

2. Standards in prison health: the prisoner as a patient

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Key points

- People who are in prison have the same right to health care as everyone else.
- Prison administrations have a responsibility to ensure that prisoners receive proper health care and that prison conditions promote the well-being of both prisoners and prison staff.
- Health care staff must deal with prisoners primarily as patients and not prisoners.
- Health care staff must have the same professional independence as their professional colleagues working in the community.
- Health policy in prisons should be integrated into national health policy, and the administration of public health should be closely linked to the health services administered in prisons.
- This applies to all health matters but is particularly important for communicable diseases.
- The European Prison Rules of the Council of Europe provide important standards for prison health care.

Basic principles

Several international standards define the quality of health care that should be provided to prisoners. A provision in Article 12 of the International Covenant on Economic, Social and Cultural Rights establishes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (1). This applies to prisoners just as it does to every other human being. Those who are imprisoned retain their fundamental right to enjoy good health, both physical and mental, and retain their entitlement to a standard of health care that is at least the equivalent of that provided in the wider community.

The United Nations Basic Principles for the Treatment of Prisoners (2) indicate how the entitlement of prisoners to the highest attainable standard of health care should be delivered: “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation” (Principle 9). In other words, the fact that people are in prison does not mean that they have any reduced right to appropriate health care. Rather, the opposite is the case. When a state deprives people of their liberty, it takes on a responsibility to look after their health in terms both of the conditions

under which it detains them and of the individual treatment that may be necessary. Prison administrations have a responsibility not simply to provide health care but also to establish conditions that promote the well-being of both prisoners and prison staff. Prisoners should not leave prison in a worse condition than when they entered. This principle is reinforced by Recommendation No. R (98) 7 of the Committee of Ministers of the Council of Europe (3) concerning the ethical and organizational aspects of health care in prison and by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), particularly in its *3rd general report* (4). The European Court of Human Rights is also producing an increasing body of case law confirming the obligation of states to safeguard the health of prisoners in their care.¹

The argument is sometimes advanced that states cannot provide adequate health care for prisoners because of shortage of resources. In the 11th general report on its activities, the CPT underlined the obligations state governments have to prisoners even in times of economic difficulty (8):

The CPT is aware that in periods of economic difficulty sacrifices have to be made, including in penitentiary establishments. However, regardless of the difficulties faced at any given time, the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention, screening, and treatment. Compliance with this duty by public authorities is all the more important when it is a question of care required to treat life-threatening diseases. In respect of the obligation to provide adequate health care to prisoners, there are two fundamental considerations. One concerns the relationship between the prisoner and the health care staff and the other concerns how prison health care is organized.

Relationship between the prisoner and health care staff

All health care staff working in prisons must always remember that their first duty to any prisoner who is their patient is clinical. This is underlined in the first of the United Nations Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture

¹ See, for example, the cases of *Mouisel v. France* [2002] (5), *Henaf v. France* [2003] (6) and *McGlinchey and others v. The United Kingdom* [2003] (7).

and Other Cruel, Inhuman or Degrading Treatment or Punishment (9), which states the following:

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

The International Council of Prison Medical Services confirmed this principle when it agreed on the Oath of Athens (10):

We, the health professionals who are working in prison settings, meeting in Athens on September 10, 1979, hereby pledge, in keeping with the spirit of the Oath of Hippocrates, that we shall endeavour to provide the best possible health care for those who are incarcerated in prisons for whatever reasons, without prejudice and within our respective professional ethics.

