The Principle of Equivalence Reconsidered: Assessing the Relevance of the Principle of Equivalence in Prison Medicine

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The Principle of Equivalence Reconsidered: Assessing the Relevance of the Principle of Equivalence in Prison Medicine

Fabrice Jotterand, Regis University and University of Basel
Tenzin Wangmo, University of Basel

In this article we critically examine the principle of equivalence of care in prison medicine. First, we provide an overview of how the principle of equivalence is utilized in various national and international guidelines on health care provision to prisoners. Second, we outline some of the problems associated with its applications, and argue that the principle of equivalence should go beyond equivalence to access and include equivalence of outcomes. However, because of the particular context of the prison environment, third, we contend that the concept of “health” in equivalence of health outcomes needs conceptual clarity; otherwise, it fails to provide a threshold for healthy states among inmates. We accomplish this by examining common understandings of the concepts of health and disease. We conclude our article by showing why the conceptualization of diseases as clinical problems provides a helpful approach in the delivery of health care in prison.

Keywords: professional ethics, prison medicine, health care delivery, principle of equivalence

Despite imprisonment, prisoners retain rights such as the right to speech, freedom of thought, right to proper and humane treatment, right to dignity, and right to health (see The Geneva Conventions of 12 August 1949, International Committee of the Red Cross, Geneva United Nations 1976; United Nations 1955, 1977; European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 2010). The only right that is deprived is that of free movement. Hence, when the state imprisons convicted offenders it takes on the responsibility for their care, well-being, and medical treatment (Lines 2006). There are many challenges in the delivery of health care to prison populations. The conditions of detention not only further prisoners’ health problems but they also exacerbate preexisting medical conditions. Data indicate that the current approach to the delivery of health care in the prison environment is insufficient and sometimes inappropriate (maybe with the exception of older prisoners; see Kratcoski and Babb 1990; Lesnoff-Caravaglio 2001; Schnittker and John 2007), because of the particular context of incarceration and the complexities related to providing medical care to prisoner patients (Charles and Draper 2011).

According to international guidelines stipulated by the United Nations (UN) and World Health Organization (WHO), the principle of equivalence of care is considered the minimum standard of care in prison medicine—which is, however, not fully applied in all prisons in Western countries (MacDonald 2005), and the extent of its application in developing countries is unknown. The WHO in its Health in Prisons Programme (HIPP) document captures the essence of the principle: “to encourage all prison health services, including health promotion services, to reach standards equivalent to those in the wider community.” This principle is grounded in ethical standards characteristic of the delivery of health care to the general population, but because of the incarceration conditions of inmates, particular measures have been established to ensure that the deprivation of freedom does not affect prisoners’ health status—that is, the ability to request medical care upon demand.

Lack of resources, inmate overpopulation, and a decreasing political will (mostly due to limited resources) to uplift the condition of prisoners have led to poor health outcomes among prisoners. Studies report higher burden of mental disorders (e.g., depression, mania, psychosis)
and poorer physical health conditions (e.g., heart disease, diabetes, hypertension, addictions) among prison populations when compared to individuals living in the community (Bureau of Justice Statistics 2006; Fazel et al. 2001; Niveau 2007). The incarceration environment is not only predictive of poor health but also deemed to accelerate the aging process. For instance, a prisoner who is 50 years old mimics the disease burden of an individual 60 years old in the general population (Fazel et al. 2001; Hayes, Burns, Turnbull, and Shaw 2012; Loeb et al. 2008; Mitka 2004). Thus, inmate populations have greater needs for health care services and will thereby consume these services at a higher rate than the general population (Feron et al. 2005).

The increased disease burden of prisoners calls for equivalent treatment in order to ensure proper and timely medical access as available to individuals in the general population. However, many authors argue that the equivalence principle is not sufficient to address the higher disease burden because of its emphasis on treatments obtained (Birmingham, Wilson, and Adshead 2006; Exworthy, Wilson, and Forrester 2011). There is also uncertainty as to the principle’s ability to address the needs of prisoners due to the differences that exist between the prison environment, the community, and the inherently detrimental living conditions of inmates. As a result, Lines (2006) called for measures that go beyond equivalence of treatment, pointing out that “equivalence is only a minimum acceptable standard, rather than an ideal one” (273). Other authors propose an emphasis on health outcomes that require greater treatment provisions to prisoners in order for them to reach the same health standards as those in the community (Charles and Draper 2012; Lines 2006).

