POSITION STATEMENT

Correctional Health Professionals’ Response to Inmate Abuse

Introduction

Through national standards, public openness, litigation, and accreditation, correctional facilities continue to improve professionalism and safety in our nation’s jails, prisons, and juvenile confinement facilities. Today’s professional correctional administrator ensures public safety by developing, adhering to, and enforcing sound policies and procedures and by following applicable local, state, and federal laws governing the management of detainees and prisoners.

At the same time, it is recognized that mistreatment of inmates can and has occurred. Acknowledging the challenges experienced by health professionals who may encounter, observe, or become aware of mistreatment of inmates, NCCHC has developed this position statement to assist health professionals in responding to those situations in a manner that is consistent with well-established principles of medical ethics, applicable laws, and NCCHC standards.

NCCHC is committed to the humane treatment of inmates. We reaffirm this position in concert with the statements of our supporting organizations, including the American Bar Association, the American College of Physicians, the American Medical Association, the American Nurses Association, the American Psychiatric Association, the American Psychological Association, and the American Public Health Association.

NCCHC, through its standards, has consistently affirmed the components of a policy against mistreatment. The Standards for Health Services in Prisons (2014) preclude, for example, health staff participation in nonclinically ordered restraint and seclusion, except to monitor health status (P-I-01 Restraint and Seclusion), or in the collection of forensic information (P-I-03 Forensic Information). They require informed consent of the patient for “all examinations, treatments, and procedures” and recognize the patient’s right to refuse treatment (P-I-05 Informed Consent and Right to Refuse), and protect inmates as subjects in human research (P-I-06 Medical and Other Research). Other standards require medical autonomy in clinical decision making (P-A-03 Medical Autonomy), maintenance of confidentiality of health information (P-H-02 Confidentiality of Health Records), and patient privacy (P-A-09 Privacy of Care). NCCHC standards require documentation of patients’ health status at each encounter (P-H-03 Management of Health Records), with special attention to the medical and mental health of inmates under close confinement (P-E-09 Segregated Inmates).

These standards approach but do not address directly the dilemma of a health professional who (a) is asked to participate, even indirectly, in abusive control or coercion of an inmate; or (b) witnesses inmate mistreatment or its medical or mental health consequences. NCCHC addresses these concerns in this position statement.

Background

The discussion of the health professional’s role in correctional settings is framed by a number of key ethical principles, including those of autonomy, nonmaleficence, and medical neutrality. These principles are well established in the medical profession.

Autonomy. The principle of medical autonomy dictates that the health professional act primarily in patients’ interests above all others and that medical judgments be based on the needs of patients. In general, patients’ legitimate medical needs take priority over nonmedical matters in governing the actions of the health professional.
Nonmaleficence. The principle of nonmaleficence dictates that health professionals refrain from participating in actions that may cause harm to patients. This principle is probably most familiar as the phrase “First, do no harm.”

Medical Neutrality. The principle of medical neutrality dictates that the health professional treat patients regardless of their background, status, affiliations, or position. It is commonly cited in the practice of treating all wounded in time of war, whether the wounded are comrades or enemies.

The discussion also inevitably includes the key conflict of dual loyalty. Dual loyalty is defined as a conflict between professional duties to a patient and obligations—express or implied, real or perceived—to the interests of a third party such as an employer, insurer, or the state. Dual loyalty is a potent and common moral conflict for health care professionals in institutional and managed care settings. Health professionals may find the principles of autonomy, nonmaleficence, or medical neutrality challenged by conflicting objectives of their institution.

Definitions

Mistreatment is the preferred general clinical term used to identify actual or potential harm to a patient from another person. Mistreatment may include physical abuse, sexual abuse, emotional abuse, neglect, and financial exploitation. Some forms of mistreatment may be unintentional. Other forms of mistreatment are more serious, and may lead to civil and even criminal sanctions.

Abuse is a more specific term that usually assumes deliberate intent. It has been defined as “the willful infliction of physical pain, injury or mental anguish; unreasonable confinement; or the willful deprivation of services which are necessary to maintain a person's physical or mental health.”¹ In the free world as well as in corrections, staff who observe patient abuse are usually required to report the incident to the proper authorities.

A third term, most often applied in a technical and legal sense to military and government action, is torture. While the word may sometimes be used more casually in common parlance, the technical term should apply only to extreme forms of mistreatment, and then only when accompanied by a specific purpose such as obtaining information or a confession.²

A fourth type of abuse is sexual. The Prison Rape Elimination Act (PREA) of 2003 is a federal law dealing with the sexual assault of inmates. PREA advocates a “zero-tolerance” policy toward incidents of sexual violence in correctional facilities. PREA targets correctional administrators and custody staff to be more accountable for incidents pertaining to sexual violence in corrections facilities. Through standards development, verification, training, monitoring, research, and information gathering, PREA seeks to effectively reduce the incidence of sexual misconduct and violence on inmates.

Position Statement

Should correctional health staff witness or become aware of an inmate being subjected to harm in any of the forms described above, it is their duty to report this activity to the appropriate authorities in order to protect patients and other inmates. The following principles are to guide correctional health professionals in averting and reporting the mistreatment of inmates.

1. Correctional health professionals’ duty is to the clinical care, physical safety, and psychological wellness of their patients.

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

4. Correctional health 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.

5. Correctional health professionals should refrain from gathering health information for forensic purposes or sharing confidential health information or its interpretation to authorities for use in cruel, inhumane, or degrading treatment of inmates.

6. Correctional health professionals should abstain from authorizing or approving any physical punishment of their patients, and should refrain from being used as an instrument of their employer to weaken the physical or mental resistance of inmates.

7. Correctional health professionals should review their employer’s policies and procedures, and work to ensure that they appropriately address how inmates are to be managed and what staff should do when abusive actions are suspected or witnessed.

8. Correctional administrators should ensure that policies and procedures address protections for employees who report the abusive actions of others.

9. Professional custody and health administrators should support efforts to eliminate abusive behavior toward inmates by assuring that all staff receive regular training on appropriate and professional behavior in dealing with inmates. Use of experts outside of the correctional system can be helpful in providing objective training on this issue.

Adopted by the National Commission on Correctional Health Care Board of Directors
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October 2012 — reaffirmed with revision
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Notes


2. The United Nations defined torture in 1984 as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.” The International Committee of the Red Cross notes that “the legal difference between torture and other forms of ill treatment lies in the level of severity of pain or suffering imposed. In addition, torture requires the existence of a specific purpose behind the act—to obtain information, for example.”