National Consultative Ethics Committee for Health and Life Sciences

Opinion n° 94

Health and Medicine in Prison

Members of the Working Group:

Mme: Chantal DESCHAMPS (rapporteur)

MM.: Jean-Claude AMEISEN (rapporteur)
Jean-François BLOCH-LAINE (until 2005)
Jean-Paul CAVERNI
Olivier de DINECHIN
Haïm KORSIA
Pierre Le COZ
Jean MICHAUD (until 2005)
Michel ROUX
Maxime SELIGMANN
Mario STASI (rapporteur)

Were consulted: Franck BIZOUARNE
Rémy DOUARRE
Thierry LEVY
Loïk LE FLOCH-PRIGENT
Catherine PAULET

I. Introduction

II. Health in prison: a crucial problem because prisons are disease-ridden.

A. The number of people who are ill at the time of going to prison is proportionately higher, for a given age group, than in the population at large.

B. Prisons are increasingly confronted with mental health problems.

C. Prisons also cause sickness and death: they are the scene of regression, despair, violence and suicide.

1. Suicide: prisoners awaiting trial or serving short sentences

2. The wish to die: prisoners serving long sentences.

3. "Force inmates to continue living or reinstate them as subjects and actors of their own lives?"

D. Prisons can also be the scene of life's end, caused by sickness or old age.

III. What the law provides.

A. A specific law on health in prison: the law dated January 18, 1994.

1. The hospital system goes to prisons

2. Sickness and maternal insurance systems in prison

3. Prison warders are given a crucial role in communication between inmates and healthcarers.

4. Progressively, a more direct form of contact has been set up between inmates and healthcarers

5. The law dated January 18, 1994 marks therefore the end of a regime of exception and exclusion

B. Other laws with a bearing on the health and rights of the sick and the disabled

1. The law dated March 4, 2002 on the rights of patients and the quality of the healthcare system.

2. The law dated June 9, 1999 guaranteeing the right of access to palliative care.

3. The law dated April 22, 2005 on patients' rights and the end of life.

4. The law dated February 11, 2005 on the equality of rights and opportunities, participation and citizenship of the disabled.

IV. **Despite these laws, access to healthcare and the protection of health in prison continue to raise major ethical problems.**

A. In extreme situations

1. People who are dependent, elderly or disabled are more often than not deprived of help and autonomy

2. The suspension of sentence for medical reasons at the end of life, as provided by the law of March 4, 2002, is applied very restrictively

3. In contrast with a convicted prisoner, a prisoner awaiting trial, presumed innocent until proven guilty, cannot benefit when terminally ill from the provisions for suspended sentence for medical reasons contained in the law dated March 4, 2002.

4. The incarceration of people suffering from serious mental health disorders: "madness" in prison

B. In recognition of essential needs for health protection and human dignity

1. Prison overcrowding leading to disregard of the right to hygiene, privacy, salubrious and non-degrading living conditions compatible with physical and mental health

2. Exposure of the weak to violence from other prisoners (indiscriminate cohabitation) and disregard for inmates' rights to protection of their physical and mental integrity

3. Difficulty of access to emergency medical services

4. The right to preventive healthcare and health education

5. The issue of respect for emotional, familial and sexual needs

C. In the use for security or disciplinary reasons of constraints affecting the right to the protection of health and the quality of healthcare

1. Solitary confinement: disciplinary punishment (the "block" or "pound"), isolation in disciplinary quarters and the risk for the mental health of prisoners.

2. Handcuffs and fetters during medical examination and hospitalisation

3. The relationships between custody, protection of health and access to healthcare do not begin in prison: problems arising while in police custody

D. Problems raised by the respect for the fundamental rights of sick persons as recognised by law and essential elements of medical ethics

1. Doctor-patient confidentiality

2. Free and informed consent

a) an ethical problem with an obvious solution: healthcare made available to people suffering from addiction to licit or illicit products

b) two highly complex medical ethics problems:

- Hunger strikes
- Mandatory healthcare or by injunction

V. Another obstacle to complete access to the right for protection of health and healthcare in prisons: difficulties encountered by prison personnel.

A. The devaluation of the work done by warders and the ambiguity of their role

B. The difficulties and ambiguities complicating the task of healthcarers, doctors, nurses and social workers.

VI. The lack of respect in prison for the right to the protection of health reveals a broader problem: the lack of respect in prison for the fundamental rights and dignity of inmates.

A. The non-recognition of prisoner citizenship

1. The misapplication of law in prison

2. Prisoners' lack of access to many fundamental rights

a) In prisons, regulations continue only too often to be observed to the detriment of respect for the law

b) Particular hardship for prisoners awaiting trial, who are presumed innocent, while in custodial remand

c) Denial of the right of association

d) The minimal value given in prison to one of custody's essential missions: rehabilitation

B. Denial of the citizenship of inmates is also made evident by the continued detention of people who should not be in prison or for whom the law provides the possibility of commutation to other forms of sentence (open custody)

1. People who should not be in prison

2. People who could be elsewhere than in prison: inmates whose prison sentence could be replaced by another form of punishment.

VII. For genuine reflection by society on the notion of lawful rights and on the meaning of imprisonment and of penalty.

Recommendations

1. Before imprisonment

2. When charging

3. When sentencing

4. In prison

5. After release from prison

6. In general

I. Introduction

The International Observatory of Prisons (IOP) referred to CCNE on January 3, 2005 on the subject of prisoners undergoing medical examination in hospitals. The referral concerns ethical problems connected to doctor-patient confidentiality and the conditions of medical examination of fettered prisoners in the presence of escorting prison officers to comply with security measures decreed by the Ministry of Justice on November 18, 2004.

The situation of inmates of French prisons has recently been the subject of alarming reports including those of the /French Senate (*Prisons : une humiliation pour la République/*Prisons: a humiliation for the Republic*),* of the French Parliament *(La France face à ses prisons/*France confronted with its prisons) in 2000; those by the *Inspection Générale des Affaires sociales (IGAS) /*General Inspectorate of Social Affairs and the *Inspection Générale des Services Judiciaires(IGSJ) /*General Inspectorate of Judicial Services (*L'organisation des soins aux détenus : rapport d'évaluation/*Organisation of Medical Care for Prisoners: an evaluation report) in 2001; by the *Académie de Médecine* (Academy of Medicine*)* (*Situations pathologiques pouvant relever d'une suspension de peine, pour raison médicale, des personnes condamnées, suite à l'article 720-1-1 du code civil de procédure pénale/*Pathological situations which may give rise to suspension of sentence for medical reasons of convicted persons following article 720-1-1 of the Code of Criminal Procedure) and of the *Conseil National du Sida/National Aids Council, (Note valant Avis sur la suspension de peine pour raisons médicales/*Memorandum on Suspended Sentence for Medical reasons) in 2003*;* by the *Commission Nationale Consultative des Droits de l'Homme* (National Consultative Commission on Human Rights) (*Etude sur les droits de l'homme en prison/*Note on Human Rights in Prison) in 2004; by the Commissioner for Human Rights of the Council of Europe on the Effective Respect for Human Rights in France in 2005; by the *Conseil Economique et Social* (the Economic and Social Council (*Les conditions de la réinsertion socioprofessionnelle des détenus en France/*The Conditions for Social and Professional Rehabilitation of Prison Inmates in France) and again by the National Consultative Commission on Human Rights *(Etude sur l'accès aux soins des personnes détenues/*Study on Access to Healthcare of Prison Inmates) in 2006. Finally, a public debate on detention, to which inmates made a significant contribution, formulated a set of concrete proposals in November 2006.

The above reports show that prison remains, in many respects, a place where there is no respect for the principles of access to healthcare, protection of the health and dignity of prison inmates, in particular those who are sick, disabled or at the end of life.

Two points are particularly striking in these reports.
1° Six years have elapsed between the reports by Parliament and the Senate and the latest reports by the National Consultative Commission for Human Rights and the Economic and Social Council. And yet, they all emphasise the same problems which shows that they are persistent and difficult to solve.
2° Over half of these institutions do not have as their main mission health-related issues and over half of the reports did not mention these issues in the title. And yet, all the reports underline that ethical problems raised by faulty health protection and access to healthcare are among the major problems of prison detention.

Since ethical problems relating to health, medicine and the doctor-patient relationship have always been at the heart of its concerns, CCNE felt that the referral should be extended to include all the issues raised by the connection between health,

medicine and prison, and to highlighting ethical responsibilities as regards the protection of prisoners' health.

Concerning healthcare and health protection, prison appears as a place full of contradiction, leading to loss of bearings and of significance:

- contradiction between a legitimate demand for security and essential respect for fundamental individual rights and liberties, other than freedom of movement, in particular as regards health protection;
- contradiction between a prison which makes people sick and may lead to derangement and the medical obligation to heal;
- contradiction between the meaning of penalty, based on the offenders' personal responsibility and the incarceration of an ever increasing number of people suffering from serious mental disorders, etc.

Such contradictions make prison a case in point of how our society applies the values and laws which are its foundation, in particular those concerning respect for and the rights of the sick, the disabled, people nearing the end of their lives and those suffering from serious mental sickness.

Because prisons are the institutions of the Republic which, in the last resort, must apply the law, prisons cannot be a place where inmates do not have access to the fundamental rights which the law provides for everyone, in particular the right to health protection which is guaranteed in the preamble to our Constitution.

This ethical reflection commits our society as a whole. We are all, as a community, and each one of us, as a citizen, responsible for the protection of the physical and mental health of prison inmates, be they charged and awaiting trial and as such, presumed innocent, or be they convicted by our courts "in the name of the French people".

II. Health in prison: a crucial problem because prisons are disease-ridden.

A. The number of people who are ill at the time of going to prison is proportionally higher, for a given age group, than in the population at large.

In 2005, over 85,000 people were incarcerated, of which over 70% (i.e. more than 60,000) were awaiting trial, presumed innocent, in temporary custody in short stay prisons (*maisons d'arrêt*). The number of prisoners who were released during the year (over 85,000) is just about identical to the number incarcerated in the same year and prisons contained, on average in the year 2005, some 59,500 inmates. Their average time of detention was less than 9 months.

Prison inmates are not the mirror image of the population at large and have some special health problems.

Increasingly, they are young, marginalised, poor, and not integrated in social, economic and cultural terms. The number of young people aged between 18 and 24 years is seven times higher than in the population at large. Almost a third of those entering prison are addicted to narcotics, 10% live in precarious housing conditions, 5% are homeless, over 15% are illiterate, over 25% left school before the age of 16 and half of them left their families three years earlier than youngsters in the general population.

Despite the creation in 2000 of the *Couverture Maladie Universelle/ CMU,* (medical insurance for all) and of the state funded medical assistance scheme (*AME - Aide Médicale d'Etat*), over 13% of people detained in 2003 did not benefit from any kind of social protection (a percentage which is seven times greater than in the population at large). Prison population has had little formal schooling compared to the public at large as is illustrated by the fact that in 2005, over 40% of prison inmates were given primary school lessons.

"Prison has become a place where those that society has more and more difficulty integrating are given medical care — a true observatory of precarity"[*]. A year later, a joint report by *IGAS* (Inspection générale des affaires sociales/*) /*General Inspectorate of Social Affairs) and *IGSJ (Inspection Générale des Services Judiciaires /*General Inspectorate of Judicial Services) came to the same conclusion: "The difficulty of access to medical care for this sector of the population before incarceration and, more importantly, the conditions of precarious exclusion in which they have to live, are such that risk factors accumulate".

In detention centres, living conditions vary with the judicial status of those concerned. In 2005, out of 59,500 prisoners, over 19,000 — more than a third — were remand prisoners, mostly individuals who had been charged or awaiting trial; only just under 3% were awaiting retrial in appellate courts or the supreme court (*Cour de Cassation*/Court of Cassation). All of these individuals were in temporary custody in a *Maison d'Arrêt* (prisons for remand and short term sentences), for an average of a little over four months.

Twenty per cent (12,000) of prisoners were serving sentences of less than one year, also in the *Maisons d'Arrêt*.

Twenty one percent (13,000) were serving sentences of one to five years and 23% (14,000) were sentenced to over five years (of which 8,000 for over ten years). These are detained in the *Maisons Centrales* where long sentences are served.

The most serious problems — indiscriminate overcrowding, poor living conditions and health protection — are encountered in the *Maisons d'Arrêt*.

Health protection is essential to the entire prison population, but some categories of prisoners have special needs which need particular attention.

1. The young, who are in great numbers. In 2005, almost one prison inmate in two was under 30 years of age (some 25,000 individuals). Sentenced on average to less than nine months, these young prisoners may well, in the absence of **health education** and care, run the same serious risks to their health, or even worse risks, when they leave prison as those to which they were exposed prior to incarceration.

2. The over 60s. Their proportion has tripled in the last 15 years so that they represented 3.5% of the total, i.e. over 2,000 prisoners in 2005. In 2003, the prison population included more than 300 people over 70 and some 15 individuals over 80. If the census is extended to the over 50s, the proportion has doubled in the last 15 years so that it totalled more than 12%, i.e. over 7,000 prisoners in 2005. The growing numbers are due in particular to an increase of sentencing for sex-related offences which particularly concern these age-groups and, above all, to the increase in extended prison sentences. The handicaps and diseases that come with age affect them particularly.