In this article we critically examine the principle of equivalence of care. We argue that while the principle sets minimal standards in the delivery of health in prison, it lacks a conceptual framework defining the very notion of health or what it means to be healthy in prison, in terms of either access or outcomes. First, we provide an overview of how the principle of equivalence is utilized in various national and international guidelines on health care provision to prisoners. Second, we outline some of the problems associated with its applications, and argue, along with other authors, that the principle of equivalence should go beyond equivalence to access and include equivalence of outcomes. However, because of the particular context of the prison environment, third, we contend that the concept of “health” in equivalence of health outcomes needs conceptual clarity; otherwise, it fails to provide a threshold for healthy states among inmates. We accomplish this by examining common understandings of the concepts of health and disease (i.e., species-typical levels of species-typical functions). Finally, we conclude our article by showing why the conceptualization of diseases as clinical problems provides a helpful approach in the delivery of health care in prison.

INTERNATIONAL AND NATIONAL GUIDELINES

In this section, we outline various national and international guidelines pertaining to health care provision for prisoners that refer to the principle of equivalence of care (Table 1). In particular, we are interested in delineating what values and norms best articulate the nature of the principle. First we focus on international guidelines, before we examine national recommendations from Switzerland, the United Kingdom, and the United States.

### International Guidelines

The UN documents addressing the delivery of health care in prison include (1) the Principles of Medical Ethics (United Nations 1982), (2) Body of Principles for the Protection of all Persons Under any Form of Detention or Imprisonment (United Nations 1988), and (3) the Standard

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<tr>
<th>International and national settings</th>
<th>Ethical and legal documents</th>
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<tr>
<td>United Nation</td>
<td>(a) Principles of Medical Ethics defining the role of physicians</td>
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<td>(b) Body of Principles</td>
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<td>(c) Standard minimum rules for the treatment of prisoners</td>
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<tr>
<td>Council of Europe</td>
<td>(a) CPT (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment)</td>
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<td>(b) COE Committee of Ministers Recommendation No. R (98) 7—Ethical and organizational aspects of health care in prison</td>
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<td>World Medical Association</td>
<td>(a) Declaration of Lisbon on the rights of the patient</td>
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<td>(b) Declaration of Edinburgh on prison conditions and the spread of tuberculosis and other communicable diseases</td>
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<td>World Health Organization</td>
<td>Health In Prison Program: A WHO guide to the essentials in prison health</td>
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<td>Switzerland</td>
<td>Swiss Academy of Medical Sciences (SAMS) medicolegal guidelines defining care of detained persons</td>
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<tr>
<td>United Kingdom</td>
<td>National Health Service (NHS) guidelines</td>
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<td>United States</td>
<td>Eighth Amendment and case laws</td>
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Minimum Rules for the Treatment of Prisoners (United Nations 1955; 1977). In what follows we briefly present their key elements to determine their guiding principles.

The Principles of Medical Ethics aim at protecting prisoners and detainees against torture and other cruel, inhuman, or degrading treatment or punishment. The document delineates the role of health care personnel (mainly doctors) in a prison context. Relevant to our discussion is Principle 1, which implicitly expresses the principle of equivalence of care: “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 second UN document, the Body of Principles, does not refer to the principle of equivalence but sets standards for the protection of all persons under any form of detention or imprisonment, guaranteeing access to proper medical treatment. These principles state that (1) each detained person should be treated in a humane manner and with respect to his/her human dignity, (2) human rights of persons apply in circumstances of detention also, (3) equal treatment of person should apply despite origin, (4) prisoners must be informed of their rights in a language that they understand, should have the right to communicate with their family, and should be allowed to maintain relationships with their social networks, and (5) health care provision includes proper medical treatment upon detention free of charge. The third UN document, the Standard Minimum Rules for the Treatment of Prisoners, concerns mostly the living conditions of inmates in a prison environment (clothing, housing, work hours, food, exercise, etc.). Specific recommendations concern medical services, such as (1) availability of at least one qualified medical officer at every detention institution, (2) provision of medical treatment to sick prisoners in hospitals and if treatment is provided in the institution, the equipment, furnishing, and drugs should be as needed by the medical treatment, (3) dental services should be available to prisoners, (4) examination of prisoners upon admission is mandatory and thereafter as necessary, and (5) medical officers must respond to the complaints and health needs of sick prisoners. Our analysis of the UN documents indicates that three main principles emerge from these guidelines: access to health care, equality of treatment (equivalence of care), and autonomy.

