Humane Health Care for Prisoners

Ethical and Legal Challenges

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monitoring, and enabling the torture—including waterboarding, stressful positions, and sleep deprivation—of alleged terrorists to elicit information during our recent history after the 9/11 attacks and the Iraq war. Regrettably, these allegations were revealed to be only too true.

In June 2016, the U.S. Central Intelligence Agency (CIA) released hundreds of declassified documents as required by law under the Freedom of Information Act. The documents showed that torture had been conducted by the CIA, principally to deter terrorist activities. Despite considerable redaction in the documents, there is clear and disturbing evidence of the significant role played by physicians and psychologists in the United States who enabled these unethical activities. The following examples are just a few of the statements contained in these documents. Note the obvious role ambiguity and the almost contradictory positions being proclaimed:

The Medical Officer is expected to deliver the highest quality of care possible under the restrictive conditions usually encountered during rendition operations. The background and circumstances of the detainee do not override the obligation to maintain the highest professional and ethical standards and deliver appropriate care. Medical responsibilities include continuous monitoring of the handling of the subject, and the medical officer has the authority to alter current handling if such handling may cause serious or permanent injury to the subject...

A cavity search with the intent of locating potential harmful devices must be performed during the acceptance medical evaluation. . . . [Italics in original]

At times it may be necessary to sedate a subject during the initial transfer or subsequent transport, to protect either the subject or the rendition security team. Sedatives are not to be used merely for the convenience of the security team. The decision to provide sedation is the responsibility of the Medical Officer...

The Office of Medical Services is responsible for assessing and monitoring the health of all Agency detainees subject to "enhanced" interrogation techniques, and for determining that the authorized administration of these techniques would not be expected to cause serious or permanent harm....

[T]echnique-specific advanced approval is required for all "enhanced" measures and is conditional on on-site medical and psychological personnel confirming from direct detainee examination that the enhanced technique(s) is not expected to produce "severe physical or mental pain or suffering."

"Psychological personnel" can be either a clinical psychologist or a psychiatrist. Unless the waterboard is being used, the medical officer can be a physician or a PA; use of the waterboard requires the presence of a physician.

Adequate medical care shall be provided to detainees, even those undergoing enhanced interrogation. . . . These medical interventions, however, should not undermine the anxiety and dislocation that the various interrogation techniques are designed to foster....

Follow-up evaluations during this period may be performed in person, in the guise of a guard, or through remote video. All interventions, assessments and evaluations should be coordinated with the Chief of Site and interrogation team members to ensure they are performed in such a way as to minimize undermining interrogation aims to obtain critical intelligence.... If during the initial phase of interrogation detaine are deprived of all measurements of time (e.g., through continuous light and variable schedules), a time-rigid administration of medication (or nutrition) should be avoided. . . .

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Even more troubling, amid these recent revelations, was that the set of guidelines issued by the Office of Medical Services outlined in detail methods to inflict pain, discomfort, anxiety, and disorientation on the detainees without causing serious physical injury or death. These guidelines describe the "correct technique" for effective application of each level of the enhanced interrogation methods.

The AMA defines torture as "the deliberate, systematic, or wanton administration of cruel, inhumane, and degrading treatments or punishments during imprisonment or detention." In its Principles of Medical Ethics, the association requires that physicians oppose and refuse to participate in torture for any reason. Moreover, they may not employ their services or their knowledge in any way to facilitate the practice of torture, nor may they even be present when torture is being used or threatened.

With respect to interrogation, AMA points out that the role of physician-interrogator undermines the physician's role as healer and erodes trust not only in the individual physician but also in the medical profession. Physicians are therefore prohibited from conducting or directly participating in an interrogation. Nor may they monitor an interrogation in order to intervene, if needed, because even this would constitute direct participation. At the same time, the AMA did not intend to deprive torture victims of medical care and explicitly allows physicians to treat prisoners and detainees "if doing so is in their best interest" but cautions that this treatment may not consist of verifying that they are healthy enough for torture to be resumed.