[*] Dr Olivier Obrecht, Revue Projet (Spring 2002)

3. The disabled. To the growing number of people suffering from age-related handicaps with onset during custody by reason of the increase in long term sentences, should be added those who were already disabled prior to incarceration: **in 2003, over 5,000 people were already disabled when they were taken into custody**. More often than not, there are no cells in prison specifically designed for the disabled and adequate management of disablement is in fact impossible, particularly in the *Maisons d'Arrêt*, but the problem is simply ignored.

4. Women. **Over 3,500 women were incarcerated** in 2005, most of them young (average age is 30) and most of them on remand. They should be assured of whatever degree of privacy is required and the bond between mother and child must be specially protected. Their precarious status (33% have no social protection) and their health, both physical and mental, cannot compare with women of the same age in the general population. Furthermore, these problems are more serious than is the case for male prisoners.

5. Children born in prison and very young children of mothers in custody. For mothers of very young children, or women who have given birth in prison to a child from whom they will be separated after 18 months, the constraints of incarceration are compounded by the sorrow of being separated from their children. Every effort must be made to protect the children's health and well being and to allow the bond between mother and child to develop. As is emphasised by the International Convention on the Rights of the Child: "In all actions concerning children (...) the best interests of the child shall be a primary consideration." Underlining the importance of the bond between mothers in custody and their children in no way detracts from the consideration that must also be given to the bond between fathers in custody and their children.

6. Minors. Over 3,300 minors were incarcerated in 2005, most of them on remand, with major problems related to drug addiction, mental health and alienation from school and society. **Minors in custody are always highly vulnerable.** In the absence of any specific arrangements for young people, it is all too often in prison that they learn to be seriously delinquent. It is therefore very important to take every possible action to avoid sending them to prison and if imprisonment cannot be avoided, complex arrangements must be made to provide treatment suited to their specific age. Generally speaking, the management of young people's mental health raises very important issues. Minors in principle should be held in specialised institutions for young offenders, but in fact they are frequently held in special sections for minors in prisons intended for adult men or women.

7. Foreigners. Over 20% of the prison population (12,000 people) in 2005 were foreigners. As interpreters are frequently unavailable, access to healthcare is particularly difficult.

8. People reaching end-of-life

and

9. People with serious mental illness have special problems outlined below.

B. Prisons are increasingly confronted with mental health problems.

Increasingly, prisons are being used to secure psychiatric patients: there are twenty times more psychiatric disorders in prison than in the general population. In 2004, an epidemiological study requested by the *Direction Générale de la Santé (DGS)* (Ministry of

Health) and the *Direction de l'Administration Pénitentaire (DAP)* (Prison Service) revealed that 14% of the prison population suffered from full psychosis (over 8,000 prisoners) of which 7% (over 4,000 prisoners) were schizophrenic.

In fact there is a migration from psychiatric institutions to prisons. Incarceration of people suffering from serious mental disorders can only lead to loss of bearings and direction, that is a loss of understanding even of the penalty and of imprisonment, in particular the notions of criminal responsibility, healthcare and the role of healthcarers or the role of prison warders.

Mental disorders are source of suffering for the person affected ("Prison itself aggravates mental disease", emphasised the IGAS and IGSJ 2001 report), but they also cause suffering and confusion for fellow prisoners who are continuously exposed to intolerable and contagious "madness",

C. Prisons are also the cause of sickness and death: they are the scene of regression, despair, self-inflicted violence and suicide.

1. Suicide: prisoners awaiting trial and serving short term convictions.

More than 25 years after the abolition of the death sentence, prisons are still a place associated with death: **122 suicides in 2005 (a level seven times higher than in the general population).** That same year, there were over 950 attempts at suicide as well as a large number of self-mutilations, which not only inflict wounds but also frequently are a form of attempted suicide or are the warning signs of impending suicide.

The DGS and DAP epidemiological study in 2004 reported that 40% of prisoners were suffering from depression.

Half of the suicides involve prisoners awaiting trial, presumed innocent and occur within weeks of their incarceration (over 70% of the prison population is composed of people who are in custody pending trial).

Suicide figures are worse for women prisoners than for their male counterparts.

Disciplinary measures are the second leading cause of suicide: solitary confinement (the "block" or "pound") which may be imposed on both remand and convicted prisoners. In 2003, the suicide figures were seven times higher in the isolation units than for any other form of detention.

The Jean-Louis Terra report on the prevention of suicide in prisons submitted to the Ministries of Health and Justice on December 10, 2003, proposed that "...a climate in which all prisoners would be able to talk about their troubles" should be facilitated. In this kind of environment there is a need to reduce the level of stress and anxiety in prisoners as much as possible, in particular by improving relations between prisoners and prison personnel, decent living conditions, the assurance that they will not be subjected to brutal treatment and through maintaining family ties".

2. The wish to die: those serving long sentences.

Long sentences sometimes generate a condition that could be described as "confinement disease", characterised by a death wish which is the expression of a need to have the intolerable conditions in which prisoners live revised. It may also be the expression of a real desire to die, a request for euthanasia in another form. Proof of this is the recent

appeal from certain detainees in the Clairvaux high security prison, asking for capital punishment to be reinstated as the only alternative to a life so wretched that it leaves no hope of any meaningful remedy.

3. "Force inmates to continue living or restore them in their dimension as subject and actors of their own life?"

In a circular dated May 29, 1998, prison authorities insisted that a suicide prevention policy "could only be justified and effective if it sought not just to force inmates to continue living but to restore them in their dimension as subject and actors of their own life."

But two years later, the Parliamentary report described prisons "as a world where inmates are treated like irresponsible children".

How can prisoners be restored "in their dimension as subject and actors of their own life" when they are kept in a state of helpless dependency, denied any form of responsibility, maintained in forced idleness, deprived of privacy, when there is no real rehabilitation policy, so that overcome by the impossibility of expressing themselves and making their voice heard, they fall into regression and violence leading to self-mutilation and suicide?

How can this goal be achieved when so many of the deprivations that characterise life in prison are conjugated: lack of sleep, lack of family and emotional bonds, depression which affects almost one in every two prisoners, chronic exposure to stress and to violence from other prisoners?

D. Prisons can also be the scene of life's end, from sickness or old age.

People also die in prison, from sickness or old age: apart from the 120 individuals who die by their own hand every year, the National AIDS Council reported in October 2005 that some 120 prison inmates die annually of sickness or old age.

Between April 2002, when the law dated March 4, 2002 on patients' rights and the quality of the public health system was implemented, and the end of 2004, 165 people have avoided death in custody by benefiting from the articles in the law providing for release from prison for reason of ill health.

During this same time interval of two years and nine months, some 320 people (almost twice the number of those released) were not allowed to benefit from these provisions and died in prison.

III. What the law provides

A. A specific law on health in prison: the law dated January 18, 1994.

Following the publication of a report by the *Haut Comité de la Santé Publique* (Committee on Public Health) in 1993 underlining the difficulty of providing health care in a prison environment, a reform of the system was undertaken.

1. The hospital system goes to prisons

Since the entry into force of the law dated January 18, 1994, healthcare in prisons is now the responsibility of the Ministry of Health and no longer of the Ministry of Justice, with the exception of two major French penitentiary hospitals, Fresnes and Les Baumettes, over which the Ministry of Justice still exercises control, which does raise serious issues of division of responsibility.

. Two structures share responsibility for healthcare in prisons, each of which is administratively dependent on various structures: proximity hospital, university teaching hospital, general or private hospital:

- *Les Unités de Consultation et de Soins Ambulatoires (UCSA)* (Out-patient consultation and care units),
- *Les Services Médico-Psychologiques Régionaux (SMPR)* (Regional Medical and Psychological Care Units)

- *The Unités de Consultation et de Soins Ambulatoires (UCSA)* deal with diseases of the body.

At this time, there are 189 units. Their mission comes under four main headings:

1) Treatment in the prison environment, i.e.:
- General medical healthcare (outpatient or doctors' visits, including routine medical examination;
- Nursing care, including the dispensing of medicines;
- Specialist medicine if it is possible on site;
- Dental care;
- Laboratory tests which are available on site;
- On site treatment when healthcarers are not present.

2) Organisation of the admission and management by neighbouring hospitals of prisoners for outpatient procedures or tests requiring access to technical installations and for emergency hospital care or hospitalisation for less than 48 hours.

3) Preparation of medical monitoring after release, in coordination with the *Service Pénitentiaire d'Insertion et de Probation (SPIP)* (Penitentiary Rehabilitation and Probation Service).

4) Preventive and educational healthcare in coordination with national, regional or other community authorities, associations, etc.)

The aim of this preventive care is to screen for TB and sexually transmitted diseases, voluntary screening for HIV and hepatitis, vaccination, etc.

The object is to give prison inmates a sense of responsibility for their own health and to facilitate later rehabilitation, in particular by establishing treatment continuity. Such action implies cooperation from prison authorities during custody and at the time of leaving prison so that external structures can take over and help to ensure lasting good health

A national hospitalisation scheme for prisoners (except for psychiatric conditions) was created in 1999 and is gradually becoming functional. It aims to improve the conditions in which prisoners are hospitalised and rationalise their supervision. It is based, in conformity with the recommendations contained in Article R. 711-19 of the Code of Public Health, on inter-regional secure hospital units *(UHSI/Unités Hospitalières Sécurisées Interrégionales),* of which only three were operational by early 2006.

In the last ten years or so, despite serious problems as regards protection of health and access to care still persisting in prisons, management by public hospitals of serious somatic disorders has contributed to improving prisoner health. In some cases, prisoners have had access to vastly better healthcare in prison than would have been available to them outside prison.

However, in a December 2003 report, the *Académie de Médecine* remarked: "There is clearly a notable disparity in the quality of treatment from one hospital to another as regards financing, premises and equipment. There is a considerable shortage of medical and paramedical staff to respond to needs and in some cases they lack training for their very specific tasks".

- *The Services Médico-Psychologiques Régionaux (SMPR)* were created in 1986 and their mission was defined by the January 18, 1994 law. They are psychiatric units set up inside prisons by hospitals tasked with dealing with mental health problems (26 centres).
Two levels of care exist in prisons:
- Outpatient management is the responsibility of the local general psychiatric unit.
- More diversified treatment (including hospitalisation with patient consent) is given in the regional medico-psychological units.

As regards hospitalisation for mental illness without patient consent, this is managed according to the usual sectioning procedures in specialised hospital units, outside the prison environment,. The procedures for psychiatric hospitalisation of prison inmates were reformed by the general law on justice dated September 9, 2002, which provided for a redefinition of the management of psychiatric care for prisoners. Article 48 is concerned with the creation of specially equipped hospital units (UHSA), a system which is presently being defined.

In his 2005 report, the Human Rights Commissioner for the Council of Europe remarked: "...although they are granted substantial funds, SMPRs are faced with many problems. For instance, some are housed in dilapidated buildings which are unsuitable for medical care. Les Baumettes SMPR in Marseilles has 32 beds, which are divided among 14 cells each measuring 10 sq. m. Six of these cells are occupied by three patients on bunk beds. These conditions seriously undermine the standard of treatment

provided and make the carers' work considerably harder. The main point to emphasise is the very low number of places available in SMPRs in the light of actual needs. This means that they have very rapidly lost any regional function and prisons which do not have their own SMPR are reduced to providing routine treatment whereas they do not always have the support of a specialised medical team. In some prisons such as Le Pontet, psychiatric units have been incorporated into UCSAs, but there are no signs of this becoming a general approach. **The situation is even more difficult for women**, as there only two SMPRs reserved for women in the whole of France. Fleury-Mérogis prison houses one of these but offers only ten places. In mixed prisons, women do not always have access to the types of therapy managed by SMPRs".

But prisons cannot and should not — as is increasingly the case today — become a substitute for psychiatric hospitals. This growing confusion between the meaning of penalty and the meaning of care raises serious ethical problems.

. In both kinds of structure, UCSAs and SMPRs, doctors are hospital practitioners nominated through the same procedures as other hospital practitioners in public hospitals. Assistant and seconded doctors are on temporary contracts and are specialists, general practitioners and dentists. They are on call 24/24. Nursing staff are employees of the public hospital to which the prison is assigned and as in any other public hospital are under the authority of the hospital's management.

. The dichotomy between the two structures — UCSA and SMPR — sometimes creates relational and coordination problems which vary from one institution to the other, because the two hospital regulatory systems differ.

2. Sickness and maternal insurance in prison.

Since the January 18, 1994 law, once people are taken into custody, they are covered by the general national social security medical insurance system and, since 2005, they are supposed to benefit from the universal complementary sickness insurance system (CMUC). The State pays the relevant social contributions into the sickness insurance system financed by an item in the Ministry of Justice budget. It also funds the portion which is not covered by the sickness insurance system: the "user fee" for care and hospital stays.

3. Prison warders are given a crucial role in the communication between inmates and healthcarers.

Prison guards are made available to help medical staff make medical premises secure. They are bound by rules of medical confidentiality.

Requests to see a doctor in both UCSAs and SMPR are made by prisoners, in which case they are transmitted to prison warders, or are requested by the warders themselves or by healthcarers. Warders therefore play a crucial role in the protection of prisoners' health and providing access to healthcare.

