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# A Narrative Review of Dual Loyalty Conflicts in Custodial Settings and Implications for Community Practice

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## Abstract

Dual loyalty dilemmas are conflicts between health care professionals' obligations toward their patients and third-party interests. These conflicts are more common and starker in custodial settings, such as jails and prisons, military detention facilities, immigration detention centers, and involuntary psychiatric institutions. Despite encountering patients in custody, health care professionals (HCPs) in community settings have limited knowledge and training. In this narrative review, we examined dual loyalty conflicts faced by HCPs working in custodial settings and then applied the identified themes to community-based hospitals where HCPs care for patients in custody. We searched databases for original papers relating to patients in custody and dual loyalties and then abstracted key themes, findings, and characteristics of the conflicts. There are five categories of competing loyalties that give rise to dual loyalty conflicts: institutional and organizational entities, legal and regulatory guidelines, ethical and moral responsibilities, social and public responsibilities, and other individuals. Themes include the inappropriate withholding or delaying of care, the provision of intervention despite patient refusal, the violation of patients' rights to privacy, cruel non-clinical interventions (e.g., torture), and the failure to document or report information accurately. Mitigation strategies in the literature emphasize expanding human rights education, improving patient communication around possible conflicts, and raising clinician awareness of institutional policies. Common in the care of patients in custodial settings worldwide, dual loyalty conflicts can impact patient care. However, pursuing mitigation strategies can lessen their impact.

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## Case study

*A hospitalist at a large urban medical center is caring for a 52-year-old incarcerated man transferred from the county jail with sepsis due to an infected diabetic foot ulcer. Two uniformed correctional officers are permanently stationed outside his hospital room, restricting his movement and monitoring his interactions with staff. When the hospitalist attempts to conduct a private physical examination, one of the officers insists on remaining in the room, citing security protocols. The patient looks visibly distressed and withdraws from further discussion. The hospitalist asks the officer if he can remove the patient's ankle shackles to enable a complete assessment. The officer declines, again citing security protocols. Later, the hospitalist documents incomplete findings in the medical record, noting limited access to the patient for an adequate assessment. In the afternoon, a prison administrator calls the hospitalist, requesting updates on the patient's condition and estimated discharge date. A hospital administrator asks whether the hospitalist could expedite discharge to the jail infirmary due to limited bed space in the hospital.*

## Introduction

Dual loyalty dilemmas arise when health care professionals (HCPs), defined as anyone involved in the care of a patient, experience conflicts between their ethical obligations toward their patients and competing responsibilities to third parties.[1] These conflicts are particularly pronounced in custodial settings, such as military combat zones, military or government detention facilities, immigration detention centers, involuntary psychiatric institutions, and jails or prisons. The existing literature has extensively described dual loyalty conflicts among HCPs working directly within these custodial settings. However, there is limited application of dual loyalty frameworks to community HCPs caring for patients in custody in traditional, non-custodial hospital settings. On-site medical services at correctional facilities are typically limited to primary care, and incarcerated patients requiring emergent or specialty care are transferred to community hospitals. In the United States, more than 730,000 incarcerated adults receive care in community hospitals annually, often under the custodial supervision of correctional officers and with institutional policies that may inadvertently contribute to dual loyalty conflicts.[2] Community HCPs often lack formal training to address the unique challenges that arise when balancing the needs of patients in custody against institutional or legal demands.[3] Unfortunately, there are few clinical guidelines surrounding the care of in-custody patients in traditional, non-custodial hospitals.[4]

This paper adopts a two-part approach. First, we present the results of a narrative review of dual loyalty conflicts faced by HCPs working in custodial settings. Second, we apply the identified themes to a related but underexamined context: community-based hospitals where HCPs care for patients in custody. Although structurally distinct, both settings feature hierarchical structures of authority, security oversight, and limitations in patients' freedom that give rise to similar dual loyalty conflicts. Finally, we propose mitigation strategies tailored to the unique nature of dual loyalty conflicts experienced by community HCPs in non-custodial, traditional hospitals.

Some dual loyalty scenarios, such as those that involve favoring third-party competing interests in the interest of distributive justice, are considered ethically supportable and arise from duties to promote fairness across populations. However, this paper focuses on dual loyalty conflicts that emerge from external pressures that may compromise patient care. These frameworks share a structural similarity of focusing on competing obligations. However, there is a distinction in the moral stakes. While distributive justice reflects principled ethical prioritization, many custodial dual loyalty conflicts result from external demands contradicting principles of patient-centered care.

