

# Health care in custody: Ethical fundamentals

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**Abstract** German and French abstracts see p. 149

A trustful doctor-patient relationship is central in clinical medicine. This partnership is particularly important for the provision of equitable care to vulnerable populations. It is critical not only to the patient, but also to the physician and his/her management goals, and especially critical towards the public health of the community as a whole. However, the doctor-patient relationship is put under pressure within the provision of health care systems that exist in the detention setting. Institutional challenges such as conflicts of dual loyalty, administrative limitations, and financial restrictions can act as barriers against quality health care in prison. On the relationship-level, mutual understanding and communication is rendered challenging secondary to patient characteristics such as language and cultural differences.

This article reviews health care in custody, in light of the following biomedical ethics principles: 1. Autonomy, 2. Non-maleficence, 3. Beneficence, and 4. Justice. These parameters are then used to analyse barriers to the seven fundamental principles of prison health care, which we discuss here: 1. access to a doctor, 2. equivalence of care, 3. patient consent and confidentiality, 4. preventive health care, 5. humanitarian assistance, 6. professional independence and 7. professional competencies. Non-adherence to any of these principles is a barrier to a functional doctor-patient relationship and leads to low quality health care in this setting. This review summarises why these fundamental principles should be incorporated into all national policies, worldwide.

**Keywords:** ethics, prison, detention, jail, prison health care, human rights

## Introduction

Prisoners represent an underserved, vulnerable population. Vulnerability can be defined as an increased likelihood of incurring additional harm or greater prejudice [1]. Truly, prisoners are by nature, vulnerable patients, given the stresses and trauma of their daily confinement to an institutional living situation. But as well, the prison setting is often an endpoint for many groups with specific lifetime risk factors for poor health – frankly speaking, it is a place where vulnerable people end up. Prisoners frequently have limited access to healthcare due to social and economic disadvantages, family dysfunction, high rates of school dropout and lack of appropriate support in the early years of life [2–5] The accumulation of these negative social determinants of health explain why detainees have such a high burden of disease [4, 6–9]. This disadvantage continues even after release into the community. One study found

that the risk of death among former inmates was 12.7 times higher than that of non incarcerated residents during the first two weeks after release, with a markedly elevated relative risk of death from drug overdose [10].

The detention setting has been identified as a significant opportunity to address the health needs of vulnerable groups. Modern prison health services should aim to reduce inequalities by providing a range and quality of health care equivalent to that available in the community, according to the principles outlined by the Council of Europe [11] This article will highlight the ethical aspects of medical management in custody with special attention to the doctor-patient relationship (one important aspect of provision of health care in prison), which is at the centre of this issue.

## Doctor-patient relationship in custody

Physicians must aim «to help and do no harm»; this was Hippocrates's essential message when he developed the theory around the inevitable link between clinical care and ethical duty in third century BC. The Hippocratic work *On the Physician* recommends that physicians always be «well-kempt, honest, calm, understanding, and serious» [12].

Until the second half of the twentieth century, the doctor-patient relationship was dominated by a paternalistic model of health care delivery, comparable to an adult-child relationship in which the doctor decides what he/she thinks is best for the patient [13]. Nowadays, a model of shared decision making is predominant, meaning that the physician provides the necessary information, allowing the patient to make his/her own decision, thus achieving autonomy in the management of his/her own health [13].

The doctor-patient relationship is always a delicate dance, particularly if the physician and the patient are of different ages, sexes or come from different socio-cultural backgrounds [14]. All these factors may render communication more challenging. The relationship, which ideally consists of two partners meeting at the same level, may develop into one where one partner possesses the medical knowledge (doctor) and the other (patient) feels incompetent and obeys whatever the knowledge-holder wants. This is particularly true in the context of institutionalisation or, as described by Goffman: a total institution [15]. Prisons are considered total institutions because they disrupt the barriers that

usually separate the main spheres of life (sleep, eat, play and work). As well, the total institution (prison) organises all detailed aspects of daily living for its inmates, generally in a bureaucratic manner, carried out in the company of a large group of individuals, companions who were not chosen by the inmate [15]. Such settings may seriously harm the personality of the inmates and lead to the loss of self-identity and the feeling that time spent in custody is wasted time.