When specialists are needed, they may come to the prison to give an opinion, but more generally prisoners are transported to their designated hospital with police and prison warder escort. If they are kept in hospital, they are guarded by the police.

4. A more direct form of contact between inmates and nursing staff has gradually been put in place so that in particular a prisoner may ask for an appointment by inserting a request directly into a letter box specially provided for that purpose. Medications are now distributed by nurses and prisoners being treated for drug abuse may in certain cases go to the prison infirmary to be given that treatment. The development of such direct relations between inmates and healthcarers should certainly be encouraged with the aim of giving prisoners healthcare of a quality approaching what is offered to the population as a whole.

5. The law of January 18, 1994 does therefore mark the end of a regime of exception and exclusion: the object being to provide prison populations with quality and continuity of healthcare as well as access to prevention, screening and health education to an equivalent degree as is available to the population as a whole.

A Methodological Guide for the Medical Management and Social Protection of Detainees has been drafted jointly by the Ministries of Health and of Justice. It was the subject of a circular dated December 8, 1994. On January 10, 1995, an initial update of the Guide was the subject of a circular. It reports on progress with implementing the reforms, notes difficulties which still need attention and formulates new recommendations.

The recommendations were concerned with the attention to be paid to patients' rights as regards information, consent, and suspension of sentence for medical reasons, instructions for responding to medical emergencies, hygiene in health caring facilities, health education and prevention (in particular for sex offenders and addicts), suicide, the management of the disabled and the essential partnership between healthcarers and prison staff.

The Guide will be updated as and when legislation and regulations evolve as regards public health and healthcare and to comply with new European directives. A monitoring committee, composed of representatives of the institutions concerned and members of the medical professions has been set up to deal with this updating procedure.

B. Other laws concerned with the health and rights of the sick and the disabled.

Subsequent to the law dated January 18, 1994, specifically concerned with health in the prison environment, four new laws concerning more generally the health of the population at large have given new breadth to the notion of the rights of the sick, the disabled and those reaching end-of-life.

Only one of these laws contains an article specific to health in prisons. This is:

1. The law dated March 4, 2002, relating to the rights of patients and the quality of the healthcare system.

It contains in article 10 provisions which have been inserted into the *Code de Procédure Pénale* (Code of Criminal Procedure), article 720-1-1 and which permit the possibility of release for medical reasons to be applied to terminally ill convicted prisoners.

Other laws apply to the medical management of inmates since they concern all citizens, although they do not refer specifically to prisoners:

2. The law dated June 9, 1999, which aims to guarantee the right of access to palliative care.

The law does not refer at any time specifically to the prison population, even though they may be receiving care in a public hospital, but obviously there could not be any justification for denying patients "*whose state of health requires it*" the right to palliative care and psychological support simply by reason of their being in custody.

3. The law dated April 22, 2005 on patients' rights and end-of-life situations.

No more than in the previous case does this law specifically provide for prisoners. But since it applies to individuals who are "*in an advanced or terminal phase of a serious or incurable affection*" and it provides new regulations for psychological support and ending life with dignity, it is also obvious that a prisoner could not be excluded from the benefit of the law, simply by reason of being in custody.

4. The law dated February 11, 2005 on equality of rights and opportunity, participation and citizenship of the disabled.

Clearly, this law does not, any more than the others, contain any clause regarding the exclusion of prisoners.

IV. Despite the existence of these laws, access to healthcare and the protection of health in prison continues to raise major ethical problems.

A. In extreme situations

1. People who are dependent, elderly or disabled are more often than not deprived of help and autonomy.

"Disability is more frequent in prison than outside" reported the 2002 enquiry by *Handicaps — Incapacités — Dépendance — Prisons.*

"In prison, one person in two suffers from behavioural disorders or disorientation in time or space, or some incapacity, difficulty or even impossibility to perform the elementary actions of everyday life, such as getting dressed, washing, speaking, etc."

An enquiry in 2003 on the condition of people at the time they were taken into custody showed that 2.4% were receiving benefits for disabled adults (*Allocation pour Adulte Handicapé/AAH*), 3.3% were invalids and 3.8% were entitled to non-payment of the "user fee" because of long-term illness (*Affection de Longue Durée/ALD*). In total, over 6% of people at the time of incarceration (i.e. some 5,000) were concerned by at least one of these criteria.

The *Académie de Médecine*, on the more general subject of prisoners aged over 60, stated in its December 2003 report that most of them "were incarcerated in buildings inappropriate for age-related physical impairment: numerous staircases, no lifts, lack of ramps so that many facilities were inaccessible, including medical facilities, with users of wheelchairs faring even worse."

The disabled are confronted with three main types of difficulties in prison:

- inaccessibility of premises
- total or partial lack of technical assistance
- and above all the absence of any help for the essentials of daily life.

- The inaccessibility of premises prevents disabled prisoners from using public facilities (showers, working areas, libraries, prison yards, etc.).

Most prisons, of archaic construction, are partially or totally lacking in access ramps, lifts, specially constructed showers and toilets, individual cells with sufficient space for special beds and wheelchairs.

- Technical assistance (special beds, sheet protectors, hoisting systems, wheelchairs, etc.).

Up to early 2005, the legal benefits provided to dependent people and intended to help them buy certain items of equipment were reduced or withdrawn if they went to prison for over 45 days, including those who were charged or on remand and presumed innocent.

As regards the presence of a helper for the necessities of everyday life or providing specific care (such as physiotherapy), this was not allowed until the beginning of 2005.

Assistance to disabled prisoners depended entirely on the good will of those around them (prison warders but mainly fellow prisoners) with all the gaps and risks that this entails.

The circular dated January 10, 2005 on the updating of the *Methodological Guide regarding healthcare and social protection for persons in custody*, in a chapter on "the management of dependent and/or disabled persons", states: "The number of elderly dependent or disabled people in custody is rising.

People in custody already receiving benefits for disabled adults (AAH) may now also receive specific benefits such as third party assistance compensation (*allocation compensatrice pour tierce personne (ACTP)* and personal autonomy benefits (*aide personnalisée à l'autonomie (APA)."* It remains to be seen, and to be verified, that these measures are implemented in the very near future.

In the same chapter "updating of the guide (management of dependent and/or disabled persons)", it is stated that "Dependent, elderly or disabled persons should benefit, during the time they are in custody, from services and conditions of detention which are appropriate to their situation, in particular cells reserved for the disabled ".

It is only however new prisons that are supposed to have "at least one cell designed for the disabled". It is hard to understand how new prisons which do have one special cell (one for every 200 inmates, i.e. 0.5% in the new prisons only, whereas the percentage of disabled people in custody for all the prisons, old and new, was 6% in 2003) could possibly solve the problem for the entire disabled prison population, since to the number of prisoners entering the prison bearing a handicap must be added those who have aged while they were in prison. As a result, "...the disabled are subjected to living and detention conditions which are contrary to dignity", to quote the terms used by the National Consultative Commission on Human Rights in their *Study on Access to Healthcare of Prison Inmates* in 2006.

When any adequate management of disablement is in fact impossible, a disabled person in custody is in practice excluded not only from the scope of the law dated February 11, 2005 as regards equality of rights and opportunity, participation and citizenship of the disabled, but also from the application of the law dated January 18, 1994, which aims to give

people in custody the same access to healthcare and protection of health as is available to the population at large.

2. The suspension of sentence for medical reasons at the end-of-life, as provided by the law of March 4, 2002, is applied very restrictively.

These provisions, which were added to the Code of Criminal Procedure in article 720-1-1, provide for the suspension of sentences involving deprivation of liberty for "convicted persons for whom it is established that they are suffering from life-threatening disease or whose state of health is lastingly incompatible with being kept in custody".

The Study on Access to Healthcare of Prison Inmates in 2006 by the National Consultative Commission on Human Rights quotes the figures published by the Ministry of Justice on July 19, 2005, to the effect that between April 2002 when the law became effective and December 31, 2004, 165 people had been granted a suspension of their sentence for medical reasons. The study compares these figures with those published by a group of associations and practitioners ("*Pôle suspension de peine*") which reported a total of 436 requests for suspension during the same period of time, in other words a rejection rate of over 60%.

The January 10, 2005 circular on the updating of the *Methodological Guide regarding healthcare and social protection for persons in custody*, recalls that "suspension of sentence for medical reasons requires, for its acceptance, two concurring medical examinations. Time must therefore be allowed for those examinations to take place and joint action by the prison services and the medical and social services is required, in particular to decide on an appropriate place to go for a person benefiting from the suspension. The final decision however is taken by the judge responsible for prisoners' conditions of sentence or the regional probation jurisdiction".

In reply to written questions from two members of parliament, in May and July 2005, the Minister for Justice stated that one of "the main existing difficulties" to apply the suspension of sentence for medical reasons procedure resides with finding "solutions to the problem of suitable hospital, family or hostel accommodation".

Previously, in an Opinion dated March 11, 2003, the National Aids Council expressed the hope that: "... authorities take steps for this article of law to be applied in a manner which complied with the wishes of legislators".

Whatever reasons may be preventing the implementation of a law drawn up to prevent people dying in prison and which stated that "health considerations" alone should enter into the decision to suspend sentences for medical reasons, the inescapable fact is that since the law dated March 4, 2002 entered into force, until end 2005, i.e. three and a half years, upwards of 800 prison inmates have probably died in custody: over 400 by their own hand and over 400 from sickness or old age.

3. Contrary to convicted prisoners, terminally ill remand prisoners, presumed innocent until proven guilty, cannot benefit from the provisions for suspended sentence for medical reasons contained in the law dated March 4, 2002.

A person in remand, be it pending investigation (charged), awaiting trial or retrial by an appellate or supreme court, is totally excluded from the provisions of article 720.1.1 in the Code of Criminal Procedure relating to the March 4, 2002 law on the rights of sick prisoners which aims to apply the possibility of release for medical reasons to end-of-life situations.

The possibility of suspension of custody is left to the appreciation of the investigating magistrate. To this particular status, set apart from the scope of the law concerning persons at the end-of-life — or more generally persons whose "state of health is lastingly incompatible with continuing detention" or suffering from "a life-threatening pathology" — are added living conditions which are generally discreditable for people who are in temporary custody, incarcerated in prisons where overcrowding, lack of privacy and poor hygiene are incompatible with palliative care and humane treatment when a life is ending.

Some inmates as they reach the end of life start proceedings with reference, for example, to the European Convention for Human Rights which prohibits degrading treatment. But proceedings take too long to be compatible, in most cases, with their life expectancy. All the more so because a prisoner taking his case to the supreme court (Court of Cassation) remains on remand. This paradoxical situation is an encouragement for remand prisoners to abstain from appealing so as to be sentenced as soon as possible and therefore benefit from the right to claim for release by virtue of the March 4, 2002 law.

This discrimination creates a major ethical issue. Terminally ill people must be treated with reference to their condition and not to their judiciary status, be they in remand — charged, awaiting trial or retrial on appeal or by a supreme court — or convicted. The paradox being again that a person in remand is presumed innocent.

All those nearing the end of their life should be spared incarceration.

4. The incarceration of people suffering from serious mental health disorders: "madness" in prison.

This situation, as previously mentioned, is one of the major ethical problems which arise due to the growing confusion between the respective meanings of penalty and care on the one hand, and the right to protection of health and access to care on the other hand. These serious ethical issues involving denial of the right to the protection of health and access to healthcare threaten both the right of sick people to the best possible psychiatric medical treatment to allay their sufferings and the right of their fellow prisoners to protection for their own mental health endangered by constant confrontation with "madness".

B. The recognition of essential needs for the protection of health and human dignity.

1. Prison overcrowding and disregard for the right to hygiene, privacy, salubrious and non-degrading living conditions compatible with physical and mental health.

In its report in 2000, the French parliament stated that "overcrowding in prisons is the cause of treatment to prisoners which can be justifiably described as inhumane and degrading".

In its 2004 study, the National Consultative Commission on Human Rights emphasised that "as regards personal hygiene, France trailed behind a number of other

European countries" and that "the lack of privacy imposed on the majority of people detained in prisons was one of the more degrading aspects of the status of prison inmates in France".

In their 2006 study, the National Consultative Commission on Human Rights recalled that in 2005, the European Commissioner for Human Rights had described some of the prisons he had visited in France as "squalid".

To give a single example of this, when three or four people are confined in a cell measuring nine square meters, featuring a toilet bowl which is not isolated from the rest of the area, is not just unhygienic but also a major psychological injury. Inmates having to satisfy elementary needs without any degree of privacy is a violation of human dignity.

The scarcity of showers (which in short stay prisons particularly are extremely dirty due to outdated facilities) creates both hygiene and human dignity problems. In their 2006 study, the National Consultative Commission on Human Rights recalled that "shower rooms are frequently insalubrious, unventilated and covered in mould. Article D. 350 of the Code of Criminal Procedure states: "to the greatest extent possible, they (inmates) must be able to take showers at least three times a week". However, in the view of the National Consultative Commission on Human Rights "this rule, *a fortiori* with that qualification, is no longer acceptable in the 21st century. Prisoners must be able to shower every day".

