Bernice S. Elger, "Response to Douglas and Goold," *The Journal of Clinical Ethics* 19, no. 3 (Fall 2008): 271-73.

Response to Douglas and Goold

Bernice S. Elger

Bernice S. Elger, MD, PhD, MA (theol.), is a Professor at the University Center of Legal Medicine of Geneva and Lausanne, Switzerland, *Bernice.Elger@hcuge.ch.*

First of all, I thank Sharon Douglas and Susan Dorr Goold for supporting my claim that the neglected domain of ethics for healthcare professionals who work in prisons needs more attention, and for acknowledging that "studies paint a dim picture"[1] about the ethics of correctional healthcare in practice, in the U.S. and elsewhere.

I am glad to have the opportunity to discuss briefly some aspects of the statements by the AMA concerning medical ethics in prisons because these statements help to illustrate the points I made in my article. Because of the limited space, I will present a few examples. A more detailed comparison of AMA policy concerning healthcare ethics with recommendations from the Council of Europe[2] and the World Medical Association (WMA) will follow in a future separate publication.

THE PRINCIPLE OF EQUIVALENCE

In the three bodies of AMA policy available on the internet (health ethics, including the AMA *Code of Medical Ethics,* AMA directives, and AMA governance),[3] the *principle of equivalence* or the term *equivalent care* for detainees are not mentioned. Instead, policy D-430.998 (entitled "Health Care Standards in U.S. Correctional Facilities")[4] states only that standards in correctional settings are under evaluation and that AMA is consulting "appropriate medical specialty societies and the National Commission on Correctional Health Care (NCCHC)." As Douglas and Goold acknowledge, standards that meet those of persons "in the outside community at large" are mentioned in a specific context only, namely concerning HIV treatment for detainees ("Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to all approved therapeutic drugs and generally employed treatment strategies," H-430.988 "Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities").[5]

Furthermore, the same policy departs from the equivalence principle when it recommends mandatory HIV testing ("Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes mandatory testing for HIV infection and tuberculosis followed by appropriate treatment for those infected"). The position of the AMA is in contrast with European soft law, which clearly allows only voluntary testing based on respect for the principle of equivalence: "Epidemiological HIV/AIDS monitoring including anonymous, non-correlated screening could be considered only if such methods are used in the general population and if their application to prison populations appears likely to yield results useful to prisoners themselves."[6]

No one questions that, as Douglas and Goold argue, "respect for individual autonomy may be outweighed by other obligations to that patient or by other considerations, including the good of society."[7]

Rather, as shown by the example of mandatory versus voluntary testing of prisoners, the point is that the cut-off thresholds in the balance between individual rights and public health must be the same inside and outside prisons.

BODY SEARCHES

Another interesting example is AMA policy on body searches. The Council of Europe states clearly that "prison doctors should not become involved in such procedures."[8] The WMA allows physicians to participate in exceptional and emergency circumstances: "This non-medical act may be performed by a physician to protect the prisoner from the harm that might result from a search by a non-medically trained examiner."[9] In contrast, the AMA endorses physicians' participation in body searches in a routine manner, outside urgent and exceptional situations: "(1) Since searches of body orifices are conducted for security and not medical reasons, there is usually no need for them to be performed by medical personnel and, as a general rule, it is preferable that they be performed by correctional personnel who have been given special training. (2) Where state laws or agency regulations require that body cavity searches be conducted only by physicians or other medical personnel such as physician assistants, nurses or nurse practitioners, such searches should be performed by healthcare personnel other than those employed to provide care to inmates" (H-430.999, "Searches of Body Orifices").[10] This example of AMA policy reinforces a point made in my article, that professional organizations should go beyond acknowledging the ethical dilemmas that face healthcare professionals in prisons when legal or prison practices require unethical conduct: "If a physician in a particular situation can only act in an unethical way. . . professional organizations could — as they do for physicians who participate in capital punishment and torture — sanction members who engage in such practices."[11] This may force the states to change their policies and laws (especially if the sanctions involve loss of professional licenses). Rather than adapting AMA policy to accommodate state laws, the AMA could set clearer ethical limits for physicians.