Within such a difficult context, health services play an even more important role for these patients. A trustful doctor-patient relationship is critical not only for the patient, but also for the satisfaction of the treating physician, and even for the community as a whole (particularly when dealing with vulnerable populations). In the custody setting, this important relationship is under pressure for several reasons. In pretrial environments where many detainees are of foreign origin, doctor-patient understanding and communication are complicated by language and cultural barriers. Furthermore, conflicts of dual loyalty as well as administrative and financial restrictions worsen quality of health care in custody [14; 16]. Providers of health care working under these forces must integrate elements of ethical reflection and questioning into their daily work, paying special attention to medical management and drug prescription.

## Principles of biomedical ethics and treatment in custody

Four key ethical principles are generally used to guide bioethical decision making [17]: We then discuss these in context of the barriers to the fundamental principles for health care in custody.

### 1. *Autonomy*

Abiding by the principle of autonomy is a cornerstone in medical decision making [18]. At minimum, this requires the ability of the patient to make a decision independent of outside pressures, and to understand the indications and risks of treatment, in order to make the most meaningful choice. A prerequisite for autonomous decision making is for the individual to display the capacity to receive, retain and repeat the information that she/he is given. The information must be complete and communicated in a manner in which the patient can understand. This enables the patient to process the information according to his/her own beliefs and convictions. An autonomous decision should never be overruled by a health care provider.

### 2. *Beneficence*

The term *beneficence* connotes an act of mercy, kindness or charity, and is understood to include all forms of action intended to benefit or promote the good of other persons. The duty to do good is central to the role

of health care professionals. They seek out action for the good of the patient, not limited to medical interventions but broadened to encompass all aspects of social, psychological and physical well-being [19].

### 3. *Non-maleficence*

«Primum non nocere»– «first do no harm», captures the principle of non-maleficence. Medical interventions can have dangerous side effects, and for some patients, these effects may prove fatal. A careful risk-benefit analysis needs to be developed for every intervention. Each physician should thoughtfully consider the potential positive and negative effects that the intervention may confer. As is done with medical practice taking place outside the detention setting, the physician should deliver professional and competent service through evidence-based practice, upholding the same standards.

### 4. *Justice*

The principle of justice is defined by the moral obligation to act on the basis of fair adjudication between competing claims. Thus, it is linked to fairness, entitlement and equality. In regards to health care ethics, this concept can be subdivided into three categories: fair distribution of scarce resources (distributive justice), respect for people's rights (rights-based justice) and abidance by morally acceptable laws (legal justice) [20]. In the medical setting, justice translates into the allocation of health care resources in a fair way. Fair allocation may be encompassed by the goal of equal distribution (egalitarianism), or it can be approached as a way to maximise the total or average welfare across the whole society (utilitarianism) [21]. Fairness, however, requires restraint on the part of individuals or groups who aim to take more than their «fair share». When health care budgets are limited, the issue of justice towards patients is an important and controversial one. The just distribution of health care services may be threatened by the perceived scarcity of resources in the prison setting. And although these institutional issues are often outside the scope and control of the individual physician, the provider nevertheless works under the force of these monetary pressures.

Because these four bioethical principles are essential elements in clinical medicine, they were integrated into the seven fundamental principles of health care in custody by the council of Europe and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) [11, 17, 18, 22, 23]:

These seven principles must be routinely applied to clinical practice. Penal Reform International delineates this precondition in the following way: «Confidence of prisoners in the health care of a prison can only be obtained if it is known to everyone in the prison that for a prison physician, nurse or health care worker, the patient has to have, and indeed has priority over order, discipline or any other interests in the prison» [24].

Access to a doctor	Detained persons shall have unrestricted access to medical care, without discrimination regarding their legal situation
Equivalence of care	Medical care in prison should be equivalent to that provided to the general population in the same region
Patient consent and confidentiality	The detained person must give informed consent prior to treatment and patient confidentiality must be strictly observed
Preventive health care	The detainee has the right to health education and preventive health measures
Humanitarian assistance	Vulnerable groups in custody such as women, older inmates, and ethnic or cultural minorities need protection and assistance by health professionals
Professional independence	Health professionals who are in charge of a detained person must be able to treat their patient independently of the judicial and prison hierarchies that govern the institution
Professional competence	Health professionals in charge of a detained person must have professional competence and training

Table 1: Fundamental principles for health care in custody [23].

To reiterate, these principles must be applied because these patients are at great risks in terms of their life-course well-being. The vulnerability of detained persons is two-fold. As described above, it is explained by the lifetime disadvantage of the detainees, and as consequence, vulnerable populations are more likely to be imprisoned. Secondly, the vulnerable status relates to the confined environment (as described by Goffman) which amplifies already-existing disparities.