The guidelines of the World Medical Association (WMA) contain the same three principles evident in the UN guidelines. For instance, the Declaration of Edinburgh (World Medical Association General Assembly 2005) states that prisoners have the same health care right as the general population, which include right to humane treatment and appropriate medical care. This declaration also indicates that the patient–physician relationship ought to be identical to that for patients in the general population regardless of the status of prisoners. The Declaration of Lisbon highlights that every person should receive appropriate medical care without discrimination, including prisoners who should be regarded primarily as patients. Specifically, the document mentions that inmates should have access to good quality medical care, that is, care without discrimination, best-interests care, fair selections to limited treatment, and right to continuity of care, and should have the right to choose physicians and change physicians and to receive information about one’s medical condition. In addition to the already-mentioned three principles, the guidelines stress the importance of principles such as informed consent, confidentiality/right to privacy, and dignity.

The Council of Europe sets standards that focus on access to health care and prison conditions in general (CPT Standards 2010: European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment; see also Recommendation No. R (98) 7). In particular, CPT stipulates that inmates should have access to a doctor at any time and without delay. More importantly in the context of this article, it explicitly refers to the principle of equivalence of care: “A prison health service should be able to provide medical treatment and nursing care, as well as appropriate diets, physiotherapy, rehabilitation or any other necessary special facility, in conditions comparable to those enjoyed by patients in the outside community” (29).

The last international guideline we considered is the WHO HIPP document. It aims to encourage the promotion of public health and reduce health inequalities outside and within prison health systems through the implementation of “recognized international codes of human rights and medical ethics.” It acknowledges the relevance of the principle of equivalence of care in the health care delivered to inmates.

National Guidelines

The guidelines of the Swiss Academy of Medical Sciences (SAMS 2012) are based on international recommendations and provide guidelines to doctors concerning the delivery of medical care to detained persons. Patient autonomy and medical confidentiality are the basic principles that must be followed; hence, no medical care or assessments can be conducted on a detained person without his or her consent. In addition, information obtained from prisoners enjoys the same level of confidentiality as any other patient from the community. Doctors should in no way, implicit or explicit, be involved in any activity that could result in harm, torture, or any degrading acts committed on a prisoner, similar to the UN principle of medical ethics. The principle of equivalence (equality of treatment) also governs the delivery of health care to inmates: “detained persons are entitled to the same level of medical care as
persons living in the community at large.” The principle is applicable in the case of prevention, diagnosis, therapy, nursing health care, informed consent, and medical confidentiality.

In the United Kingdom, Health Services for Prisoners (National Health Service 2004) for medical care to inmates focuses mainly on two principles: equivalence and access. Equivalence means that the standards of health care in prison should be identical to those available in the general population. The Prison Service, in collaboration with the National Health Services (NHS), is responsible to ensure that inmates have access to equivalent health services available to the general public through the NHS (Prison Service Order 3200: Health Promotion [2003]). The two principles reflect the values of the NHS. In the British system each individual (general population or inmates) is entitled to health care, which includes treatment but also health promotion and disease prevention.

In the American context, no principle is explicitly mentioned as the basis for prison medicine. Rather, it is a case law that paved the way for the early reflections with regards to the rights of prisoners to medical care. In *Newman v. Alabama* (1972) the U.S. district court found Alabama state correctional system in violation of the Eighth Amendment rights.3 The Eighth Amendment states that “Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.” According to Posner, the Supreme Court stated that the Eighth Amendment promotes the dignity of the human being (Posner 1992). Since prisoners are deprived of their liberty, they cannot care for themselves and consequently are entitled to access to health care. The courts thus recognize that the government cannot withhold basic necessities of life such as health care (for an overview of health care in U.S. prisons, see Binswanger, Krueger, and Steiner 2009; Wilper et al. 2009). It follows that inmates in the U.S. prison system are entitled to appropriate living conditions, right to access to care, right to the care that is ordered, and right to a professional medical judgment.