## Methods

### *Search strategy*

A qualitative literature review was conducted to identify and categorize instances of dual loyalty conflicts among HCPs practicing within custodial

settings. We searched PubMed, Web of Science, and Embase for peer-reviewed, English-language, original studies published up to February 20, 2024. We used free-text terms such as "dual loyalties," "physician," "jail," "prison," and "correctional facilities."

## Inclusion and exclusion criteria

Search results were uploaded into Covidence for deduplication and screening. Two independent reviewers evaluated each article for inclusion in the analysis, with discrepancies resolved by consensus via discussion with a third reviewer.

Articles were included if they (1) described dual loyalty conflicts where HCPs faced tensions between patient care obligations and third-party interests, (2) focused on HCPs practicing directly in custodial settings, including military combat zones, government or military detention centers, immigration enforcement facilities, inpatient psychiatric units, and jails or prisons, and (3) provided empirical data, case studies, or normative ethical analyses of dual loyalty conflicts.

Articles were excluded from analysis if they (1) focused on dual loyalty conflicts in health care without discussing custodial settings or (2) addressed health care in custodial settings without specific references to dual loyalty conflicts.

### *Data extraction*

A structured, four-tiered data extraction framework was developed to systematically identify and categorize data. This framework enabled consistent coding and thematic synthesis across diverse sources that included empirical studies, case reports, ethical analyses, legal discussions, and policy documents. The framework included identifying the following within included papers: (1) competing objects of loyalty that are not the patient and patient's interests, (2) contexts in which dual loyalty conflicts occurred with examples, (3) themes describing the nature of dual loyalty conflicts, and (4) mitigation strategies for dual loyalty conflicts. Dual loyalty conflicts were explicitly described as dual loyalty conflicts by article authors or inferred by reviewers based on discussion of conflicting obligations. Each article was coded for content across these four dimensions by two independent reviewers, with key excerpts extracted verbatim where applicable. Discrepancies were resolved by consensus via discussion with a third reviewer.

### *Thematic analysis and categorization*

The extracted data underwent inductive and thematic analysis. Two independent reviewers coded studies, with discrepancies resolved through consensus discussion. To ensure consistency, codes were iteratively refined, consolidating overlapping themes. Coded excerpts were cross-checked with existing ethical and legal frameworks, including international human rights law, professional medical ethics guidelines, and institutional policies. Extracted themes were organized into a narrative synthesis.

While our literature review is limited to studies addressing custodial contexts, we incorporate additional references into the discussion to contextualize the application of these findings to non-custodial settings. These references were not included in the formal review process but serve to bridge thematic insights into clinical environments where HCPs may encounter patients in custody in traditional, non-custodial hospitals.

## Results

Our initial search returned 639 studies, of which 63 met inclusion criteria and were abstracted for analysis. These studies provided insights into the competing objects of loyalty influencing HCPs, contexts of dual loyalty conflicts, thematic categories of dual loyalty dilemmas faced by HCPs in custodial settings, and proposed mitigation strategies for dual loyalty conflicts.

### *Competing objects of HCP loyalty in dual loyalty conflicts in custodial settings*

HCPs practicing in custodial settings face obligations to many competing objects, including institutional and organizational entities;

legal and regulatory guidelines; ethical, moral, and professional responsibilities; social and public responsibilities; and individual people. As shown in Table 1, institutions such as hospitals, military organizations, and immigration agencies shape medical decision-making through policies and administrative pressures. Legal requirements, such as mandatory reporting laws and national security considerations, may also create dual loyalty conflicts. Professional commitments, personal morals, and broader societal responsibilities, such as public safety and resource allocation, also complicate dual loyalty dynamics.

### *Contexts and examples of dual loyalty conflicts in custodial settings*

Across the literature, five common custodial contexts emerged in which HCPs experience dual loyalty conflicts: military combat zones, military and government detention, immigration deten-

TABLE 1. Competing objects of HCP loyalty in dual loyalty conflicts within custodial settings

| Objects of loyalty | Examples |
|---|---|
| Institutional and organizational entities | • Managed care plans<br>• Insurance companies<br>• Clinical leadership<br>• Prison administration<br>• Universities and medical schools<br>• Military<br>• Immigration agencies<br>• Corporations<br>• The government<br>• "The state"<br>• Health quality and performance metrics |
| Legal and regulatory guidelines | • Mandatory reporting requirements<br>• National security<br>• Local, state, and federal law<br>• International human rights law<br>• Military law<br>• Criminal legal system<br>• Fear of liability<br>• Professional licensing and credentialing bodies |
| Ethical, moral, and professional commitments | • Principle of justice within medical ethics (clinician may feel like or need to conserve or allocate scarce health care resources for the benefit of the community and other patients rather than the patient before them)<br>• Specific doctrines or treatises (e.g., Hippocratic Oath, Geneva Conventions)<br>• Preservation of life<br>• Professional identity<br>• Personal morals and beliefs<br>• Religious and cultural beliefs |
| Social and public responsibilities | • Public health<br>• Public safety<br>• One's own country<br>• National security<br>• Community values<br>• Resource utilization<br>• Advancement of medical knowledge<br>• Medical education |
| Individual people | • Family members<br>• Employers<br>• Colleagues<br>• Supervisors<br>• Correctional staff<br>• One's physical safety<br>• One's personal interests |

