22] https://www.washingtonpost.com/blogs/fact-checker/wp/2015/07/08/donald-trumps-false-comments-connecting-mexican-immigrants-and-crime/

[23] US: Release Detained Migrant Children, Mothers. (2015, July 27). Retrieved August 5, 2015.https://www.hrw.org/news/2015/05/15/us-trauma-family-immigration-detention-0

[24] Thomas, J. C., Sage, M., Dillenberg, J., & Guillory, V. J. (2002). A code of ethics for public health. *American Journal of Public Health*, *92*(7), 1057-1059.