Resolving Ethical Conflicts in Practice and Research

Dual Loyalty in Prison Health Care

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Despite the dissemination of principles of medical ethics in prisons, formulated and advocated by numerous international organizations, health care professionals in prisons all over the world continue to infringe these principles because of perceived or real dual loyalty to patients and prison authorities.

Health care professionals and nonmedical prison staff need greater awareness of and training in medical ethics and prisoner human rights. All parties should accept integration of prison health services with public health services.

Health care workers in prison should act exclusively as caregivers, and medical tasks required by the prosecution, court, or security system should be carried out by medical professionals not involved in the care of prisoners. (*Am J Public Health.* 2012;102:475–480. doi:10.2105/AJPH.2011.300374)

DUAL LOYALTY IS AN ETHICAL dilemma commonly encountered by health care professionals caring for persons in custody.[1,2] Dual loyalty may be defined as clinical role conflict between professional duties to a patient and obligations, express or implied, to the interests of a third party such as an employer, an insurer, or the state.[1] The dual loyalty practitioners most commonly face in prison is between their patients and the prison administration or the state authority.[1] We aim to shed light on the problem of dual loyalty in prison health care and to identify measures to reduce and solve the problem.

DOCUMENTS ON MEDICAL ETHICS IN PRISONS

Ethical rules for health care professionals in prisons are amply and clearly defined in rules, resolutions, declarations, and recommendations by the United Nations (UN),[3–6] the Council of Europe,[7–9] the World Medical Association,[10–14] the International Council of Nurses,[15] Physicians for Human Rights,[1] and Penal Reform International.[16] A few national codes also relate to health care matters in prison.[17–21]

According to these documents, the sole task of health care professionals working in prisons is the care of physical and mental health of the prisoners by

- acting as the private caregiver to the prisoners and observing the 7 essential principles of medical care in prison as quoted in the standards of the European Committee for Prevention of Torture (free access to medical care, equivalence of prison health care and community health care, confidentiality, patients' consent, preventive health care, humanitarian assistance, complete professional independence and competence)[9];
- advising the prison director on health affairs in prison, strictly obeying the 7 principles; and
- acting as a health and hygiene officer by inspecting and reporting on food, hygiene, sanitation, heating, lighting, ventilation, clothing, bedding, and physical exercise.

All of these tasks must be performed with complete loyalty to the prisoners; medical activities not in the interest of prisoners should not be undertaken by professionals who provide health care to prisoners, as stated clearly in principle 3 of the UN resolution on principles of medical ethics relevant to the role of health personnel in prison:

> It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.[4]

Such activities include forensic assessments, disclosure of patient-related medical data to others without consent of the patient, assisting in body searches or obtaining blood or urine for analyses for safety and security reasons, providing medical expertise for the application of disciplinary measures, and assisting or being complicit in physical or capital punishment, force-feeding, or torture.

The claim of exclusive concern with patients' welfare may strike some as excessive in light of the obligations health professionals have to third parties in other health care settings. However, health care professionals in prisons face extraordinary ethical challenges: prisoners, who cannot choose their care provider and who are fully dependent on the health care provided to them, are a vulnerable population, as demonstrated by the many exploitations, abuses, and violations of their human rights in the past.

Prisons are totalitarian and repressive institutions where "structures to support responses with human rights of patients are nonexistent or ineffective"[1] and "where there is often deliberate ambiguity about the health professional's role in the institution."[1]

Health care professionals working in prisons are also in a vulnerable position and may face pressures to serve medical purposes other than patient care.

> [They] often try to accommodate their medical skills to the limitations imposed on them. They often need to adjust standards of practice to institutional constraints. Moreover, many health professionals working in this environment are subject to employment arrangements that formally subordinate them to officials responsible for institutional operation, thus compromising their ability to exercise independent judgment. In other cases, they become part of an institutional culture that subordinates patient interests to the financial, political, or administrative agendas of the institution.[1]

VIOLATIONS OF MEDICAL ETHICS IN PRISONS

Despite this international body of ethical documents, health care professionals working in prisons continue to be at risk for violating principles of medical ethics,[1] and prison authorities, representatives of states, and even scholars of criminal law ignore or override them time and again.

