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Medical Ethics in Correctional Healthcare: An International Comparison of Guidelines

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MEDICAL ETHICS IN CORRECTIONAL HEALTHCARE: INCREASED ATTENTION REQUIRED

Although a number of recent publications have addressed issues related to ethics in correctional healthcare that have led to public outcry, such as the documented participation of physicians in torture in U.S. prisons,[1] general articles on this subject are rare. This is particularly surprising, as medical ethics in correctional healthcare not only must confront dilemmas of the most serious kind, but must apply to a very large number of patients, especially in the U.S., where 1 percent of the adult population is incarcerated.[2]

Indeed, a search for correctional healthcare and ethics or prison and ethics in the abstract or title of publications recorded in MEDLINE during the past 10 years yields 170 articles, the principal focus of which is ethical problems related to prison medicine. They discuss single ethical issues related to the recent participation of doctors in torture,[3] the conduct of research with prisoners,[4] hunger strikes in prisons in Turkey[5] or Guantanamo,[6] healthcare for terminally ill inmates,[7] capital punishment,[8] mental health issues in prisons,[9] AIDS lawsuits and prisoners,[10] or addiction in prisons.[11] Older articles address psychological research[12] and the quality of healthcare in prisons,[13] and only some of them, most of them written in 1980 and before, are general articles on ethics in correctional healthcare.[14] The relative scarcity of recent general articles on ethical issues in places of detention is particularly surprising, as medical ethics in correctional healthcare applies to an important number of patients, especially in the U.S. where it concerns 2.3 million detainees; as stated above, this represents approximately 1 percent of the adult U.S. population.[15] While the U.S. accounts for 5 percent of the global population, it accounts for 25 percent of the world's prisoners in U.S. prisons and jails.[16] (Later in this article, the terms *prisoner* and *prison* are employed in the sense of *place of detention*, and are meant to include jails and other places of detention, as well as detainees in general.)

Several factors predispose the creation of ethical problems in healthcare in correctional institutions. Not only is the prevalence and impact of these problems currently rarely examined, but many of these problems are in need of conceptual clarification, especially since various courts have come to contradictory conclusions.[17] The requirements of security and the need for healthcare services[18] conflict and regularly cause ethical problems, due to the prevalence of ethically sensitive medical and social problems in the inmate population.

We will provide a brief description of these problems here, using U.S. statistics. In other countries inmates present similar problems, although the prevalence of prisoners with addictions and mental illness varies according to different penal strategies and the availability of community healthcare plans in other

countries; for example, the prevalence of rape in prison seems to be much lower in most Western European places of detention, based on reports from routine private discussions with inmates in Europe.[19]

Socio-demographic characteristics of detainees in the U.S. indicate that inmates in the U.S. are overwhelmingly working class and poor; members of minority groups are disproportionately represented in the prison populations; racial minorities account for nearly 80 percent of all drug offenders at the state level; more than 80 percent of incarcerations in the U.S. are for nonviolent crimes; two-thirds of convicted jail inmates were actively involved with drugs prior to their admission to jail.[20]

The overwhelming prevalence of medical problems in places of detention is illustrated by statistics concerning HIV[21] and hepatitis. The prevalence of these diseases in prisoners has been found to be substantially higher than in the general population,[22] for example, in Maryland, 7 percent of prisoners have HIV, 30 percent have hepatitis C, and 25 percent have hepatitis B;[23] among all inmates in the U.S. the rates of hepatitis C infection are reported to be 30 to 40 percent.[24] In addition to the other serious harms it creates, rape is an important vector of infection.[25] According to leading prevalence studies, 7 to 12 percent of responding male inmates in the U.S. had been raped an average of nine times.[26] Sexual coercion has been reported by as many as 27 percent of some inmates of U.S. correctional facilities for women.[27]

The aim of this article is to fill an important gap in the existing ethical literature: to present the foundations of medical ethics in correctional healthcare. After a summary of general issues in medical ethics in the prison context, we will present recommendations from professional organizations outside the U.S., as well as the legal context created by international bodies such as the United Nations (U.N.) and the Council of Europe. Following this, recommendations and guidelines from the U.S. will be described. In the discussion section, European and international standards will be compared to the legal context and professional guidelines in the U.S., and, in addition, the U.S. recommendations will be critically evaluated in light of international ethical and human rights standards.

