LAW, ETHICS AND MEDICINE

Relevance and limits of the principle of "equivalence of care" in prison medicine

Gérard Niveau

J Med Ethics 2007;33:610–613. doi: 10.1136/jme.2006.018077

The principle of "equivalence of care" in prison medicine is a principle by which prison health services are obliged to provide prisoners with care of a quality equivalent to that provided for the general public in the same country. It is cited in numerous national and international directives and recommendations.The principle of equivalence is extremely relevant from the point of view of normative ethics but requires adaptation from the point of view of applied ethics. From a clinical point of view, the principle of equivalence is often insufficient to take account of the adaptations necessary for the organization of care in a correctional setting. The principle of equivalence is cost-effective in general, but has to be overstepped to ensure the humane management of certain special cases.

Correspondence to:
Dr G Niveau, IUML, Avenue de Champel 9, 1211 Geneve 4, Switzerland; Gerard.Niveau@hcuge.ch

Received 15 June 2006
Revised 20 September 2006
Accepted
22 September 2006

The principle of "equivalence of care" in medicine prison is the principle whereby persons detained must have the benefit of care equivalent to that dispensed to the general public in the same country.

The principle of equivalence is cited with increasing frequency as a reference when health-care standards have to be implemented for persons in detention. It is a matter of general principle, which is already mentioned under point 9 of resolution 45/111 of the United Nations Organization (UNO) of 14 December 1990 concerning the "Basic principles for the treatment of prisoners" in the following form: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation".[1]

The principle of equivalence is also cited by the World Health Organization (WHO) in the context of the Health in Prisons Project, one of the strategic objectives of which is: "to promote all prison health services, including health promotion services, to reach standards equivalent to those in the wider community".[2]

In the USA, the principle of equivalence is present in the jurisprudence relating to the care of prisoners. Following the case of Estelle v Gamble (1976), it is recognised that the right of prisoners to receive healthcare is enshrined in the eighth amendment to the US Constitution.[3] Although the principle of equivalence is not named among these rights, it is indirectly included among them and appears in the standards of accreditation of health services in the USA.[4]

As regards European authorities, the Committee for the Prevention of Torture specifies in its 31st annual report for 1993 the seven basic principles that must prevail in the organisation of care for prisoners: access to a doctor, equivalence of care, patient consent and confidentiality, preventive healthcare, humanitarian assistance, professional independence, and professional competence.[5] In addition, the Committee of Ministers of the Council of Europe has issued Recommendation No R (98) 7 of 8 April 1998 concerning "The ethical and organizational aspects of health care in prison" according to the following four elements: access to a doctor, equivalence of care, patient consent and confidentiality, and professional independence.[5]

Many countries have adopted the principle of equivalence in their laws and regulations relating to care in a correctional setting. The most significant example is the United Kingdom, where, according to the directives of the Health Advisory Committee for the Prison Service, the purpose of care in prison must be "to give prisoners access to the same quality and range of health care services as the general public receive from the National Health Service".[6]

However, the principle of equivalence is far from being applied in all prisons in Western countries.[7]

This article discusses the relevance, from ethical, clinical and economic standpoints, of the principle of equivalence of care as implemented by prison health services.

ETHICAL ASPECTS

The equivalence of care in a correctional setting is a measure of the extent to which a society practises the principle of equality of citizens. The principle of equivalence can be considered as an ethical reference from the point of view of political philosophy.

In the field of normative ethics, several texts define the principle of equivalence as one of the pillars of the ethics of healthcare in prison. With regard to international directives, this principle is mentioned for the first time in resolution 37/194 adopted by the United Nations General Assembly of 18 December 1982, entitled: "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". The first principle of this resolution is worded as follows: "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''.[1]

As far as the Council of Europe is concerned, the principle of equivalence is mentioned, as we saw above, in Recommendation No R (98) 7 as a simultaneously ethical and organisational aspect of care in a correctional setting.

Some countries have issued national ethical directives that include the principle of equivalence in the recommendations for personnel practising in a place of detention. For example, the Swiss Academy of Medical Sciences has issued medicoethical directives specifying that ''A person deprived of liberty has the right to the same quality of care as the wider community''.[8]

With regard to applied ethics, the principle of equivalence satisfies the fundamental values of justice and solidarity.[9] However, this value of justice may be called into question where there is an excessive disparity of care in population subgroups of the community. The aim of equality of care is then confronted by the question of the choice of reference standard. In some countries, it is only in prisons that disadvantaged groups can hope to have access to satisfactory care.[7] In these situations, the value of charity takes precedence over that of justice and the principle of equivalence can no longer be applied simply and directly. It must be adapted to the norms of minimum care according to international standards.