The most spectacular violations in recent history that were brought before the public and widely discussed involved force-feeding of hunger strikers by health care professionals,[22,23] participation in carrying out the death penalty,[24] and complicity in torture.[25,26]

However, many subtle, much less spectacular situations in daily prison life cause health care professionals to forsake loyalty to their patients, often unwittingly or by failing to scrutinize routine procedures, decrees, or laws against the standards of medical ethics and human rights:

- The medical examination on admission of prisoners is of indisputable importance for the detection and treatment of health disorders, particularly those incompatible with imprisonment. However, the health care professional who is to care for the health of the prisoner as a private caregiver[9,16] should not issue certifications that prisoners are fit for imprisonment—a professional act that clearly is outside the principles of medical ethics and hardly ever fosters a trustful relationship with the patient.
- Penal systems with laws or decrees requiring the involvement of health care professionals in the approval of punishments and in the medical supervision of certain punitive or security measures (e.g., the penitentiary laws or regulations of Austria, Azerbaijan, and Germany), activities that are clearly outside the scope of health care to prisoners, likewise conflict with principles of medical ethics and are therefore rejected by international documents.[4,9]
- Health care professionals in prisons may be requested by prison authorities to obtain and analyze blood, urine (e.g., for drug detection), or other body samples; carry out intimate body searches[12]; or disclose confidential medical data to the prison administration for forensic or security purposes.
- Health care professionals in prisons often are asked to hand over prisoner health records for forensic purposes that may contravene patients' interests; this is explicitly rejected by international documents.[1,8,16] This ethical problem also arises when treatment in detention is ordered by the court and the duration of detention depends on the success of the treatment, which the treating physician has to assess (e.g., hospital treatment order, forensic psychiatry).[27]
- Prison administrations may pressure health care professionals not to provide evidence-based treatments available to the community for financial reasons (e.g., hepatitis C treatment) or for security or ideological reasons (e.g., opiate substitution treatment). If health care professionals yield to this pressure, they forsake loyalty to their patients and violate the principle of equivalence of health care.[9]
- Contractual obligations, overt or concealed, or just perceived pressure by prison authorities; professional isolation; and habit may lead health care professionals to subordination to or accommodation of negative institutional cultures that may prevent them from detecting and reporting abuse or circumstances and practices adverse to the health of prisoners.

For instances in which health care professionals must depart from undivided loyalty to prisoner patients, some documents[1,6,16] offer an ethical loophole: if the health care professional makes a prisoner clearly understand that the role of the professional has changed in a particular instance and the reason for the change, such a departure can become morally and legally acceptable. However, the switch from a professional's position of personal confidential caregiver with undivided commitment to the prisoner patient to acting as a forensic or public health officer accountable to the authorities—whose report might harm the patient—certainly is detrimental to the patient's trust, even if thoroughly explained.

The only way to avoid these dual-loyalty conflicts is a clear assignment of different medical roles to separate persons by (1) conceding to health care professionals who care for prisoners complete and undivided loyalty to their prisoner patients and (2) calling in forensic or public health officers who do not have a clinical relationship to patients for all tasks in which the prison administration or the state needs medical expertise that does not accord with the interests of prisoners.

The professional caring for a patient is solely accountable to the patient, and a forensic expert or a public health officer is primarily accountable to the state and to the community. Public

health officers and forensic experts can follow the principles of public health ethics rather than those of individual health ethics because their relationship to patients is transient, patients know the nontherapeutic purpose of their task, and therefore fidelity concerns are typically small enough to be outweighed by the accompanying social benefits.[28]

CONTINUING PREVALENCE OF DUAL LOYALTY IN PRISON HEALTH CARE

International documents on medical ethics in prison health care were formulated and published decades ago, but most prison health care professionals and prison systems still struggle with dual loyalty. Several reasons explain the delay in adopting these ethical standards:

- Health care professionals working under the hierarchies of justice or prison authorities receive little if any training in medical ethics regarding health care in prison. Professional ethics was one of the highest-priority training needs in a survey of doctors in English and Welsh prisons.[29] Untrained prison health care professionals may not identify potential role conflicts.
- Despite the declarations regarding ethics of health care in prison by international organizations and by some countries,[17–21] national professional organizations have largely failed to advocate on this issue. The relevant documents belong to what is called soft law: no legal sanctions apply to violators. If not covered by national law, deviation from principles of medical ethics can only be sanctioned by national professional boards and licensing bodies, which generally have no strongly developed interest in health care in prison.
- Prison directors, representatives of prison administrations, and criminal justice experts need greater knowledge and understanding of the principles of medical law and ethics, the role of health care professionals in prisons, and relevant international documents. One proof of this is the publicly expressed opinion of a professor of criminal law that "medical ethics apply to private doctors but not to prison doctors."[23]
- Political influence and calculation may play a role. For instance, as a result of 2 recent workshops, on military medical ethics regarding dual loyalty[30] and on interrogations, force-feedings, and the role of health professionals,[31] the ethicist G.J. Annas noted that the summaries

> dramatically demonstrate that, for the first time in the history of the US military, the Department of Defense has a medical policy that goes directly against a well recognized international medical ethics standard.[32(p1737)]

- In times of scarcity of public resources, prison health care may not be given priority. However, according to the revised European Prison Rules,[7] neglect of the human right of prisoners to appropriate health care is not justified by lack of resources.

