Sharon Douglas and Susan Dorr Goold, "When Prisoners Are Patients," *The Journal of Clinical Ethics* 19, no. 3 (Fall 2008): 249-53.

When Prisoners Are Patients

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In "Medical Ethics in Correctional Healthcare,"[1] presenting and contrasting recommendations from professional organizations in and outside the U.S., with the goal to describe "the foundations of medical ethics in correctional healthcare," Bernice Elger begins with Hippocrates: "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."[2] This same standard is affirmed by the American Medical Association (AMA) in its *Code of Medical Ethics*, as it states that the patient-physician relationship "gives rise to physicians' ethical obligation to place patients' welfare above their own self-interest and above obligations to other groups. . . ."[3]

Indeed, the AMA "Principles of Medical Ethics" also includes the physician's duty to provide "competent medical care," the physician's "respect for human dignity and rights," the physician's safeguarding "patient confidences and privacy," the physician's "responsibility to the patient as paramount," and the physician's supporting "access to care for all people."[4] Sections of the *Code of Medical Ethics* prohibit any physicians' involvement in executions, interrogations, or torture.[5] Outside the *Code of Medical Ethics*, AMA House of Delegates policy H-430.988, "Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities," clearly states that standards of care, consent, and confidentiality should be equivalent within and without of correctional facilities.[6] This philosophy is consistent with that of the World Medical Association (WMA),[7] and forms the ethical foundation for the patient-physician relationship, whether this relationship exists inside a correctional facility (or any place of detention), in a rural practice area, managed-care setting, academic center, government facility, or a free clinic.

It is thus surprising that Elger neither quotes nor cites the AMA *Code of Medical Ethics* in her article. Instead the author discusses ethical guidelines from the American College of Physicians, the American Psychiatric Association, the National Commission on Correctional Health Care, the British Medical Association, the WMA, and the Council of Europe. Other countries' codes, guidelines, and laws are nowhere to be found. Yet the ethics of treating prisoners has been commented upon in other countries,[8] to say nothing of the treatment of detainees and prisoners during World War II in Germany or during apartheid in South Africa. U.S. guidelines (as described by Elger) and practice are contrasted with "international" standards (although only the WMA codes could rightly be painted with those colors) and, not surprisingly, U.S. guidelines and practice are found to be inferior. Unfortunately, practices in other countries — even those in Europe — are not similarly examined.

In Elger's article, the spotty treatment of other countries, and the focus on criticizing the U.S. system (for there is no question that the U.S. system of incarceration disproportionately affects the poor, the mentally ill, the addicted, and minorities), detracts from what could otherwise be an important updating of the ethics of caring for prisoners. Other than the topics of capital punishment, torture, and psychiatric care (for psychiatrists have long recognized the problems of dual loyalty, confidentiality, and consent that pose special challenges for the incarcerated), correctional healthcare ethics has received little attention. We hope that Elger's article will inspire others, as it has us, to turn their attention to this important subset of patients.

In her article, Elger advocates the principle of equivalence of care proposed by the *European Committee for Prevention of Torture and Inhumane or Degrading Treatment*, applying it to issues of consent, confidentiality, and access, and this commentary will discuss these further.[9] Elger also briefly discusses physicians' participation in interrogation, physicians' participation in execution, and physicians' attitudes towards abuse and torture of inmates, which we will also address in this commentary. In conclusion, we will argue for American physicians' responsibility to treat all patients competently and humanely, including those in correctional facilities or detention. We will also argue that physicians should advocate, when needed, for consistent treatment, report deficiencies in standards of care, and promote medical education on appropriate treatment of patients in all settings.