A physician who perpetrates such crimes [acts of torture] is unfit to practice medicine.

—World Medical Association

One can only react with shock and disbelief at this historical recital of horrors. Yet if we are to take effective measures to prevent ever again any recurrence of such events, we must pay close heed to what has gone before. Then we must reassess our own commitment to ethical principles.
In its *Declaration of Tokyo* in 1975, the World Medical Association specifically denounced the practice of torture and other forms of cruel, inhuman, or degrading procedures with prisoners:

1. The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures.

2. The physician shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The physician shall not use or allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals.

4. The physician shall not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened.

The World Medical Association reiterated its prohibition in 1997: "Physicians are bound by medical ethics to work for the good of their patients. Involvement by a physician in torture, war crimes, or crimes against humanity is contrary to medical ethics, human rights, and international law. A physician who perpetrates such crimes is unfit to practice medicine."

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Health professionals have an affirmative obligation to report abuses, acts of cruelty, or torture to the appropriate authorities—even if this reporting is perceived as being disloyal. There are sins of omission as well as sins of commission. One can do wrong by not doing right, if one has an affirmative duty to do the right thing. In other words, one can be complicit in wrongdoing, not only by acting, but by failing to act, and even by silence.

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The NCCHC has consistently affirmed the components of a policy against torture and other cruel, inhuman, or degrading treatment of inmates. On October 14, 2007, the organization adopted a formal position statement on the “Correctional Health Care Professional’s Response to Inmate Abuse.” It reads, in part:

Corrections health care professionals should not condone or participate in cruel, inhumane, or degrading treatment of inmates. When such abusive treatment is either witnessed or suspected, they should identify and report such incidents to the appropriate authority.

Corrections health care professionals should refrain from participating, directly or indirectly, in efforts to certify inmates as medically or psychologically fit to be subjected to abusive treatment.

Corrections health care professionals should refrain from being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation.
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Reporting Abuses by Staff

As stated previously, the vast majority of staff working in U.S. prisons, jails, and juvenile facilities adhere faithfully to the ethical tenets of their professions and do not participate in or condone abusive behavior toward inmates. Nevertheless, even though instances of abuse may be rare, we must know our ethical responsibilities and take timely and appropriate action should such practices ever come to our attention.

Inmate abuse by staff can be difficult for supervisors to discover and prove. A “conspiracy of silence” often prevails, resulting in insufficient evidence to conclude an investigation in a satisfactory manner. An implied, although misguided, code of conduct deters employees from informing their colleagues. In a correctional setting, this bond among peers can be extremely strong because these same coworkers must count on one another for protection in a disturbance or inmate-initiated attack.

Persuasive as these considerations may be, a higher ethical responsibility applies to situations in which the misconduct is abusive to prisoners. Any employee who is aware of such activity but fails to report its occurrence or take appropriate action to prevent it from happening becomes a responsible party and shares in the blame for the injury or abuse inflicted.

Thus, a physician or nurse must report to the proper correctional authority any evidence that reasonably suggests that an inmate may have suffered a trauma or injury inflicted by an officer or when any abusive behavior is observed. Similarly, a worker on a mental health unit is obliged to report to proper authority any staff abuse of the rights of patients. The American Public Health Association states, “Health care staff are obliged to reveal medical evidence of staff brutality, including mental and physical abuse, to the appropriate authorities.” Furthermore, the NCCHC states, “Should correctional health staff witness or become aware of an inmate being subjected to harm in any of the forms described above [namely, mistreatment, abuse, torture, or sexual abuse], it is their duty to report this activity to the appropriate authorities to protect patients and other inmates.”

When documenting injuries that could have been caused by violence or abuse, the documentation and reports should contain the inmate’s account of how the injury occurred.