CURRENT STRUCTURES FOR HEALTH CARE IN PRISONS

Health care in prisons is organized in various ways according to the authority responsible for administration of prison health care and the employment status of professionals providing health care for prisoners. Listed in decreasing order for risks of dual loyalty for health care professionals, these consist of (1) the agency in command of the prisons (e.g., Ministry of Justice, Ministry of Interior, Ministry of Defense, police) in order from those who are integrated in military or military-like hierarchies to those who are full-time employed civil servants to those who are privately employed full or part time, and (2) community health services (e.g., Ministry of Health, Health Department, other public health authority) in order from those who are full-time employed civil servants to those who are privately employed full or part time.

Health care professionals working in prisons who are integrated into uniformed executive bodies face the greatest challenges in defending professional independence and undivided loyalty to their patients because they are subjected to military-like chains of command. Health care professionals employed as civil servants of the prison authority and subject to civil service rules also may encounter demands for dual loyalty and limitations of medical independence and confidentiality. This is particularly the case whenever nonmedical superiors in the administrative prison hierarchy abuse their responsibility of supervision by interfering in medical issues.

Private health care professionals, subject to no other command than their professional code, are less likely to defer to prison authorities who pressure them to compromise exclusive loyalty to their patients. Full-time prison health care professionals are more likely to succumb to institutional cultures that subordinate patient interest to agendas of the prison than are part-time professionals who also work outside of prison walls and maintain continuous contact with health care in the community. Nevertheless, private health care professionals employed by the prison administration also can experience pressure from the threat of dismissal. Furthermore, economic constraints or budgetary problems communicated to doctors may influence their decisions.

Dual loyalty is least likely to arise where health care services are organized independently of the prison authorities. Prison authorities then take responsibility only for medical tasks deemed necessary for safety and security or for forensic purposes.

PRISON SYSTEMS WITH INDEPENDENT HEALTH CARE ADMINISTRATION

The canton of Geneva, Switzerland, in 1963 pioneered prison health care completely independent of prison authorities. Prison

health care was transferred to the Geneva University Hospitals in 1999 and integrated within the community health care system. The cantons Waadt and Vallis followed this lead, but prison health services in the remaining 23 Swiss cantons still lack independence.

In accordance with the principle that prisoners retain all human rights not lawfully taken away from them, the Norwegian Association for Penal Reform implemented its import model regarding health services in 1988: responsibility for health services in prisons was transferred from the Ministry of Justice to the Ministry of Health. By 1994 municipalities became responsible for primary health care services in prisons and by 2002 the regional health authorities became responsible for specialized health care.[33,34]

In France, prison health care became the responsibility of the General Health Directorate for public health issues in the Ministry of Health in 1994 and is organized in cooperation with the nearest public hospitals, which set up consultation and health care units in each prison. They are responsible for all health services to prisoners and also organize continuity of medical care on release from prison.[34]

In New South Wales, Australia, prison health care was already the responsibility of the Minister of Health when in 1997 arrangements were consolidated under the Health Services Act. The health care service also provides basic health services to periodic detention centers (where convicted persons live when performing mandated community service) and works in police cells and courts, operating by means of a statutory memorandum of understanding with the Department of Corrective Services.[34]

After publication of a highly critical report on prison health care in 1996, the National Health Service and Her Majesty's Prison Service established a formal partnership that aimed to bring health care standards in prisons up to the level of community standards. In 2003 the budget moved from the Prison Service to the Department of Health, and in 2004 primary health care trusts took over responsibility for delivering health care to some prisons; the handover was completed by 2006. Each prison has a health steering group that is responsible for enacting the local partnership between the prison and the health care provider.[34]

The Public Health Model of Correctional Health Care in Ludlow, Massachusetts, provides for seamless integration of professional staff, medical information systems, and disease treatment and prevention between a large jail facility and a network of community centers.[35] Several countries are considering similar moves, including Georgia, Scotland, and Spain.[36,37]

A ROADMAP TO ENDING DUAL LOYALTY

As a first step we should strive to meet the guidelines and proposed institutional mechanisms of the 2002 Physicians for Human Rights document *Dual Loyalty and Human Rights in Health Professional Practice*,[1] including

- Raise awareness of principles of medical ethics as well as human rights among health care professionals and nonmedical prison communities and prison administrations.
- Train health care professionals working in prisons in human rights, medical laws and ethics, and skills to identify dual loyalty.
- Increase involvement of international and national professional bodies and boards of health care professionals in both active support and oversight of health care professionals working in prisons. (Active support comprises support of individual health care professionals as well as collective professional actions to uphold undivided loyalty of health care professionals in prison to their patients. National professional organizations and their licensing bodies should hold professionals accountable for violations of medical ethics and human rights and should advocate for developing, implementing, and monitoring national policies that comply with the principles of medical ethics and human rights in prison health care.)