tion, inpatient psychiatric facilities, and jails and prisons. Within each of these contexts, specific examples illustrate the complexity of the dual loyalty dilemmas, as outlined in Table 2. For example, in military settings, HCPs may prioritize their own soldiers over enemy combatants. In detention settings, HCPs have historically participated in practices such as force-feeding hunger strikers, disclosing confidential medical information to authorities, or even evaluating detainees' fitness for torture. Immigration enforcement introduces unique dual loyalty dilemmas, such as conducting forensic age assessments or evaluating detainees for deportation despite inadequate medical evaluations. In psychiatric facilities and prisons, conflicts arise in cases involving disclosure of patient information, forensic evaluations, and participation in punitive measures, such as solitary confinement or competency restoration for execution.

### *Themes of dual loyalty conflicts in custodial settings*

From these diverse contexts in which HCPs work directly in custodial settings, we identified five overarching themes of dual loyalty conflicts, as summarized in Table 3. These themes are as follows:

1. **Withholding or delaying care inappropriately**

   DL conflicts may lead HCPs to delay or withhold treatment, particularly in military combat

Table 2. Contexts and examples of HCPs' dual loyalty conflicts in caring for patients in custody

| Context | Settings | Examples |
|---|---|---|
| Military combat zones | • Australian Defence Force[1]<br>• Dutch military in Srebrenica[2]<br>• French Operation Barkhane in the Sahel[3]<br>• Israeli Defense Forces in Palestine[4] | • Prioritizing care for own soldiers over enemy's soldiers[5]<br>• Delaying care to foreign civilians in favor of own soldiers[6]<br>• Providing inadequate care to enemy soldiers[7]<br>• Delaying ambulance transportation of civilians and enemy soldiers[8]<br>• Delaying or withholding care from civilians or captured enemy soldiers[9] |
| Military or government detention | • Israeli Prison Service and Israeli Defense Force detention of Palestinians[10]<br>• Global War on Terrorism<br>- United States Abu Ghraib prison in Iraq[11]<br>- United States Guantanamo Bay detention facility[12]<br>- United Kingdom Operation Herrick in Afghanistan[13]<br>- Canadian operations in Afghanistan[14]<br>- French Operation Barkhane in Sahel[15]<br>• Arab Spring in Bahrain and Syria[16]<br>• South African Apartheid[17]<br>• Nazi Germany[18]<br>• Sadaam Hussein's Baathist regime[19]<br>• Augusto Pinochet's regime in Chile[20]<br>• Uruguayan dictatorship[21]<br>• Former Soviet Union[22]<br>• China and the Falun Gong movement[23]<br>• Turkish detention centers[24] | • Participating in torture, including evaluation of victims' fitness[25]<br>• Failing to report witnessed abuse[26]<br>• Force-feeding individuals engaged in hunger strikes[27]<br>• Forcibly dialyzing a detained patient[28]<br>• Inadequately completing or falsifying medical records[29]<br>• Failing to ensure appropriate discharges and continuity of care[30]<br>• Disclosing medical information to third parties without consent (e.g., to facilitate interrogation)[31]<br>• Providing inadequate care for chronic conditions (e.g., hypertension)[32]<br>• Providing inadequate screening or treatment for indicated conditions (e.g., hepatitis C)[33]<br>• Withholding indicated care from patients (e.g., blood transfusions)[34]<br>• Killing patients via medication overdoses[35] |
| Immigration enforcement | • United States Immigration and Customs Enforcement (e.g., Mexico border)[36]<br>• Australian Immigration Detention Centers (e.g., Nauru)[37]<br>• German Office for Migrants and Refugees[38] | • Assessing age of detainees via dental radiographs[39]<br>• Force-feeding individuals engaged in hunger strikes[40]<br>• Resource limitations or third parties preventing HCPs from providing needed care[41]<br>• Assessing fitness to travel for deportation[42]<br>• Complying with the manacling and guarding of immigration detainees in hospitals[43]<br>• Misdiagnosing self-harm behaviors as manipulative or personality-driven[44]<br>• Participating in torture[45]<br>• Disclosing medical information to third parties without consent (e.g., to facilitate deportation proceedings)[46]<br>• Failing to report witnessed abuse[47] |

