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Commentary on Elger's "Medical Ethics in Correctional Healthcare"

Joel A. Dvoskin

Joel A. Dvoskin, PhD, ABPP, is a Clinical Assistant Professor, Psychiatry, at the University of Arizona College of Medicine in Tucson, *JoeltheD@aol.com.*

Bernice Elger has written a proposal for the ethical requirements, aimed largely at healthcare professionals in the United States, that she would apply to jails and prisons.[1] For the most part, Elger's suggestions are already well entrenched in various ethical codes, including one of which she is apparently unaware; that is, that of the Society for Correctional Physicians. The exception, her proposed principal of "equivalence," was considered and rejected by the American Psychiatric Association,[2] for reasons that are discussed below and in the commentary on Elger by Robert Keisling, also in this issue of *JCE*,[3] because it could have meant a diminution in the care to which some inmates and detainees are entitled.

One important underlying premise of Elger's ethical proposals is a restatement and reification of an inaccurate myth; specifically, her allegation that "the requirements of security and the need for healthcare services conflict" could not be more wrong. It is not surprising that she has made this error, as her source for this claim, an analysis of military tribunals at Guantanamo Bay, has virtually nothing in common with American jails and prisons.[4]

In contrast to the "security versus treatment" myth, it has been my consistent experience that correctional staff and officials are often vocal advocates for adequate health and mental healthcare, and the most strident critics when such care is not provided. In my own work as an expert witness for plaintiffs and defendants in conditions of confinement class actions, the data upon which findings of unconstitutional conditions are made were often provided by custody staff. This is not to suggest that all corrections staff and officials are equally strong advocates for treatment. However, the generalization that they are not is unsupported by data or experience.

Elger's allegation that security concerns trump the medical needs of captives is unsupported by any data whatsoever. She fails to give a single example of a physician who was prevented from providing care due to custody or security concerns. This is not to say that care is always adequate; often it is not. However, the reasons for inadequate care in jails and prisons are generally the same as the reasons for inadequate care in the free world, and those reasons almost always start with a lack of money. In order to meet miserly public budgets, managers of care in corrections, just like managers of care in the community, are forced to make difficult choices about how to spend money. In response, they may limit formularies, and both groups have difficulty paying high enough salaries to recruit enough competent doctors and nurses.

The notion that security and treatment are not complementary is best refuted with several simple case examples. Suppose that an inmate receives six months of outstanding psychological treatment for post-traumatic stress disorder (PTSD), and a week later is raped by his cell mate. Does Elger really believe that prevention of the rape would be less beneficial to the inmate than provision of therapy? What she may not understand is that security means prevention of violence within the jail or prison, and, without it, inmates are

the first to suffer. Equally important, safe jails and prisons are more likely to be able to retain competent healthcare professionals, who seldom want to work where they feel endangered. Simply put, not only can security and treatment coexist, they are interdependent.

Elger cites three overarching principals of adequate medical care; (1) access to treatment, (2) consent of prisoner patients, and (3) confidentiality. As noted elsewhere in this commentary, access to treatment is limited in a variety of healthcare settings in the U.S., especially those that serve communities of poverty and color, and this is especially problematic for the "working poor" who may be ineligible for Medicaid. Consent requirements in correctional settings tend to be similar to those in the free world; indeed, Elger cites no exceptions. The third criterion, confidentiality, is closely tied to clinical independence, and each has similar correctional exceptions.

To be sure, Elger is right when she calls for clinical independence for careproviders, but she is wrong when she alleges, without evidence, that such independence does not commonly exist in U.S. correctional facilities. In my experience, there are several circumstances in which confidentiality is violated and when medical decisions may be influenced by custodial concerns: (1) when the patient poses or expresses a risk of harm to self, (2) when the patient poses or expresses a risk of harm to others, (3) when the patient poses or expresses a risk of escape or disrupting the order of the institution.

Interestingly, the first two exceptions, danger to self and others, are applied as a matter of law and ethics in virtually all healthcare settings, in and out of corrections. In regard to mental healthcare, these are usually affirmative legal duties. The third, escape and institutional disorder, seems a fair subject for debate. Certainly, the concept of escape has little relevance without some form of captivity, and this would not apply to the community. Unfortunately, Elger does not tell us whether she would agree to violate confidentiality in the face of a planned escape attempt, but I am happy to argue that she should. Escaping prisoners pose *and* face great dangers, not the least of which is being shot when recaptured. Further, allowing them to escape has nothing whatsoever to do with their medical care. Similarly, any effort to disrupt the prison order, for example, by inciting a riot, poses great risk to everyone who lives and works in jails or prison.