This principle is particularly important for physicians. In some countries, full-time physicians can spend their whole careers working in the prison environment. It is virtually inevitable in such situations that these physicians will form a close relationship with the prison management and indeed may be members of the senior management team of the prison. One consequence of this may be that the director of the prison will occasionally expect the physician to assist in managing prisoners who are causing difficulty. For example, the security staff may ask the physician to sedate prisoners who are violent to themselves, to other prisoners or to staff. In some jurisdictions, prison administrations may demand that physicians provide them with confidential information about a person's HIV status. Physicians should never lose sight of the fact that their relationship with every prisoner should be first and foremost that between physician and patient. A physician should never do anything to patients or cause anything to be done to them that is not in their best clinical interests. Similarly, as with all other patients, physicians should always seek consent from the patient before taking any clinical action, unless the patient is not competent on clinical grounds to give this consent. An internet diploma course entitled *Doctors working in prison: human rights and ethical dilemmas*, provided free on the internet by the Norwegian Medical Association (11) on behalf of the World Medical Association, focuses on many of these issues. See also the World Medical Association Declaration on Hunger Strikers adopted by the 43rd World Medical Assembly, Malta, November 1991 and revised by the World Medical Association General Assembly in Pilanesberg, South Africa, in October 2006 (12).

This primary duty to deal with prisoners as patients applies equally to other health care staff. In many countries nurses carry out a variety of basic health care functions. These may include carrying out preliminary health assessments of newly admitted prisoners, issuing medicines or applying treatments prescribed by a physician or being the first point of contact for prisoners concerned about their health. The nurses who carry out these duties should be properly qualified for what they do and should treat people primarily as patients rather than as prisoners when carrying out their duties. The International Council of Nurses published a statement saying, among other things, that national nursing associations should provide access to confidential advice, counselling and support for prison nurses (13).

Organization of prison health care

One method of ensuring that prisoners have access to an appropriate quality of health care is by providing close links between prison-administered health services and public health. In recent years, some countries have begun to create and strengthen such relationships. Many prison and public health reformers argue, however, that a close relationship is not enough and that prison health should be part of the general health services of the country rather than a specialist service under the government ministry responsible for the prisons. There are strong arguments for moving in this direction in terms of improving the quality of health care provided to prisoners. In Norway, for example, the process of giving local health authorities responsibility for providing health care services in prison was completed in the 1980s. In France, legislation was introduced in 1994 placing prison health under the General Health Directorate for Public Health Issues in the Ministry of Health. In the United Kingdom (England and Wales), responsibility and the budget for prison health care were transferred to the National Health Service in 2002.

The Committee of Ministers of the Council of Europe has urged that "health policy in custody should be integrated into, and compatible with, national health policy" (3). The Committee points out that, as well as being in the interest of prisoners, this integration is in the interest of the health of the population at large, especially as concerns policies relating to infectious diseases that can spread from prisons to the wider community. The vast majority of prisoners will return to civil society one day, often to the communities from which they came. Some are in prison for very short periods. When they are released, it is important for the good of society that they return in good health rather than needing more support from the public health services or bringing infectious diseases with them. Continuity of care between prisons and communities is a public health imperative. Many other people go into and

come out of prison on a daily basis: staff, lawyers, officials and other visitors. This means that there is significant potential for transmitting serious disease or infection. For these reasons, prisons cannot be seen as separate health sites from other institutions in society.

WHO strongly recommends that prison and public health care be closely linked. The Moscow Declaration on Prison Health as a Part of Public Health (14) elaborated on some of the reasons why close working relationships with public health authorities are so important, as under:

- Penitentiary populations contain an overrepresentation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions, drug users, vulnerable people and those who engage in risky activities such as injecting drugs and commercial sex work.
- The movement of people already infected with or at high risk of disease to penitentiary institutions and back into civil society without effective treatment and follow-up gives rise to the risk of the spread of communicable diseases both within and beyond the penitentiary system. Prevention and treatment responses must be based on scientific evidence and on sound public health principles, with the involvement of the private sector, nongovernmental organizations and the affected population.
- The living conditions in most prisons of the world are unhealthy. Overcrowding, violence, lack of light, fresh air and clean water, poor food and infection-spreading activities such as tattooing are common. Rates of infection with TB, HIV and hepatitis are much higher than in the general population.

