

## Confidentiality and Reporting : Medical Ethics, Victim Safety, and Facility Security

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Privacy in correctional environments relative to medical evaluations has been difficult to achieve for years. The nature of correctional environments is primarily one of security. As a Warden once said to a medical monitoring team in an Eastern U.S. prison, “Security is number one, number two and number three”. Observation of inmates and monitoring of their activity is a security function. This can violate privacy as it relates to medical interviews. For this reason, most accrediting bodies including the National Commission on Correctional Health Care and the American Public Health Association have standards which recommend that medical encounters between the health care worker and the inmate patient occur in private.

In reality, these standards are difficult to achieve. Accreditation standards are voluntary in the United States and in addition, adherence to standards is subject to local security rules. Privacy is not always perceived as essential to adequate medical care. In the National Commission on Correctional Health Care Standards<sup>1</sup> for Jails, privacy of care is an important as opposed to an essential standard. All essential standards must be adhered to in order to achieve accreditation. Important standards are not all required. This means that failure to adhere to this one standard will not result in loss of accreditation. Relating to privacy of care in corrections there are two parallel worlds; one is the world of medical standards in corrections and the other is the world of custody rules and regulations. In reality these parallel worlds may or may not converge into collaboration. Custody chooses to accept or ignore medical standards based on personalities, local rules, custody practices. The world of security and the world of medical practice often do not come to agreement; instead there is an accommodation which is predicated upon power and other relationships within facilities and jurisdictions and the ability of

medical leadership to persuade custody leadership to accommodate medical privacy issues. Unless medical leadership is knowledgeable, proactive in protecting privacy rights, and capable of influencing custody leadership medical privacy rights suffer. Unless custody leadership accepts medical privacy it usually does not happen.

Legally, inmates have a constitutional right to privacy, but that right may not necessarily be violated when health care staff voluntarily report or are required to report medical findings to prison or jail executives with a reason to know.<sup>ii</sup> The legal right of a warden or prison/jail executive to manage their facility often trumps standard medical confidentiality rights that are accorded to ordinary citizens.

Against this backdrop there is the issue of prison rape. Inmates who are raped are vulnerable, usually weaker inmates who often have fear of retaliation and therefore are afraid to confess to their victimization. In this sense, inmates are no different than other victims of rape in other civilian settings. A more powerful person victimizes a weaker one by force and creates fear. In the civilian setting, rape victims may be unwilling to present their victimization to legal authorities because of fear of retaliation by a more powerful and threatening spouse or assailant. There is a similar fear in correctional settings but this fear is compounded by a general mistrust of correctional authorities. The fear in correctional settings is compounded by the reality of confinement and the realization that the assailant still lives in the same facility. This is a real fear.

Issues of privacy arise relating to the medical encounter during which a rape victim is evaluated and in any reporting that must occur between the medical professional and custody officials. Regarding medical encounters, all interviews and evaluations should occur in private. This is difficult to obtain in many correctional systems but health professionals must insist on this. Also, all rapes should be

reported. This requires reporting details to a custody official. Reporting rape to custody officials must occur in order to protect the victim and to identify the perpetrator. Reporting rape breaks the confidentiality bond between the inmate patient and the physician. However, this must occur because the remedy to stop further victimization within correctional settings requires separation. In order to create separation, a custody official must be involved. Custody officials will typically not change a housing assignment based upon a medical professional recommendation without a reason. Medical staff therefore must inform custody officials about rapes in order to effect this change of housing and therefore the rape event must be made known to them. Making the rape known to custody officials can be quite public in some facilities even to the extent of officers mocking the victim further; medical staff can contribute to this by their lack of sensitivity. This uncertainty of trust in correctional settings and the absolute reliance on custody for protection creates embarrassment, fear, and uncertainty in the inmate. Inmates probably weigh the possibilities of successfully obtaining transfer against that of not obtaining transfer and being returned to the same setting with the same assaulter, having been publicly known to have disclosed the assault. In this setting, disclosure is related to the trust that inmates have in custody officials. There is therefore a strong chance that inmates who are raped will not disclose their victimization. For all these reasons the reporting of rape and the subsequent guarantee of protection is essential to stopping rape in prisons and jails.

There is a sound basis for medical professionals breaking normal confidentiality and reporting rape to a custody official. Rape is a criminal act. In certain circumstances medical professionals have a legal obligation and responsibility to report criminal acts. For example, in many states there is a legal responsibility to report suspected child abuse. In a similar vein, protection of rape victims is the responsibility of physicians is so far as to cooperate with those responsible for protecting inmate victims. While laws may not require reporting of rape, medical ethically physicians should out of

concern for protecting their patient, report rape as a necessary precondition to safe housing for the inmate. Reporting of rape should be placed in a similar category as reporting child abuse. This would require that health professionals play a role in protection of rape victims.

Once rape is reported it is the responsibility of custody officials to investigate and protect the inmate. Because prisoners are often not treated with respect or dignity, when an inmate is assaulted there can be a tendency to dismiss the assault as part of normal prison life. This is countered by unambiguous policy. The custody mentality is based on a military style of governance. Rules and procedures are paramount. Post orders are specific rules that must be adhered to at each post. Officers are more likely to act appropriately toward victims of rape if custody policy and procedure is in place. Unless policy is clear and unambiguous, correctional staff can drift into actions that are based on their interpretation of how to act. Policies should emphatically state that all reported rapes are addressed in a similar fashion. Custody must take into consideration both the security of the inmate and security in their facility. Policies must include immediate separation of the victim for a medical evaluation, an automatic transfer of an inmate to a safe housing assignment, and a follow up interview to obtain details of the event and to initiate a disciplinary chain of events. These procedures must be addressed sensitively. Interviewers of inmates after rape should be specially assigned similar to special assignments on mental health units as an example. Training should be included for those officers who interview victims of rape. Separation housing should be determined in advance so that off-hour rapes do not result in lack of appropriate separation. If these safeguards are not present, inmates will be reluctant to report rape for fear of retaliation.

To summarize:

- 1 All inmates who are suspected of being raped should be presented for a medical evaluation.
- 2 That evaluation should be in private.
- 3 Medical professionals should be required to report rape. In my opinion, medical ethics and patient safety are the reasons that reporting rape should be a professional obligation.
- 4 Policy and procedure should be developed at all correctional facilities that addresses the precise reporting chain regarding any victim of rape.
- 5 Policy and procedure should include automatic housing transfer to a safe location.
- 6 That policy should include maintaining confidentiality to only those with a need to know. Training should occur for officers and medical staff regarding confidentiality.
- 7 The inmate-patient should be informed about how the rape will be reported and to whom it will be reported.
- 8 Only those with a need to know should be informed regarding details of a rape. Confidentiality must be maintained.
- 9 Officers who interview inmates who have been raped should receive training in how to conduct such interviews and how to maintain confidentiality.

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i Standards for Health Services in Jails, 2003, National Commission on Correctional Health Care

ii Rold, William, Legal Considerations in the Delivery of Health Care Services in Prisons and Jails Chapter 35 pages 526-27 in Clinical Practice in Correctional Medicine, Michael Puisis, D.O. Editor