Prison Health Care Governance: Guaranteeing Clinical Independence

Clinical independence is an essential component of good health care and health care professionalism, particularly in correctional settings (jails, prisons, and other places of detention), where the relationship between patients and caregivers is not based on free choice and where the punitive correctional setting can challenge optimal medical care.

Independence for the delivery of health care services is defined by international standards as a critical element for quality health care in correctional settings, yet many correctional facilities do not meet these standards because of a lack of awareness, persisting legal regulations, contradictory terms of employment for health professionals, or current health care governance structures.

We present recommendations for the implementation of independent health care in correctional settings. (*Am J Public Health.* 2018;108:472–476. doi: 10.2105/AJPH.2017.304248)

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See also Wynia, p. 440.

In 2015, more than 10 million individuals were incarcerated worldwide at any one time. Approximately 30 million individuals enter prisons each year,[1] and many thousands more migrants and asylum seekers are detained.[2] The provision of health care for detained persons (those living in correctional settings, including prisons, jails, and other places of detention) has several pervasive, though not unique, characteristics. First, the state is responsible for delivery of all health care, which, legally or de facto, is the same entity responsible for rescinding liberty. Second, on average, detained persons have higher rates of morbidity and thereby greater health care needs than nondetained persons.[3,4] Additionally, cramped and sometimes overcrowded living conditions, common in correctional and detention facilities, carry health risks both for inmates and for the communities to which most will one day return.[5] The primary purposes of correctional facilities include separating the individual from society to serve a sentence and maintaining safety and security through administrative control. Each of these purposes can pose a challenge to the provision of high-quality health care. Finally, detained patients cannot choose their health care professionals.

Behind bars, it is not uncommon for health professionals to have a conflict between a primary duty to care for the health and well-being of patients and a secondary duty to follow the rules of prison management, whereby prisoners are not primarily patients but rather objects of surveillance, punishment, or rehabilitation. Therefore, health professionals often have a dual loyalty to their patients and to the institution.

There are a number of ethical, organizational, and structural barriers that are common in correctional health care. These include conflicts related to dual loyalty for health professionals; the provision of health care that is equivalent to the community standard in a unique health care delivery system; the assurance of timely access to health care professionals despite the competing demands of security in the facility; and the clinical independence of health care staff to ensure that the decisions made are in the best interests of their patients.[6–9]

The aims of this essay are to illuminate the importance of independent health care services in correctional settings and to provide recommendations for the implementation of independent health care services in correctional settings.

LEGAL AND ETHICAL BASIS

The World Medical Association (WMA) defines "clinical independence" as the "assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue influence by outside parties or individuals," and it "is a critical component of high quality medical care and an essential principle of health care professionalism."[10] This is of particular importance in correctional and detention settings, where the relationship between health care providers and patients is not based on free will.[11]

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The international legal basis for physician independence is provided by Article 12 of the International Covenant on Economic, Social and Cultural Rights, which guarantees "the fundamental right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[12] In General Comment No. 14 to Article 12 of the covenant, the UN Economic and Social Council declares that "In particular, states are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum-seekers and illegal immigrants, to preventive, curative and palliative health services." In addition, "all health facilities, goods and services must be respectful of medical ethics."[13] It is worth mentioning that the United States has not ratified this UN covenant.

The WMA has also developed an International Code of Medical Ethics: "A physician shall always exercise his/her independent professional judgment" and "A physician shall owe his/her patients complete loyalty." In 2008,[14] The WMA added "the individual physician's right to treat patients without interference, based on his best clinical judgment."

In addition to the general codes of health care ethics cited in this section, guidelines for the provision of health care in the ethically delicate and conflict-prone correctional health care setting have been elaborated in numerous international documents (see the box on this page). The essence of these documents includes the following:

1. The health care provided must be confidential and respectful of the patient's autonomy, with humanitarian support, clinical independence, and professional competence.
2. The sole task of health care providers in correctional settings is to provide health care with undivided loyalty to the patients, with unrestricted clinical independence, acting as the patient's personal caregiver without becoming involved in any medical actions that are not in the interest of patient health and well-being. States, in exercising their responsibility for the health of prisoners, must provide "full clinical independence" for health care providers.[15]

DOCUMENTS ON HEALTH CARE ETHICS IN PRISON AND DETENTION SETTINGS

- Revised UN Standard Minimum Rules for the Treatment of Prisoners—"Nelson Mandela Rules 2015"[15]
- UN Human Rights Office of the High Commissioner: 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, 1982[16]
- Bangkok Rules: United Nations Rules for the Treatment of Women Prisoners and Noncustodial Measures for Women Offenders[17]
- Council of Europe Recommendation R(98)7 of the Committee of Ministers to Member States Concerning the Ethical and Organizational Aspects of Health Care in Prisons[18]
- European Prison Rules 2006, Council of Europe Publishing[19]
- CPT standards, Substantive section of the CPT's General Reports[20]
- World Health Organization: Prisons and Health, 2014[5]
- Amnesty International: Codes of Ethics and Declarations Relevant to the Health Professions, 2011
- 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, 2006
- World Health Organization, Regional Office for Europe–Council of Europe: Strasbourg Conclusions on Prisons and Health, 2014

Note. CPT = European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment; UN = United Nations.