This overview of international and national guidelines reveals some common features among the documents. Our analysis shows that there is consensus on the following four principles regarding the delivery of health care in prison: (1) equivalence of care, (2) access to care (justice), (3) autonomy, and (4) human dignity (beneficence) (see Table 2). The principle of equivalence constitutes the overarching principle and satisfies the requirement of other fundamental values in medical ethics such as justice, autonomy, and beneficence. The question that remains concerns the applicability of the principle and its ability to provide a framework that improves the quality and access to health care in prison.

### Table 2. Principles guiding the health care of prisoners

<table>
<thead>
<tr>
<th>Guiding principle</th>
<th>Ethical and legal documents</th>
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<tr>
<td>Access to care (justice)</td>
<td>(a) Council of Europe—CPT and European Prison Rules</td>
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<td>(b) WMA—Declaration of Lisbon</td>
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<td></td>
<td>(c) UN—Body of Principles and Standard Minimum Rules</td>
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<td></td>
<td>(d) Eighth Amendment of the U.S. Constitution</td>
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<tr>
<td>Principle of equivalence</td>
<td>(a) Switzerland—SAMS</td>
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<td>(b) UK</td>
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<td>(c) UN—Principles of Medical Ethics (PME)</td>
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<td>(d) WMA—Declaration of Edinburgh</td>
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<td></td>
<td>(e) Council of Europe (COE)—Recommendation (98) 7 and CPT</td>
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<tr>
<td>Human dignity (beneficence)</td>
<td>(a) Eighth Amendment of the U.S. Constitution</td>
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<td></td>
<td>(b) UN—Body of Principles and Standard Minimum Rules</td>
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<td>(c) WHO—Health in Prison Program</td>
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<tr>
<td>Autonomy</td>
<td>(a) UN—Body of Principles and Standard Minimum Rules</td>
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<td>(b) WMA—Declaration of Lisbon</td>
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<td>(c) CPT</td>
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<td>(d) Switzerland—Swiss Academy of Medical Sciences (SAMS)</td>
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Critical Analysis of the Principle of Equivalence

Although some authors have pointed out that the principle of equivalence is far from being adequate in the delivery of health care to prisoners (Birmingham, Wilson, and Adshead 2006; Charles and Draper 2011), considering the specificities and complexities of the prison environment, some issues are worth mentioning here. These are classified into clinical problems, conceptual issues, and environmental considerations.

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3. See also *Plata v. Schwarzenegger* (2009). This federal class action lawsuit concerned the alleged inadequate provision of healthcare by the California Department of Corrections and Rehabilitation (CDCR), in violation of the Eighth Amendment (in addition to the American with Disabilities Act and section 504 of the Rehabilitation Act of 1973).
Clinical Problems

Niveau (2007) outlines some key issues encountered in the delivery of health care in prison. First, there are questions related to the autonomy of the inmates. In a correctional setting a comprehensive medical checkup is mandatory before inmates enter the facilities. The prison medical staffs seek the consent of detainees, but the process is much more assertive compared to the general population, as a medical checkup is obligatory. In addition, inmates have some restrictions with regard to the selection of health care services accessible to them since these depend on what is available in the correctional facilities and what could be arranged by the facility based on existing resources. For Niveau, these two points—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 (Niveau 2007, 611). In short, the prison environment is not conducive to the fostering of autonomous decisions, hence undermining one of the key components of the principle of equivalence of care.

The second consideration is the nature of the patient-physician relationship in a prison environment. Compared to the clinical encounter taking place in the general population, the therapeutic relationship in prison can be subject not only to manipulation on the part of the inmates (and the guards) to obtain particular favors from physicians but also to absenteeism on the part of inmates, which affects the quality of therapeutic interventions. It is also worth pointing out that to avoid an acculturation of the carceral context and its peculiarities, it is recommended that physicians practicing in a prison environment also practice in a nonprison setting so as to remain as neutral as possible and cognizant of the most current standards of care among the general population (Niveau 2007).