Engaging autonomous patients in informed consent for medical care is ethically and legally required of physicians.[10] The practice of consent demonstrates respect for the patient's right to self-determination, and requires accurate medical facts and skilled communication of recommendations relative to treatments.[11] The patient is able to ask questions and the physician must be sure to discuss the nature of the condition, the objectives of treatment, any alternatives to treatment, possible outcomes, and the risks involved with proposed treatments.[12] However, even with the great value placed on patients' rights to informed consent to treatment in the U.S., respect for individual autonomy may be outweighed by other obligations to that patient or by other considerations, including the good of society. An inmate being treated for active tuberculosis who does not want such treatment, for instance, could be required to continue treatment, and this practice would be equivalent to what often happens outside correctional facilities. In another example, the World Health Organization vaccinated some individuals against their will in the campaign to eliminate smallpox, justifying that practice by appealing to the health of the public (although not without criticism).[13]

Correctional facilities that entail forced confinement of a population in close quarters inherently present a greater than average share of tensions between individual liberty and public health. Add a population *defined* by the loss of liberty in most domains of their daily lives, and it is not difficult to see how respect for autonomy could be threatened. Medical personnel need to critically consider exceptions to ethical standards (such as consent), and be especially sensitive to the influence that a context of restricted liberties, even a culture of "penal harm"[14] might have on such judgments (by the patient, physicians, or others).[15]

Similar to consent, confidentiality is a fundamental tenet of medicine but it is not absolute.[16] A patient should be able to disclose information to a physician knowing that the physician will respect the confidentiality of such information. The physician should not divulge confidential information without a patient's consent unless overriding ethical considerations justify exceptions. Overriding considerations should be rare, and in such cases the patient should generally be notified and the minimal amount of information should be disclosed. The AMA, in its *Code of Medical Ethics*, states that physicians should advocate for protection of patients' confidential information and at times work toward changes in policy or law when needed.[17] Elger holds as a standard the risk of harm to identifiable others, while she discusses the "security concerns" in a correctional facility. Yet threats of violence or suicide *should* receive serious consideration, given the prevalence of mental illness (and violence) in prisons, and protection of the patient and fellow inmates may, if no alternatives exist, require breaching confidentiality.

According to the *Code of Medical Ethics* of the AMA, access to care includes "a basic right to have available adequate health care" as well as a right to continuity of care.[18] This concept applies to all patients, including prisoners. "Principle IX" of the AMA *Code of Medical Ethics*, "A physician shall support access to medical care for all people," speaks for itself.[19]

Elger points out that the American College of Physicians (ACP), in its "Ethics Manual," characterizes correctional systems as having "limited access to health care." She alludes to, but does not use, as a test of "equivalency" the (shameful) fact that some prisoners might have even worse access to care outside prison than they do while incarcerated.

While limited access to healthcare should never affect the ethics of the patient-physician relationship, it can certainly affect how a patient responds to a standard-of-care recommendation made by a physician: according to a recent report by the Commonwealth Fund, more than one-third (37 percent) of all U.S. adults reported going without needed care because of costs in 2007.[20]

We agree with the ACP that "physicians should advocate for timely treatment and make independent medical judgments about what constitutes appropriate care for individual inmates." Such advocacy will indeed vary with the circumstances. It may be as simple as providing a patient with contact information for a source of help, or as involved as multiple phone calls and letters or leadership in a community or organization to ensure access for vulnerable populations — again, including, but not limited to, prisoners. We would be hard-pressed to identify what specific behaviors would constitute sufficiently ethical advocacy, as might be suggested by Elger.

The AMA, like the ACP, proscribes physicians' participation in capital punishment, interrogation, and torture.[21] As stated in an AMA opinion on participation in interrogation, "physicians who engage in an activity that relies on their medical knowledge and skills must continue to uphold principles of medical ethics."[22] These very clear American ethical guidelines for physicians provide solid justification for doctors and medical organizations to refuse to participate in state-ordered executions and can provide military physicians with a similarly strong set of ethical guidelines.

All physicians should support ethics education relative to the patient-physician relationship, and the challenges and complexities of various settings, including correctional facilities. We agree with Elger that insufficient attention is paid to this marginalized, vulnerable population. Such education should start in medical school and should be available as continuing education for all physicians. As Elger notes, the WMA has developed a web-based course for healthcare personnel working in prisons, which should be applauded.

