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Physicians, Mass Incarceration, and Medical Ethics

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Thousands of physicians work in United States prisons where ethical dilemmas are numerous. At the same time, ethics training for U.S. medical physicians is typically meager. A recent well-publicized survey of U.S. medical students found that fully one-third of the 1,756 that responded to the survey could not state when they would be required to disobey an unethical order. Further, 37 percent did not know that the Geneva Conventions prohibit ever threatening or demeaning prisoners or depriving them of food or water.[1] In an era of mass incarceration, a phenomenon made possible in part by the support of medical professionals, the need for a vigorous discussion of the ethical roles of physicians in prisons is pressing. Yet a review of the medical literature yields very few articles discussing the general ethics for health professionals working in correctional settings. In this issue of *The Journal of Clinical Ethics,* Bernice Elger makes a timely and important contribution with a review and discussion of the issue of medical ethics in correctional healthcare with reference to both U.S and international guidelines.[2]

The fundamental ethical dilemma in correctional medicine is established because physicians are ethically bound to act first in the interest of their patient while the institution engaging the physician's services often acts first in the interest of the state, and often against the interests of the patient. The physician's competing obligation to the patient and the institution can be described by the term *dual loyalty,* a "conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer or the state."[3] Dual loyalty is an ethical conflict shared by physicians working in other settings including the military, occupational medicine, and even managed care. While the concept of dual loyalty is helpful in describing the inherent conflict that correctional physicians confront, it does not establish ethical parity of the competing loyalties. Even in the face of compelling competing values, the physician's primary loyalty remains to the patient. As cited by Elger in her review, the United Nations' *Principles of Medical Ethics relevant to the Role of Health Personnel* states that physicians have a duty to protect health and treat disease using the same standards applied in the community, and there may be no derogation from this obligation on any grounds "including public emergency."[4] *The World Medical Association Declaration of Tokyo* states, "The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose."[5]

To many, the role of physicians in jails and prisons appears to be incidental. Individuals are detained; they have health needs, so the custodial institution seeks the services of physicians to address those needs.

But the role of physicians in the establishment of correctional institutions is fundamental. Both legally and ethically, a prison or jail cannot exist without the support of physicians. In 1976 the United States Supreme Court ruled in *Estelle v. Gamble* that the failure to provide access to medical services is a violation of the Eighth Amendment's prohibition on cruel and unusual punishments.[6] At the same time, physicians who work in jails and prisons are often inattentive or unaware of the effect their presence has in conferring legitimacy to the correctional institution. As a profession, medicine has not adequately confronted or debated the role the healing profession has had in the support and development of mass incarceration in the U.S.

The United States has undertaken an expansive and unprecedented social experiment with a program of mass incarceration. During the past 20 years, the prison population in the United States has grown to more than 2.3 million, roughly 1 percent of the population, a remarkable accomplishment for a country founded on the principles of liberty.[7] No other country incarcerates anywhere near as large a percentage of their population.[8] The long-term effects of mass incarceration on the health of the incarcerated individuals, their families, and their communities are not yet fully known.

The ethical conflicts created by physicians' engagement in this system of mass incarceration in general are further complicated because mass incarceration has taken a punitive approach to medical illness. Addiction and mental illness are medical conditions. In combination, these two conditions affect the vast majority of inmates in U.S. jails and prisons.[9] However, access to adequate medical treatment for these conditions is often deficient or lacking in U.S. prisons.[10] Treatment for mental illness and addiction are often afterthoughts to the institutional mission, if they are addressed on an institutional level at all. The mass incarceration of the mentally ill and those suffering from addiction also represent a failure by the community. When criminal activity is a potential consequence of inadequately treated addiction and/or mental illness, the prison becomes the unintended consequence of an inadequate healthcare system. Should physicians be content with the status quo?