The health professional need not have conclusive evidence or certainty that the injury or trauma resulted from an act of abuse because it is not his or her role to render a judgment. The situation is analogous to a community physician reporting a suspicion of child abuse to protective services, even while conceding the reasonable possibility of a more benign explanation. Guidance on this matter is also supplied by the American Correctional Association’s Code of Ethics: “Members shall report to appropriate authorities any corrupt or unethical behaviors in which there is sufficient evidence to justify review.” Examples of suspicious circumstances might be the prisoner who tells the doctor that his black eye was caused by bumping into a doorknob or who explains his bruises as caused by falling down the stairs.

Only in this way can abusive behavior patterns be stopped. Supervisors have an obligation to protect the informant from retaliatory action, and each facility should have a policy that ensures protection for employees who report the abusive actions of others. By the same token, false reporting or frivolous accusations should not be condoned. The responsibility to report abusive behavior of other employees should be taught in new employee school and regularly encouraged by supervisors. Every facility should make it clear that this is a zero-tolerance policy for abusive behavior.

Although reporting on colleagues may be difficult or repugnant for some—either out of a sense of loyalty to one’s buddies or a fear of reprisal—this must be countered by a strong sense of duty and responsibility. Officers and health care staff are in positions of trust and have an obligation to protect their charges from harm, whether intentional or negligent. Therefore, true loyalty to all of their brethren and to their professional association requires taking this action.

Competing loyalties can create a conflict between health professionals’ commitment to their patients’ welfare and their institutional roles and responsibilities. It is not acceptable, however, for a health professional who observes abusive behavior toward a prisoner to remain silent. The basis of this obligation is the principle that medical professionals will “do no harm to the patient” (nonmaleficence), will remain autonomous from nonmedical authorities in making clinical judgments about their patients, and will honor their patient’s trust. These are fundamental principles in the practice of medicine. This topic is also addressed in Chapter 9, “Corrections and Health Care Working Together,” under “Speaking Out Loyally.”

Because violence and assaultive behavior are harmful to health, their prevention clearly falls within the purview of correctional health care professionals who have an ethical duty to be supportive of the safe and secure management of prisons and jails.
Areas of Significant Ethical Role Conflict 81

A NOTE OF CAUTION—EROSION AND BURNOUT

Despite initial strong commitment to ethical principles, many health professionals begin to experience a blunting of these ideals after spending some time in corrections. The erosion is a gradual process and often appears proportional to the degree of direct contact with inmates. The erosion also will be greater the more the professional works in isolation from supportive peers.

Sometimes, the first signs are a growing tendency or willingness to deal punishly with patients such as putting "no shows" at the bottom of the list for rescheduled appointments, if at all, or identifying "malingers" (those who report sick call without legitimate medical problems) to correctional staff for punishment. Other signs may be the feeling that the inmates already are getting more than they are entitled to, given the nature of their crimes, or the belief or comment that "maybe going through withdrawal will teach him a lesson." Singling out perpetrators of socially disapproved behaviors as being less deserving of treatment reflects social prejudices rather than good logic. Sometimes, too, correctional health care staff become callous and unresponsive to prisoners' complaints of chronic pain. Other evidence of the erosion may be reflected in the tone of voice adopted by nurses or doctors when addressing inmates. It is not customary in doctors' offices, outside of correctional institutions, for a nurse or receptionist to open the door to the waiting room and shout the patient's surname to summon him or her into the examination room. Insistence on habits of courtesy and respect, just as in community practice, serves as a reminder to staff and also will earn the reciprocal respect of inmates.

Dr. Robert Cohen, an experienced correctional physician, has observed this phenomenon and offers the following insight:

Prisons are places of violence, and they inure physicians and other health workers to the serious injuries caused by violence, sometimes involving them as participants. Prisoners are seen as less than persons, and their welfare becomes secondary to the welfare of the correctional institution.