The third clinical challenge concerns the provision of proper and timely mental health care to prisoners due to the high prevalence of inmates suffering from psychiatric disorders (Fazel and Lubbe 2005). Inmates might enter prison with preexisting mental disorders, but incarceration itself is a factor in the development of mental health problems—under conditions of isolation, hostility, violence, and so on (Blaauw and van Marle 2007). Proper treatment requires an appropriate environment that many institutions struggle to provide (Wilson 2004; Earthrow, O’grady, and Birmingham 2003), and hence satisfying equivalence of care becomes a real issue.

Conceptual Issues

Charles and Draper (2011) note that the principle of equivalence has been implemented to achieve equivalence in the process of care. This means that prison medicine should reflect the standards of care available to the general population in terms of service availability and how health care is delivered. For this reason, the authors put forth a consideration of the equivalence of health outcomes in addition to the equivalence in the process of care. Equivalence, they contend, must consider identical populations and settings, which is obviously not the case when comparing prison populations and the general population. As they put it, “considerably different health outcomes may result from equivalent process in dissimilar populations” (Charles and Draper 2011, 2). They rightly conclude that a “process-driven interpretation of the principle of equivalence” does not take into account the complexities and realities of prison populations and the incarceration setting. Advocating equivalence of outcomes in addition to equivalence in the process of care would maximize health equity through a careful consideration of the relevant factors determining the health status of inmates.

Environmental Considerations

The distinction between equivalence of outcomes and equivalence in the process of care raises an important issue in the implementation of the principle of equivalence. Improving prisoners’ health status requires the implementation of preventive measures that include provision of information, education, screening, campaigns against high-risk behaviors, treatments, and vaccinations tailored to the specific context of the prison environment (Niveau 2007). However, prisons are not by nature in the business of health promotion (Ginn 2013), and the goals of prisons (control and surveillance) and the goals of medicine (care and treatment) are inherently in contradiction (Smith 2000). The question is whether prison environment satisfies the fundamental conditions (i.e., availability of resources, proper nutrition, social activities, and medical staff) essential for the development of a healthy lifestyle.

The (existing) preventive measures in prison assume a particular notion of health that is imported from a conception of health descriptive of the general population. For instance, when does the use of drugs become a health issue in the general population versus prison environment (use vs. abuse) and what measures are considered adequate to restrict substance abuse in a correctional context? Also, in the prison environment screening for HIV/AIDS, under certain conditions, is mandatory (U.S. Department of Justice, Bureau of Justice Statistics 2009; U.S. Federal Bureau of Prisons 2008), and confinement is required in the case of the diagnosis of a mental disorder that could endanger the life of other inmates or staff. In both instances, the measures in place undermine the autonomy and the right to confidentiality of inmates, which does not empower inmates to take responsibility for their health.

4. According to Blaauw and van Marle (2007), “About 4% of male and female prisoners have psychotic illnesses, 10% (men) to 12% (women) have major depression, and 42% (women) to 65% (men) have a personality disorder, including 21% (women) to 47% (men) with antisocial personality disorder. . . Research . . . has also shown that 89% of all prisoners have depressive symptoms and 74% have stress-related somatic symptoms” (133).
HEALTH AND CLINICAL PROBLEMS IN PRISON MEDICINE

The Concepts of Health and Disease

The most common understanding of the concepts of disease and health refers to the search of a set of functional standards within human biology. Boorse (1975; 1977) articulates the concept of disease according to the notion of species-typical levels of species-typical functions. His approach refers to the biological organization of the natural functions of a living organism, which includes four principles summarized as follows: (1) the reference class is a natural class of organisms of uniform functional design; specially, an age group of a sex of a species; (2) a normal function of a part or process within members of the reference class is a statistically typical contribution by it to their individual survival and reproduction; (3) a disease is a type of internal state that is either an impairment of normal functional ability, that is, a reduction of one or more functional abilities below typical efficiency, or a limitation on functional ability caused by environmental agents; and (4) health is the absence of disease (Boorse 1977, 562, 567). This classification attempts to provide normative standards of normality (healthy states) in which any deviation creates the possibility to discover the nature of disease.