And yet, article D. 349 (Decree dated December 8, 1998) of the Code of Criminal Procedure states: "The conditions of incarceration must be reasonably hygienic and healthy". Article D. 350 says: "Places of detention, in particular areas used for accommodation, must comply with rules of hygiene". Article D. 351, says that "toilet and washing facilities must be clean and decent".

The Code of Criminal Procedure includes a full list of verifications procedures to make sure that these rules are in fact applied.

For instance, article D. 348-1 stipulates: "The general inspectorate of social affairs and the local ministerial services in charge of health will see to the observance of measures required to maintain the health of prisoners and to ensure hygienic conditions in places of detention. These services will ensure that prison establishments implement the rules and regulations pertaining to public health and perform all necessary inspections".

Article D. 348-3 states: "The interministerial committee [for the coordination of health in prisons] will consider all matters pertaining to the protection and improvement of prison inmates' health and to hygiene in prison establishments. It will enforce the instructions regarding prevention and the organisation of healthcare and hygiene in prison establishments".

Finally, article D. 380 states: "the physician in charge […] ensures that rules of collective and individual hygiene are observed within prisons. For this purpose he is entitled to visit all prison premises and notify the appropriate authorities of any deficiencies regarding hygiene and generally of any situation that could affect the health of inmates; he recommends remedies for shortcomings".

Overcrowding and lack of privacy in cells concern **mainly remand prisoners,** presumed innocent, detained in **short stay prisons *(maisons d'arrêt).*** The *centrales* which are not overpopulated, house prisoners sentenced to long prison terms, not remand prisoners.

As an example, in 2005, in 8 short stay prisons, the occupancy rate was over 200%.

The number of remand prisoners incarcerated every year in temporary custody is astonishing: over 60,000 in 2005 although the law dated January 6, 1995 stipulates that preventive custody should be the exception.

Furthermore, there is a contradiction between the overcrowding and lack of privacy in cells housing remand prisoners and article D. 716 of the Code of Criminal Procedure (corresponding to the law dated January 4, 1993) which states: "indicted, charged and accused persons held in temporary custody are held individually, by night or by day".

Prior to the law dated June 15, 2000 on the presumption of innocence, this article continued in the following way: "this principle must be observed unless the imprisoned persons request otherwise or, if they ask for employment, by reason of the organisational demands of their work". Article D. 716 states that this is applicable as of June 16, 2003 (i.e. over three years ago).

However, four days before this deadline, article 41 of the law dated June 12, 2003, on the reinforcement of repression of road violence (!) prolonged it by five years, leading to a new modification of article D. 716 which now reads "this principle must be observed unless:

1) those concerned request it; 2) if their personality requires that they are not left alone, in their own interest; 3) if they have been authorised to work or to attend vocational or educational training the organisation of which demands it; 4) within five years of law n° 2003-495 of June 12, 2003 reinforcing repression of road violence, if the internal layout of prisons or the number of prisoners in custody prevent individual imprisonment".

In other words, the principle of individual incarceration, which has been stated by law for 13 years, has never ceased to be the subject of exceptions delaying its implementation, at this point until 2008.

In their studies on *Human Rights in Prison* in 2004 and on *Access to Healthcare of Prison Inmates* in 2006, the National Consultative Commission on Human Rights called on the need to "ensure incarceration in private cells as the only system capable of protecting the physical and psychic integrity of prison inmates".

Inadequate hygiene in prison goes beyond overcrowding, lack of privacy and woefully dilapidated premises. It also concerns food since there is inequality between prisoners, most of whom are poverty stricken. Some foods and dietary complements are only available to prisoners if they can purchase them. In his 2005 report on the *Effective Respect for Human Rights in France*, the European Commissioner for Human Rights noted, for example, that the price of sugar in certain prisons was higher than in shops in the same area!

2. Exposure of the weak to violence from other detainees (indiscriminate cohabitation) and disregard for inmates' rights to protection of their physical and mental integrity. Young presumed offenders sharing a cell with hardened criminals are in a situation of extreme vulnerability.

In its report in 2000, *France faces up to its prisons*, the French Parliament emphasised: "Prison overcrowding is of course also the cause of increasingly frequent occurrences of self-inflicted violence (self-mutilation, attempted suicide, suicide), aggression between prisoners, racketeering and violent behaviour directed at prison warders".

This ever-present violence is exacerbated by the indignity of detention conditions in short stay prisons, by lack of privacy and by the massive intrusion of mental ill health inside prisons.

It is made even worse by the lack of attention for states of mind, such as stress and anxiety for which the only and grossly excessive remedy is increased security or medication.

Generally speaking, violence is dealt with in two ways:

- intensive use of psychotropic drugs justifying its description as "medicinal incarceration" or "pharmaceutical straitjacket";
- disciplinary action which often increases the disorder it is meant to eradicate.

It seems surprising that the Statistical Report on Justice, Serving of Sentences and Prison Services for 2006 (*Annuaire Statistique de la Justice, Exécution de peines et administration pénitentiaire)* — which lists data concerning the prison population, including the 2 to 3,000 "collective or individual incidents occurring during the year", including aggressions against prison staff, escapes, hunger strikes, suicide and attempted suicide — made no mention of the existence of violence between inmates, as though it did not exist or was not worth mentioning and including in the important data given about prisons.

Yet the National Consultative Commission on Human Rights, based on an analysis of disciplinary offences listed by the prison authorities, highlighted the extent of such violence: in 2002, over 6,800 cases of physical aggression between inmates were reported, of which 80% (over 5,300 instances) occurred in short stay prisons.

Incarceration implies that the physical and mental integrity of prisoners can be protected and their safety ensured at all times, be it against the risk of aggression between prisoners, self-mutilation or suicide, or against the risk of serious ill health requiring urgent action, at night in particular (acute asthma, infarction, etc.).

3. Difficulty of access to emergency medical services.

Emergency healthcare, or medical counselling required in case of severe anxiety, is sometimes rendered inaccessible:

- **At night, inaccessible** because of insufficient night rounds so that it is impossible to call for medical help in the event of acute distress.
- **During week-ends** and even on **week days, difficult** because of the lack of attention given to prisoners' calls by guards who hear too many cries and are frequently untrained to single out complaints requiring immediate attention.

It is, however, unacceptable that people locked up in cells, in a situation of total dependence generating anxiety **cannot obtain, in case of emergency, around-the-clock access to medical help.**

IGAS and IGSJ, in their 2001 report, noted that "the absence of a doctor on standby, the guards' degree of alertness, the time needed to access cells" were "all components of a situation which could lead to unsatisfactory management of an emergency".

The *Académie de Médecine*, in their December 2003 report, noted furthermore: "A treatment prescribed for round-the-clock administration has every chance of being interrupted. Non-stop supervision as is specifically needed for type I diabetes cannot be

provided. The occurrence of an acute medical condition at night is dealt with by calling on emergency medical services if, of course it is identified (by whom? cellmates?) and the abnormal condition has been made known".

The National Consultative Commission on Human Rights, in their 2006 *Study on Access to Healthcare of Prison Inmates*, noted the **unwieldy procedures** required in the event of nocturnal medical emergencies. "Not only must the guard hear the calls of the distressed prisoner or those of his cellmates, he must evaluate the seriousness of the situation, possibly send for a senior officer — who alone is allowed to unlock the cell —and then contact medical emergency services who will send a doctor to the scene.

The National Consultative Commission on Human Rights also underlined that the *Methodological Guide regarding healthcare and social protection for persons in custody*, in the revised April 2004 edition, invited each prison establishment to "...set up a system enabling the prisoner concerned to communicate directly over the telephone with emergency medical services in or outside the prison".

The circular dated January 10, 2005 on the updating of the *Methodological Guide regarding healthcare and social protection for persons in custody,* in the chapter on responding to emergencies, stated: "A system facilitating direct communication with emergency medical services in or outside the prison must be set up, so that life-threatening emergencies can be identified and delays in the administration of healthcare with potentially serious consequences for those in custody can be avoided".

In their 2006 *Study on Access to Healthcare of Prison Inmates,* The National Consultative Commission on Human Rights recommended: "...making available as a general rule means of calling for help from detention cells (interphones) and the early installation of a system enabling prison inmates to communicate directly with emergency medical services".

4. <u>The right to preventive healthcare and health education.</u>

The Code of Public Health says that "access to prevention and healthcare is a priority objective of public health policy".

The circular dated January 10, 2005 on the updating of the *Methodological Guide regarding healthcare and social protection for persons in custody*, in the chapter on *prevention and health education* states that "prevention is a component of the general health management of persons in custody. The physician attached to the UCSA coordinates, with the prison establishment, preventive healthcare and health education".

The *Methodological Guide regarding healthcare and social protection for persons in custody* emphasises: "One of the important points of healthcare policy in prison establishments is to give a population which is frequently made up of people who are young, fragile and who have had little access to healthcare prior to incarceration, the benefit of preventive care which could improve their future level of health".

However, in their 2006 *Study on Access to Healthcare of Prison Inmates,* The National Consultative Commission on Human Rights remarks: "It nevertheless appears that, generally speaking, including in cases when such a plan exists, it remains inoperative. A number of reports by UCSAs confirm this. In this case also, the overcrowding in short stay

prisons is frequently an obstacle to the implementation of these programmes. Faced with growing waiting lists of patients, medical services focus their attention on ordinary healthcare".

5. The issue of respect for emotional, familial and sexual needs.

For those who are excluded from society for variable lengths of time, maintaining family links is essential, particularly for their mental health. This is one of the pillars allowing prisoners to keep their psychological balance and faith in the future. It is also, as the Economic and Social Council underlined in its 2006 report, "one of the pillars supporting rehabilitation", for which one of the important components is continuity of healthcare, prevention and protection of physical and mental health after leaving prison.

Article D. 402 of the Code of Criminal Procedure states that "particular attention must be paid to maintaining and improving relationships [of detainees] with their families, in so far as this appears to be in the best interests of both parties".

Article D. 410 states that "remand prisoners must be allowed visits at least three times a week and convicted prisoners at least once a week".

In the real life situation of French prisons, short stay prisons in particular, full access to that right is frequently impossible: excessive distance between the prison and the prisoner's home, transfers to other prisons sometimes used as disciplinary measures, complicated visiting schedules, poor visiting arrangements, lack of public transport, all of which are aggravated by extremely limited visiting days and hours.

Furthermore, these visiting rights are further restricted for **foreign** prisoners, as a result of article D. 407 which stipulates that "inmates must speak French. If inmates or visitors cannot express themselves in that language, they must be supervised by an agent who can understand them. If no such agent is available, the visit is only authorised if the permit which was delivered expressly states that the conversation may take place in a foreign language".

Children — who are deprived of contact which is all the more important because they only see the incarcerated parent rarely and briefly — **are particularly vulnerable. They are profoundly affected by the psychological and emotional breakdown of family ties**. And yet, the child's interests should be overriding. The International Convention on the Rights of the Child, in article 3-1, states "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration".

In 1995, a report by the prison services underlined the "emotional deprivation" of people in custody. Until very recently, it was unthinkable in our country that couples, families, parents and their children, could meet in privacy. To be deprived of the freedom to come and go was synonymous with being deprived of intimate emotional and family relations. As to the possibility for a couple of maintaining emotional and sexual relations when one of them was serving a lengthy prison sentence, it was totally excluded.

And yet, in Canada, the possibility for couples of meeting in privacy and in conditions respectful of human dignity have existed for 25 years. In certain European countries such as Denmark and the Netherlands, non-supervised visits are allowed in premises designed for privacy are allowed once a week.

In France, article D. 406 of the Code of Criminal Procedure states that "in any event, a warder is present in the visiting room. He must be able to hear the conversation".

In 2003, a Family Visit Unit (*Unité de Visite Familiale/ UVF)* composed of three apartments was built in the women's prison in Rennes. This enables women who are serving long sentences to see their families and loved ones four times a year, for 6 to 72 hours in an apartment where prison warders do not enter. The importance of this arrangement cannot be too highly stressed. "The UVF is seen as an area signifying freedom", stated in November 2006 the Rennes prison governor. "This is an innovative project which proves that prison services have moved with the times".

At this time, only three prisons boast a UVF which is a tiny number compared to the 190 French prisons. In September 2006, the Minister for Justice announced the forthcoming creation of four new UVFs. Their extension to all long stay prisons is planned for 2009.

It remains to be hoped that the full implementation of such measures, which are essential to mental health and personal dignity, will not be constantly deferred — as has been the case for access to the right of release from prison for medical reasons, access to the right of care for the disabled, access to the right of incarceration in individual cells (see above) — but on the contrary will be rapidly forthcoming.

C. In the use for security or disciplinary reasons of constraints affecting the right to the protection of health and the quality of healthcare.

1. Solitary confinement: disciplinary punishment (the "block" or "pound"), isolation in disciplinary quarters and the risk for the mental health of prisoners.

In prisons, order and security are almost entirely based on disciplinary and isolation measures.

A decree dated April 2, 1996, defines discipline violations and resulting sanctions. The Code of Criminal Procedure, in article D. 283-1, states that a prisoner can be isolated in a special location as a precautionary and safety measure. No maximum duration of isolation is specified.

In its 2004 report, the National Consultative Commission on Human Rights noted: "In 2002, 161 prisoners had been held in isolation for over a year". In his 2005 report, the European Commissioner for Human Rights remarked: "In the course of the visit I met people who had been in total solitary confinement for several years".