A BASIC RIGHT

As Douglas and Goold state, under the AMA *Code of Medical Ethics*, access to care includes "a basic right to have available adequate healthcare," as well as a right to continuity of care, which applies to all patients, including prisoners. Douglas and Goold note, " 'Principle IX' of the AMA *Code of Medical Ethics*, 'A physician shall support access to medical care for all people,' speaks for itself."[12] Yet in fact, the voice of the AMA *Code* is rather muffled. The principles in question need to be applied to the correctional context more clearly and openly — and more often. Of the eight articles published since 2004 in the *Journal of the American Medical Association* that include the key word *prison*, only one (by Linder and colleague, published after the final redaction of my article),[13] refers to the AMA *Code of Medical Ethics.*

Indeed, physicians do not possess magic wands to make "access to care" and "confidentiality" a reality. How should a physician, faced with an AMA recommendation that is in favor of mandatory HIV testing, respond to the following text from the same recommendation: "Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate" (H-430.988), if, as is often the case, confidentiality is not respected in the facility where the physician works?[14] Although Douglas and Goold are right that "Unfortunately we know very little about correctional healthcare ethics in practice,"[15] some things *are* widely known, such as the lack of confidentiality and the great variation among correctional facilities concerning access to healthcare services in the U.S. The interesting question that needs more attention is: *What should an individual physician do in an unethical context?* This dilemma is not resolved by Douglas and Goold's reminder that the AMA requires physicians to denunciate unethical colleagues. Most prison physicians are willing to respect medical ethics, but many have few alternatives — accept unethical compromises, quit their job, or lose their job because they do not comply with prison directives.

I appreciate the opportunity provided by the commentary from CEJA to restate my conclusion that "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."[16]

ACKNOWLEDGMENT

I thank Alex M. Capron, LLB, for his comments and encouragement.

NOTES

1. S. Douglas and S.D. Goold, "Commentary on "Medical Ethics in Correctional Healthcare," in this issue of *JCE*.

2. It is worth mentioning that the Australian Medical Association (also abbreviated as AMA) defends positions that repeat those of the Council of Europe concerning the principle of equivalence as well as body searches. Australian Medical Association, "Health Care of Prisoners and Detainees — 1998," *http://www.ama.com.au/web.nsf/doc/SHED-5G4V6U,* accessed 30 August 2008.

3. To access the AMA *Code of Ethics, Policies of the AMA House of Delegates,* and the *AMA Constitution and Bylaws* online, use the AMA Policy Finder: *http://www.ama-assn.org/ama/noindex/category/11760.html,* accessed 30 August 2008.

4. American Medical Association policy D-430.998, "Health Care Standards in U.S. Correctional Facilities," *Policies of the AMA House of Delegates,* use the AMA Policy Finder, *http://www.ama-assn.org/ama/noindex/category/11760.html,* accept the terms of use, and search on D-430.998.

5. Ibid.

6. Council of Europe, "Recommendation No. R (93)6 of the Committee of Ministers to Member States concerning prison and criminological aspects of the control of transmissible diseases including AIDS and related health problems in prison," *http://www.legislationline.org/legislation.php?tid=160&lid=4908&less=false,* accessed 30 August 2008. The same recommendation states, "In the present state of knowledge, compulsory testing of prisoners should be prohibited since it would be ineffective and discriminatory and therefore unethical."

See also "Council of Europe Committee of Ministers Rec(1998)7 on the ethical and organisational aspects of healthcare in prison, explanatory memorandum," *http://www.unav.es/cdb/ccoerec98-7exp.html,* accessed 30 August 2008, which states, "28. Opportunity should be made available to all incoming prisoners to receive, in private, advice concerning infectious ailments which may have been acquired prior to entry into the prison. In this perspective voluntary screenings for such diseases as hepatitis, sexually transmitted diseases, tuberculosis or infection with HIV are required."

7. Douglas and Goold, see note 1 above.

8. "Council of Europe Committee of Ministers Rec(1998)7 on the ethical and organisational aspects of healthcare in prison," *http://www.coe.int/t/e/legal_affairs/legal_co-operation/prisons_and_alternatives/legal_instruments/Rec.R(98)7%20.asp,* accessed September 2007.

9. WMA. World Medical Association Statement on Body Searches of Prisoners. Adopted in Budapest, Hungary, October 1993.

10. American Medical Association policy H-430.999, "Searches of Body Orifices," *Policies of the AMA House of Delegates,* use the AMA Policy Finder, *http://www.ama-assn.org/ama/noindex/category/11760.html,* accept the terms of use, and search on H-430.999.

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

12. Douglas and Goold, see note 1 above.

13. J. F. Linder and F. J. Meyers, "Palliative Care for Prison Inmates: 'Don't Let Me Die in Prison'," *Journal of the American Medical Association* 298, no. 8 (2007): 894-901.
14. AMA policy D-430.998, see note 4 above.
15. Douglas and Goold, see note 1 above.
16. Elger, see note 11 above.