These documents, increasingly cited by international bodies in legal actions related to health care deficiencies in correctional settings,[21] are also the basis for the recommendations formulated in this essay and apply equally to all whose liberty of movement is denied by a government, including immigrant detainees.[7,22,23]

IMPEDIMENTS TO CLINICAL INDEPENDENCE

There are a number of factors peculiar to correctional and detention settings that may impair clinical independence, including the following.

Correctional health care professionals are frequently compelled to report to correctional—rather than health care—leadership in the facility. These military-like, hierarchical chains of command, which frequently require an oath to superiors, can exert undue influence and interference by custody staff on health care professionals and may obligate them to report patient-related medical information to the prison director or administration, when it is deemed necessary to carry out the custodial sentence.[24–26]

Correctional health care professionals are sometimes compelled to participate in custodial measures, such as in matters of discipline (e.g., to certify inmates as medically fit for punishment), solitary confinement, or the performance of body cavity searches or the retrieval of body fluids for testing for illicit drugs, even when there are no medical indications for such actions.

Patients' capacity to exercise their fundamental right to self-determination (informed consent or dissent) is often complicated in correctional facilities. For example, in contrast to the free world, where an appointment made by a patient with a physician implies basic consent for the physician to make a diagnosis and offer treatment, in the correctional setting such an implied consent cannot be assumed because detainees cannot choose their physician and the admitting medical exam is rarely initiated by the patient, but is instead ordered by the correctional institution.

Typically, in detention settings, there is a paucity of knowledge and awareness of health care ethics, including an understanding of the importance of clinical independence, yet

there are few training programs in medical ethics available to correctional health care staff.[27–30]

Internationally, there is a great variety of health care governance structures in prisons and detention centers. In the vast majority of states, the authority or ministry responsible for the administration of prisons and detention centers is also responsible for the health care of imprisoned or detained individuals. This structure conflicts with the World Health Organization (WHO) and UN Office On Drugs and Crime (UNODC) declaration that "Prison health services should be fully independent of prison administrations and yet liaise effectively with them."[11] In addition, "the management and coordination of all relevant agencies and resources contributing to the health and well-being of prisoners is a whole-of-government responsibility; health ministries should provide and be accountable for health care services in prisons and advocate healthy prison conditions."[31]

In an attempt to provide more independence for health care staff from the prison administration, several countries (e.g., Germany, Georgia, Azerbaijan) have subordinated medical departments directly to the relevant ministry rather than to the prison administration. Such governance allows for an independent health care budget that is separate from the general prison or detention center's other competing fiscal demands.

Prisons and immigration detention centers managed by for-profit companies or where the health care services are contracted out to for-profit companies are special cases. In the United Kingdom and the United States, for example, about 14% and 8%, respectively, of the national prison populations are detained in private prisons. The high profit margins of the "prison–industrial complex"[32] and doubts about the cost efficiency for the state, security, and quality of privately run prisons have raised public debates and resulted in a recent announcement by the US Department of Justice to end contracts with for-profit prison operators,[33] although this decision may be reversed by the current administration. Likewise, contracts with for-profit prison companies have been terminated in Canada.[34] In Israel, the Supreme Court has declared privately run prisons to be unconstitutional.[35] By contrast, contracted for-profit companies run immigrant detention centers in many nations, including the United States.

Compared with their colleagues employed by public administrations, health care professionals employed and paid by for-profit companies are exposed to the same, if not greater, challenges regarding professional independence.

The appeal of WHO–UNODC,[11] the Council of Europe,[19] the revised UN Standard Minimum Rules,[15] and other international organizations[36] to organize health care services in prison in close relationship with the general public health administration has been followed to a varying extent. In many countries, there is virtually no cooperation between the administrations of prisons and detention centers on the one hand and health authorities on the other. In other nations (e.g., Austria, Germany, Netherlands), health authorities are requested at least to perform the inspection and supervision of hygiene or the licensing and accreditation of health care facilities and health care personnel in prisons and detention institutions. In some states (e.g., Argentina, Estonia, Montenegro, Slovenia, Turkey), prison health care has been partially integrated within the national health system. A number of countries have succeeded in a complete integration of prison health care with the national public health by transferring its responsibility and administration to the national health system and ministry of health; these include Norway; France; the United Kingdom; the Swiss cantons of Geneva, Vaud, Valais, and Neuchatel; New South Wales in Australia; Italy; Kosovo; Catalonia in Spain; and Finland. Others have started the process of transfer.

DELIBERATION AND RECOMMENDATIONS

Unrestricted clinical independence[15] for health care providers constitutes the bedrock of ethically sound health care for individuals in detention, and is based on the assertion that the sole task of health care professionals is to evaluate, protect, or improve their patients' physical and mental health.[16] This is not necessarily the primary goal in detaining facilities, however, where conflicts and misunderstandings between health care and custodial staff are commonplace occurrences. In reality, neither ethical health care in prisons and detention centers nor humane detention is possible without close cooperation between the professional groups committed to their differing objectives. However, this cooperation can be successful only on the basis of a clearly defined separation of professional roles and tasks and a mutual understanding of the respective roles, legal and ethical guidelines, and challenges of each profession.