Of all the disciplinary measures, being placed in solitary confinement is the punishment most feared by prisoners.
In the isolation cell, prisoners remain in total solitary confinement for a maximum of 45 days. They are deprived of everything which made up their life in prison, already a life of deprivation: activity, contact with other prisoners, visits from family, etc.

This extreme punishment has been the subject of a large number of reservations and warnings:

- The "block" has self-destructive effects with sometimes as a consequence suicidal attempts in the first few days after a prisoner emerges from total isolation.
- The "block" may aggravate to the point of becoming uncontrollable mental disorders and violent impulses.

The European Committee for the Prevention of Torture (CPT) underlined, in their 2000 report that they had serious reservations as regards the status of a number of prisoners in administrative isolation that their delegation met during the visit; reservations concerned both the duration of isolation for years at a time and the highly restrictive regime to which such prisoners are subjected in the absence of any structured and/or collective activities. The CPT recalled the comments they had already made in their 1996 report: "Solitary confinement can, in certain circumstances, amount to inhuman and degrading treatment" and " in any event should be as short as possible".

In its report in 2000, the French Parliament underlined that "the desocialising and destructuring consequences of solitary confinement for the psyche were pointed out by members of the prison services and observed during the visits".

The French Senate's report of the same period, stated that "the maximum duration of solitary confinement, which is now 45 days, should be reduced to 20 days".

The European Commissioner for Human Rights underlined in his 2005 report that the 45 day maximum period of solitary confinement in a disciplinary cell as specified by article D. 251-3 of the Code of Criminal Procedure "...makes the French disciplinary regime one of the strictest in Europe. The maximum period of punitive isolation is three days in Scotland and Ireland, nine days in Belgium, 14 days in England, 15 days in Italy and the Netherlands, and 28 days in Germany".

The CPT, the International Observatory of Prisons *(Observatoire International des Prisons (OIP)* and most doctors agree that such punishment should never be inflicted for more than 15 days and have several times drawn the attention of the French authorities to the degrading nature of this disciplinary measures inflicted in unacceptable conditions (a mattress on the ground with a toilet bowl for a view).

Over 20 years ago, the maximum security quarters in prisons were considered degrading and they were dismantled. The "pound" which represents the same degree of inhumanity has been retained in total opposition with all the statements on human rights.

In their 2004 report, the National Consultative Commission on Human Rights recommended that "legislators should look into the matter", as regards the maximum duration, proportionality of penalty, the principle of fair trial by a disciplinary board and a generalisation of the judicial remedy.

The Commission notes: "By an order dated July 30, 2003, the Conseil d'Etat reversed its own 'Fauqueux' case-law which ruled that placing in solitary confinement was to be considered as internal discipline which therefore did not allow for any remedy. The order has therefore opened the way for appeal as regards administrative isolation".

Should solitary confinement be necessary, it should be strictly regulated since otherwise it contradicts its own disciplinary purpose by endangering the mental health of the

prisoner. In fact, serious ethical issues are raised by this form of punishment: the demarcation line between punishment and degrading treatment and torture; the boundary between the powers of an institution and the protection of fundamental human rights, in particular the right to protection of mental health.

Furthermore, article D. 381 of the Code of Criminal Procedure raises a problem of medical ethics in connection with the confusion between the role of physician as a healthcarer in the service of a patient and as an expert in the service of the prison administration. Article D. 381 states that "general practitioners […] provide medical care following requests formulated by detainees or, as the case arises, by prison staff or by any person acting in the interest of the prisoner". The same article continues: "these physicians also [a)…]; b) visit prisoners in the disciplinary block […] whenever they deem necessary and in any event at least twice a week; c) visit the isolation block […] whenever they deem necessary and in any event at least twice a week".

A truly trustful relationship between doctor and patient **is impossible when the same doctor** is the one who **hears and provides care for the patient** and the one **who authorises the continuation of a disciplinary sanction which can threaten the prisoner's mental health.**

Another paradox must be underlined: the contrast between reluctance to grant prisoners a cell of their own without any possibility of isolation (as emphasised above, in chapter IV-B-1) and the excessive recourse to incarceration in an individual cell — the "pound" — as a part of disciplinary punishment. In other words, detention in an individual cell — which has been requested for many years as a measure of protection of physical and mental integrity, stipulated as the rule for remand prisoners, except by derogation, by the Code of Criminal Procedure, the implementation of which is constantly deferred in short stay prisons — is only used as part of violent mental health-threatening punishment.

2. Handcuffs and fetters during medical examination and hospitalisation.

In the last two years, the use of handcuffs during medical examinations and hospitalisation has never ceased to increase for reasons of security and fears of escape. Yet in 2005, the number of jailbreaks during transfers for medical examination in a hospital or for hospitalisation was very low (4) compared to the number of transfers (55,000), i.e. a proportion of under 1/13,000.

This use of handcuffs and/or ankle shackles was intensified by the Prison Service's circular dated November 18, 2004 on the subject of the organisation of escorts for prisoners undergoing medical examination which defines the degree and procedures of supervision by prison services and means of restraint (handcuffs and/or ankle fetters) not only during the journey but also during medical examination.

It is remarkable that among the three "levels of supervision" described by the circular, none correspond to the absence of restraint or the absence of supervision during the examination. At the lowest level of supervision "level I", handcuffs are still a possibility. As a result, handcuffs are used almost systematically during medical visits and examinations.

Such practices are indisputably **humiliating, inhumane and degrading, endangering the relationship of trust between doctor and patient which is essential to any medical act. Furthermore it can endanger the quality of medical examination and care**. Medical or surgical examination of a handcuffed and fettered prisoner, or worse a gynaecological or

obstetrical examination of a female prisoner with the same restraints, should only apply in absolutely exceptional circumstances when there is grave danger or a high potential for escape and medical staff, having been duly informed of these circumstances, request it.

In fact restraints can lead to a perfectly legitimate refusal to provide care. Several spectacular cases were needed — such as a handcuffed woman giving birth or fetters on an aged prisoner only able to move with the help of a walking frame — before attention was given to this vital question.

On two occasions, in 2002 and 2003, the European Court of Human Rights ruled that France had violated human dignity in the course of a medical examination.

In its report of December 2005, CPT noted that "examining shackled prisoners is a highly disputable practice both in ethical and clinical terms and hinders the required climate of trust between doctor and patient. In the last resort, the decision must be made by health carers".

Uninterrupted and close supervision by prison services during medical examination raises also the serious ethical issue of medical confidentiality which is a stated essential principle of healthcare in the Code of Public Health and the Code of Medical Deontology (see below).

3. The relationships between custody, protection of health and access to healthcare do not begin in prison: problems arising while in police custody.

Police custody is a deprivation of freedom to allow criminal investigation authorities to detain and interrogate on police premises in discretionary circumstances (sleep deprivation, succession of interrogators, indifference to state of health, etc.) a person who is presumed innocent.

Police custody which, depending on the gravity of the charges, may last 24 to 96 hours, concerns very large numbers of people (426,000 in 2003, 460,000 in 2004) leads frequently to detention in conditions of deplorable hygiene and lack of privacy.

The rules of this deprivation of freedom to come and go are clearly set out in the law dated January 4, 1993. One of these rules provides for the **intervention of a doctor,** upon request by the person in custody, by a relative of that person or by the police authorities exercising custody of that person.

The doctor's role in this situation is to verify that custody and the circumstances of custody **do not endanger the health of the person concerned.**

Medical examination is often complicated by the fact that the interests of the investigators and those of the person in custody are generally opposed, particularly if that person has special medical needs and ailments: sickness (diabetes, asthma, hypertension, etc.), pregnant women, minors (13 to 18 years) whose age the doctor is sometimes expected to assess[*].

In such a sensitive context, to which are added difficulties connected to practical factors (premises unsuited to the purpose, sometimes insalubrious and dirty), presence of

[*] See CCNE's Opinion N° 88 on *Age determination methods for legal purposes*

police personnel demanding to attend the examination, doctors on call by the police station are confronted with a number of ethical problems, such as medical confidentiality, the possibility of establishing a trustful relationship with the person under examination, the freedom to prescribe if that is necessary and, above all, to determine whether the requirements of the investigation are not taking precedence over medical deontology. An opinion on whether custody is compatible with the state of health of the person is often difficult to come by, as are opinions on the actual circumstances of custody.

Theoretically, physicians are entirely independent, but a tense atmosphere can make the expression of that independence difficult. There can be incompatibility between medical care given to the person in custody and a mission of expertise. Respect for a person's consent to sample-taking is sometimes ignored. One of the most frequent complaints by doctors called in for such examinations is the difficulty of proceeding with medical examination in privacy and confidentiality. The request, not to speak of demand, on the part of certain policemen to be present during a medical examination by reason of the fact that the person concerned is in police custody, is deontologically unacceptable, apart from cases of individuals who may represent a grave danger, that doctors must be allowed to evaluate themselves.

A consensus conference was held in December 2004 on *Medical intervention for persons in police custody*. It underlined the need for strict observance of confidentiality during medical examination of people in police custody.

There are other places besides prisons holding people who have lost the right come and go freely: closed educational establishments where minors under police supervision are held and administrative holding centres for foreigners awaiting deportation. Specific ethical problems for the protection of physical and mental health are attached to all these establishments.

D. Problems raised by the respect for the fundamental rights of sick persons as recognised by the law and constituting essential elements of medical ethics.

Among the rights recognised by law, two are both founding components and emblematic of medical ethics, be it in the field of biomedical research, treatment or preventive medicine: the right to **medical confidentiality** and the right to **free and informed consent.**

1. Physician-patient privilege.

Physician-patient privilege is one of the most ancient ethical demands of medicine, as illustrated by the Hippocratic Oath.

Article L. 1110-4 of the Code of Public Health states that "Any person treated by a healthcarer, an institution or healthcare network or any other body participating in prevention or healthcare is entitled to privacy and observance of the rule of confidentiality regarding personal information. Except in cases expressly provided for by law, the rule of confidentiality applies to all information which healthcarers have become aware of […] and to all healthcarers or persons working in the healthcare system".

Article 4 of the Code of Medical Deontology states that "physician-patient privilege as instituted in patients' interests, is an obligation on all physicians as established by law. Confidentiality covers everything that physicians have learned in the exercise of their

profession, that is not only what they were told in trust, but also what they may have observed, heard or understood".

The Council of Europe, in 1998, underlined that: "medical confidentiality must be guaranteed and observed [in prisons] as strictly as in the population at large".

In their 2006 *Study on Access to Healthcare of Prison Inmates,* The National Consultative Commission on Human Rights referred to: "...multiple violations of medical confidentiality occurring in prisons". The Commission quoted the 1996 and 2000 reports of CPT: "The presence of members of the police forces during medical examinations in a hospital or during the administration of care to hospitalised patients is contrary to medical ethics. CPT recommends that French authorities ensure that any medical examination, tests and care administered in civilian establishments be conducted out of earshot and, except if specifically requested by healthcarers for a particular prisoner, out of the sight of police forces".

The November 18, 2004 circular drafted by the Prison Services regarding the *organisation of escorts for prisoners undergoing medical examination* — which defines the extent and method of supervision exercised by prison staff (and the means of restraint, handcuffs and/or ankle fetters) during medical examination, and which also defines a degree of supervision in which medical examination takes places "under the constant supervision of prison staff" — obviously raises an ethical problem as regards the observance of medical confidentiality.

In fact, encroachments on medical confidentiality occur already at the stage when a committal order is delivered since the order includes a medical section which is filled in by the magistrate ordering detention and is handed to the policeman taking the prisoner to his place of detention, and not to the prisoner himself.

Although the information in this section is in fact necessary since it includes in particular the prisoner's medical requests so that medical risks can be avoided, it seems regrettable that the file is handed to the police escort and by the police to the prison registrar before the latter finally hands the medical information sheet to the doctor.

Later, once the committal order has been implemented and the prisoner is incarcerated, medical confidentiality is all the more difficult to observe because imprisonment and security rules often involve the presence of a third party: the prison warder.

Medical examinations must take place in conditions which **respect the confidentiality** of private dialogue. The **data which is given and received** must remain **inaccessible to prison authorities. The administration of medication** must not lead to **revealing the pathology which it is treating.**

Medical files must not remain in prison after release. They must be transmitted to a nearby hospital chosen by prisoners so that, once they are back in the community, they may have access to them as is the case for any other citizen.

2. Free and informed consent.

Unlike medical confidentiality, which is one of the most ancient components of medical ethics, free and informed consent is a more recent principle, adopted at the time of the Nuremberg trials in 1947. Initially adopted in the field of biomedical research, free and informed consent more recently became one of the fundamental rules of the physician-patient

relationship in medical practice generally, as is demonstrated, inter alia, by the law dated March 4, 2002 on the rights of patients and the quality of the healthcare system.

Article D. 362 of the Code of Criminal Procedure states: "Except if the health of a prisoner makes it necessary to resort to diagnostic or treatment to which he or she is not able to consent, then in compliance with article 36 of the Code of Medical Deontology, he or she must be allowed to express his or her prior consent to any medical act and, in the event of refusal, must be informed by the physician of the consequences of this refusal".