THE FOUNDATIONS OF MEDICAL ETHICS IN CORRECTIONAL HEALTHCARE

General Medical Ethics

The lack of recent general articles on ethics in correctional healthcare might be explained by an assumption that, seen from a broad ethical perspective, there seems nothing new to say. In places of detention, the same ethical principles apply as outside correctional institutions. To start with the most ancient tradition, one could refer to the Oath of Hippocrates, which states, "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."[28] In the tradition of medical ethics, no distinction is made between patients who are prisoners and those who are not. To quote a more recent mainstream approach in medical ethics,[29] the famous *prima facie* principles of medical ethics — respect for autonomy, beneficence, nonmaleficence, and justice — are as valid to guide the decisions of healthcare personnel working in correctional institutions as they are for healthcare personnel working outside prison settings. In the U.S. it appears, however, that neither the healthcare provided nor the principles of medical ethics actually applied in correctional institutions are equivalent to those outside correctional institutions, and, beyond this, there is no unanimous agreement that they should be equivalent.[30] In this respect, the principle of justice gains a special meaning in places of detention: the principle of equivalence — that the healthcare services that are provided inside and outside correctional institutions should not differ — is derived from the principle of justice.[31] Applying the principle of equivalence in countries that have national health systems and the right to basic healthcare assured through obligatory health insurance seems straightforward. It is not surprising that the principle of equivalence, as we will argue below, is the guiding principle in European "soft law," and that it is enforced by the European Court of Human Rights, but not in the U.S., where the courts and several professional organizations use different standards. International bodies such as the U.N. and the Council of Europe have adopted several recommendations that deal with prisoners' rights to healthcare and mention the principle of equivalence. These quasi-legal instruments are often called "soft law" because they are not legally binding, in contrast to

international conventions that have been ratified by a country or state. However, it should be noted that the European Court of Human Rights refers to soft law standards in its judgments, and this represents a unique enforcement mechanism for soft law in Europe. Several judgments of that court concern medical care in prisons, because prisoners and former prisoners have complained about inadequate healthcare during incarceration,[32] as will be discussed below.

Recommendations from Professional Organizations Outside the U.S.

Since general medical ethics in and outside correctional institutions follow the same principles, existing recommendations in various areas concerning healthcare should apply to prison medicine as well.[33] Not surprisingly, therefore, recommendations from international and European professional organizations address mainly those issues that are specific, if not unique, to the prison environment. Examples are the *World Medical Association Declaration on Hunger Strikers;*[34] the *World Medical Association Declaration of Tokyo,* which contains guidelines for physicians concerning torture and other cruel, inhuman, or degrading treatment or punishment in relation to detention and imprisonment;[35] and the *World Medical Association Statement on Body Searches of Prisoners.*[36] Another ethical issue addressed by several professional organizations is the role of physicians in capital punishment. The World Medical Association (WMA) emphasizes that prescribing drugs for lethal injection is not ethically acceptable.[37] The British Medical Association (BMA) urges doctors to not become embroiled in speculation about whether an individual should be subject to capital punishment.[38] The WMA, the BMA, and the World Psychiatric Association agree that, in the context of capital punishment, giving evidence on future dangerousness contravenes the ethical standards expected of all doctors.[39] To do so contravenes the ethical standards expected of all doctors not only because it can lead to the death of an individual, but also because the science involved is so inexact that one can never safely and accurately say that an individual could not be dangerous in the future or would be dangerous in the future. Since "dangerousness" relies not only upon the mental state of the individual, but on the circumstances in which he or she may find him- or herself, such a judgment can never be exact, and the possibility of inaccuracy renders such judgments unethical, if the consequence could be the death penalty.

In addition to having responded to a need for guidelines in the past, the WMA has recently noted an urgent need for education concerning medical ethics in correctional healthcare. As a consequence, in 2004 the WMA made available a web-based course for healthcare personnel working in prisons.[40] The WMA states that physicians who work in prisons must be able to provide adequate healthcare in the special environments that exist in prisons: "The doctor's conduct must not be in conflict with international human rights and ethical standards. . . . In many countries education of prison doctors is not a priority. Many doctors do not even have access to international conventions and rules regulating healthcare services for prisoners. They encounter human rights violations, but do not know how to deal with them adequately. We hope this course will meet some of the needs many prison doctors have for more knowledge and skills in human rights and medical ethics." The stated objectives of the program are to "present relevant international statements regulating the medical treatment of prisoners and to raise prison doctors' awareness of their role in various areas of conflicting interests between the prisoner (patient) and the prison administration, for example, hunger strikes, the patient's right to confidentiality, certifying prisoners for special punishment, etc."