*Examples marked with an asterisk are considered in many circumstances to be an ethically or legally appropriate prioritization of third-party interests. In taking care of patients in custody, public health and public safety may be favored over individual patient priorities.

and detention. HCPs may prioritize their own soldiers over enemy combatants or civilians, provide inadequate care, withhold necessary treatments, or delay decisions due to resource constraints. In jails and prisons, concerns about medication misuse may limit appropriate prescribing by HCPs. These dual loyalty dilemmas force HCPs to balance competing priorities between national interests, orders from superiors, loyalty to colleagues or soldiers, security needs, and just allocation of resources.

2. **Providing interventions against patient wishes**

The primary forced intervention highlighted in the literature is force-feeding individuals on hunger strikes. In these situations, HCPs must balance respecting patients' autonomy and minimizing harm through traumatic force-feeding with institutional priorities of preventing in-custody deaths due to starvation.

3. **Violating a patient's right to confidentiality and privacy**

HCPs may inappropriately disclose medical information without patient consent or for non-clinical purposes, such as deportation proceedings or interrogations. In these situations, HCPs must balance respecting patients' rights to privacy and confidentiality, maintaining trust in the patient-physician relationship, upholding societal justice as defined by third parties, promoting institutional security and public safety, and adhering to legal and institutional disclosure policies.

TABLE 2. *continued*

| Context | Settings | Examples |
|---|---|---|
| Inpatient psychiatric care | • Court-mandated mental health treatment in Switzerland[48]<br>• Patient-physician confidentiality (and exceptions) in the United States[49] | • *Obtaining and disclosing medical information from forensic evaluations (e.g., determining competency to stand trial or receive death penalty, evaluating criminal responsibility)[50]<br>• Failing to report witnessed abuse[51]<br>• *Disclosing a patient's medical information to ensure safety of third parties (e.g., *Tarasoff* warnings)[52]<br>• Presenting identifiable clinical information in an academic forum[53] |
| Jail and prison settings | • United States[54]<br>• United Kingdom[55]<br>• Ireland[56] | • Assisting in body searches or obtaining body fluids for analysis[57]<br>• Assessing fitness for punishment (e.g., solitary confinement)[58]<br>• Altering assessment of patient injuries based on security staff reports of "what actually happened"[59]<br>• Disclosing medical information to security staff for reasons unrelated to provision of care[60]<br>• Supervising trainees to a lesser degree in caring for incarcerated patients[61]<br>• Allowing trainees to perform invasive exams due to perceived inability of patients to decline (e.g., rectal exams)[62]<br>• Inappropriately limiting treatment due to concerns about medication diversion[63]<br>• Force-feeding individuals engaged in hunger strikes[64]<br>• Limiting guideline-based treatments (e.g., for asthma)[65]<br>• Limiting guideline-based diagnostics and screening (e.g., for hepatitis C)[66]<br>• Participating in execution, including restoration of competence for execution[67]<br>• *Testing for communicable diseases without consent (e.g., HIV, tuberculosis, hepatitis C)[68]<br>• Delaying medical decision-making due to difficulty in contacting family members[69] |

4. **Engaging in unnecessary or cruel interventions**

   HCPs have participated in unnecessary and cruel interventions that not only transgress clinical obligations but also contribute to human rights violations. Examples include torture, inappropriate medical evaluations (e.g., age assessments via dental radiographs and fitness for deportation or punishment), punitive measures (e.g., body searches or solitary confinement), and executions. These cases challenge HCPs' loyalty to colleagues, institutional policies, state-based third parties, legal systems, and national security.

5. **Falsifying or omitting medical documentation**

   HCPs may withhold reports of abuse, misdiagnose self-harm behaviors, or alter injury assessments based on non-medical staff reports. In these situations, HCPs face dual loyalty conflicts stemming from their professional obligation to protect patients from harm, legal or institutional reporting requirements, institutional pressure to conceal abuse or avoid negative publicity, and perceived obligations to protect public safety.