The next step is the uncompromising separation of medical roles in prison. Professionals caring for prisoners should strictly and exclusively adhere to their role as caregivers to their inmate patients, acting in complete and undivided loyalty to them, and should firmly refuse to take over any professional obligation that is outside the interest of their prisoner patients. Professionally, they should be supervised by an authority other than the prison authorities, for example, the public health service or their professional association. In addition, inspections should be performed by an agency or organization that is independent of the prison authority or ministry of justice.

For all prison medical functions that are carried out in the interest of the state, the prosecution, the court, or the security system of the prison, public health officers, forensic experts, or other medical professionals not involved in the care of prisoners should be called in by the prison authorities.

Prison administrations and health authorities, although serving the same government, have completely different and often conflicting interests. The prison administration's main task is safety and security; the health authority's is health care. As long as health care professionals working in prisons are employed by the prison administration, they are vulnerable to pressures to serve medical purposes other than patient care. Therefore, responsibility for the provision of health care should be transferred from the prison administration to the public health authorities to avoid dual loyalty.

Better integration of prison health care and the public health service and equivalence of health care for prisoner and nonprisoner patients should be supported by common use of resources, infrastructure, personnel, expertise, training facilities, administration, management, documentation, and planning. This will lead to

- improved quality of health care in prison,

- inclusion of prisoners in public health initiatives,
- uninterrupted continuity of care when prisoners are transferred or released,
- completion of epidemiological surveillance, and
- better recruitment and qualification and less isolation of prison health care staff.

These benefits have been shown in countries that pioneered integration of prison health care with the public health services.[34,36–38] However, it also has been shown that the process of transition requires careful preparatory advocacy, establishment of interministerial steering committees, and a stepwise process that takes several years until full implementation. It is high time to start this process. ■

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Informed Consent and Cluster-Randomized Trials

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We argue that cluster-randomized trials are an important methodology, essential to the evaluation of many public health interventions.

However, in the case of at least some cluster-randomized trials, it is not possible, or is incompatible with the aims of the study, to obtain individual informed consent. This should not necessarily be seen as an impediment to ethical approval, providing that sufficient justification is given for this omission.

We further argue that it should be the institutional review board's task to evaluate whether the protocol is sufficiently justified to proceed without consent and that this is preferable to any reliance on community consent or other means of proxy consent. (*Am J Public Health.* 2012;102:480–485. doi:10.2105/AJPH.2011.300389)

THE PARADIGM CASE FOR RE-search testing the effectiveness of medical interventions is the randomized controlled trial (RCT), in which individual patients are randomly allocated to 1 of 2 or more different interventions to test their relative effect on a predetermined outcome variable. The randomization process, together with other features of the design of RCTs, controls for extraneous factors that could plausibly influence the outcome variable and thereby lead to confounding.[1] This focus on RCTs and the ethical issues that they create has also influenced the development of research ethics, in which the RCT seems well established as the assumed methodology of choice. However, other methods are often used, and we focus on the cluster-randomized trial.

A cluster-randomized trial randomizes at the social group level (e.g., village, hospital, school)—hence "cluster"—rather than at the level of individual patients. Cluster-randomized trials are popular in the assessment of organizational change and social, behavioral, and community-level interventions in public health.[2] They retain the element of randomization and thus have many of the benefits of RCTs in terms of seeking to avoid confounding, and this is why many hold them to be superior to the obvious alternative method of cohort studies. Cluster-randomized trials are not merely an alternative to RCTs but are used when an RCT is inappropriate or impossible. This alternative design might be indicated for the following reasons.

First is the nature of the intervention. Some interventions that we wish to assess are delivered at the cluster rather than the individual level, such that it is not possible to randomly assign individual patients to interventions. Kumar et al.[3] studied 3 different approaches to behavior change management relating to childbirth, delivered through a community education approach; the unit of randomization was the village rather than individual community members.

Second is the nature of the delivery of the intervention. For example, on some occasions, the target of the intervention is not the patient directly but the care provider. If the intervention involves the education of practitioners or a change in their practice, then the results of such an intervention cannot be applied selectively to certain patients in that practitioner's caseload. Hence Figueiras et al.[4] used a cluster-randomized trial design when testing educational outreach visits relating to Portuguese physicians' reporting of adverse drug reactions.

Third is obtaining a clear and consistent answer to the chosen research question. For example, some treatments (e.g., certain behavioral or educational interventions) are susceptible to contamination, whereby individuals who have not been allocated to the intervention in question may nonetheless be exposed to it through interaction with those who have been allocated to it. Therefore, Peri et al.[5] adopted a cluster-randomized trial design when evaluating functional activity in residential care facilities. Although activity programs were individually designed, there would be a risk in an individually randomized trial that residents