International and European Law

It is not without good reason that the WMA points to the importance of international law. Several documents from the U.N. establish standards for medical ethics in places of detention. A central issue in these documents that deals with medical ethics in correctional healthcare is the principle of equivalence of care, which includes the equivalence of medical ethics inside and outside correctional institutions. In its *Basic Principles for the Treatment of Prisoners,* the U.N. states, "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."[41] Another relevant document from the U.N. is the *Principles of Medical Ethics relevant to the Role of Health Personnel;* Principle 1 states that "physicians . . . have a duty to provide them [prisoners] with protection of their physical

and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained. . . . There may be no derogation from the foregoing principles on any ground whatsoever, including public emergency."[42]

It is in Europe that these international documents have been further elaborated, legislated, and legally enforced by the European Court of Human Rights (ECHR). In 2004 the Council of Europe Committee of Ministers published "Recommendation No R (98)7 concerning the Ethical and Organisational Aspects of Healthcare in Prison," which describes the main characteristics of the right to health in prison. Equivalence of care is explained to include access to a doctor "at any time . . . day and night"; "medical, psychiatric and dental treatments equivalent to those enjoyed by the general public" of the same country; and the right to outside treatment if it is not available inside the prison. The patient's consent and confidentiality must be "guaranteed and respected with the same rigour as in the population as a whole." Professional independence is another key element: "Medical decisions should be governed only by medical criteria. Healthcare personnel should operate with complete independence. . . . " Professional independence in its most complete form means that a complete separation of power exists, as it has, for example, been realized in the prison medicine department of the University of Geneva. The prison administration and correctional officers are employed by the cantonal department of justice and police (which includes correctional institutions), but the prison healthcare system is part of the university, that is, it is under the cantonal department of health.[43]

The legal enforcement of the principle of equivalence of care in Europe through human rights law and the ECHR was created as a reaction to its own history. The aftermath of the Doctors' Trial at Nuremberg is keenly felt in Europe, where the violations, including the human rights of persons deprived of their liberty, took place. The human rights framework set up in Europe since 1950 (the "Convention for the Protection of Human Rights and Fundamental Freedoms"[44]) strongly emphasizes the protection of all detainees. The principle of equivalence of healthcare is legally enforced through the European Court of Human Rights, also known as the Strasbourg Court (it is physically located in that city). The current incarnation of the court was instituted on 1 November 1998, replacing the then-existing enforcement mechanisms that included the European Commission of Human Rights, created in 1954, and the previous, limited Court of Human Rights, created in 1959. The European Court of Human Rights responds to requests by individuals, and its judgments have binding force. The notion of equivalence in healthcare emerged in the case law of the ECHR in 1979 and is now part of a normative framework covering 47 countries, the members of the Council of Europe.

Inadequate medical care is considered inhuman treatment and is a violation of Article 3 of the "Convention for the Protection of Human Rights and Fundamental Freedoms": "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."[45] Several cases have affirmed the principle of equivalence of healthcare for detainees (*Bonnechaux v. Switzerland,* 1979; *De Varga Hirsch v. France,* 1983; *Patanye v. Italy,* 1986; and most recently *Farbtuhs v. Lettonie,* 2004, and *Gelfmann v. France,* 2004).[46]

A further layer of protection is achieved through the Council of Europe Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (or CPT). The mandate of the CPT is from the "European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment,"[47] which has been ratified by all 47 member states of the Council of Europe. Article 1 of the "Convention" states: "The Committee shall, by means of visits, examine the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of such persons from torture and from inhuman or degrading treatment or punishment."[48] The CPT is comprised of independent experts. Under the "Convention," CPT delegations have unlimited access to places of detention and the right to move inside such places without restriction. They interview persons deprived of their liberty in private and communicate freely with anyone who can provide information. The recommendations that the CPT formulates, based on its visits, are included in a confidential report that is sent to the country concerned. This report becomes the starting point for an ongoing dialogue with this country. If the country fails to cooperate or refuses to improve the situation in the light of the committee's recommendations, the CPT may make a public statement.

Over its years of activity, the CPT has developed standards relating to the treatment of persons deprived

of their liberty. In its judgments, the European Court of Human Rights quotes the existing European recommendations. Through this mechanism, the recommendations of the Council of Europe as well as the CPT standards are legally enforced.

It is therefore important to look in some more detail at the content of these recommendations. In the "3rd General Report on the CPT's activities covering the period 1 January to 31 December 1992," the CPT affirms the principle of equivalence of healthcare: "prisoners are entitled to the same level of medical care as persons living in the community at large. . . . "[49] In this report, the CPT emphasizes further that the provision of healthcare services to persons who have been deprived of their liberty is a subject of direct relevance to the CPT's mandate. An inadequate level of healthcare services may rapidly lead to situations that can be described as "inhuman and degrading treatment." Further, the healthcare services that are provided in a given establishment may play an important role in combating ill-treatment, both in that establishment and elsewhere, in particular in police establishments. The considerations that have guided the CPT during its visits to prison healthcare services include the following:

- Access to a doctor,
- Equivalence of care,
- Patients' consent and confidentiality,
- Preventive healthcare,
- Humanitarian assistance,
- Professional independence, and
- Professional competence.