### *Mitigation strategies for HCPs experiencing dual loyalty conflicts in custodial settings*

The reviewed literature also identified a range of strategies to mitigate dual loyalty conflicts, including education, transparent communication between HCPs and patients, and institutional policy development, as detailed in Table 4. Educational interventions include integrating human rights principles into medical school curricula and providing specific training on dual loyalty conflicts. At the individual HCP level, strategies focus on careful documentation, transparent communication with patients about conflicting loyalties, and proactive advocacy efforts. Institutions have sought to mitigate dual loyalty conflicts by ensuring separation between HCPs and third-party influences, establishing whistleblower protections, and adopting mechanisms for independent oversight. Developing quality improvement frameworks and peer support systems can empower individual HCPs to inform organizational policy and seek support when needed.[5]

## Discussion

The findings from our literature review demon-

TABLE 3. Thematically organized examples of dual loyalty conflicts from all custodial contexts

| Theme | Examples |
|---|---|
| Withholding or delaying care inappropriately | • Withholding or delaying screening and treatment of chronic conditions<br>• Blocking emergency medical transportation<br>• Providing inadequate care due to external limitations (e.g., resource limitations, triage decisions, state or institutional policies, concern for medication diversion)<br>• Delaying care due to difficulty identifying and contacting surrogate decision-makers<br>• Providing limited supervision for trainees<br>• Failing to ensure appropriate discharges and continuity of care |
| Providing a clinical intervention that has been refused by the patient | • Forcibly performing invasive medical interventions (e.g., force-feeding individuals engaged in hunger strikes, forced dialysis)<br>• Performing non-indicated interventions or exams solely for training or at the request of the correctional facility |
| Violating a patient's right to confidentiality and privacy | • Disclosing medical information without consent<br>• Disclosing medical information for non-clinical reasons (e.g., interrogation, deportation, security)<br>• Disclosing more than the minimal amount of medical information needed to correctional staff<br>• Presenting identifiable clinical information in an academic forum |
| Providing an unnecessary intervention that is cruel or transgresses clinical obligations | • Participating in torture<br>• Conducting inappropriate medical evaluations (e.g., fitness for deportation or punishment)<br>• Assisting in punitive measures (e.g., body searches, solitary confinement)<br>• Participating in executions |
| Failing to accurately report or document relevant information | • Failing to accurately report or document clinical information (e.g., misdiagnosing self-harm behaviors, altering injury assessments)<br>• Failing to report witnessed abuse |

strate the diverse contexts and recurring themes of dual loyalty conflicts experienced by HCPs taking care of patients directly in custodial contexts. While these insights offer independently valuable lessons, dual loyalty conflicts also often manifest distinctly in non-custodial, traditional hospitals where community HCPs encounter patients in custody. These HCPs encounter patients in custody less frequently in their day-to-day practice and often without the benefit of formal training or institutional guidance. This lack of clarity may heighten clinicians' deference to correctional officers or institutional authority, especially when security protocols are unfamiliar or may seem to supersede clinical norms. However, both custodial settings and non-custodial, traditional hospitals are characterized by hierarchical structures, an emphasis on security, and care for patients with limitations on their freedom. In the discussion of our findings, we extend the themes identified in our narrative review of custodial settings to assess how analogous dual loyalty dilemmas arise in non-custodial hospitals. In this process, we hope to provide a framework for understanding the challenges faced by HCPs in non-custodial settings and for identifying tailored mitigation strategies.

### *Withholding or delaying care inappropriately*

As described in Table 3, withholding or delaying care is a common theme of dual loyalty conflicts in custodial settings. In non-custodial hospitals, dual

TABLE 4. Mitigation strategies for dual loyalty conflicts encountered by HCPs caring for patients in custody

| Focus area | Mitigation strategy | Examples |
|---|---|---|
| Education | Adjusting graduate and undergraduate medical education structure[1] | • Prioritizing socially minded applicants[2]<br>• Mandatory training in ethics, law, and human rights (e.g., all medical schools in South Africa)[3]<br>• Continuing medical education involving human rights[4]<br>• Instructing trainees in clinical settings with a high prevalence of dual loyalty conflicts[5] |
| | Explicit education on dual loyalties[6] | • Addressing the hidden curriculum of diagnostic skepticism, misplaced deference to third parties, and violation of incarcerated patients' rights[7]<br>• Providing education and training for health professionals on the dual loyalty challenges they may face in custodial settings[8] |
| | Changing teaching methods to focus on human rights framework[9] | • Emphasis that human rights cannot be deprioritized except under very limited circumstances[10] |
| | Courses in ethics and professional development[11] | • Professional development and training in reflective listening[12] |
| Individual HCPs | Carefully documenting encounters and maintaining confidentiality[13] | • Documenting evidence that might underpin civil advocacy<br>• Documenting the rationale for breaking confidentiality and the decision-making process[14]<br>• Requesting that correctional staff not be within earshot during history-taking[15] |
| | Reporting abuse and human rights violations[16] | • Using an independent medical authority[17]<br>• Setting up internal channels[18] |
| | Transparently communicating with patients about dual loyalty conflicts[19] | • Involving the patient in the decision-making process and explaining the conflicting loyalties to the patient[20]<br>• Balancing transparency and unchecked information-sharing[21]<br>• Addressing the importance of clear communication in early therapy sessions[22]<br>• Communicating the limits of confidentiality with the patient[23]<br>• Respecting patient's pace and perceived coercion[24]<br>• Allowing patients to read (but not edit) documentation prior to submitting it to authorities[25] |
| | Advocacy[26] | • Boycotting employment with institutions known to perpetuate human rights violations[27]<br>• Letter writing, lobbying, protests, campaigns, and marches[28]<br>• Providing witness testimony in official inquiries[29]<br>• Developing position statements and conducting research[30] |