### Barriers for the implementation of the fundamental principles in custody

Today, physicians aim to provide competent and accessible care, preserve confidentiality and to communicate honestly and compassionately. So, which are the barriers against the application of these virtues and these fundamental principles when working in a detention setting?

#### Cost, lack of independence and dual loyalty

Prison doctors are generally employed by judicial or penitentiary authorities. These governing individuals sometimes place pressure on the physician to limit use of expensive interventions or treatments for patients. This is particularly true in the case of hepatitis C therapy, a proven cost-effective therapy for a highly prevalent problem in custody (up to 30–40% of detainees have hepatitis C) [8, 25, 26]. Depending on the geno-

type, medication costs for one patient can run up to 75 000 \$ which places stress on the medication budget of detention centres. Even when such treatment is medically indicated (and as such, care should be given to the patient according to the principle of equivalence) and in the community would be covered by most health insurances, a prison doctor’s decision about treatment could still be influenced by cost in a dual loyalty scenario. If doctors are employed directly by prison authorities, they find themselves in this conflict: should he/she be solely loyal to the patient and prescribe the treatment despite the expenses (adhering to medical ethics), or should there be some loyalty to the employer (the prison or justice administration) by giving considerations to the medication budget and tailoring treatments because of costs? Such conflicts touch upon the basic ethical principals of beneficence and non-maleficence. This example also illustrates how the quality of the individual doctor-patient relationship can still be affected by institutional factors, on the health system level.

#### Lack of autonomy

*a. No autonomous choice of the health care provider*  
Autonomy is generally limited in prison and from the ethical point of view, one can of course question whether an imprisoned patient, who generally does not have the choice of health care provider, is really autonomous in his/her decision to follow the therapeutic advice of a physician he/she did not select. In general, detainees simply don’t have this choice. Particularly in small detention centres where one may find only one general practitioner, this limitation further limits autonomy within the doctor-patient relationship. As a consequence, the quality of health care as well as the public health security of the whole detention centre and the surrounding environment is threatened.

#### *b. No self-medication*

Detainees have high morbidity, and so, many drugs are prescribed to these patients while in custody [8, 9]. Given provider caution against drug abuse (particularly of psychotropic drugs), self-medication is usually forbidden in detention. Prisoners therefore have few opportunities to resort to self-care and are more likely to request medical help even for simple complaints [27].

#### Lack of confidentiality

Confidentiality problems frequently arise in detention. Health professionals guard confidential, and sometimes troubling information, about their patients, and prison authorities may put inappropriate pressure on providers to reveal this information. In terms of confidentiality about patient diagnoses, some treatments and/or disease presentations may make it rather simple, even for a lay person, to figure out the diagnosis (e.g. medication for HIV or other viral infectious diseases). Also, when prison officers distribute drugs, this

potentially damages a trustful doctor-patient relationship. Patients might withhold important information from providers for fear of being stigmatised by prison officers, other prisoners, and anyone else in the prison setting because of their illness.

#### **Lack of Communication Resources**

Language barriers are associated with poorer quality of care and lower patient satisfaction [28]. Furthermore, health care providers overestimate their self-assessed competency in working with an interpreter [29]. Detention centres, particularly in pretrial detention, have a high burden of allophonic patients, meaning that they do not speak the language of the region. For example, in Geneva, Switzerland, 92% of the inmates were of foreign origin in 2007, with more than one hundred different nationalities [9]. Therefore it is disconcerting to observe that professional translation services are not available in the majority of detention centres, even in the richest countries. These language and communication issues intersect with central ethical principals like autonomy: the patient does not fully own his/her decision if he/she is not able to understand the information given. Beneficence and non-maleficence are also implicated in these settings as the health care provider may make decisions without thoroughly understanding the clinical picture. Finally, the principle of justice comes into play in these scenarios as misunderstandings secondary to the lack of cost-effective and proven resources that improve communication (such as interpreters) may lead to long, incorrect and misled clinical investigations. These types of mistakes represent preventable drains on the prison budget, representing money that could have been put to better use elsewhere.

#### **Medical knowledge and training**

Health care providers in detention centres need specific training competencies in therapies addressing clinical complaints in infectious disease, addiction medicine, psychiatry and other common problems in primary care (skin, musculoskeletal, trauma/injury, digestive, respiratory issues) [8, 9]. Most countries lack a training curriculum which addresses the specifics of providing health care for patients while in institutional detention. In some countries, particularly where the stewardship of prison health care is under the auspices of the Ministry of Justice, postgraduate training is not mandatory for physicians who work in custody. Furthermore, in those settings, public health strategies and improvements are less connected with detention health services. Because of this fragmentation, continuity of care deteriorates for patients that are imprisoned [30].