Furthermore, autonomy, which is another fundamental ethical value, cannot always be addressed in a correctional setting in the same way as in the community. Indeed, the security and discipline objectives of the detaining authorities may conflict with respect to the autonomy of prisoners in the domain of health.[10] The most obvious example of this is the impossibility for prisoners to have the benefit of real free choice of doctor. These prisoners may refuse the care offered by the doctors of the prison medical services, they may sometimes be visited by an external doctor or, on occasion, attend a consultation outside the prison, but they cannot undertake regular treatment from a doctor whom they would have chosen outside the prison.

The autonomy of prisoners may also be affected by subtle forms of constraint. Health sometimes represents a factor in the duration or the conditions of deprivation of liberty imposed on the prisoners. This creates a constraint on their freedom of choice with regard to medical care and treatment. For example, a prisoner may assent to elective surgery in order to gain time in a hospital, or to accept an anti-androgen or anti-psychotic treatment in the hope of gaining remission or parole. It is customary for doctors to take non-medical factors into consideration when assessing patients' freedom to consent, but in a correctional setting, the doctor must be careful not to participate himself in these constraints on the patient, and to keep in mind that the patient is subject to constraints of which he has no option but to risk his own body and sometimes his health. Thus the concept of autonomy is often more complex to analyse in prison medicine than by simple equivalence with the general population.

CLINICAL ASPECTS

Primary care

Prisoners represent a relatively small percentage of the general population, but their healthcare needs are quantitatively high.[11 12] Because of the correctional setting, primary care in prison needs to be practised in a more interventionist fashion than for the general population.

On the one hand, every prisoner must have the benefit of the most comprehensive and rapid medical check-up possible upon arrival.[13] This examination must be practised on the basis of consent by the person detained, but it must be offered in a much more active manner than for the general population.

On the other hand, the demand for care must be regulated much more authoritatively than for the general population. The demand for care is indeed considerably greater than it is for the general population. In the UK, prisoners consult, on average, three times more often—and in Belgium 3.8 times more often—for general care than a demographically equivalent population in the community.[14] While respecting the principle of free access to a doctor, the demand for care must be regulated in accordance with the characteristics of what is properly available in a correctional setting, which represents a considerable difference with regard to the regulation of demand in the community.

These two requirements of the correctional setting—systematic intervention and regulation of demand—do not call into question the principle of equivalence, but do clearly show the difficulties involved in putting it into practice and the special efforts necessitated by professional practice to avoid deviating from it.

Primary care sought by prisoners is not exactly equivalent to that of people of the same sex and age group among the general population. A large proportion of consultations are justified on administrative and mental-health grounds; respiratory, gastrointestinal, musculoskeletal and dermatological pathologies follow in decreasing order of frequency, cardiovascular disorders being the most rare because of the average age of the prisoners.[14–16] This primary care must meet these demands for care but must also be oriented towards the specific pathologies that are known to be over-represented in a prison population: hepatitis, HIV, tuberculosis and sexually transmitted diseases.[13] Primary care in prisons must therefore have a different orientation from that offered to the general population.

One aspect that is difficult to grasp in its entirety, and is very characteristic of care in the correctional setting, is the question of malingering, which undermines the therapeutic relationship between clinician and patient. A doctor working in a prison has to be particularly careful to avoid being manipulated, by either the inmates or the warders. This can considerably modify the quality of a relationship, in comparison with a normal therapeutic relationship, and some authors recommend that prison doctors should also practise in a non-prison setting, to avoid ''acculturation''. It can indeed be difficult for a doctor who is too deeply involved in the functioning of the prison to remain neutral enough to avoid deviating from the principle of equivalence.

Psychiatry

It is in the field of psychiatry that clinical reality makes it most difficult to apply the principle of equivalence. The very high proportion of prisoners suffering from psychiatric disorders is a phenomenon common to most prisons in Europe and the USA.[17 18] Prison is where a considerable number of patients for whom care in the community has failed will end up. Cases of the dual diagnosis of mental illness and drug dependence are common.[19] Furthermore, the imprisonment of these people is often justified by acts of violence, and the question of danger to the public has considerable weight in their assessment and treatment.

The care available to tackle this situation is often limited and never equivalent to that available in the community.[20] For this reason, psychiatrists have to concentrate on the most urgent situations: risk of suicide, acute psychotic decompensation and major behavioural disorders.

Care for drug users is a source of particular problems in relation to the notion of equivalence of care. Although deprivation of liberty is not the best situation in which to cease consumption of drugs, addicts often have involuntary withdrawal forced upon them, and turn to the prison medical service for that reason. Doctors are led to start methadone cures

in accordance with criteria very different from those applied in the wider community.