The legal enforcement of patients' rights and professional independence in correctional healthcare protects healthcare providers' ability to act according to general standards of medical ethics, especially with respect to maintaining confidentiality, reporting violence, reporting torture, and conflicts of interest, that is, when the welfare of the detainee-patient is in conflict with administrative or security requirements.

The Legal Context in the U.S.

Not surprisingly, for a country such as the U.S., in which nearly 16 percent of the population does not have access to basic healthcare,[50] applying the principle of equivalence is difficult, and might even be used to justify the absence of healthcare services for poor prisoners. In the U.S., the courts have noted that prisoners cannot choose where they live,[51] and, likewise, prisoners cannot choose whether to enroll in a health insurance plan once they are incarcerated. In Europe the prevailing attitude is that punishment is limited to the deprivation of liberty and does not affect the right to equivalent healthcare; in the U.S., a prevailing principle used by the courts to determine whether the healthcare provided to prisoners is inadequate was described as "deliberate indifference to their serious health care needs" in a landmark case, *Estelle v. Gamble* (1976).[52] The question discussed in this Supreme Court decision was, "what must a plaintiff prove for a prison's medical action/inaction to constitute a violation of their 8th Amendment right to be free from cruel or unusual punishment?"[53] The Court answered, "Prisoners who claim an Eighth Amendment violation as to healthcare needs must demonstrate both an objective serious medical need as well as prison officials' subjective culpable state of mind in denying the prisoner medical care . . . . the crucial test for an Eighth Amendment claim has therefore been whether prison officials knew about a prisoner's . . . [serious health] condition and whether they disregarded the prisoner's need for health care."[54] The courts have subsequently given different characterizations to the concept of deliberate indifference.[55] Three categories are worth mentioning: "denied or unreasonably delayed access to a physician for diagnosis and treatment, failure to administer treatment prescribed by a physician, and the denial of professional medical judgment."[56]

Recommendations from Professional Organizations in the U.S.

Professional standards in the U.S. have been established and have evolved under the influence of legal cases. Among the most important of the professional organizations that have established ethical guidelines

for correctional healthcare is the National Commission on Correctional Health Care (NCCHC). This not-for-profit organization began its activities in the early 1970s, when a study by the American Medical Association "found inadequate, disorganized health services and a lack of national standards" in U.S. jails.[57] The NCCHC evaluates and develops policy and sets standards for health services in correctional facilities that it publishes on its website and in separate volumes for prisons, jails, and juvenile confinement facilities.[58] Although many professional organizations refer to general medical ethics in their recommendations concerning correctional healthcare, one remarkable characteristic of professional guidelines in the U.S. is that professional organizations find ethics and clinical medicine in the prison context sufficiently different from practice outside correctional institutions that they have written separate guidelines for each. The reasons for these different recommendations are illustrated by the "NCCHC Clinical Guideline for Health Care in Correctional Settings: Asthma."[59] Although this clinical guideline is based on a national U.S. guideline ("Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma,"[60] issued by the National Heart, Lung, and Blood Institute of the National Institutes of Health), modifications were judged necessary for the prison and jail context: "Correctional settings tend to house large numbers of patients with asthma, and the phenomenon can lead to serious problems with morbidity and mortality. The modifications [in these guidelines] were designed to simplify the NAEPP [National Asthma Education and Prevention Program] guidelines and be more cautious due to the special challenges of providing care in the correctional setting. Our intent is for clinicians to focus on those patients whose disease is categorized as moderate or severe as well as any patient whose clinical status is unstable."[61] This quotation from the NCCHC "Clinical Guideline" clearly indicates that the standards recommended for prisoners are lower than those outside prisons because prison physicians do not have the time and resources to treat or diagnose mild asthma.