The American College of Physicians ethical code states, "Under no circumstances is it ethical for a physician to be used as an instrument of government to weaken the physical or mental resistance of a human being, nor should a physician participate in or tolerate cruel or unusual punishment or disciplinary activities beyond those permitted by the United Nations Standard Minimum Rules. . . ."[11] The phrase "to weaken the physical or mental resistance" in this guideline is likely meant to address the participation of physicians in interrogations, and in any event applies to the conduct of individual physicians. Yet it suggests the question: Should medicine, as a profession, silently and blindly support institutions such as prisons that, in their present form, may do more to weaken the physical and mental constitution of prisoners than they do to promote their health and well-being?

Prisons are not always inhospitable to the promotion of health. The relative stability of the prison setting, in combination with access to quality healthcare services may provide a window of opportunity to intervene in the treatment of illness that has proven difficult to manage or that has been neglected due to lack of healthcare coverage in community settings. The relative enforcement of sobriety may provide a window of opportunity for the engagement in addiction treatment. In reality, however, the opportunity to use the period of confinement as an opportunity to address chronic health needs is often not seen as a priority of correctional institutions, as it is not part of their stated mission, and perhaps more importantly, not a budgeted priority.

Beyond the lost opportunity to address unmet health needs is the simple fact that the modern U.S. prison is not the result of a thoughtful evidence-based process designed to rehabilitate convicted criminals by means of effective programming aimed at reform and restoration of the prisoner as a person and as a member of society. The idea of reform of prisoners is all but dead in the United States. Prisons in the U.S., rather, are the result of a political process that has marginalized thoughtful discussion of potential solutions in favor of politically expedient remedies such as tough drug sentencing laws and rigid sentencing guidelines. Despite the enormous financial and human costs of mass incarceration, until recently few have asked: just what the tax paying public is getting for the money? At the same time, few physicians have asked about the health

impact of prisons on the prisoners themselves, their families, and their communities. Conditions of confinement in many cases can be quite detrimental to the health and well-being of inmates. Elger cites disturbing statistics on rape and coercive sex. Use of prolonged isolation with the advent of so-called "super-max" facilities has expanded, despite consistent evidence that prolonged isolation is harmful to the mental health of prisoners, and may even constitute torture.[12]

As a result of high costs and poor outcomes, there is growing interest among public policy makers in considering alternatives to mass incarceration. Sorting out "best practices" from ineffective ones will require expertise, data, and ongoing study. Yet, ironically, research in prison settings is logistically difficult owing to strong human subjects protections that were established in reaction to past excesses and abuses. Still, humane study protocols with ample human subject protections aimed at helping to address specific problems of the prison population and affected communities are feasible, and should be a public priority.

Physicians also cannot ignore the fact that incarceration disproportionately affects communities of color and individuals who are socioeconomically disadvantaged.[13] It is worth noting that these communities are the same groups who are under served by the healthcare system as a whole.[14]

Inside the prison there is the issue of the standard of medical care. Elger links the "principle of equivalence" — the idea that prison health standards should not differ from those of the community — with the idea of "justice." In her discussion about the guidelines issued by the NCCH (National Commission on Correctional Healthcare) for asthma, Elger points out that these special guidelines, adapted from the widely accepted community standard, unavoidably create a separate and unequal medical standard for prisoners. The NCCH cited the logistical challenges of providing care in prisons as the justification for a modified standard. A similar discussion surrounded the development of the 2002 National Institutes of Health guidelines for the management of hepatitis C. Some participants at the consensus conference suggested that hepatitis C standards should not apply to prisoners, because correctional institutions might be overwhelmed by the challenge of implementing a community standard with limited financial and medical resources for a chronic disease that affects as many as one-third of the prison population. In the end, the NIH panel wisely rejected the plea for a separate but unequal standard, and instead called for more study on how the practical and logistical challenges of delivering hepatitis care in prisons could be addressed.[15] This is a more ethically sound approach. It is fair to acknowledge the challenges of meeting community standards in prisons, but the accepted community standard of treatment should not be compromised for prisoners.