There are many physicians whose daily practice contradicts this formulation. They deserve praise and tribute. Compassion is not easily taught but is effectively grounded by the daily experience of working in prison. Disrespect for prisoners is easily learned. The doctor-patient relationship is often fatally compromised by the transformation of the patient into a prisoner; with a consequent loss of sympathy and standing. It will not be possible to effectively apply the methods of quality assurance to correctional medicine unless health professionals working in prison identify the goal of quality solely as patient welfare. Health professionals must identify with the welfare of their patients, not with the needs of the prison.83

Contact with fellow health professionals, regular attendance at professional conferences, and periodic discussion of ethical considerations among health care staff are therefore to be encouraged. Coworkers also can be a strong source of support and encouragement in maintaining and sharpening the awareness of medicine's lofty principles.

As detailed in Chapter 7, "A Patient or a Prisoner?", terminology is important. If correctional health professionals persist in calling their patients inmates, prisoners, or offenders, they will soon conceptualize them as such and begin to treat them differently. How contrary to their training and professional preparation, when they were taught how to care for patients! Although this distinction in terminology may appear to be trivial, it is a combination of many small things that makes us what we are and influences what we do. And for those who work in the correctional environment with its strong focus on punishment and restriction of freedom, one can too easily learn to disrespect one's own patients. There are sound ethical and practical reasons to insist that health care professionals refer to their patients (clients) as such. This applies to references made in speech, in written reports, and in medical records.

What we have been exploring in this section—namely, the gradual erosion of professional ethical values among correctional health care staff—cannot be properly understood without also recognizing the broader phenomenon of employee burnout, which is so common among health professionals in general and among correctional custody staff and law enforcement personnel. It should thus not be regarded solely or even primarily as a consequence of disparity between the medical world and the world of corrections, although these factors certainly come into play and cannot be overlooked.

By the same token, the solution or treatment must address more than bolstering one's moral compass and needs to look also to balancing one's lifestyle, dealing appropriately with stress, securing adequate rest and relaxation, and, in some instances, availing oneself of counseling or psychotherapy. Interested readers are encouraged to explore recent research and writings that discuss burnout among health professionals and correctional staff.

Burnout syndrome is a special type of job stress and consists in a state of mental, emotional, or physical exhaustion that may be combined with doubts about one's own competence and even the value of the work being performed. People in such situations can become cynical and overly critical and behave irrationally and impatiently with coworkers and patients (or clients). Sometimes this is partly the result of poor job fit, but many other factors can be involved.

"It [burnout] can destroy some of the most highly motivated, selfless people in the helping professions," according to a literature review on the subject of burnout.84 Common symptoms, according to García-Arroyo and Domínguez-López, include "detachment from work, depersonalization, insensitivity to the people being helped, lack of empathy, etc."85

Larry Schoenly summarizes the situation for nurses, and the picture she describes can be applied with few alterations to physicians, psychologists, dentists, and other health care staff in corrections. "Moral distress in nursing is described as a psychological imbalance or disequilibrium that occurs when nurses find themselves in situations where they feel unable to do the right thing. This conflict can cause physical, emotional, and spiritual suffering. The residual build up of continuing moral distress can lead to burnout and burden."
Schoenen continues:

Correctional nurses have unique situations that lead to moral distress. Examples include conflict with custody over inmate access to care, a higher volume of healthcare needs than resources available to meet them, and continuing need for guarded evaluation of potential manipulative patient behaviors. Other potential sources of moral distress include nurse-physician conflict, disrespectful interactions, workplace violence, and clinical ethical dilemmas.86

According to Bonnie Sulton, a social worker and criminologist, "Correctional environments take their toll on all who pass through the gates," referring explicitly to the staff who work there and not just to the inmates who are required to live there.

There is something superhuman in law enforcement and first response work. When the urge to run away is overtaken by the urge to run towards, these people become something more than even they once thought they could be. With this ability comes great responsibilities and stresses. We ask a lot of our law enforcement officers. We ask for superhero strength and superhuman heart. The balance is a difficult one. It causes much stress in personal and professional lives. How does one take off the cape and, once again, become human?87

For correctional health providers, burnout can be occasioned or potentiated by overwork, staffing or resource shortages, obvious inmate patient need, and limited coping resources. In some cases, it can be linked to compassion fatigue.