The January 10, 2005 circular concerning the updating of the *Methodological Guide regarding healthcare and social protection for persons in custody,* states in the chapter on the *rights of patients*: "The ordinary and general rule, in particular the law dated March 4, 2002 regarding the rights of patients and the quality of the healthcare system applies also to prisoners, regardless of whether medical care is given in the Out-patient consultation and care units (*unités de consultations et de soins ambulatoires/UCSA*), in a Regional Medico-Psychological Unit *(Services Médico-Psychologiques Régionaux (SMPR*), or in a hospital". As regards information and consent, "prisoners are entitled to information on their state of health, on the treatment proposed, to consent or refusal of care, to access of information contained in their medical file […]. Prisoners exercise their right of consent to care in the same manner as it is exercised in the community".

The process of free and informed consent plays an essential role in giving patients a sense of responsibility regarding their own health. In prison, however, there is a further dimension: it is one of the only too rare circumstances in which the prisoner's responsibility, autonomy and freedom of action can be exercised. For this reason, it could be one of the components of the prison authorities' suggestions in the circular dated May 29, 1998 as regards a policy for the prevention of suicide: "...restoring [the prisoner's] role as subject and actor of his own life."

Observing **medical confidentiality** and observing the principle of **free and informed consent** are but **two sides of the same coin**: the fact that a **prisoner is not considered to be** the **"object" of care,** but as **a subject in law**, the holder of a right.

There are at least three circumstances in prison where the conditions of free and informed consent raise very particular ethical issues.

- a) An ethical problem for which there is an obvious solution: offer of care to persons suffering from addiction to licit and illicit substances.

By its very nature, free and informed **consent implies access to an offer of care** and, if there are several therapeutic options, to a **choice**.

In their 2006 *Study on Access to Healthcare of Prison Inmates,* The National Consultative Commission on Human Rights remarked: "Penitentiary and healthcare services lack the means and specific structures required to offer care to addicts. Some institutions can only fall back on voluntary associations. At a time when, according to official figures supplied by the health and social services concerned (*Directions des affaires sanitaires et sociale/DDASS*) to the OFDT (*Observatoire français des drogues et des toxicomanies* - French observatory on drugs and drug abuse) 34,7% of prisoners suffer from some form of addiction to a substance (of all kinds). An investigation carried out by the Ministry of Health on those entering prison

[in 2003] revealed that only 6.3% of them were provided with specialist medical help regarding illicit drugs abuse and 6% for alcohol abuse".

The January 10, 2005 circular concerning the updating of the *Methodological Guide regarding healthcare and social protection for persons in custody,* refers to this problem. In the chapter on *public health policy adjustments: addictions,* its states: "The interministerial Health/Justice memorandum dated August 9, 2001 outlines the improvements to be made to sanitary and social policies for the management of persons in custody with addiction to licit or illicit substances or who consume them to excess. The memorandum recommends exhaustive and transversal treatment. It recommends monitoring of such persons throughout their time in custody through identification, diversification of types of management, development of preventive measures, offers of drug substitution treatment, preparation for release from prison...".

The treatment of prisoners with licit or illicit drug addictions varies from one institution to the other, ranging from abrupt withdrawal, with or without the administration of psychotropic medication, to drug substitution programmes using methadone or Subutex. The local policy of an institution must not be based on prejudice in favour of laxist or, on the contrary, repressive theories**. Nor can it be allowed to vary from one institution to the other. This is a minimum ethical requirement.**

- b) Two extremely complex medical ethics problems: hunger strikes and compulsory medication.

- Hunger strikes.

By its very nature, the concept of free and informed consent can, in certain extreme situations, enter into conflict with the duty to provide assistance to a person in danger.

CCNE has already examined the ethical problems raised by hunger strikes, in particular in Opinion n° 87 on *Treatment Refusal and Personal Autonomy*.

A hunger strike is a voluntary act of indeterminate duration which may become life-threatening. Abstinence from consuming liquids is not compatible with survival beyond a week.

Hunger strikes may be individual, collective, connected to various demands or the result of depression. They are numerous, about 1,500 every year, but no more than 10 become life-threatening.

A doctor confronted with a hunger strike is duty bound to inform immediately the person concerned of the risks incurred, without seeking to modify the person's determination nor its underlying causes. The physician's attitude must remain strictly neutral. The medical information must be repeated on several occasions in the course of a dialogue respecting the motivations for the decision to go on hunger strike. At no point, except in circumstances bordering on loss of consciousness, should the doctor proceed to force-feeding. In all these cases, the difficulty for a doctor is to respect the wishes of prisoners (Code of Deontology), that is to refrain from force-feeding while protecting them from the danger of death. Physicians are medical **mediators**. Their negotiation is based entirely on a renewable pact of determined duration respecting both the convictions and wishes of the patient and medical independence.

The essential ethical issues at the core of hunger strikes are respect of the prisoner's wishes, absence of moral blackmail and more importantly t**he closest vigilance**, since a hunger strike is always the expression of distress. **The difficulty of this ethical mission resides in trying to preserve prisoners from serious risk to health** while **observing their wishes.**

- The issue of compulsion or medication by order.

By its very nature, free and informed consent implies complete liberty to refuse medical treatment and therefore, the absence of constraint or punishment in the event of refusal.

The Code of Criminal Procedure includes a probation order as an alternative to prison and other reductions of prison sentences which may be granted to a convicted offender if he or she agrees to therapy aiming to limit the risk of subsequent offences. If the person accepts treatment, release from prison is a possibility whereas refusal signifies staying in prison. There is no possibility of free and informed consent in such a case since refusal entails a loss of opportunity.

Members of the medical profession practising in the penal environment protested against their obligation to medicate prisoners and against the notion that therapy can be summed up as a limitation of recidivism.

The existing **offers of treatment** during custody, in particular for the authors of sexual crimes, are now in frequent use. **This system is compatible with the exercise of true free and informed consent.**

"Treatment does not (and must not) aim to prevent subsequent offences. Its purpose is to embark on a (difficult and uncertain) journey to psychic construction allowing a sufferer to understand his mental and relational processes and their consequences and, possibly to arrive at a remedy. To state the above is not equivalent to culpable disengagement. On the contrary, it is a therapeutic necessity, particularly in psychiatry. Care can, possibly and additionally, contribute in this way to prevention. In this respect, it must be said with humility but with determination, that there is no such thing as a risk-free situation and that predicting the future is an impossibility, but that human beings are capable of evolution and change". "It is through refocusing medicine, and psychiatry in particular, on its primary object, namely the sick person, that therapy can be most effective. And not through medical blackmail offering therapy as an alternative to imprisonment".*

Medical blackmail with the aim of avoiding subsequent offence seems unacceptable in ethical terms in so far as it violates the principle of free and informed consent, that is the possibility of accepting or refusing without fear of sanction. And yet, despite the importance of this ethical principle, one cannot help considering the question of the benefit offered to an offender, for example the authors of a sexual offence, who will be released from prison if they accept treatment.

But new issues arise at once: should a sick person be in prison rather than in hospital? Is treatment really offered as a benefit to the person concerned or simply as a measure to reduce second offences, in other words simply to protect society which is not the physician's true mission?

What can and should a doctor do in these circumstances?

* Dr Catherine Paulet, psychiatrist, SMPR of the Marseilles Penal Centre, President of the Association for Penal Institutional Psychiatry, *(association des secteurs de psychiatrie en milieu pénitentiaire/ASPMP)*

This is a situation where the ethical issues raised by the ambiguity and the complexity of the relationship between medicine and justice, and the consequent risk of confusion and loss of bearings are at their most perplexing.

V. Another obstacle to complete access to the right for protection of health and healthcare in prison: difficulties encountered by prison staff.

The serious problems arising out of various forms of disregard for human dignity, the prisoners' frequently squalid living conditions and lack of access to health and healthcare protection rights, are compounded by problems experienced by prison personnel: the devaluation of their qualifications and ambiguous nature of their task.

A. The devaluation of the work done by prison warders and the ambiguity of their role.

In France at this time, there are some 22,300 prison warders. **Their work is essential** in a prison which is, perforce, a **place where people live.**

Their task is thankless and their efforts in some cases to make incarceration more humane do not gain recognition, so that the bulk of attention centres on the aspect of their work which is concerned with preventing escape. Rehabilitation objectives, which alone provide some degree of gratification, are overshadowed by the keen attention given to any hint that public order is under threat. The remarkable human qualities of some warders go unnoticed while simplistic and dehumanising watchwords are given prominence. In today's society, it is sometimes difficult to own up to being a prison warder although a stated objective of social rehabilitation giving them a truly educational role would give prestige to their task without detriment to their important security tasks. They sometimes harbour the bitter feeling that any effort directed at improving the lot of prisoners detracts from the attention given to their own fate. It should be possible to deny this absurdity categorically.

Recent research commissioned by the *Mission de Recherche Droit et Justice* (Law and Justice Research Committee) evidenced that warders feel that their integrity, dignity and identity are under threat. They experience uneasiness which they express as feeling "that they work in one of society's scrap heaps, that they are pawns on the institution's chessboard, that they are a figment of the fantasies of public opinion giving free rein to hate and indignation...". This is a clear expression of the close connection between the sufferings of prisoners and those of warders.

Arising out of this situation are ethical issues such as the need to "reconstruct" men and women whose role is to help others reconstruct themselves, providing opportunities for feelings to be expressed and heard, more uplifting in-depth training, choosing new working methods.

But probably most important is the issue of giving **meaning** to their activity.

Warders are charged with **ensuring secure conditions** and **implementing disciplinary measures**, carrying out **humiliating body searches of naked prisoners**, participating in **protection of health and access to medical treatment** and playing a **role in rehabilitation**, more often than not **without the benefit of adequate training or clear instructions** for these various functions. **They are confronted with the "madness" of a**

large number of prisoners, they are often **despised by society**, so that warders are forced into **a situation fraught with confusion and loss of bearings on the true meaning of their work.**

As the report quoted above emphasises: "Prison staff live in a world where boundaries are no more, where lines are blurred between reason and folly, normality and pathology, the humdrum and the news headlines, between what is prohibited and what is allowed and between guilt and innocence...".

B. The difficulties and ambiguities of the role of healthcarers, doctors, nurses and social workers.

Torn between the conflicting tasks of giving emergency care, intercritical treatment and preventive care, organising health education and preparing for continuity of care as part of rehabilitation; confronted with the weight, inflexibility and constraints of prison rules and the paucity of means provided for UCSAs and SMPRs; constantly in contact with mental disease outside a hospital environment; frequently cut off from any possibility of direct contact with prisoners except during medical examinations; frequently obliged to examine in hospital, in the presence of a warder, prisoners who are handcuffed and shackled; frequently faced with living conditions for prisoners which they know to be incompatible with adequate protection of their physical and mental health, doctors and nurses often work in extremely difficult and stressful circumstances which compromise the quality of their performance and the ethics of their profession.

Doctors must also act as in an **expert role** which puts them in difficult ethical situations. For example, article D. 380 of the Code of Criminal Procedure requires them to "ensure that conditions of collective and individual hygiene prevail in the penal institution, to inspect the entire premises and to inform competent departments of failings as regards hygiene and any situation which could compromise the health of the prison population, and to make recommendations regarding the possibility of remedial action".

Doctors' feelings of discouragement are easy to imagine. Living conditions which endanger the physical and mental health of prisoners, which they regularly report on to no avail, might in the end seem almost normal. Another point is that they are both the guardians of prisoners' health and, when prisoners are held in solitary confinement in a disciplinary cell, the experts called in to authorise the continuation of punishment. In these circumstances, can the truly trustful relationship which is essential in a caring situation be established?

Called upon to alleviate suffering in an environment which constantly generates suffering, healthcarers are caught in a confusing ethical quandary where the dividing line is blurred between the obligation to carry out an essential mission and the risk of becoming the guarantor, or even of abetting detention conditions which threaten the physical or mental health of those they are caring for.

What is in fact missing and which should be developed, is **proper recognition by the prison services of the role of mediator** and of the **duty of healthcarers to interfere** in all maters pertaining to the right to protection of health and **more generally matters related to the dignity of human beings.**

VI. The lack of respect in prison for the right to the protection of health reveals a broader problem: the lack of respect in prison for the fundamental rights and dignity of inmates.

A. The non recognition of the prisoner's citizenship.

1. The misapplication of law in prison.

Prisoners, who are legally deprived only of their right to come and go at will, must be allowed to access the other fundamental rights which the law recognises them, as it does for everyone, in particular as regards the protection of their health, access to palliative care and equality of rights and opportunity for the disabled.

2. The prisoner's lack of access to many fundamental rights.

a) Prison regulations continue only too often to be observed to the detriment of respect for the law.

There have been recent improvements, in particular since the order dated July 30, 2003 by the *Conseil d'Etat* (Supreme Administrative Court in France) which gave prisoners the possibility of being defended by a lawyer and appealing disciplinary measures. But precedence is still given to internal prison regulations, justified by **reasons of security which are a frequent obstacle to the elementary rights of all citizens** to present and defend their essential interests, in particular as regards their health.

b) The particularly unfavourable status of remand prisoners, who are presumed innocent, while in custody before trial.