In the same vein as Boorse, Kass (1985) articulates an understanding of health in terms of biological standards. Health, he writes, is “a state of being that reveals itself in activity as a standard of bodily excellence or fitness, relative to each species and to some extent to individuals, recognizable if not definable and to some extent attainable” (173). For Kass, health is a norm that displays intrinsic standards of bodily functionalities relative to each species.

Engelhardt challenges the idea that health and disease depend uniquely on a species-typical level of species-typical functions. He argues that the “blind outcomes of nature” cannot be determined in advance and therefore a taxonomy of disease in relation to the functional organization of the body, as proposed by Boorse (and Kass), must fail (Engelhardt 1996, 202–203). He further asserts that the characteristic polymorphisms relative to a species require a particular understanding of “human nature, its purpose, and its values,” which determine the normality or abnormality of a biological trait (Engelhardt 1996, 207). Accordingly, the concepts of health operate both negatively and positively. On the one hand, concepts of health can be described as proscriptive in the sense that they indicate what aspects of human existence (e.g., smoking, unhealthy eating habits, sedentary lifestyle) ought to be avoided in order to promote, or at least, not damage one’s health. Simply put, to be healthy means not to be diseased (Engelhardt 1996, 206) and the concepts of health and disease are shaped by the interaction of various values that “give substantial direction regarding the significance of well-being and of human flourishing” (Engelhardt 1996, 207).

It follows that a neutral or purely descriptive account of health and disease is unsatisfactory. Engelhardt suggests describing diseases as clinical problems, which refers to physiological or psychological states that affect one’s abilities to function, to be free from pain, and to achieve expected bodily form. What medicine addresses as diseases are problems not because they are species-atypical levels of species functions but because they prevent individuals from achieving particular human goals and ends (Engelhardt 1984). These goals and ends are personal and context specific, and therefore any conceptualization of health and disease needs a careful explanation of its nature and meaning in order to become relevant to particular contexts and populations, such as the prison environment and inmates.

Health and the Prison Environment

The improvement of the delivery of health care in prison and the implementation of preventive measures require conceptual clarity concerning ideas of health, what it means to be healthy, notions of well-being, and human flourishing. As Smith rightly remarks, “Health promotion [in prison] is a very broad area of action and there is little consensus about the underpinning ideas which inform health promotion practice, in particular ideas about what ‘health’ is, what is it to be ‘healthy’ and what the principal health goals should be” (Smith 2000, 350). The lack of consensus is principally due to the fact that conceptions of health and disease are value-laden. Key assumptions that are part of our understanding of these concepts include competing values with regard to conceptual models (nosology, etiology), notions of the aesthetic in human form (body), and notions of human flourishing, cultural expectations, ideologies, and social norms (Engelhardt 1984; 1996).

To further elaborate on this point, but from a somewhat different perspective, it is worth considering Aday’s account of the social origins of health and disease. She remarks that community and related individual characteristics are risk factors—attributes or exposures (smoking, drug use, etc.) that increase the probability of occurrence of disease—associated with poor physical, psychological, and/or social health (Aday 1994). Among the sociocultural and material resources that affect one’s health, Aday
mentions three main factors: personal characteristics (age, sex, and race/ethnicity) of the individuals, the nature of the ties between them (e.g., family members, friends, and neighbors), and the schools, jobs, incomes, and housing that characterize the neighborhoods in which they live (Aday 1994). The prison environment deals with its own particular populations living in a hostile and confined setting. The health status of inmates depends on a complex web of factors inherent not only to the correctional context but also to inmates’ prior behaviors and lifestyle choices. The delivery of health care in prison must then include an understanding of health and healthy behaviors that takes into account how determinants of health in the prison environment impact its populations, who may enter prison with history of risky behaviors.