The practical implementation of the objectives of health care in prisons and detention centers requires the support and permission of the governor of the institution—for example, transferring inmates for medical interventions to outside facilities or the procurement and installation of health equipment in the institution. In this regard, the Mandela Rules state that "Clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical prison staff."[15]

Patients' rights of self-determination are important cornerstones in medical ethics and apply to health care in detention settings just as they do in the community. Implied consent of an imprisoned or detained person to undergo medical care can be assumed only if it has been made clear to the patient that the physician is obligated to offer the examination on admission, but the inmate has the right to refuse, as with any other medical intervention. In this unique situation, building a sustainable patient–doctor relationship requires that the detained patient can at least rely on the unrestricted clinical independence of the physician.

Theoretically, prison health care staff can exercise clinical independence in whatever governance structure they face, grounded in sound knowledge of health care ethics, firm conviction, personal courage, and job security. However, the risk of interference by prison and detention administrations with clinical independence is certainly greater if health care is directly subordinated to these administrations, particularly if health care professionals are integrated into military-like (command-control) hierarchies. Health professionals

who concurrently work in prison and in the community are more likely to retain their sense of professional independence. Also, they may benefit from the intellectual stimulation and cooperation of colleagues in community health services. The greater the cooperation with and supervision from national health authorities, the lower the risk of inappropriate interference with clinical independence by custodial constraints. These observations and considerations lead us to formulate the following recommendations for the practical implementation of the standards of health care ethics, particularly that of clinical independence in detention settings.

Education and training:

- Comprehensive training of correctional health care professionals in health care ethics to raise awareness of the importance of clinical independence;
- Facilitated workshops with medical and custodial staff to improve acceptance of medical ethics and establish organizational and administrative conditions at the institutional level that allow for health care to be delivered consistent with health care ethics.

Structural reforms:

- Strict personal separation of health care provision from medical activities commissioned for forensic purposes by third parties such as the prison and detention center administration, prosecutors, courts, and state authorities (e.g., certificates for the prison administration, the prosecutor, or the court; body searches; drug testing for security reasons) to reduce dual loyalty conflicts;
- Professional organization and national representation by national and international medical boards of health care professionals working in prisons and detention centers to strengthen corporate identity and provide professional backup in conflicts with penitentiary authorities;
- Systematic and regular inspection and supervision of health care services in prisons and detention institutions by independent public health authorities to measure clinical performance and to ensure that care is ethical. This is particularly relevant for institutions run by private companies.

Financial and legal reforms:

- Separation of health care budgets from prison and detention budgets on the institutional and central administrative levels to allow for health care budgets independent of the general prison or detention center's other competitive financial needs;
- The amendment of laws and regulations that conflict with health care ethics and the anchoring of health care ethics into codes of imprisonment and detention.

Service delivery reforms and evaluation:

- Stepwise transfer of responsibility for prison and detention health care to national or state health authorities and employment of health care professionals by public health authorities on a local, regional, or national level;
- Employment of health care professionals who concurrently work both in prison and in the community to reduce the perils of the professional isolation that accompanies practice exclusively behind bars and also to facilitate equivalence of care;
- Scientific evaluation of the impact of the transfer of responsibility, with particular attention to the quality of health care, including the physician–patient relationship. In addition, barriers related to the transfer must be evaluated.

Given the scarcity of national reporting and quality outcomes data,[37,38] the precise impact of the transfer of prison health care to public health authorities is not yet available. However, countries that have undergone this process report increased professional independence for health care professionals.[39] WHO and UNODC have made clear "that transferring prison health care to the jurisdiction of health ministries will be a long process" and "that success, and not putting prisoners at increased health risks, require that governments give this process the highest political commitment, communicate fully across all levels of management and personnel, and carefully plan and implement the practical steps, including all necessary budgetary implications and transfers of funding."[11] Improving national reporting and developing solid indicators for prison health care quality is paramount for success of these measures.

CONCLUSIONS

Although some time has passed since the current standards for health care ethics in prison were established, the delivery of health care in many correctional settings has not adapted to fully comply with the current standards. This shortcoming is particularly true for clinical independence. To "make the current standards work,"[40] we present recommendations to enhance clinical independence in prison health care. The advancement of independence among health care professionals practicing in correctional settings will help to improve timely access to high-quality prevention and health care services. Whether detained people reintegrate back into free society sooner or later, their improved health will serve public health and the entire community. AJPH

CONTRIBUTORS

J. Pont and H. Wolff led the writing, with support from S. Enggist and H. Stöver and input from B. Williams and R. Greifinger. All authors made substantial contributions to the conceptualization and analysis of the work, revised it critically, and approved the final version of the essay.

HUMAN PARTICIPANT PROTECTION

No protocol approval was necessary because data were obtained from secondary sources.

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