Codes and guidelines for physicians (and other medical personnel) are important to "get right," but not nearly as important as ethical practice. Unfortunately we know very little about correctional healthcare ethics in practice, in the U.S. or elsewhere. A few studies[23] paint a dim picture, and, as would be true in any practice setting, physicians have ethical obligations to report unethical colleagues, as stated in AMA policy H-275.952, "Reporting Impaired, Incompetent or Unethical Colleagues."[24] In its *Code of Medical Ethics*, "Principle II," the AMA also makes clear physicians' duty to expose physicians who are deficient in character.[25] The AMA and state licensing boards, for their part, should continue to sanction members who do not follow ethical guidelines. Physicians also have the responsibility, individually and through organizations such as the AMA, "to seek changes in those [legal] requirements which are contrary to the best interests of the patient."[26]

In conclusion, we applaud Elger for bringing attention to a too often neglected domain of ethics for healthcare professionals. The ethical obligation to provide "equivalent" treatment, when applied to *any* vulnerable population, confronts challenges of limited resources, conflicts with the rights and interests of others, and exists in a context of restricted liberties and rights. Physicians working in such settings, like physicians working with the homeless or with refugees, must be especially vigilant to ensure that they remain "dedicated to providing competent medical care, with compassion and respect for human dignity and rights," "regard responsibility to the patient as paramount,"[27] and be mindful that "health and human rights are interrelated."[28]

NOTES

1. B. Elger, "Medical Ethics in Correctional Healthcare: An International Comparison of Guidelines," in this issue of *JCE*.

2. "Oath of Hippocrates," in *Harvard Classics* (Boston: P.F. Collier and Son, 1910.)

3. American Medical Association, Opinion E-10.015, "The Patient-Physician Relationship," in *Code of Medical Ethics,* 2008-2009 ed. (Chicago: AMA, 2008), 348-50, available at *http://www0.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-10.015.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-9.132.HTM&nxt_pol=policyfiles/HnE/E-10.01.HTM&,* accessed 26 August 2008.

4. American Medical Association, "Principles of Medical Ethics," in *Code of Medical Ethics*, 2008-2009 ed. (Chicago: AMA, 2008), Principles I, IV, VIII, and IX, available at *http://www0.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-0.001.HTM&&s_t=&st_p=&nth=1& prev_pol=policyfiles/CEJA-TOC.HTM&nxt_ pol=policyfiles/HnE/E-0.001.HTM&,* accessed 26 August 2008.

5. American Medical Association, Opinion E-2.06, "Capital Punishment"; E-2.067, "Torture"; and E-2.068, "Physician Participation in Interrogation," in *Code of Medical Ethics,* 2008-2009 ed. (Chicago: AMA, 2008), 20-31, available at *http://www0.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/E-2.00.HTM&&s_t=&st_p=&nth=1&prev_pol=redirect.htm&nxt_pol= policyfiles/E-1.00.HTM&,* accessed 26 August 2008.

6. American Medical Association, H-430.988, "Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities," in *Policies of the AMA House of Delegates;* to access online, use the AMA Policy Finder: *http://www.ama-assn.org/ama/noindex/category/11760.html,* accept "Terms and Conditions," and enter "H-430.988" in the search engine; accessed 20 August 2008.

7. *World Medical Association International Code of Medical Ethics,* 2006, *www.wma.net/e/policy/c8htm,* accessed 20 August 2008.

8. J.D. Tucker and X. Ren, "Sex Worker Incarceration in the People's Republic of China," *Sexually Transmitted Infections* 84, no. 1 (February 2008): 34-5; L. Condon et al., "Users' Views of Prison Health Services: A Qualitative Study," *Journal of Advanced Nursing* 58, no. 3 (May 2007): 216-26; J. Howitt, "Poor Conditions of Detention Compromise Ethical Standards," *Journal of the Royal Society of Medicine* 88, no. 1 (January 1995): 40P-1P.

9. Council of Europe, *European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment,* European Treaties ETS No. 126, *http://www.cpt.coe.int/EN/documents/ecpt.htm,* accessed 6 August 2008.