Compassion fatigue is a form of secondary traumatic stress that "refers to the emotional distress and PTSD-like symptoms that result when professional helpers hear about the firsthand traumatic experiences of persons whom they are helping...[T]he symptoms of PTSD, but to a lesser extent and without meeting all criteria for the disorder."88

A well-researched paper by Spinaris, Denhof, and Morton develops the definition of "correctional fatigue" as a further specification of compassion fatigue, "to better capture the nature and impact of traumatic exposure on correctional professionals (whether indirect or direct) and its interactions with organizational and operational stressors." The authors state that correctional fatigue is "fueled by repeated exposure to traumatic and other high-stress events, potentially manifesting in a negatively altered outlook on self and others, functional impairments, and, in more severe cases, in the development of psychiatric disorders." They term it "an unavoidable occupational hazard. No one who works in corrections is completely immune to it." They also point out how the organizational culture of correctional agencies can be affected over time by the attitudes and behaviors characteristic of trauma-affected correctional staff, including cynicism, pessimism, disrespectful behaviors, a negative mood, emotional callousness, indifference, mistrust, a susceptibility to conspiracy theories, disproportionate or extreme vigilance, hostility, and aggression. "The 'normalized' behaviors can drastically affect staff wellness and functioning, and counter what new employees are taught at the training academy."89

CONCLUSION

Finally, a word to those well qualified and highly ethical health care professionals who begin a career in the world of corrections but quickly become disillusioned and frustrated at the gap between what they see and what they know should be. They fear that they may compromise their own ethical principles if they remain. They feel the pressures of role conflict. They dislike the conditions of confinement in which they find their patients. They feel their evaluations and patient interviews are being rushed. They want to see their patients more frequently, but their caseloads are too great. They are not allowed to make the changes they feel important. They are faulted by supervisors for being too caring. They feel powerless to influence the tone and direction of the correctional system in which they work. Ultimately, they ponder the question, "Should I quit my job?"

To people like these, this author has said, "Don't give up. If good and caring health professionals leave, who will be left? It will be only those who do not care as much as you do. While correctional health care in many places is less than ideal, imagine that it could get much worse. The only hope of improving conditions and eventually making the authorities aware of needed changes is to get enough good people working in the field. By staying there, at least you have a chance to make things better—to provide relief where you can, and to serve as a patient advocate."

These ideas and admonitions are eloquently expressed by correctional psychologist Joel A. Dvoskin:

Some ethicists argue that participating in unacceptable systems is wrong. They argue that the participation of credentialed professionals legitimizes and thus perpetuates these systems. They admonish such professionals to simply walk away... And these arguments seem reasonable. But when I meet the people who have stayed, I do not find them less ethical or less moral for it... To maintain one's standards of decency and professionalism in the face of an apparently uncaring political system takes courage and tenacity and goodness of heart... Watch what happens when a psychologist quits in moral indignation. See if the place closes down. It won't, and no matter how good the quitter feels about having quit, if he or she were any good, it is the clients who have been hurt, not the system.... Your jail or prison or hospital or free clinic is a little better each day because you are there. You leave each of your clients a little better than you find them, and occasionally foster hope in people for whom hope is but a distant memory.90
Should you find that you are required to compromise your principles and to act in an unethical manner, then it may be time to leave. Do not just walk out, however. In a polite and respectful manner, let the person in charge know how you feel and why you are obliged to leave, so as not to violate the principles of your profession. Or respectfully but firmly refuse to comply when directed to administer a sedative for behavior control, reveal confidential information, witness the use of force, or perform duties that fall outside the scope of your license. If you take this route, seek support and assistance from your professional association. You may be inviting dismissal, but at least you can appeal that action up to the highest levels and perhaps your point of view will prevail.