#### **Access and equality of care**

Access to a physician is the first of seven fundamental principles of health care in custody (table 1). Unfortu-

nately though, countries are regularly convicted by the European Court of Human Rights for inhumane or degrading treatment violations, stemming from a lack of prisoner access to health care during detention [31]. For example, in Switzerland, 113 prisons exist for 6065 detainees, serving an average of 50 prisoners per detention facility [32]. Because smaller facilities in some of the cantons do not have doctors or nurses coming in every day, this conflicts with the European Prison Rules, which state that systematic health screening for every incoming detainee should happen within 24 hours [22]. Thus even in one small country, equal access to health care and uniform organisation among prisons is problematic [33]. These issues are only magnified among larger and more complicated national systems.

Disparities in health service access have important therapeutic consequences. For example, opiate substitution therapy (OST) is available worldwide in 77 countries, but this is offered in the prisons of only 41 of these countries [34]. It is also crucial to note that the presence of OST in prison in one country does not translate to its availability in every detention centre of that country. The situation is even more dramatic concerning needle and syringe exchange programs (NSP). While this strategy is available worldwide in 86 countries, only 10 of these countries permit the program in detention settings [34]. Furthermore countries with NSP in detention rarely disseminate the service broadly: for example, although Germany counts as one of the countries with NSP in prison, the service exists in only one institution.

Variable prison care standards are also brought to light with the example of bodypacking (individuals who are arrested for trafficking drugs in their bodies). This is a serious medical emergency that can lead to devastating and possibly fatal clinical consequences. The evidence shows that hospital management of body packers reduces the risk of clinical complications [35]. However, not all care institutions abide by these best practices. While some Swiss cantons (eg. Geneva, Bern) ensure that all body packers are routinely hospitalised until the expulsion of all the packets, there are other cantons (eg. Zurich) that do not implement such medical surveillance. Thus, these examples illustrate a major problem, when prison care, even in a small country, inconsistently adheres to the principle of equivalence of care for health provision [33].

#### **Solutions**

Health care in custody is complex, and health services in these settings need to be better prioritised by governments all over the world. Given the numerous challenges (systematic, patient level) that physicians are up against in treating these vulnerable patients, the seven fundamental principles of prison health care (table 1)

should be incorporated into the legislation for prisoner rights of all countries. Measures should be taken to ensure strict adherence to these guidelines. Ignoring these principles or an unawareness of their importance is a barrier to the trustful doctor-patient relationship – an aspect of health which is at the core for the provision of high quality medical care for patients detained in prison. We highlight the following take-away points, based on the seven principles:

Confidentiality must be respected. Health care should be organised in a confidential manner only involving professionals who are health care providers, or part of the patient's medical management team (nurses, pharmacists, therapists, etc.).

Communication and partnering with allophonic patients can be improved by augmenting the availability of trained professional interpreters. It has been shown that the use of professional interpreters reduces medical errors and facilitates doctor-patient understanding. This has a favourable impact upon service utilisation, clinical outcomes and patient satisfaction [36]. Better communication leads to a better doctor-patient relationship, which is crucial to the improved health of patients in detention.

Health care centres in prison need to be better integrated into national and global public health strategies. When prison health care centres are well-functioning and well-connected, they become important care centres for hard-to-reach populations (e.g. drug users who have high morbidity and mortality). Health care policies focusing on prison health prevention and treatment will have a beneficial impact on the public's health and also on the health care resources of the general community.

Finally, a crucial point relates to the stewardship of prison health centres. In order to achieve the principles outlined in this review, it is recommended that stewardship be transferred from the Ministry of Justice to the Ministry of Health. Some example countries who embody this strategy are Norway, France, United Kingdom, New South Wales in Australia, and Geneva, Vaud and Valais in Switzerland. The 2012 Geneva Declaration on prison health care suggests a 3-step approach to achieve the goal of professional independence [37]:

1. Expand training and available information, particularly in the fields of medical law and ethics, of all personnel involved in prison health issues, in order to:
  - a. Better identify situations of dual loyalty and therefore improve care management with the best interests of the patient in mind, not those of the institution.
  - b. Clarify roles and missions of all professional bodies working in the prison towards patient health, in order to foster mutual respect.
2. Strengthen the involvement of supervising health care authorities, professional societies and medical ethics committees.

3. Separate judicial and penitentiary tasks from health care issues; place the latter under the sole responsibility of the health authority.