Equivalence of care in psychiatry will never be achieved because, on the one hand, prison constitutes an environment detrimental to mental health, and, on the other hand, a doctor will never be able to give the psychiatric patient in prison the things he most needs, such as stable family or emotional relations, fulfilling work or, of course, liberty.[21]

Promotion of health and prevention

The health services must develop prevention and promotion policies for health that are appropriate in their objectives and resources. Various international directives call for this type of action.[2 5] Their introduction into the correctional setting is an ideal opportunity for extending preventive action to this population, which is generally hard to reach.

With knowledge of the risk factors and target pathologies, specific action can be defined for the promotion of health in a correctional setting. Four groups of contagious diseases must be targeted in particular by prevention policies, as they are the most prevalent in prison: HIV, the different varieties of hepatitis, tuberculosis, and sexually transmitted diseases.[22] These pathologies constitute problems of variable importance according to the geographical zones in which the prisons are located.

Action can be grouped into five main categories: information and education, screening, campaigns against high-risk behaviours (sexual behaviour and use of contaminated equipment), treatments, and vaccinations.[13] These actions cannot be undertaken in a manner precisely equivalent to those with similar aims among the general population. They must be carried out in a more direct and intensive manner, so as to be adapted to the target population. They must also be more specifically aimed at the high-risk behaviours associated with life in prison: exchanges of equipment, injection of drugs, and intimate same-sex relationships.[23]

Efforts to promote health, and preventive care, need to be maintained when prisoners move between prisons, and particularly when they are released into the community. Access to primary care services in the community must be especially facilitated and prioritised for released prisoners, despite the common economic and cultural difficulties. However, confidentiality has to be handled in a special way in order to transmit the information necessary for the continuation of care while avoiding the effects of stigmatisation of the patients.

Finally, the principle of equivalence is relevant in this field with regard to the objectives that must be targeted, but insufficient with regard to the means of action that must be taken in order to achieve these objectives, as it does not take into account the need to adapt this action to the specific requirements of the correctional setting.

ECONOMIC ASPECTS

Imprisonment is an opportunity to give care to a population that usually slips through the healthcare net.[24] From this point of view, the economic performance of the principle of equivalence is theoretically high, as it enables a considerable improvement in the health of a disadvantaged population for average healthcare outlay. Different studies have shown that screening and vaccination actions are particularly cost-effective.[25–28] Prevention in prison can reduce the risk of dissemination of contagious diseases by prisoners after their release and is thus clearly cost-saving.[29]

Nevertheless, the application of such care to the whole prison population can lead to a fall in economic efficiency because of the de facto heterogeneous character of this population. Indeed, Miller *et al*[30] demonstrate that systematic screening of an entire population of prisoners by the Mantoux test is less efficient than the targeted screening of a homeless population. Awofeso and Rawlinson[31] also show that, for the risk of a flu epidemic, the cost/benefit ratios favour early antiviral chemotherapy for symptomatic individuals over a mass vaccination approach. Furthermore, after imprisonment, most prisoners return to their normal living environment and escape the control—and benefits—of health services. The notion of equivalence of care during detention is limited by the need to design care policies that take account of this social reality. Prolonged and complex treatments cannot usually be continued after detention, or they may be interrupted on transfer from one prison to another. For economic and sometimes also clinical or ethical reasons, they cannot be undertaken at the time or in the manner that they would be if the decisions were made solely according to the principle of equivalence of care.

Finally, it should be noted that the use of certain specific techniques is sometimes more economically viable than the simple application of the principle of equivalence, because of the peculiarities of the correctional setting. This applies to telemedecine, which is less costly than a customary consultation with a specialist.[32 33]

The principle of equivalence is thus very cost-effective with regard to actions that enable all prisoners to benefit from basic care similar to that available to the majority of the population. But for more prolonged or complex treatments and preventive actions, the principle of equivalence is insufficient to take into account the adaptation essential to the correctional setting.

CONCLUSION

The principle of equivalence of care in prison medicine represents a reference standard, especially in the ethical domain, for prison health services which have to provide the same quality and range of care as in the wider community. However, from clinical and economic viewpoints, the principle of equivalence is often insufficient to take into account the adaptation of the organisation of healthcare essential to the correctional setting. When deviation from the principle of equivalence of care cannot be avoided, the tendency must always be to exceed community standards, and never to fall short of them.

A new step forward for medicine in a correctional setting must therefore be rigorous rationalisation of all actions relating to screening, prevention and treatment. The integration of evidence-based medicine into the concept of equivalence of care is a vital stage in this process. Such changes require more in-depth research, the development of pilot projects, and a synthesis by meta-analyses of the aggregation of different knowledge bases. Considerable efforts need to be made to converge with international guidelines.

Competing interests: None declared.

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