This example illustrates the dilemma that most professional organizations that have members who provide healthcare for prisoners face: like the NCCHC, the American College of Physicians (ACP) acknowledges in its "Ethics Manual": "Limited access to health care is one of the most significant characteristics of correctional systems in the United States."[62] The gap between the level of healthcare services that are available outside prisons and the conditions in correctional institutions is a great ethical burden, with which professional organizations, every prison physician, and prison directors[63] must struggle. In a report to the U.S. Congress, the NCCHC stated that it regrets the lack of available specific "guidance or advice on moral issues that are unique to correctional heath care settings. Correctional healthcare professionals function in a highly restrictive and unique environment. There is limited opportunity for peer review of medical policies and administrative actions in a correctional environment."[64] Therefore the NCCHC recommended that a national advisory panel be established on ethical decision making among correctional and health authorities, to assist it in addressing the ethical dilemmas encountered in correctional healthcare, especially issues such as confidentiality, informed consent, and access to care for infectious diseases.[65]

In the following sections, we will summarize the ethical recommendations from various U.S. professional organizations concerning the three most central issues in general medical care:

- Access to treatment,
- Consent of prisoner patients, and
- Confidentiality.

In addition, we will address briefly recent pressing issues:

- Participation in interrogation,
- Participation in execution, and
- Physicians' attitudes towards the abuse and torture of inmates.

We will focus here on a description of those aspects in which U.S. guidelines differ from international and European recommendations and evaluate these differences later in the discussion section.

Access to Treatment. Recommendations from U.S. professional organizations concerning access to treatment vary widely from a general requirement that healthcare should be "available," from the American Bar

Association[66] and the American Public Health Association;[67] to statement invoking "unimpeded access to health care," from the American Correctional Association;[68] to the principle of equivalence, from the American Psychological Association: "The fundamental policy goal should be to provide the same level of mental health services to patients in the criminal justice process as are available in the community."[69]

In addition, the need to communicate information about access to healthcare services to inmates, orally and written in a form and language they can understand, upon arrival in a prison,[70] as well as a need "for a system of processing complaints regarding health care" by the ACC,[71] is stressed.

As the clinical guidelines from the NCCHC on asthma indicate, the requirement to make healthcare "available" is often acknowledged to be limited to the more severe forms of a disease. Similarly, the American College of Physicians (ACP), after stating that it has multiple reasons (scientific, ethical, and policy) to be involved in the politics and care of prisoners, notes "the future challenges posed to internal medicine," especially "the prioritization of funds and expenditures in a capitated setting." It also reminds readers, "if one accepts that societies may be judged by how they handle their most vulnerable populations, ensuring quality healthcare delivery in prisons clearly belongs among the College's missions."[72]

The ACP "Ethics Manual," after reminding readers that correctional systems in the U.S. are characterized by their "limited access to health care," adopts the vague standpoint that "physicians who treat prisoners as patients face special challenges in balancing the best interests of the patient with those of the correctional system." Despite these limitations, the ACP "Ethics Manual" states, "physicians should advocate for timely treatment and make independent medical judgments about what constitutes appropriate care for individual inmates."[73] No guidance is given regarding what this "advocacy" requires in terms of the personal obligations of prison physicians or the responsibility of professional organizations (for example, to eject members who do not refuse to comply with unethical health standards).

Consent. The "NCCHC Clinical Guidelines" refer to strict standards for informed consent to treatment, which include the requirement to obtain consent according to legal standards set by the states, documentation of consent, and exceptions specified by law.[74] In practice, however, treatment may be given to an inmate without his or her permission if refusal of treatment would place others at serious risk.[75] Guidelines are more explicit on consent for mental health treatment. For example, the APA "Draft Forensic Mental Health Standards and Guidelines" states, "The principles of informed consent as embodied in the ethical guidelines of the American Psychiatric Association remain applicable to patients in lock-ups, jails, and prisons. The patient should participate, to the extent possible, in decisions about evaluations and treatment. Psychiatrists should offer to discuss with their patients the nature, purposes, risks, and benefits of the potential types of treatment."[76] In a training manual, "HIV Mental Health and Prisons," the APA emphasizes that "refusing medical treatment or missing a therapy appointment is not generally an appropriate reason for a disciplinary infraction, as anyone, including inmates, has the right to refuse medical treatment. Refusing medical treatment or missing therapy sessions is generally best handled in the context of the therapeutic relationship and explaining to the inmate the consequences of the refusal (e.g., they may be discontinued from your caseload, their medical condition may not resolve, etc.) is a more appropriate way to handle this situation."[77] This statement is somewhat ambivalent because the term "generally" might be seen to imply that a disciplinary action could sometimes be justified when an inmate refuses treatment.

