

Prison medicine: ethics and equivalence

LUKE BIRMINGHAM, SIMON WILSON and GWEN ADSHEAD

Summary Guidelines for good medical practice do not reflect the complex reality of the ethical problems that arise in prison. Perhaps the best a doctor working in prison can do is realise that there are ethical dilemmas everywhere, try to recognise them and feel the tension.

Declaration of interest None.

Prison healthcare in England and Wales is undergoing major reform. The principle behind this, providing prisoners with a standard healthcare equivalent to that in the wider National Health Service (NHS), is laudable, but it does not do justice to the complex reality of imprisonment. We argue that being a prisoner is not the same as being an ordinary citizen and ignoring the realities of the differences between prisoners and ordinary NHS patients leads to complex ethical dilemmas for prison healthcare staff. We illustrate some of the areas where prison healthcare is different: access to care and allocation of NHS resources; patient choice and independence. Many of the examples given refer to psychiatric care, but the dilemmas apply to general medical care.

ACCESS TO CARE AND ALLOCATION OF NHS RESOURCES

About 5 years ago, when prison doctors were employed by the Prison Service, the NHS could exclude prisoners from health services. However, Department of Health guidance specifies that the NHS must now work in partnership with the Prison Service to provide healthcare in prisons. In addition, by 2006, primary care trusts will become fully responsible for commissioning these services (Department of Health, 2005). This implies that NHS treatment

guidelines and standards, such as the National Service Framework and National Institute for Health and Clinical Excellence (NICE) guidelines, now apply equally in prison.

These changes have been driven by the ethical principle of justice, especially justice for the vulnerable in terms of access to resources. This has been formulated clinically as the 'principle of equivalence'. This states that prisoners are entitled to have access to the same range and standard of treatment as any other potential NHS patient (Joint Prison Service and National Health Service Executive Working Group, 1999). This suggests that prisoners live in a community of their own. Their penance is their loss of liberty. Deprivation of healthcare is an additional punishment which the state is not entitled to inflict.

It is extremely difficult to provide 'equivalent care' in prisons, where physical and mental health problems are commonplace and healthcare budgets are relatively meagre. Prison doctors will find it difficult to justify prescribing expensive treatments that are readily available in the wider community. The range of treatments may be reduced further by the lack of resources to administer or monitor certain treatments in prison. Prison doctors delivering primary care to prisoners are often faced with situations in which it would normally be appropriate to seek a specialist opinion, but financial constraints can put pressure on them not to refer prisoners for treatment outside prison and there has been a general reluctance on the part of NHS specialists to establish prison out-patient clinics or visit patients in prison.

All healthcare resources have to be rationed but it is not clear on what basis care to prisoners should be. For example, a specialist hepatology service may refuse to offer this to prisoners with hepatitis on the grounds that demand would outstrip supply: can this decision be justified? What remedy is there for prisoners if it is not provided?

Prison doctors quite often refer prisoners with serious mental health problems to the NHS, seeking transfer to hospital for treatment only to find that they are rejected (Coid, 1999). What is the responsibility of the prison psychiatrist in this situation who believes in-patient treatment is necessary but has no power to override another healthcare provider's decision? There is no equivalent of a prison healthcare centre in the wider NHS and statutory powers to treat mental disorder do not apply in prison, so, if patients refuse treatment, they must remain untreated and mentally ill in prison (Wilson, 2004). Rarely, in such cases the doctor has to resort to common law to justify enforcing treatment for mental disorder without the prisoner's consent (Wilson & Forrester, 2002; Earthrowl *et al*, 2003).

PATIENT CHOICE AND AUTONOMY

Recruiting suitably qualified and trained doctors to work in prison has always been difficult (Department of Health, 2001). The NHS encourages patients to exercise control over the doctor they see. Prisoners do not get this choice. Choice is a particular issue in mental health, a recent inquiry report (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003) recommending that all detained patients have a right to a second opinion about their diagnosis. How could this be accommodated in prison?

There are further difficulties with 'choice' given the coercion inherent to imprisonment. Capacity to consent or refuse treatment is rarely explored in prison despite there being case law which states that competent refusals of medical treatment must be respected. If a competent adult prisoner refuses medical treatment, this decision should be respected, even if the consequences could result in their death. When seeking consent the doctor must not knowingly or unwittingly compromise the prisoner's autonomy by pressurising them into accepting treatment. This not only applies to decisions about medical treatment, it could also involve participation in offender treatment programmes that may have a bearing on the prisoner's eligibility for early release.

The question of consent in custodial settings is a complex one, and it is often argued that valid consent is almost always

impossible in prison. It is possible to enforce treatment under common law under certain circumstances in prison, but the powers of the Mental Health Act 1983 do not extend to this setting. Some would say that this is a good thing, but others would argue that denying prisoners with serious mental health problems prompt treatment, regulated by statutory safeguards, is unethical and out of line with the principle of equivalence (Wilson, 2004).

National Health Service patients have increased rights to determine what happens to information about them. The principle of equivalence implies that prisoners have the same rights. However, prisoners are not routinely informed about the limits of confidentiality on entry to prison. Although many (if not most) prisoners may be highly suspicious of any claims to confidentiality offered by doctors, equally there are some who may assume that doctors can offer total privacy.