Incarcerated in short stay prisons where overcrowding, lack of privacy and hygiene are generally incompatible with respect for human dignity and the protection of physical and mental health, **remand prisoners**, although they are **presumed innocent, do not benefit from the rights granted to all citizens and not even the rights granted to convicted criminals.** They are **excluded from the scope of the provisions of the March 4, 2002 law** regarding persons close to the end of their lives — or more generally persons whose "state of health is persistently incompatible with detention in prison" or suffering from a "life-threatening pathology" — which allow a convicted prisoner at the end-of-life to be released from prison so as to receive support and palliative care in a suitable environment.

c) The denial of the right of association.

More generally, many reports, including those of the National Consultative Commission for Human Rights in 2004 and the Economic and Social Council in 2006, underlined the restriction of access of prisoners to many fundamental rights granted to all citizens, such as freedom of speech, or adequate pay and conditions of work or the freedom to associate.

The denial of the right of association has **implications on the protection of health** with reference to the increasingly recognised **role** of **patient support groups in access to healthcare and prevention**. The large population of sick or disabled prisoners cannot for the time being create a patient support group or an association of disabled persons.

d) The minimal value given in prison to one of custody's essential missions: rehabilitation.

This lack of consideration for the one of the main missions of the prison services is probably a cause of the failure of the prison sentencing system and of the growing frequency of reoffending.

And yet, this rehabilitation mission is written into the Code of Criminal Procedure and repeated insistently: it must "allow the prisoner to prepare for release in the best possible conditions" (article D. 478 of the Code of Criminal Procedure). This is the task of the Probation and Rehabilitation Section (*Service Pénitentiaire d'Insertion et Probation/SPIP*), in cooperation with UCSAs as regards health education, prevention and continuation of healthcare after release from prison.

However, as emphasised by the Economic and Social Council in its 2006 report on The Conditions for Social and Professional Rehabilitation of Prison Inmates in France, the real situation is very different due to lack of human resources (social workers, technical trainers, teachers, psychologists, healthcarers, prison visitors, etc.), material resources (workshops, work paid at an equitable rate, etc.) and for lack of follow-up (family networking, counselling, health monitoring, etc.).

Rehabilitation means "searching for possible pathways: reconstructing broken family ties, finding time through work or training courses to prepare for a break with yesterday's blind alleys, allowing for a dialogue with visitors, mediators, chaplains, etc., reconciliation with self and with society, help with becoming more responsible for oneself and as regards others, finding ways of making use of time served ."[*]

When rehabilitation fails, release from prison adds to vulnerability. To be outside **without bearings, without training, without medical and social counselling generates exclusion, disintegration and leads to reoffending.**
Rehabilitation must therefore take place inside prison but also outside prison, in cooperation with families, support groups, rehabilitation institutions, healthcarers and above all social workers whose numbers are regrettably inadequate.

Rehabilitation is a way of making time served time better spent than in a complete "vacuum", than a ceaseless repetition of unbearable present experience. It provides prisoners with a possible future.

If, as soon as incarceration begins and with respect for human dignity, a preview of what life can become after release can be made to emerge, the connection between prisoners and society can be maintained and reinforced and the citizenship of prisoners can be recognised.

B. Denial of the citizenship of inmates is also made evident by the continued detention of people who should not be in prison or for whom the law provides the possibility of commutation to other forms of penalty (open prison).

[*] Bertrand Cassaigne, Revue projet (Spring 2002)

1. People who should not be in prison:

- a) **The 20% of prisoners suffering from psychiatric disorders that can only be treated and alleviated in hospital (some 12,000 people with serious mental health problems, including 4,000 with schizophrenia).**

In his 2005 report on the *Effective Respect for Human Rights in France*, the Commissioner for Human Rights of the Council of Europe commented:
"The doctors I met in the seven prisons I visited [....] also highlighted the effects of the increasing tendency to penalise the mentally ill: since the adoption of Article 122-1 of the Criminal Code, experts have been tending to favour impaired judgment over diminished responsibility and hence to send people with mental illnesses to prison. (Article 122-1 of the Criminal Code, renewing article 64 of the 1810 Criminal Code, stipulates that persons suffering from psychic or neuropsychic disorders which have impaired their judgment or their self-control are nevertheless punishable; however judges will take this circumstance into account when sentencing"). Consequently, at the beginning of the 1980s, 17% of convicted persons were held to have shown diminished responsibility but this figure had dropped to 0.17% by 1997, and has changed little since. **Punishment seems to take precedence over treatment**, which is not always provided in prison. This was already noted in a report by the Senate in 2000, but no serious conclusion seems to have been drawn since. Worse still, everyone I talked to said that the situation had markedly declined...".

- b) **the majority of the 33% (20,000) of remand** prisoners, **who are presumed innocent, in preventive custody awaiting trial,** recognised at the time of their arrest as not dangerous and who should not be incarcerated, in compliance with the law dated January 6, 1995 which considers that **such incarceration should be the exception.**

2. People who could be elsewhere than in prison: inmates whose prison sentence could be replaced by another form of penalty (open prison):

- a) **Community service:** The law dated January 6, 1995 provides that prisoners whose remaining sentence to be served is under a year should be released to perform community services (only 6% of them at this time). Twenty per cent (12,000) of the prison population is made up of people whose sentences are for under one year, not to mention those sentenced to longer periods of imprisonment with under a year left to serve.

- b) **Probation**: For this measure, which was introduced by a law dated August 14, 1885, to be taken, the prisoner must have already served half of the sentence. It is applied less and less frequently for fear of censure by public opinion.

Even if it was considered, although this is not so, that some of these categories overlap, applying these laws would allow for the immediate release of approximately half of the present prison population.

The former Minister for Justice, Robert Badinter, who was 25 years ago one of the major movers in the abolition of the death sentence in France, recalled recently in the closing session of a meeting on conditions in prison organised by the National Prison Observatory (OIP) that "prison should be the only remaining solution, the last resort".

Incarcerating and keeping in prison people who **could lawfully be treated, judged or punished outside** prison **is obvious evidence of the non recognition of citizenship of prisoners.**

VII. <u>For genuine reflection by society on the notion of lawful rights</u> and on <u>the meaning of imprisonment and of penalty.</u>

Why are so many laws, articles in the Code of Criminal Procedure, Code of Health, Code of Medical Deontology, so many circulars, rules and recommendations on the dignity and health of the prison population, **not at all or only partially observed?**

Why are so many studies and reports by highly respected French and European institutions — the French Senate, the French National Assembly, the Inspectorate for Social Affairs, the French Academy of Medicine, the European Commission for Human Rights, the French National Consultative Commission for Human Rights, the Economic and Social Council — denouncing the unacceptable conditions in which the prison population, and consequently prison warders, have to live, **with no effect, or with hardly any effect?**

Why are so many appeals, made over many years by all the professions (lawyers, psychiatrists, physicians, etc.) or associations — members of the Cimade, the Gisti, the International Prison Observatory, the Committee for the Prevention of Torture, etc. — **left unheeded or almost unheeded?**

Why is there so much inertia concerning prisons?

Perhaps the answer to those questions should be sought in the meaning given by French society to sanction — the penalty to be paid by a person who has committed a crime or an offence, particularly a prison sentence.

Today's society seems increasingly motivated by a single purpose, which is sometimes explained by fear: "Increasing severity for delinquents and deviants, increasing the penalty, lengthening prison sentences, making them ever harsher and more humiliating in the hope they have a deterrent effect[*] …".

In its quest for security, our society forgets that a prison sentence is only defined by the restriction of freedom of movement.

It does not understand that this punishment is only meaningful if those who are subjected to it are given the chance to change, to reform so as to be able subsequently to reintegrate society and live the life of an ordinary citizen. All prisoners may ultimately be released. Increasing the incoming population without a thought for release except as a reason to be fearful, amounts to denying the substance of the sanction and aggravating the penalty, which can only be temporary, by adding violation of dignity to the punishment, leaving in its wake permanent impairment of health and integrity.

Our society seems to have a blurred vision of sanction, reparation and vengeance, as the European Human Rights Commissioner pointed out in his 2005 report: "... the determination of some people to ensure that conditions of detention are harsh can only be accounted for by a desire to take revenge on a person who has already been punished...

[*] Journal Réforme (February 2006)

Prisons must become places of rehabilitation, not places that harden people's attitudes and make them more likely to reoffend."

This deadly state of mind generates serious problems of which the most pronounced are the following:

- **Mentally ill people** who have committed criminal acts and offences while of **unsound mind** are more and more frequently denied recognition of diminished responsibility. "Madness" which is known to be no more than a disease which is difficult to live with and difficult to cure "has ceased to be innocent". And those affected are no longer recognised as being sick.

- **The dying, the very old and the extremely disabled, who should not be or should no longer remain in a prison environment,** are kept in custody. Disregard for the law is one of the reasons for this situation, but also the difficulty in finding where to move them, since even when terminally sick, they are still objects of suspicion. It is true of course that outside prison, these highly vulnerable people are also treated with a great deal of indifference.

- **The family units** — existing in many prisons elsewhere in Europe and in other countries such as Canada, which are so necessary to maintain family ties and encourage rehabilitation — are slow to emerge in France. This is due to lack of understanding and repudiation on the part of society which cannot tolerate the notion that some degree of consolation can be given to someone whose life must be made up of hardship and every form of deprivation.

Our society, which pursues an ideal of maximum security, does not wish to witness the sufferings of those who more often than not have been incarcerated following an excess of mental misery or of emotional and social deprivation.

As a result, silence envelops an inhuman burden: overcrowding, violence, suicide, mental illness, unacceptable living conditions, sparse rehabilitation efforts, underpaid work, insufficient preparation for release, humiliation, etc.

The European Institutions' repeated condemnation of conditions in France, the innumerable appeals by associations and volunteers engaged professionally or in charity with assistance to prisoners, the conclusions of the French Parliamentary Commission convened to discuss the Outreau proceedings, all of these have had so little effect that an essential ethical issue arises concerning prisons: "Are prisoners — some innocent, some "insane" and some guilty — still seen by our society as entirely human?" If we dehumanise them, what can be expected of their social behaviour, in other words their behaviour as human beings?

Can we accept that prisons remain a place of punishment, suffering, sickness, insanity, exclusion and oblivion, if we accept that the object of prison is to allow sanction to reconstruct an individual?

Can we hope for rehabilitation or integration if prisons are a place where regression, loss of autonomy, absence of purpose, violence and dependence are the rule?

Can we expect prison to socialise or resocialise if prison desocialises?

Can we hope to teach, in or out of prison, respect for law and human dignity if society does not see to it that its prisons respect law and human dignity?

The major ethical issue — which is at the heart of medical ethics but which, as is often the case, goes way beyond the confines of this subject — **is respect for human dignity.**

There is a need to constantly reiterate that prison is the institution in the Republic which in the last resort is bound to enforce the law and see to it that the law is effectively enforced. The law states that detention is a sanction defined by the sole deprivation of the freedom to come and go. **Prison cannot be a place where inmates do not have access to the fundamental rights guaranteed to all by law, in particular the right to health.**

For this reason, reflection on health in prisons cannot be separated from reflection on prisons themselves. **This is a problem which is of concern to society as a whole: we are all,** both collectively and **individually** as citizens, **responsible for the respect of human dignity of prisoners**, be they on remand, awaiting trial and presumed innocent or convicted "in the name of the French people".

Certain commitments were made in 2006. In January 2006, France adopted the 108 recommendations of the Council of Europe regarding prisons and committed itself to their implementation. The Minister for Justice announced last autumn that it was intended to task the Republic's Mediator (Ombudsman) with a supervisory mission as regards prisons. The survey undertaken by the International Prison Observatory (OIP) addressed to prisoners and prison services which was published this autumn by the *Etats Généraux de la Prison* took place for the first time with the support of the Ministry of Justice.

It is to be hoped that these commitments are evidence of a different mind set which will lead swiftly to significant, concrete and visible change.

Recommendations

The conditions for the advent of an **ethical prison** and of **meaningful penalty** must be sought both **outside** and **inside** prison, **before** and **after** the event, **before, during and after** incarceration, **and as an alternative to incarceration**.

1. Before imprisonment:

- Ensure **access to fundamental rights** for everyone, in particular as regards **health**, **education and social protection.**

- Pay particular attention to mental health issues affecting **minors in difficulty** and all **vulnerable individuals.**

2. When charging:

- Avoid **incarcerating those who are charged but presumed innocent** and who are not dangerous, **as the law provides.** If needed to preserve the integrity of evidence, find alternatives to custody (reinforced judiciary supervision following the example of reinforced guardianship).

3. When sentencing:

- Make certain that **severely mentally ill people** are not sent to prison. Approving the incarceration and keeping in prison of the **mentally ill** raises **serious ethical issues.**

- Whenever possible, rather than as a discretionary measure, choose **punishment in the community** which is always preferable to incarceration.

4. In prison:

- Consider prisoners as **subject to law**. Respect **their human dignity**, that is **their fundamental rights**, including the **right to protection of their physical and mental integrity.**

- **Encourage elected representatives and/or legislators** to ensure that **laws on the health of prisoners are properly enforced**. These laws are clearly set out in the " *Methodological Guide regarding healthcare and social protection for persons in custody".*

- Give those who have reached the **end-of-life** and **prisoners who are disabled, aged or suffering serious somatic or mental disorders** whose "state of health is lastingly incompatible with imprisonment", the benefit of suspended sentences, **as the law provides**.
This signifies:

. Encouraging the management of **palliative care units** in public and private hospitals to provide shelter within their institutions for terminally ill prisoners whose sentence has been suspended for medical reasons.