Even with these profound ethical conflicts, physicians are duty bound to remain engaged with correctional institutions as long as they exist, because the widescale abandonment of patients is not a practical or morally acceptable option. However, physicians as individuals and as a profession need to reclaim leadership in the reform of sentencing laws that have led to the mass incarceration of their patients, and to advocate for improvements in the wider implementation of effective evidence-based treatments for medical illness, whether it be infectious diseases such as HIV, hepatitis, and TB, or mental illness or addiction, before during and after incarceration. In addition to supporting reforms, organized medicine should provide practical and clear guidelines for physicians who work in correctional settings, explicitly reaffirming the obligations of physicians to preserve and protect the health and human rights of their patients. Finally, health professionals who work in correctional settings must have legally enforceable professional independence and autonomy in both clinical management of their patients' medical conditions and in their efforts to protect their patients' basic health and human rights. Simply put, physicians must demand that the correctional institutions they support respect the human dignity of their patients. Further, as an ethical and public health matter, physicians must work to ensure that, at a minimum, the institutions they support do not undermine the physical and mental health of their patients.

NOTES

1. J. Boyd et al., "U.S medical students' knowledge about the military draft, the Geneva Conventions, and military medical ethics," *International Journal of Health Services* 37, no. 4 (2007): 643-50.

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

3. Report of the International Dual Loyalty Working Group, "Health Professional Practice: Proposed Guidelines and Institutional Mechanisms," 2002, *http://physiciansforhumanrights.org/library/documents/reports/report-2002-duelloyalty.pdf,* accessed 30 August 2008.

4. United Nations, "Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Adopted by the General Assembly resolution 37/194 of 18 December 1982," *http://www.unhchr.ch/html/menu3/b/h_comp40.htm,* accessed 30 August 2008.

5. *The World Medical Association Declaration of Tokyo. Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment,* adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975, and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 and the 173rd Council Session, Divonne-les-Bains, France, May 2006, *http://www.wma.net/e/policy/c18.htm,* accessed 30 August 2008.

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

7. "Prison Brief for United States of America," World Prison Brief, Kings College London, 2008, *http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief/wpb_country.php?country+190,* accessed 17 May 2008..

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10. U.S. Department of Justice, Office of Justice Programs, "Study Finds More than Half of All Prison and Jail Inmates Have Mental Health Problems," *http://www.ojp.usdoj.gov/newsroom/pressreleases/2006/BJS06064.htm,* accessed 4 August 2008.

11. L. Snyder and C. Leffler, "American College of Physicians, Ethics Manual, Fifth Edition," *Annals of Internal Medicine* 142, no. 7 (2005): 560-82.

12. Physicians for Human Rights, "Leave No Marks: Enhanced Interrogation Techniques and the Risk of Criminality," 2007, *http://physiciansforhumanrights.org/library/report-2007-08-02.html,* accessed 30 August 2008.

13. M. Mauer and R. King, "Uneven justice: State rates of incarceration by race and ethnicity," *http://www.sentencingproject.org/dmin%5CDocuments%5Cpublications%5Crd_stateratesofincbyraceandethnicity.pdf,* accessed 19 September 2008; J. Cass and C. Curry, "America's cradle to prison pipeline. Children's Defense Fund," 2007, *http://www.childrensdefense.org/site/DocServer/CPP_report_2007.pdf?docID=5041,* accessed 19 September 2008.

14. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," Institute of Medicine, March 2002, *http://www.iom.edu/?id=16740,* accessed 19 September 2008; "The 2005 Kaiser Low-Income Coverage and Access Survey: Survey Methods and Baseline Table," Pub. no. 7788, Kaiser Family Foundation, September 2008, *http://www.kff.org/uninsured/7788.cfm,* accessed 19 September 2008.

15. "Management of Hepatitis C: 2002, National Institutes of Health Consensus Conference Statement, June 10-12, 2002," *http://consensus.nih.gov/2002/2002HepatitisC2002116html.htm,* accessed 30 August 2008. (The account of the discussion leading to the guidelines is based on the author's recollection and his participation in the event. The final NIH recommendations are as cited.)