Confidentiality. Although the NCCHC guidelines refer to court cases that establish the constitutional right of inmates to privacy in their medical diagnoses and other healthcare records and information (*Doe v. Coughlin,* 1988; *Woods v. White,* 1988), B. Jaye Anno, one of the founders of NCCHC, states in the guidelines that this "right is not violated by the reporting of medical findings in the ordinary course of prison medical care operations or probably even to prison and jail executives with a reason to know."[78] What seems to be unconstitutional is only the "casual, unjustified dissemination of confidential medical information to nonmedical staff and other prisoners" (*Woods v. White,* 1988:874).[79]

The APA training module on HIV, mental health, and prisons contains explicit sections on the limitations on privacy and confidentiality within correctional systems: "As mental health professionals steeped in the ethics of confidentiality, working in a correctional system where little is confidential is challenging. Most

correctional systems respect the importance of confidentiality for outside providers operating in the system; however, each system has explicit requirements for reporting. All professionals are accustomed to reporting requirements for credible threats of harm to the self or others or to children or vulnerable adults. However, in prisons, threats of harm can take the form of information concerning planned break outs — a source of harm that outside professionals may not consider. It is important to clarify your ethical reporting responsibilities and procedures. Similarly, you must plan how you will inform inmates clearly about the limitations of confidentiality in your work."[80] Of particular concern to the APA is the problem of confidentiality in the case of suicidal ideation: "In correctional settings, professionals must carefully balance the potential threat of self-harm with the potential harm caused by reporting. In prisons, threats of self-harm are generally not met simply with understanding and reassurance. Inmates who report thoughts or attempts at self-harm may be strip-searched and placed in segregation. Hence, your responsibility as a professional is increased to ensure that all potential harms are considered in reporting."[81] In light of the risks to confidentiality in the correctional setting, the APA goes so far as to suggest that, in the case of potentially damaging information collected in the course of HIV research, such as information on sexual behavior or substance abuse (which have potential legal and disciplinary consequences for inmates), researchers must not only ensure that sensitive information is protected, but also "that information that is potentially damaging is not collected."[82] Similarly, the APA recommends that some health information should not be put into the medical record of a detainee, but kept in locked separate files by the psychologist: "The psychological report may go in the medical packet, but the raw test data should be kept in a separate locked file in your office. This insures that individuals who do not understand the psychometric properties of the testing material or interpretation [assumed to be security personnel] are not given the raw data to falsely interpret."

The APA guidelines make clear that the ethical dilemmas that face health personnel around confidentiality in correctional institutions is caused by the conflict of some state laws with ethical values: "Inmates may divulge reportable offenses (substance use, sexual activity, possession of contraband) to you in the course of your counseling, education, or prevention interventions. While most prisons only require suicidal or homicidal intent or ideation, child/vulnerable adult abuse, and threats to security (such as, elopement or escape plans), be sure to check your specific requirements." Also, "Then, be sure to outline the limits of confidentiality to every patient that you work with at the prison. Understand that while confidentiality issues may be clear to you, some prison administrators may not abide by these limits and try to pressure you to violate confidentiality of your patient. Be polite but firm in stating your reporting obligations to administrators." It should finally be noted that the APA makes an effort to remind health personnel to send security officers out of the consultation room to ensure privacy: "When conducting an evaluation, be sure to get as private a space (within the constraints of security) as possible. This communicates respect to your patient, in addition to just being good ethical practice. Instead of having an officer in the room during the assessment, check to see if the officer could sit outside the room and look in through the window. This will be dictated entirely by security practices and if this is not possible, you will need to decide whether to conduct the assessment."[83]

The stance of the APA might be characterized as acknowledging that general professional ethics might need to be partly abandoned in the prison context, due to state law and individual prison policy, and as attempting to minimize limitations of confidentiality as much as possible. Some state government bodies, such as the New York State Office of Mental Health, more adamantly oppose restrictions to confidentiality in the correctional setting, especially in situations such as the involvement of physicians in capital cases: "The concerns raised by the CDO [Capital Defender Office] are serious ones and not to be taken lightly. The CDO considers all statements made by capital defendants to be protected and confidential and that by participating in clinical interviews, inmates do not waive their statutory rights to confidentiality or their constitutional rights to freedom from self-incrimination. . . . The SCOC [State Commission of Correction] and the OMH [Office of Mental Health] have assured the CDO that mental health service providers zealously protect the confidentiality of their interactions with inmates according to strict codes of ethics under which the various treatment professions practice. Moreover, the provisions of Mental Hygiene Law §33.13 adequately protect the constitutional and confidentiality rights of capital defendants since all clinical information is presump-

tively confidential and barred from disclosure unless expressly authorized under the statute. Since there is no statutory exception for the disclosure of otherwise confidential clinical information to prosecutors of capital cases, the only applicable exceptions would be inmate consent or a court order requiring disclosure upon a finding that the 'interests of justice significantly outweigh the need for confidentiality' (for example, a judicial subpoena without this finding would be insufficient to release the information)."[84]