loyalty conflicts in caring for patients in custody can lead HCPs to delay or withhold care due to security concerns resulting from competing loyalties, as outlined in Table 1. For example, institutional pressures from hospital administrators or correctional facilities may result in patients in custody receiving fewer diagnostic tests and treatments than other patients while they are in non-custodial hospitals.[6] These delays mirror examples from custodial settings (Table 2), where prioritization of institutional needs over patient care often hinders timely treatment. Security measures in non-custodial hospitals, such as concealing patients' locations or treatment plans to mitigate real or perceived safety risks, further extend these delays.[7]

Community HCPs caring for patients in custody also face barriers to effective discharge planning and continuity of care. Security protocols frequently restrict communication by community HCPs with patients in custody about their pending discharge, and follow-up care can be neglected due to difficulties coordinating with correctional facilities.[8] Security protocols may limit communication with patients' surrogate decision-makers, and adapting follow-up plans to the limited resources available in correctional facilities further complicates safe discharge planning.[9]

Community HCPs often lack guidance on decision-making authority for incapacitated patients in custody, leading to delays in care. Examples from Table 2, such as prioritizing institutional demands over patient autonomy in detention centers, further demonstrate the ingrained systemic barriers that perpetuate these delays. Community HCPs have reported collaborating with correctional staff to make decisions for unrepresented patients, bypassing legal surrogate decision-making processes and violating patients' decisional rights.[10] This type of violation also occurs within jails and prisons, as noted in Table 2.

### *Providing interventions against patient wishes*

In custodial settings, HCPs may be compelled to perform interventions against patients' wishes, such as force-feeding or non-indicated procedures (Table 2). Similar conflicts arise in non-custodial hospitals, where community HCPs may incorrectly believe that patients in custody cannot legally refuse recommended treatments.[11] These perceptions by HCPs are often influenced by loyalties to

TABLE 4. *continued*

| Focus area | Mitigation strategy | Examples |
|---|---|---|
| Organizational and institutional | Separating HCP employers and third parties[31] | • Completely separating health care personnel and prison administration[32] |
| | Implementing reporting mechanisms and whistleblower protections[33] | • Requiring reporting by institutions on how they are meeting their own and international standards[34] |
| | Evaluations by independent entities[35] | • Civilian oversight (e.g., HCPs skilled in ethical issues and human rights)[41]<br>• Peer review (e.g., independent psychiatrists review psychiatrists working in carceral setting)[42]<br>• Military ethics tribunals[43]<br>• Establishing peer review structures such as case conferences, grand rounds, and journal clubs in high-risk settings[44] |
| | Professional guidelines on dual loyalty conflicts[45] | • Encouraging medical associations to formally endorse recommendations of the International Dual Loyalty Working Group[46]<br>• Guidelines minimizing judgment required of individual physicians[47] |
| | Quality improvement framework for breaches[48] | • Integrating mechanisms for documentation into electronic health record to review for lapses[49] |
| | Supporting HCPs via peer support and mentorship[50] | • Support from senior medical officers to ensure that military HCPs are not professionally isolated and have access to necessary resources and expertise[51]<br>• Forming peer networks and support networks among HCPs[52] |
| Regulatory | Accountability for violations of human rights[53] | • Instituting systems in licensing bodies to discipline members for human rights transgressions[54] |

institutional policies or legal frameworks, as can be seen in Table 1. This misconception is evident when correctional staff inappropriately attempt to make unilateral decisions about withdrawing life-sustaining treatment for patients in custody.[12] However, like the general public, patients in custody retain the right to refuse medical interventions, except in cases involving high-risk communicable diseases, forensic testing, or involuntary treatment for severe agitation that poses risks to themselves or others.[13] Overriding an incarcerated patient's refusal typically requires a court order.