The Declaration makes a series of recommendations that would form the basis for improving the health care of all detained people, protecting the health of prison personnel and contributing to the public health goals of every Member State in the Region:

- Member governments are recommended to develop close working links between the Ministry of Health and the ministry responsible for the penitentiary system so as to ensure high standards of treatment for detainees, protection for personnel, joint training of professionals in modern standards of disease control, high levels of professionalism amongst penitentiary medical personnel, continuity of treatment between the penitentiary and outside society, and unification of statistics.
- Member governments are recommended to ensure that all necessary health care for those deprived of their liberty is provided to everyone free of charge.
- Public and penitentiary health systems are recommended

to work together to ensure that harm reduction becomes the guiding principle of policy on the prevention of HIV/AIDS and hepatitis transmission in penitentiary systems.

- Public and penitentiary health systems are recommended to work together to ensure the early detection of tuberculosis, its prompt and adequate treatment, and the prevention of transmission in penitentiary systems.
- State authorities, civil and penitentiary medical services, international organizations and the mass media are recommended to consolidate their efforts to develop and implement a complex approach to tackle the dual infection of tuberculosis and HIV.
- Governmental organizations, civil and penitentiary medical services and international organizations are recommended to promote their activities and consolidate their efforts in order to achieve quality improvements in the provision of psychological and psychiatric treatments to people who are imprisoned.
- Member governments are recommended to work to improve prison conditions so that the minimum health requirements for light, air, space, water and nutrition are met.
- The WHO Regional Office for Europe is recommended to ensure that all its specialist departments and country officers take account in their work of the health care needs and problems of penitentiary systems and develop and coordinate activities to improve the health of detainees.

European Prison Rules

All the countries that are members of the WHO Health in Prisons Project are also members of the Council of Europe. In 1973, the Committee of Ministers of the Council of Europe adopted the European Standard Minimum Rules for the Treatment of Prisoners (15), which were closely modelled on the United Nations Standard Minimum Rules for the Treatment of Prisoners (16). In that year, the Council of Europe had 15 members. At the beginning of 1987, when it had expanded to 21 members, the Committee of Ministers of the Council of Europe adopted a new set of European Prison Rules (17). At the time, the Committee of Ministers noted "that significant social trends and changes in regard to prison treatment and management have made it desirable to reformulate the Standard Minimum Rules for the Treatment of Prisoners, drawn up by the Council of Europe (Resolution (73) 5) so as to support and encourage the best of these developments and offer scope for future progress". By 2005, the membership of the Council of Europe expanded further to 46 states. For that reason, the Council of Europe decided to revise the 1987 European Prison Rules.

The revised European Prison Rules, adopted on 11 January 2006 by the Committee of Ministers of the Council of

Europe (18), contain a significantly expanded section on health care in the prison setting. For the first time, the European Prison Rules specifically refer to the obligation of prison authorities to safeguard the health of all prisoners (§39) and the need for prison medical services to be organized in close relationship with the general public health administration (§40).

Every prison is recommended to have the services of at least one qualified general medical practitioner and to have other personnel suitably trained in health care (§41). Arrangements to safeguard health care begin at the point of first admission, when prisoners are entitled to have a medical examination (§42), and continue throughout the course of detention (§43). The commentary to the European Prison Rules refers to some recent developments in imprisonment with implications for health care. One is the increasing tendency for courts to impose very long sentences, which increases the possibility that old prisoners may die in prison. Related to this is the need to give proper and humane treatment to any prisoner who is terminally ill. The Committee of Ministers of the Council of Europe has also made a recommendation on the treatment of prisoners on hunger strike (3). In addition to dealing with the health needs of individual prisoners, those responsible for prison health are also recommended to inspect the general conditions of detention, including food, water, hygiene, sanitation, heating, lighting and ventilation, as well as the suitability and cleanliness of the prisoners' clothing and bedding (§44). The European Prison Rules also recommend that provision is made for prisoners who require specialist treatment (§46) and those who have mental health needs (§47).

One important change should be noted. The 1987 European Prison Rules provided that prison authorities could only impose "punishment by disciplinary confinement and any other punishment which might have an adverse effect on the physical or mental health of the prisoner" if the medical officer certified in writing that the prisoner was fit to undergo such punishment. This led to concerns that, by providing this certification, the physician was in effect authorizing the imposition of punishment, in contradiction to the Hippocratic Oath. The revised European Prison Rules remove this requirement.

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Further reading

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