Participation in interrogation, participation in execution, physicians' attitudes towards abuse and torture. Finally, we think it important to mention briefly the publication of several recent professional guidelines in the U.S. triggered by the recent events in Guantanamo and with respect to the war on terror. Whereas some organizations in the U.S. are not unanimous in their defense of a standard that considers nonequivalent healthcare as inhuman and degrading treatment, some have adopted strict positions against the participation of physicians in torture and capital punishment,[85] which are in line with U.N. recommendations and European guidelines. An ACP statement, "Relation of the Physician to Government,"[86] is similar to a recent position paper from the NCCHC, "Correctional Health Care Professionals' Response to Inmate Abuse."[87] The ACP states, "Physicians must not be a party to and must speak out against torture or other abuses of human rights. Participation by physicians in the execution of prisoners except to certify death is unethical. 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 for the Treatment of Prisoners."

Discussion: Differences between the U.S. and International and European Regulations Concerning Ethics in Correctional Healthcare

The recommendations of U.S. professional organizations, as well as the U.S. legal framework, clearly differ in many respects from European and U.N. guidelines, especially concerning access to healthcare and confidentiality. While equivalent healthcare for detainees is required by human rights law in the European and U.N. guidelines, a large body of soft law, and specific enforcement mechanisms, in the U.S. the principle of equivalence is never mentioned in court cases and emerges only rarely in professional guidelines. As a consequence, U.S. professional organizations do not use the same guidelines for prisoners and nonprisoners, but struggle with the proposition of special guidance and its ethical justification.

From a strict human rights approach, in line with the recommendations of the Council of Europe, neither a lack of access to healthcare for a significant proportion of non-incarcerated individuals nor a similar (or worse) lack for detainees is acceptable. But even given the high priority that Americans assign to an individual's freedom to decide whether to purchase health insurance or to spend money on other goods, the lack of healthcare for prisoners is difficult to justify because incarcerated persons do not have the freedom to choose. They cannot choose between different health insurance plans, nor can they rely on family or other supportive resources (such as, for example, help from a charitable organization) when they encounter health problems. This situation is similar, if not worse, than the situation of limited choices available for other parts of the population, such as the poor and the uninsured elderly, for whom the U.S. provides federal insurance coverage. In the absence of a uniform standard of care in the U.S., the principle of equivalence should at least be interpreted as an obligation to assure healthcare access for prisoners that would be equivalent to Medicaid, as reported in Oregon.[88]

Professional organizations in the U.S. might be hesitant to do this because providing healthcare services for prisoners is a sensitive issue, and it may be difficult to admit that prison physicians are forced to constantly breach basic ethical principles when they agree to work in circumstances that are fraught with ethical problems. U.S. professional organizations would deal more appropriately with the ethical dilemmas of healthcare professionals who work in correctional institutions by stating clearly that a prisoner does not differ from any other patient with respect to deontological and ethical obligations within the patient-physician relationship. Such clarity would allow a consideration of the actual ethical dilemma: the unethical conditions under which many physicians work in correctional institutions.

Professional organizations can do more than acknowledge that the ethical dilemmas that healthcare professionals in prisons face justify an explicit discussion of triage or other models, and attempt to find an efficient and just way to distribute limited resources. Another solution has been, at least in theory, used in some European countries. If a physician in a particular situation can only act in an unethical way, for example, being forced to under treat a patient, professional organizations could — as they do for physicians who participate in capital punishment and torture — sanction members who engage in such practices. If professional organizations ban members from working in clearly unethical prison environments, correctional institutions will be exposed to increased pressure to change.

It is surprising how far, compared to international and European standards, the American College of Physicians departs from the general values of medical ethics. What does it mean, when it states in its "Ethics Manual," that physicians need to "balance . . . the best interests of the patient with those of the correctional system"?[89] From a European standpoint, decisions made in correctional healthcare must use the same ethical principles as those used outside prisons. What makes ethics in correctional healthcare different from ordinary medical ethics is not the reasoning process, but the context in which the balancing of ethical principles takes place. The obligation of a physician is not to balance the interests of a patient against the interests of the correctional system; rather, the principles of beneficence and nonmaleficence require a physician to consider what constitutes a good outcome for a patient, and also the possible outcomes that can be expected in the prison context, compared to the possible outcomes outside prison.