## Conclusions

Provision of health care in custody, and particularly, the doctor-patient relationship are under pressure within the detention setting. Variable and inconsistent organisation of prison health care by countries is unethical and is a detriment to these vulnerable patients. Respect for the seven fundamental principles of prison health care should be incorporated into national policies and legislations, worldwide. The improvement of these patients' health care translates into an elevation of human rights for a vulnerable population.

**Conflict of interest:** None to declare

## Zusammenfassung

### Gesundheitsversorgung im Gefängnis: ethische fundamentale Prinzipien

In der klinischen Medizin ist ein vertrauensvolles Arzt-Patienten-Verhältnis von zentraler Bedeutung. Besonders wichtig ist dieses Verhältnis hinsichtlich eines fairen Zugangs zur Versorgung speziell für Angehörige vulnerabler Gruppen. Es ist nicht nur für den Patienten, sondern auch für den Arzt bzw. die Ärztin und dessen bzw. deren Managementziele wesentlich, ganz besonders mit Blick auf Belange der öffentlichen Gesundheit. In der Gesundheitsversorgung unter Haftbedingungen steht dieses Arzt-Patienten-Verhältnis unter besonderem Druck. Institutionelle Herausforderungen wie Loyalitätskonflikte, verwaltungsmässige oder finanzielle Grenzen können eine qualitativ hochstehende Gesundheitsversorgung im Gefängnis behindern. Je nach Charakteristika eines Patienten können zudem auf der Beziehungsebene das gegenseitige Verstehen und die Kommunikation zu einer Herausforderung werden, insbesondere hinsichtlich der Sprache und kultureller Differenzen.

In diesem Artikel wird die Gesundheitsversorgung unter Haftbedingungen im Lichte folgender Prinzipien der biomedizinischen Ethik reflektiert: 1. Autonomie, 2. Nicht-Schaden, 3. Fürsorge und 4. Gerechtigkeit. Diese Parameter werden anschliessend benutzt, um die Barrieren zu den sieben fundamentalen Prinzipien der Gesundheitsversorgung im Gefängnis zu analysieren: 1. Zugang zu einem Arzt, 2. Gleichwertigkeit der Versorgung, 3. Zustimmung des Patienten und Vertraulichkeit, 4. Prävention, 5. humanitäre Unterstützung, 6. berufliche Unabhängigkeit, 7. berufliche Kompetenzen. Das Nichteinhalten eines dieser Prinzipien bildet ein Hindernis für eine funktionierende Arzt-Patient-Be-

ziehung und führt zu einer niedrigen Behandlungsqualität in diesem Bereich. Der vorliegende Beitrag zeigt im Überblick, warum diese fundamentalen Prinzipien weltweit in alle nationalen Politiken integriert werden sollten.

## Résumé

### Les soins de santé en prison: principes éthiques fondamentaux

Une relation de confiance médecin-patient est absolument indispensable en médecine clinique. Cette relation est particulièrement importante dans le cadre de l'offre équitable des soins aux populations vulnérables. Elle est importante pour le patient, mais aussi pour le médecin et la réalisation de ses buts, et plus spécialement la réalisation du but de santé publique. Cette relation est plus particulièrement mise à l'épreuve dans le cadre de l'offre de soins dans les établissements pénitenciers. Des difficultés de nature institutionnelle liées notamment aux conflits de loyauté, aux limitations administratives et financières peuvent avoir un effet sur la qualité des soins médicaux en prison. En outre, en ce qui concerne le niveau relationnel, les caractéristiques culturelles et linguistiques propres aux patients peuvent rendre la compréhension et la communication plus difficile.

Cet article présente les soins médicaux en prison au regard des principes suivants d'éthique biomédicale: 1. autonomie, 2. non-malfaisance, 3. bienfaisance et 4. justice. Ces paramètres sont ensuite utilisés pour l'analyse des obstacles aux sept principes fondamentaux applicables aux soins médicaux en prison et que nous discutons ici: 1. accès à un médecin, 2. équivalence des soins, 3. consentement du patient et confidentialité, 4. soins médicaux préventifs, 5. assistance humanitaire, 6. indépendance professionnelle, 7. compétences professionnelles. Le non-respect de l'un de ces principes est un obstacle au bon fonctionnement de la relation patient-médecin et conduit à une qualité amoindrie des soins dans ce cadre. Cet article revient sur les raisons pour lesquelles ces principes fondamentaux devraient être incorporés à l'échelle mondiale dans toutes les politiques nationales.

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