The issue lies in how health problems in correctional settings are conceptualized, which in turn reflects the types of health needs and responses provided to address particular health problems and behaviors (Smith 2000). The provision of psychiatric care in the United Kingdom represents a good example of the challenge to apply criteria and means of treatment used in the general population to inmates. Not only are the resources available in British prisons limited compared to those in the community, but the environment itself (incarceration) is detrimental to their health. In the case of provision of mental health care, physicians are not able to provide what this patient population needs the most, such as family support, emotional stability, a fulfilling job, and freedom, to name a few. In other words, as emphasized by Niveau (2007), equivalence of care in psychiatry will never be achievable due to the prison context (Nurse et al. 2003). It is worth mentioning that the situation in the United States is different. In the American context the problem lies in the failure of the system to provide, in many instances, adequate mental health care to the general population, which underscores the difficulty of applying the principle of equivalence regarding psychiatric care to the U.S. prisons (Metzner 2012). Another example is primary care. Consultations for sexually transmitted diseases, hepatitis, tuberculosis, and HIV are more frequent in prison than in the general population and therefore the delivery of primary care must be tailored specifically to the needs of inmates, which could be very different from the general population (Niveau 2007). Therefore, imprisoned patients may depict very different needs from those of the general population, demanding unique sets of health care services and preventive measures.

Clinical Problems and Prison Medicine

The conceptualization of diseases as clinical problems offers helpful insights for a potential framework for prison medicine for various reasons. First, it provides an alternative approach to address issues related to therapeutic interventions and preventive measures, since the goal of clinical interventions is to restore individuals to an adequate level of health to function in the prison environment. Understanding diseases as clinical problems is not concerned with the achievement of a particular health status determined by standards in the general population. This allows the conceptualization of health of prisoners in their unique setting, which is unlike the principle of equivalence that compares two different settings (free social environment vs. prison environment) and populations (general population vs. prison population), and hence fails to achieve its goal in the prison setting.

Second, the concept of health problem accentuates the values intrinsic in clinical judgments and in the way interventional strategies are set for individuals in a correctional setting. As stated, the focus of clinical problems is patient specific and each patient has a different understanding of his or her own notion of embodiment, tolerance for pain, and physical discomfort. A better consideration of the culture of prisons in the establishment of health determinants would help set parameters based on medical standards specific to prisoners. The limitations concerning the resources available, the living conditions, and the populations of prison require a better adaptation in the way health promotion occurs in prison. For example, what is considered substance abuse versus recreational use of substances (tobacco, alcohol, and illegal drugs)—is very different because in prison the means to fight boredom and frustration through pleasure are limited (Smith 2000).

Third, the concept of clinical problems avoids questions surrounding notions of what is “natural” or “normal.” Rather than relying on external standards (species-typical characteristics), physicians will need to rely more on what inmates as patients communicate and express, and on how they perceive their condition. In doing so, physicians can underscore the autonomy of inmates, essential for a good exchange of information in the clinical encounter.

CONCLUSION

The principle of equivalence of care in prison medicine constitutes an accepted norm by many international and national guidelines. It provides a framework that meets the standards of clinical ethics and good medical practice, at least in theory. However, many issues remain unresolved concerning its applicability and its true impact in improving the delivery of health care in prison. So far, data available on the health of prisoners indicate that the quality of health care and health outcomes among inmates is not optimal and does not parallel the health care provided to the general population. One major limitation of the principle is the lack of conceptual clarity with regard to notions of health and what it means to be healthy in the prison environment. The principle compares two different settings and two distinctive populations and fails to provide the basis for comparison that takes into account the need for contextualizing health determinants. Notions of health and disease are descriptive of some established
criteria based on biological and physiological characteristics, but they are also shaped by values and norms applied to implement therapeutic and preventive measures. To improve health outcomes and promote healthy behavior in prison will require further examination of prison health determinants combined with a better conceptualization of notions of health and disease. The analysis we provide clarifies the reasons why equivalence of care cannot be a realistic and achievable goal in prison medicine. The challenge ahead in prison medicine will not be about the achievement of health equity, but rather about what is needed to improve health care delivery in an environment detrimental to the promotion of healthy behavior, in order to allow inmates to function (physically and mentally) in that context. Future efforts should thus focus on improving the way health care is delivered in an environment detrimental to the prisoners’ health.

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