### *Violating a patient's right to confidentiality and privacy*

As noted in Table 3, breaches of patient confidentiality and privacy are pervasive in all custodial settings, often driven by institutional and legal mandates. These violations are equally problematic in non-custodial hospitals, where community HCPs' competing loyalties to correctional authorities or fear of legal repercussions (see Table 1) may lead to inadvertent disclosures of medical information to correctional staff.[14] A multi-site study found that less than half of surveyed community HCPs knew how to access policies regarding care for patients in custody, highlighting a significant knowledge gap.[15] In another study, nearly half of surveyed HCPs reported not asking correctional staff to leave the room during patient histories or physical exams, and 42% reported sharing care plans with correctional staff without a clear justification.[16] These patterns can be clearly seen in both custodial and non-custodial settings, representing a central theme of dual loyalty conflicts.

### *Engaging in unnecessary or cruel interventions*

Cruel or unnecessary interventions, such as shackling, are another recurring theme in dual loyalty conflicts identified in Table 3. The routine use of shackling for patients in non-custodial hospitals reflects similar practices by HCPs in multiple custodial settings (see Table 2). Shackling can lead to worse health outcomes by directly interfering with medical interventions, causing psychological distress, and amplifying patients' feelings of isolation and fear.[17] Shackling has been documented even in situations where security is clearly not a concern.[18] In a single-program survey, over 65% of general surgery residents reported caring for incarcerated patients who were sedated and intubated but remained shackled.[19] However, HCPs often face significant administrative and logistical hurdles in obtaining permission to remove shackles, again demonstrating the strength of various third-party interests in dual loyalty conflicts as listed in Table 1.

### *Falsifying or omitting medical documentation*

Inaccurate or incomplete medical documentation occurs across both custodial and non-custodial settings. Community HCPs often struggle to transfer medical records between custodial and non-custodial hospitals to ensure continuity of care.[20] On a broader scale, the absence of incarcerated patients' data in national health care databases hinders efforts to monitor and address health disparities in this population, as current and formerly incarcerated individuals are often missing from datasets.[21] These documentation challenges mirror those in custodial settings, where HCPs may be pressured to alter records or misreport clinical findings to avoid exposing human rights violations (see Table 2).

### *Mitigation strategies*

Effective strategies to mitigate dual loyalty conflicts in non-custodial hospitals are those that address the precipitants of the conflicts themselves, namely resource limitations, policy misunderstandings, and challenges in collaborating with correctional institutions.[22] Our literature review highlights three key focus areas for mitigation strategies for dual loyalty conflicts in custodial contexts, as described in Table 4. Within these focus areas, three specific mitigation strategies may be particularly relevant for community HCPs treating patients in custody in non-custodial, traditional hospitals: emphasizing human rights education, transparently discussing existing dual loyalty conflicts with patients in custody, and understanding the policies at one's own hospitals and correctional facilities.

Medical education in the United States typically emphasizes bioethical analysis to address

ethical conflicts. In this framework, ethical principles such as respect for autonomy, beneficence, non-maleficence, and justice are balanced, often with limited guidance on how or when to prioritize one over another.[23] While these principles can guide patient-centered care, they do not inherently resolve the unique tensions that can arise in dual loyalty conflicts. Thus, this framework may leave HCPs ill-equipped to manage situations where loyalties diverge between patients and other entities. While few United States medical schools have human rights curricula, all South African medical schools require such training.[24] A human rights-based approach to dual loyalty conflicts may better equip community HCPs to manage third-party demands that compromise patient care, as human rights are considered absolute and cannot be negotiated or de-prioritized.[25] One institution in the United States has implemented a human rights curriculum covering human rights frameworks, abuse documentation, and clinical skills for working with affected patients.[26] Human rights training integrated into all levels of medical education and training could better prepare community HCPs to manage dual loyalty dilemmas in non-custodial, traditional hospitals. Partnerships between correctional facilities and academic medical centers (e.g., University of Texas Medical Branch in Galveston) highlight opportunities for collaboration.[27]

Community HCPs can mitigate dual loyalty conflicts by clearly communicating the limits of confidentiality and the nature of dual loyalty conflicts with patients in custody. The literature on inpatient psychiatry offers guidance on these disclosures, which are particularly important in non-custodial, traditional hospitals since patients in custody may be unaware of HCPs' affiliations with correctional institutions. Effective communication involves clearly stating boundaries, explaining reporting obligations, and ensuring that patients understand potential breaches due to legal mandates or institutional pressures.[28] HCPs should specify which types of information will remain confidential and should reassure patients that their health needs are prioritized despite possible coercive pressures from the correctional institution.[29] Given patients' potential distrust in community HCPs due to uncertainty about their affiliations, building trust at the patient's preferred pace is essential.[30] This transparent approach has been shown to strengthen patients' trust in their HCPs.[31]

Finally, community HCPs can more effectively advocate for their patients if they understand policies regarding shackling, privacy, confidentiality, discharge disclosures, refusal of care, follow-up, and communication with patients' family members at their non-custodial hospitals and at the custodial facilities from which their patients are admitted.[32] These efforts not only improve care within non-custodial hospitals but also set the stage for broader collaboration between HCPs and correctional facilities.