. Seeking facilities outside prison for **the very old, the severely disabled and those with serious psychiatric disorders** so that they may leave prison for good.

- Encourage magistrates to suspend sentences for prisoners awaiting trial whose state of health is incompatible with living in prison (and whose unconvicted status prevents them from being released under the provisions of the March 4, 2002 law. Included would be those at the end of their life.

- Encourage elected representatives and/or legislators to ensure **respect for human dignity and ensure that living conditions** — which are too often the cause of disease and distress — **are acceptable.**
This signifies:

. **Cease deferring**, law after law, application of detention in **individual cells**, particularly in **short stay prisons**, where in fact this is already the rule in the Code of Criminal Procedure for prisoners awaiting trial, except by dispensation.
. Ensuring that the practice of putting prisoners in **shackles during medical examination**, be they serving sentence or awaiting trial, is considered absolutely unacceptable unless circumstances are exceptional.
. Ensuring the **reduction and control** of **the use and length of solitary confinement** in **disciplinary cells and quarters** (the "block"**),** which puts the **mental health** of prisoners at risk.

- Encourage physicians and other healthcarers to promote direct contact with prisoners, to turn their attention not only to solving visible problems (somatic or psychic) but also to all the circumstances of human degradation, such as humiliation, violence and despair. To reflect on the fact that using medical means, i.e. psychotropic drugs to improve security is a facile option, sometimes inevitable of course, but that frequent use masks or aggravates, rather than relieves, underlying difficulties. Used in excess, they are an insult to health and dignity. Further encourage the **development**, in consultation with **health caring teams** and **prison authorities**, of the **role of mediator** and the **duty to interfere of members of the medical professions** on every occasion where the physical and mental integrity, the right to protection of health and the respect of the human dignity of prisoners are at risk.

- Implement an **effective rehabilitation policy.** Rehabilitation must be prepared during custody. The action and resources of the SPIP (Probation and Rehabilitation Section) and the UCSAs must be reinforced as regards health education, preparation and continuity of healthcare and social counselling after release.
This signifies:

. Encouraging **plans for the future.** This is the only possibility of giving meaning to life after prison and is essential to a person's psychic and relational well-being. An important component is vocational training.
. Encouraging the creation of **Family Visiting Facilities** (*Unités de Visite Familiale/UVF*) so that prisoners can maintain **family ties**, particularly with spouses and **children** and thereby reduce destructive emotional deprivation.
. Encouraging **inmates** to be more **responsible** by setting up **facilities (in time or space)** for reinstating more balanced intra-custodial relationships: **facilities for mediation, discussion groups, etc**. These diversified possibilities of self expression for the benefit of both prison professionals and inmates would serve a useful purpose

in reducing violence, giving expression to distress, preventing suicide, ensuring more peaceful cohabitation and thus preserving the mental health of all concerned.

. **Developing community life with the support of external associations,** for example **groups providing support for patients and the disabled.** Give a more important role to members of external associations or institutions who are already giving assistance and expertise inside prison or after release (**social workers, educators, chaplains, prison visitors, etc**.).

. Developing every opportunity of **informing**, **training** and research to help personnel in charge of prisoners to work in a climate of mutual respect (professionals, inmates, prison authorities, voluntary workers, prison visitors and society) and to increase recognition for the **value** of their daily work, particularly **warders**.

- Encourage instead of restricting the possibility of **release on parole** for prisoners who have served half their time. Encourage also **release** from custody with the obligation to engage in **service to the community** for prisoners serving sentences of under a year, **as the law provides.**

- Finally, give thought to the architecture of future prisons, to be built not only out of concern for security but also to prepare for social rehabilitation.

5. <u>After release from prison</u>:

- Ensure **access to physical and psychiatric care, and to preventive care**.

- Give full attention, before release, to **social counselling** in cooperation with support and **rehabilitation** associations and institutions. The abruptness and unexpectedness of a poorly prepared release from custody is a danger to autonomy and health. **Inadequate preparation can also generate exclusion, loss of bearings and aggravation of a somatic or mental disorders. Preparation is therefore of prime importance** and the essential role of **social workers** must be fully supported.

6. In general:

- CCNE appeals in the most urgent terms to **government, elected representatives, legislators and public health authorities** to make every effort so that:

- **prisons** cease **to be a substitute for psychiatric hospitals,** due to the **dwindling resources** granted in France to the **psychiatric sector** on the one hand, and the **growing reticence** on the part of today's society to accept that people who have committed infractions to the law by reason of insanity should **be given treatment and counsel instead of punishment**.

- **all prisoners have access to respect for their fundamental rights:** in particular make sure that **prisoners awaiting trial can benefit from the provisions of the law dated March 4, 2002** which allow suspended sentencing at the end-of-life or when a prisoner's state of health is lastingly incompatible with life in custody.

- the **Council of Europe's recommendations regarding imprisonment**, signed this year by France, are implemented.

- **citizen reflection and debate on the meaning of punishment and imprisonment** are not restricted to the expression of pious hopes to little effect.

- the undeniable connection between precarity, social exclusion, isolation and incarceration be investigated so that the greatest attention can be given to individuals, children in particular, the most vulnerable and destitute, to provide them with essential medical, educational and social assistance.

* * *
* *
*

The issue of detention is all the more complex and difficult to raise, and therefore all the more difficult to solve, that it generally meets with the disapproval of public opinion which is receptive only to security problems. The paradox is that security is better gained by treating people with dignity than by eliminating it. **Dispensing with human dignity implies acceptance of and consent to indignity.**

October 26, 2006

COMPLEMENTARY CONTRIBUTIONS BY TWO MEMBERS TO THE OPINION ON HEALTH AND MEDICINE IN PRISON

1

That which gives legitimacy and clarity of purpose to an institution is its capacity to rigorously define its object. CCNE is no stranger to this rule. The right of scrutiny of the scientific and medical practices of our time that the members of the Ethics Committee exercise comes with, as is the case of any right, the duty of defining the boundaries of their remit. This is possibly the difficulty with its latest Opinion "Health and Medicine in Prison".

In broaching the question of prisons, the Committee biased its recommendations in terms of policy options and societal choices. It could hardly have done otherwise. How can the inhumanity of treatment and practices prevailing in French prisons be broached without referring to the indifference of political circles, cultural representations and the crisis in social unity? But, it remains to be seen whether it is the role of the Ethics Committee to remind society that present conditions of detention violate human rights, infringe on respect for the principle of presumed innocence and flout the democratic principle of equal dignity for everyone. It is true that the texts which define CCNE's mission, allow it to extend its critical attention to societal debates. But the extension refers to the "*Societal issues raised by the progress of knowledge in biology, medicine and health*" (Law dated August 6, 2004).

Let us be clear: the issue is not that the allegations are erroneous. They are amply supported by overwhelming facts and reports that cannot be read without sadness and indignation. The problem is whether the Committee is bound to remain within the investigative sphere to which it is confined by its own title: *the health and life sciences*.

We are not saying that the Committee cannot express opinions on political and social matters and must shy away in fear of overstepping the limits of its health territory. But citizens can rightly expect this institution to broach societal issues from the starting point of the conflict of values or events that agitate the fields of health and biomedical research. We feel that the report on "Health and Medicine in Prison" in fact follows a completely reversed logical process: it starts off with a societal issue and discusses its repercussions on health. Unless all life's problems are to be given a medical slant, unless the humiliations committed are seen as a reason for mobilising psychiatrists and unless the assistance of the medical professions is required to deal with the violation of human rights, we must come to the conclusion that prisons raise a societal debate which require the (urgent) attention of other institutions than ours.

This Opinion is useful in that it gives a striking insight into the seriousness of health problems in the prison environment. But surely the serious problems of medical treatment in prisons are more within the scope of medical deontology? In the last analysis, the Opinion itself ends up demonstrating that solutions for the medical professions are to be found outside the medical sphere. They are related to the respect for the rights of vulnerable people, to budgetary choices, to the media coverage of collectives anxieties and the rising influence of security-centred ideologies. Medicine arrives too late in the day if it is true to say that the distress experienced by individuals is above all a question of social justice. Despite all the precautionary statements and good intentions, our Opinion, because it emanates from a body initially designed to deal with biomedical ethics, gives the unfortunate impression of dragging the issue of French prisons back into the lap of medicine.

Does our society need an umpteenth report on the devastating effects of prison or rather a strong political will to implement its plans for action in favour of the prison population? As the Opinion itself states very clearly, it is the business of the authorities (the French Parliament, the French Senate, the ministers for justice or employment) to shoulder their responsibilities on the basis of the reports

which they themselves were responsible for drafting and circulating. Is it not the way to confusion to hand over the problem to a Committee that has built its reputation and legitimacy on the anticipation of ethical problems arising from biotechnologies?

Let us stand firmly on our own ground, the life sciences, and be present where it is expected of us. Prison is not the business of bioethics and the issues raised are much more concerned with social ethics than with medical ethics. The world of the health and life sciences is the ever present scene of research and discoveries that raise conflicts of values centering on the use made of medical knowledge and capabilities. Health institutions, physicians and researchers have become accustomed to turn to CCNE to submit for examination the ethical aspects connected to exploratory plans or new therapies. It is they who, little by little over the years, have made the Ethics Committee what it is today. They have shown the way and set a path from which we should not stray excessively.

2

Taking reflection on prisons a step further.

Although CCNE's referral is limited to health and the accessibility of healthcare in prisons, it seems to me that we cannot ignore the real significance of prison.
Many pathologies are the result of incarceration and desocialisation.
As regards the principle of social rehabilitation, it is at best forgotten and at worst flouted.
We could for that matter have limited our entire report to simply recalling the absolute obligation to respect every human dignity, and remember that the actions that may have been committed by some individuals do not exempt us from that obligation.
But we do know that the notion of dignity varies from one person to another and with time.
Although penal colonies were accepted in their time, they would not be accepted today. In the same way, certain prison deviations, which are almost consubstantial with prison, will soon become unacceptable when we cease to close our eyes to what is happening. They already are unacceptable for many of us.
In addition to the report, it must be said that the population of prison warders are not protected against what we denounce as the harmful effects of incarceration. In fact, they are often its first victims.
It is not intended therefore to encourage discord between "good" prisoners and "bad" warders. What is needed is to find avenues for reform which guarantee respect for everyone and working for the good of society.
The Bible, even when it is simply seen as a history book, tells the story of the life of men. It only mentions prison twice. The first is when Joseph is thrown into Egyptian jails, but unjustly and in a society which is the absolute antipode of an ideal world and the second case is when Moses arranges for a wrongdoer to be put under supervision until his case can be decided on.
Otherwise, there is no concept of prison in the Bible since to lock someone up is the opposite of the respect for everyone's freedom which the Book advocates.
This leads us to ask two questions. Can prison be completely humanised? Is prison useful?
To both these questions, the answer is no.
Only boundless optimism could attempt to humanise prisons, but that must not prevent us from trying and there is a great deal of recognition for the efforts of many members of the prison services who have retained a sense of respect for fellow men.

As an example, as regards the obvious prison overcrowding, in some quarters there is the belief that building new institutions would be **the** solution to the unacceptable lack of privacy experienced by prisoners when four people are confined to nine square metres of space.
But with more space there would be more prisoners whereas if those who should not be in prison in the first place were removed, if incarceration was considered to be the exception, if the whole gamut of non custodial sentences, which already exist and have the advantage of creating an asset for both prisoner and society, were on offer, we would have more than enough room to render acceptable the conditions of imprisonment of those that we are obliged to lock up.
As to the utility of prisons and of incarceration, they are only the result of society's incapacity to find a place, the right place, for everyone.
Although prison is justifiable for those who represent a danger to society, it cannot and should not be the catch-all of the world's miseries. It must remain the solution of last resort instead of being an immediate reflex action.
In our report, we state as the most unacceptable the situation in which are kept those who are charged but awaiting trial, those who are "presumed innocent".
In itself, this is proof that to some degree we share the notion that convicted prisoners are living in a normal situation, which they deserve because of what they have done.
But innocent or guilty, convicted or charged, it is the quality of being human to which I owe respect and dignity. If an action is unacceptable for the one, it is also unacceptable for the other. The degree of guilt does not determine the degree of respect for dignity. It is our humanity which defines our respect for others.
Furthermore, by the sheer force of numbers, prison denies the differences between individuals and treats all the men and women under its roof as are treated the worst of them. Because once a bazooka was used in an attempted breakout, any journey will be treated as being under a similar risk of attack. Because once, a "malingerer" tried to escape during medical examination, we end up making a woman give birth in handcuffs.
A society which does not differentiate between circumstances and individuals loses it discrimination and produces a world of uniformity, a monolithic world, a dangerous world.
To reflect on the meaning of punishment is not simply turning our attention to the fate of our 60,000 prisoners. It amounts to reflecting on the future of our society and on the second chance for our humanity.

Haïm Korsia
November 21, 2006