Other than these exceptions, Elger provides no evidence to suggest that the ethical standards for medical and mental health confidentiality in jails and prisons are inferior to those in the free community. The notion of "security versus treatment" is frequently cited, almost always (as in this case) without any evidence to support it. While correctional staff are undoubtedly not immune to bias and stigma, in my experience they are often advocates for better treatment, especially for inmates with serious mental illnesses. In my experience, they often proclaim that jails and prisons are ill-suited for the treatment of persons with serious illnesses, and readily admit that their training for these tasks is inadequate.

There are other reasons for correctional advocacy of better healthcare for inmates. Put bluntly, inmates who receive inadequate care complain a lot, and they tend to be harder to get along with. Further, when inmates are sick and untreated for communicable diseases, the environment becomes dangerous for everyone who lives and works there, and for the communities in which staff members live and to which inmates will eventually return.

As noted above, using the word "security" in a pejorative manner is misleading. Security is not synonymous with punishment or mean-spirited treatment. To the contrary, security should be most synonymous with safety. When correction officers keep correctional facilities "under control," they are doing the inmates a favor. Correctional facilities that are inadequately controlled are even more dangerous for inmates than for staff.

Elger makes much of the fact that access to care in jails and prisons is limited. However, this is not a criticism of American corrections, but of the American healthcare system. Care in the U.S. is limited for everyone, inmates and citizens alike, almost always by economics. The notion that inmates, if only they were not incarcerated, would be "free" to choose their health insurance, is yet another inaccurate assertion. It implies that healthcare is affordable for everyone; and clearly it is not. Ironically, the same communities from which many inmates hail are exactly the same communities in which adequate healthcare is unavailable.

As Robert Keisling notes, healthcare in prisons should not aspire to community equivalence, because, for many inmates raised in communities or poverty and color, the healthcare they receive in prison may be the best care they have ever received. This is not surprising in a country in which healthcare is not a right, but a privilege. In contrast to the community, American correctional facilities have an affirmative constitutional duty to provide healthcare, including psychiatric care, when there is a serious need.[5] The court in *Estelle v. Gamble* wisely declined equivalence as its standard, opting instead for need.

Consider the huge disparity between affluent communities and the communities from which the majority of inmates were raised. An "equivalence" standard would require more and better healthcare in rich communities than poor. A "need" standard, in contrast, places the constitutional "floor" of care at the same level for every community and every inmate.

Elger seems to implicitly understand the superiority of a needs-based ethical standard, when her argument moves from "equivalence" to inadequacy: "Inadequate medical care is considered inhumane treatment."[6] Unfortunately, she moves from there back to equivalence and (oddly) freedom from torture, thus conflating three very different ethical principles, each of which is deserving of disaggregation and careful discussion.

Elger seems offended by the concept that a whole prison might have healthcare needs, needs that might conflict with the wishes of a particular inmate. In response, I would cite the concept of public health. Medical and confidentiality decisions regarding *one* inmate might indeed conflict with public health decisions that serve the medical needs of *all* of the inmates, but this conflict is no less ethical than a decision to preclude someone with a serious, airborne infectious disease from coming to school.

Elger makes a much stronger point, and one that is deserving of serious consideration, when she calls for a right to preventive treatment. In U.S. jails and prisons, a right to treatment is occasioned by an existing "serious medical need," which would seem to preclude preventive care as a constitutional duty. Since money is always scarce and constitutional mandates always come first, it is not surprising to find that few resources are left over for preventive care.

However, Elger's suggestion is a good one, not only for its altruistic motives, but as a matter of public policy. Again pointing to a public health perspective, some diseases (for example, multiple-drug resistant Staphylococcus aureus — MRSA) can only be effectively treated by primary prevention. Finally, prevention of the most serious illnesses can save a great deal of very expensive tertiary care, thus making more medical care available for more people at the same cost.

Despite the considerable efforts of an active and competent plaintiff bar, armed with ethical standards and constitutional mandates, and coupled with advocacy from correctional administrators, it remains sadly true that correctional healthcare in America remains in great need of improvement. But to attribute these deficiencies to ethical shortcomings among American corrections and healthcare professionals is inaccurate and unfair. By far, the most important reason for inadequate healthcare in jails and prisons is the same reason that our healthcare system inadequately attends to adults and children who live in poverty: so far at least, Americans simply refuse to pay for it.

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NOTES

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

2. *Psychiatric Services in Jails and Prisons: A Task Force Report of the American Psychiatric Association,* 2nd ed. (Washington, D.C.: American Psychiatric Association, 2000).

3. R. Keisling, "Commentary on Elger's "Medical Ethics in Correctional Healthcare," in this issue of *JCE.*

4. J.A. Singh, "Military tribunals at Guantanamo Bay: dual loyalty conflicts," *Lancet* 362, no. 9383 (2003): 573.

5. *Estelle v. Gamble*, 429 U.S. 97, (1976).

6. Elger, see note 1 above.