## Case study outcome

*The hospitalist realizes that she is encountering multiple dual loyalty dilemmas. After discussion with the department chair and hospital legal team, a hospital policy regarding care of incarcerated patients is identified. It clearly states that patients in custody must be within view of correctional officers, but the officers are not required to remain in the room during sensitive history-taking and exams unless a specific security concern is cited. The hospital policy does not comment on shackling, so the hospital administrative team and correctional leadership develop a new agreement that shackles can be moved to a different extremity to allow HCPs to conduct necessary physical exams. The hospital administrative team works with the hospital legal team to develop a policy outlining which information, including protected health information, can be disclosed to specific correctional staff. The hospitalist organizes a series of reflection groups and discussion sessions to raise awareness of dual loyalty dilemmas among HCPs.*

## Conclusion

The recurring themes of dual loyalty conflicts identified in custodial settings—withholding or delaying care inappropriately, providing interventions against patient wishes, violating a patient's

right to confidentiality and privacy, engaging in unnecessary or cruel interventions, and falsifying or omitting medical documentation—mirror the experiences of community HCPs caring for patients in custody within non-custodial hospitals. These parallels offer a framework for developing mitigation strategies that address the unique challenges faced by community HCPs caring for patients in custody in non-custodial hospital settings.

Future efforts to mitigate dual loyalty conflicts for HCPs in non-custodial settings should focus on developing, implementing, and evaluating these strategies across diverse health care contexts to ensure that community HCPs are equipped to advocate effectively for their patients. Policy makers, correctional facilities, and health care institutions must collaborate to address dual loyalty conflicts experienced by community HCPs caring for patients in custody to improve health care outcomes for this vulnerable population. Addressing dual loyalty conflicts comprehensively will not only safeguard patient rights but also contribute to systemic reforms that reduce health care disparities and promote equity for patients in custody.

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32. Michaeli et al. (see note 14); Dudley et al. (see note 41); Essex, "Human Rights" (see note 41); Pont et al. (see note 58); Elger (see note 58).

33. London et al. (see note 21); Solomon (see note 30); Spiegel et al. (see note 40); Dudley et al. (see note 41); Sanggaran and Zion (see note 41); Kalra et al. (note 58).

34. Spiegel et al. (see note 40).

35. London et al. (see note 21); International Dual Loyalty Working Group (see note 1); Solomon (see note 30); Spiegel et al. (see note 40); Dudley et al. (see note 41); Essex, "Healthcare and Clinical Ethics" (see note 41); Duvall (see note 59); J. J. Shestack, "Psychiatry and Dilemmas of Dual Loyalty," American Bar Association Journal 60 (1974); D. Wendler, "Are Physicians Obligated Always to Act in the Patient's Best Interests?," Journal of Medical Ethics 36/2 (2010); S. R. Benatar and R. E. G. Upshur, "Dual Loyalty of Physicians in the Military and in Civilian Life," American Journal of Public Health 98/12 (2008).

36. London et al. (see note 21)

37. Dudley et al. (see note 41); Shestack (see note 109).

38. Solomon (see note 30); Benatar and Upshur (see note 109).

39. International Dual Loyalty Working Group (see note 1).

40. Michaeli et al. (see note 14); Filc et al. (see note 14); Singh (see note 16); Solomon (see note 30); Dudley et al. (see note 41); Essex, "Human Rights" (see note 41); Stoddart et al. (see note 41); Shaivitz (see note 59); Singh (see note 80); Winters et al. (see note 87); Wendler (see note 109); Reade (see note 74).

41. Singh (see note 16); Essex, "Human Rights" (see note 41); Stoddart et al. (see note 41); Shaivitz (see note 59); Suh and Robinson (see note 80).

42. Wendler (see note 109).

43. MacDonald et al. (see note 58); Reade (see note 74).

44. MacDonald et al. (see note 58).

45. Lamblin et al. (see note 7); Gross (see note 13); International Dual Loyalty Working Group (see note 1); Stoddart et al. (see note 41); Reade (see note 74).

46. Reade (see note 74).

47. Gross (see note 13); Stoddart et al. (see note 41).

48. Moodley and Kling (see note 8); International Dual Loyalty Working Group (see note 1); Stoddart et al. (see note 41).

49. Moodley and Kling (see note 8); International Dual Loyalty Working Group (see note 1); Stoddart et al. (see note 41).