We will illustrate the difference between the approach of the ACP and a European approach, using the example of conflicts that healthcare personnel face regarding confidentiality as a result of interaction with third parties, such as the justice system and prison security personnel. Nonmedical personnel do not need to have access to confidential information to ensure security. Imagine a detainee who suffers from an acute medical condition that requires immediate transfer to an outside hospital. In U.S. prisons it is not rare that wardens must be informed about a detainee's medical condition before they will approve transport to the hospital. However, from a classical view of medical ethics, the principles of beneficence and nonmaleficence require that a physician decide to transfer on the grounds of medical necessity alone, and obtain the consent of the detainee before any information is divulged. Within the framework of the guidelines of the Council of Europe, the responsibility of the warden is to organize the transfer of the patient and assure security. Thus, a warden needs to be told only what is necessary for the medical transfer: *Will it require an ambulance or can another transportation modality be used? To which hospital should the detainee be transferred? Should accompanying personnel wear a mask to protect them from contracting a contagious respiratory disease?* There is no need to reveal a diagnosis for security reasons. Ethical principles require a physician to inform a warden that he or she is bound by medical confidentiality.

In Switzerland the confidentiality requirement is part of criminal law. If a physician breaches medical confidentiality without a valid reason, he or she risks prosecution, as well as the loss of his or her authorization to practice. Healthcare workers who transmit medical information to a warden in this situation will not only be sanctioned by the medical institution for which they work, they will also be subject to federal law if the detainee engages in a lawsuit.

We recommend, in the case of a non-urgent conflict with a warden, that a physician inform the medical hierarchy, which will then discuss the matter with the warden. In an urgent case, should a warden refuse a transfer, requiring that he or she be given medical information that she or he does not have the right to know, a physician should explain his or her obligations to the warden, including an immediate report to the medical hierarchy, and that the medical institution will inform the warden's hierarchy about the incident and its medical consequences for the detainee.

Within the European human rights framework that regulates healthcare for detainees, the statement by the ACP that the right to confidentiality "is not violated by the reporting of medical findings in the ordinary course of prison medical care operations or probably even to prison and jail executives with a reason to know,"[90] is not acceptable unless, based on the same laws and guidelines that apply outside prison, an immediate danger to an identified person exists that can only be prevented by breaching confidentiality.

In addition, reporting suicidal ideation to non-health personnel, as discussed by the APA,[91] would not be justified within the approach recommended by the Council of Europe. Strip-searching and segregating inmates who report thoughts or attempts at self-harm would not be acceptable; instead, based on the probability of self-harm, inmates would be transferred to an in-patient psychiatric unit without any need to breach confidentiality. If the probability of self-harm is sufficiently low to justify allowing the prisoner to stay in the correctional institution, the prisoner should be asked whether security personnel may be informed that the prisoner is suicidal, the aim being to increase the vigilance of non-health personnel to meet the health needs of detainees.

CONCLUSIONS

The framework of medical ethics in correctional healthcare is outlined in international declarations. In contrast to ethical guidelines and legal regulation in the U.S., the U.N., the Council of Europe, and the WMA state unanimously that medical ethics in correctional healthcare should follow the same principles as those followed outside correctional institutions. U.S. professional organizations should make statements that are more clearly in line with international frameworks not only concerning issues of recent intensive media coverage, such as physicians' participation in torture and executions, but also access to healthcare and confidentiality. Ethical principles should be weighed in correctional healthcare using the same criteria used outside correctional institutions, taking into account the harm-benefit ratios related to the specific context as well as specific risks to decisional autonomy. The evaluation standard for the medical care of detainee patients should be: *How would I treat a patient who is not incarcerated?* Unless the situation involves immediate danger to an identified person that cannot otherwise be prevented, breaches of confidentiality and paternalism cannot be justified — the same standard used outside prisons. To remedy this disparity, efforts should be made to address the pressures created by the prison context during medical consultations, and to search for practical solutions to change or circumvent these factors.

Dual loyalty conflicts related to confidentiality should be evaluated using the same high threshold criteria as for patients at liberty; for example, confidentiality can be overridden to prevent serious, imminent harm to an identified person when it cannot be prevented in any other than by breaching confidentiality.

It should be noted that we report here basically on guidelines. A large gap may exist between what is expressed in guidelines and clinical reality. Numerous web sites and books written by former prisoners report a substantial number of ethical problems in correctional healthcare, and not only in the U.S. In spite of adequate ethical and legal standards, in Europe, the published reports of the CPT, as well as cases brought before the European Court of Human Rights, provide evidence of unmet ethical standards in many European countries. A clear need exists for empirical studies that address ethical problems and standards in correctional healthcare; these will help identify the issues and situations in which education and changes are urgently needed, and will provide the evidence needed to capture the attention of policy makers and the population at large to put the needed changes in practice.

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