Issues of choice and autonomy become even more complex in relation to restraint. Guidelines are available from the British Medical Association on the use of restraint in institutional settings (British Medical Association, 2001). When a prisoner has to be restrained for health-related reasons, healthcare professionals should always be involved. Control and restraint measures used to maintain discipline should be carried out in accordance with prescribed guidelines (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2002), but must never be used as a punishment or convenience measure. But who decides when restraint is being so used? Prison doctors were originally employed by the state to mediate the use of punishment and decide which prisoners should be exempt from certain aspects of the harsh prison regime (Gordon, 1922). Even if this is no longer the case, to what extent does the presence of a doctor legitimise restrictive practices?

Attempts have been made to address other historical anomalies involving prison doctors, such as inspecting the food and deciding whether a prisoner is 'fit' to attend court or be placed in segregation. Prison Service Order 1700 provides a simple algorithm for prisoners moved to a segregation unit. However, some of the old prison-specific roles of the doctor still remain. Healthcare staff are required to assess whether segregation is likely to be deleterious to a prisoner's mental

health. Because prisoners with mental health problems might be at increased risk of suicide in segregation, an anxious institution can interpret the algorithm to mean that no prisoner at risk of self-harm is to be segregated. They may be placed in the healthcare centre instead. This not only subverts the function of the healthcare centre, which becomes a place of punishment, it offers *carte blanche* for prisoners to assault staff without any disciplinary remedy by the prison.

WHAT DOES A 'DUTY OF CARE' MEAN IN PRISON?

The principle of equivalence states that doctors have the same duties to prisoners as to any other patient. Yet this ignores the fact that duties between persons arise out of relationships. The relationships that prison doctors have to negotiate in their work differ considerably from NHS settings.

For example, both staff and prisoners can exhibit rigid and punitive attitudes towards those detained in hospital. A prison doctor working in relative isolation can find it hard to counter the mindset of prison staff who hold very rigid, institutionalised views. It may have become somewhat easier for prison doctors who witness unacceptable practices to speak out now that the NHS has become more involved in prison healthcare, but whistle-blowing in prison is not something to be envied. Prison doctors need a good support network and adequate protection if they speak out against abuse.

Prisoners may evoke very strong emotional reactions that make it difficult for the doctor to remain objective, perhaps because of the nature of a patient's offence. Doctors working in general medicine or casualty, for example, may react strongly to admitting a man with a history of a sexual offending. Although this problem is not unique to prisons, because complex issues of this nature are so common in prison, doctors in this setting need adequate guidance and support to deal with problems that may arise.

There is also the added complexity of working in a multidisciplinary team, which must involve prison staff who have little or no mental health training or expertise. How can one expect a prison officer to look after a prisoner with borderline personality disorder who presents very challenging

behaviour, if they do not have the training to do so? Recent NHS guidance states that all professionals who work with personality disorder should have the necessary 'capabilities' (National Institute for Mental Health, 2003). Good communication is essential between those managing complex patients. Consistency, honesty and attempts to reduce the 'splitting' that can emerge in the team are vital. Dividing staff into the 'good guys' from health who are allowed to know about the patient and the 'bad guys' in uniform who must be kept in the dark is a good example of acting-out the patient's unconscious view of the world.

The National Service Framework objectives for reducing suicide rates in prison direct the duties of prison doctors through clinical governance. Yet how far can a prison doctor's duty extend in relation to prevention of suicide or trying to put in place aftercare arrangements for prisoners with mental disorder who are released without warning? What should a prison psychiatrist do about practising in an institution that is unable to safely discharge its duty of care for all prisoners? Should a prison mental health team, designed to meet the needs of those with severe mental disorder, allow itself to be subverted by the prison into preventing all prisoners from harming themselves or committing acts of violence?

Prisoners are in an institution that owes them a duty of care. In the community, people with personality disorder who are suicidal might be offered packages of treatment and support, but they might be turned away from services altogether. The principle of equivalence dictates that the same approach should apply in prison. However, the consequences of a self-inflicted death may be very different in these two settings. Suicides in prison are seen as a failure of the system, perhaps including healthcare, whereas it is perhaps easier to allow that sometimes bad things happen to people in the community.

CONCLUSIONS

Prison is a challenging environment for doctors. Guidelines for good medical practice may not always reflect the nature and complexity of the ethical problems that arise or the reality of the prison environment. Perhaps the most important fact for the prison doctor to realise is that there are overall ethical dilemmas in prison medicine and in many cases no simple

solution is available. In such cases, the best the doctor may be able to do is recognise the issues at stake and feel the tension.

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LUKE BIRMINGHAM, MD, MRCP, MRCPsych, University of Southampton, Ravenswood House, Fareham; SIMON WILSON, MB ChB, MRCPsych, Forensic Outreach Service, Maudsley Hospital, London; GWEN ADSHEAD, MBBS, MRCPsych, Broadmoor Hospital, Crowthorne, UK

Correspondence: Luke Birmingham, Senior Lecturer in Forensic Psychiatry, University of Southampton, Ravenswood House, Knowle, Fareham, Hampshire PO17 5NA, UK. Tel: +44 (0)1329 836 000; Fax: +44 (0)1329 834 780; e-mail: l.birmingham@soton.ac.uk

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