10. A.S. Jonsen and W.J. Winslade, *Clinical Ethics,* 6th ed. (New York: McGraw-Hill, 2006); American Medical Association, Opinion E-8.08, "Informed Consent," in *Code of Medical Ethics*, 2008-2009 ed. (Chicago: AMA, 2008), 245-51, available at *http://www0.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-8.08.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-7.05.HTM&nxt_pol=policyfiles/HnE/E-8.01.HTM&,* accessed 26 August 2008.

11. American Medical Association, Opinion E-8.08, "Informed Consent," see note 10 above.

12. L. Snyder and D. Leffler, for the Ethics and Human Rights Committee, American College of Physicians, "Ethics Manual, Fifth Edition," *Annals of Internal Medicine*, 142, no. 7 (5 April 2005): 560-82, *http://www.annals.org/cgi/content/abstract/142/7/560,* accessed 20 August 2008.

13. National Institutes of Health, "Smallpox: A Great and Terrible Scourge: Obstacles and Struggle," *https://www.nlm.nih.gov/exhibition/smallpox/sp_obstacles.html,* accessed 20 August 2008.

14. M.S. Vaughn, "Penal Harm Medicine: State Tort Remedies for Delaying and Denying Health Care to Prisoners," *Crime, Law & Social Change* 31, no. 4 (1999): 273-302.

15. F.R. Parker, Jr. and C.J. Faine, "Informed Consent and the Refusal of Medical Treatment in the Correctional Setting," *Journal of Law, Medicine, and Ethics* 27, no. 3 (1999): 240-51, 210; R.M. Tribe and J.D. Romeril, "Vinegar and Oil: Are the Moral/Ethical Decision Processes by Professional Prison Chaplains Superior to Hospital Chaplains?" *Journal of Pastoral Care* 54, no. 3 (2000): 313-24.

16. Snyder and Leffler, see note 12 above.

17. American Medical Association, Opinion E-5.05, "Confidentiality," in *Code of Medical Ethics,* 2008-2009 ed. (Chicago: AMA, 2008), 149; available at *http://www0.ama-assn.org/apps/pf_new/*

pf_online?f_n=browse&doc=policyfiles/HnE/E-5.05.HTM&&s_t=&st_p=&nth=1&prev_pol=policy files/HnE/E-4.07.HTM&nxt_pol=policyfiles/HnE/E-5.01.HTM&, accessed 26 August 2008.

18. American Medical Association, Opinion E-10.01, "Fundamental Elements of the Patient-Physician Relationship," in *Code of Medical Ethics*, 2008-2009 ed. (Chicago: AMA, 2008), 341-7; available at *http://www0.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-10.01.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-9.132.HTM&nxt_pol=policyfiles/HnE/E-10.01.HTM&*, accessed *26 August 2008.*

19. American Medical Association, "Principles of Medical Ethics," see note 4 above.

20. Commonwealth Fund Commission on a High Performance Health System, "Why Not the Best? Results from the National Scorecard on U.S. Health System Performance," July 2008, *http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=401577*, accessed 20 August 2008.

21. American Medical Association, Opinion E-2.06, "Capital Punishment," see note 5 above; American Medical Association, Opinion E-2.067, "Torture," see note 5 above; Snyder and Leffler, see note 12 above.

22. American Medical Association, Opinion E-2.06, "Capital Punishment," see note 5 above; American Medical Association, Opinion E-2.067, "Torture," see note 5 above.

23. Condon et al., see note 8 above; American Medical Association, Opinion E-2.06, "Capital Punishment," see note 5 above; American Medical Association, Opinion E-2.067, "Torture," see note 5 above.

24. American Medical Association, H-275.952, "Reporting Impaired, Incompetent or Unethical Colleagues," in *Policies of the AMA House of Delegates*, to access online, use the AMA Policy Finder: *http://www.ama-assn.org/ama/noindex/category/11760.html*, accept "Terms and Conditions," and enter "H-275.952" in the search engine; accessed 20 August 2008.

25. American Medical Association, "Principles of Medical Ethics," Principle II, see note 4 above.

26. American Medical Association, "Principles of Medical Ethics," Principle III, see note 4 above.

27. American Medical Association, "Principles of Medical Ethics," see note 4 above.

28. Snyder and Leffler, see note 12 above.