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Abstract

The COVID-19 pandemic is devastating the health of hundreds of thousands of people who live and work in U.S. jails and prisons. Due to dozens of large outbreaks in correctional facilities, tens of thousands of seriously ill incarcerated people are receiving medical care in the community hospital setting. Yet community clinicians often have little knowledge of the basic rights and ethical principles governing care of seriously ill incarcerated patients. Such patients are legally entitled to make their own medical decisions just like non-incarcerated patients, and retain rights to appoint surrogate decision makers and make advance care plans. Wardens, correctional officers, and prison health care professionals should not make medical decisions for incarcerated patients and should not be asked to do so. Dying incarcerated patients should be offered goodbye visits with their loved ones, and patients from federal prisons are legally entitled to them. Community health care professionals may need to advocate for this medically vulnerable hospitalized patient population to receive ethically appropriate, humane care when under their care in community hospitals. If ethical care is being obstructed, community health care professionals should contact the prison's warden and medical director to explain their concerns and ask questions. If necessary, community clinicians should involve a hospital's ethics committee, leadership, and legal counsel. Correctional medicine experts and legal advocates for incarcerated people can also help community clinicians safeguard the rights of incarcerated patients.

Keywords

correctional health, prisoners, Covid-19 in prisons, prisons, healthcare decision-making, rights of incarcerated patients, healthcare decision-making rights of vulnerable populations

An armed correctional officer stood outside an intubated patient's hospital room preventing a nurse from entering with an iPad. The nurse was doing what he would for any patient—trying to facilitate a family's final goodbye at a time when in-person visits are prohibited. But this case was different: the patient had contracted COVID-19 in the prison where he resided and was transferred to the community hospital for acute care. In another case, inpatient clinicians seeking to contact a critically ill patient's next of kin for guidance about his goals of care were told by prison officials that they were not allowed to speak with patients' families. We are physicians at an academic medical center focused on improving the health of people who live and work in prisons. In the past few months, we have received more than a dozen requests for advice about caring for seriously ill incarcerated patients who are hospitalized with COVID-19. Multiple recent articles in the popular press confirm that scenarios such as these are common.^{1,2}

The COVID-19 pandemic is devastating the health of people living and working in U.S. jails and prisons. Dozens of large outbreaks have been at correctional facilities, including the nation's single largest outbreak to date; 3,985 cases are tied to the Fresno County jail in California.³ Thousands of

incarcerated people have died from COVID-19. Due to the high-risk nature of large congregate living situations, many more will continue to fall ill in coming months. Given disproportionately high rates of chronic medical conditions in this population, incarcerated people are at increased risk of severe COVID-19 and worse outcomes—including death—from COVID-19 infection.⁴ Black and Latinx people are overrepresented in prison; the lifelong effects of systemic racism further compound the likelihood of poor outcomes from COVID-19 infection.⁵

Even before COVID-19 began to ravage correctional facilities, many community health care professionals experienced confusion and discomfort when caring for seriously ill

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incarcerated patients.^{6,7} Now community hospitals accustomed to receiving incarcerated patients 1 or 2 at a time are receiving transfers of a dozen or more patients seriously ill with COVID-19. Clarifying the ethical standards of care for seriously ill incarcerated patients is urgently needed.

Incarcerated Patients Have the Right to Advance Care Planning

Fortunately, the same standards for health care decision-making among seriously ill patients apply whether or not they are incarcerated. Incarcerated patients have the right to engage in advance care planning to specify the values and goals that should guide their care, state their preferences for specific interventions such as renal dialysis or mechanical ventilation, designate a surrogate decision-maker in case they become incapacitated, and—like non-incarcerated people—they can change their plans. In some states, including California, incarcerated patients are encouraged to complete Physician Orders for Life Sustaining Treatment (POLST) forms.⁸

Community Clinicians Should Re-Address Incarcerated Patient's Goals of Care

Wardens, correctional officers, and prison health care staff should not make medical decisions for incarcerated patients and should not be asked to do so. Because incarcerated patients sometimes mistrust their prison-based healthcare clinicians,⁹ community hospital clinicians caring for patients transferred from prisons should offer to re-address their patients' health care wishes upon hospitalization rather than relying on information that may be transferred with the patient. While mistrust between incarcerated patients and correctional health care professionals may be common, we do not intend to discount the efforts of correctional health care professionals, who often are disempowered, practicing in a setting that undermines patient trust, and whose recommendations for patient care may be stymied by forces out of their control.¹⁰

Surrogate Decision Makers for Incarcerated Patients Deserve Timely Communication

For incarcerated patients who are unable to make their own medical decisions, their designated surrogate (or next of kin as outlined by state laws) must be given the medical information they need to act on the patient's behalf.¹¹ Surrogates should be guided by the patient's values and goals; reviewing and discussing these values and goals in the face of critical illness constitutes good quality care.¹² While some information may be withheld for security reasons—such as information about an incarcerated patient's exact location—this limitation should not prevent the timely disclosure of crucial medical information, including the patient's diagnosis, prognosis, and alternatives for care. Prison officials should not obstruct families from getting the information they need to make medical decisions in line with an incapacitated patient's values.

Although some states require that information shared with next of kin go through prison staff,¹³ given the complexity of medical information and decisions, surrogate decision makers ideally should be able to ask questions directly of the patient's treating physician just as with any other patient who lacks decision-making capacity.

With the patient's permission, incarcerated patients' loved ones should be promptly informed about major changes in the patient's condition, even if they are not (yet) making medical decisions on behalf of the patient. This meets the community standard of medical care to which incarcerated people are entitled and will reduce the anguish loved ones experience when they are kept in the dark about what is happening behind closed hospital doors.

Clinicians Should Facilitate Farewell Visits for Dying Incarcerated Patients

Dying patients should have the opportunity for a farewell visit with their loved ones—even if by video or phone. Special protocols are sometimes required, and the prison must approve such a visit before it occurs, but denying this communication also denies an incarcerated person's humanity. For this reason, the 2018 First Step Act specifically grants federal prisoners diagnosed with a terminal illness a visit with family members within 7 days of receiving such a diagnosis.¹⁴ Ethically, dying patients incarcerated under state or local authorities also should be able to say goodbye to their families.

Community Clinicians Should Involve Ethics Committees, Legal Counsel, and Correctional Experts if Incarcerated Patients' Medical Care Is Being Obstructed

What should hospital-based healthcare professionals do if they are prevented from providing community standard medical care to seriously ill incarcerated patients? If care is being obstructed by correctional officers, clinicians should first contact the prison warden. If prison officials won't readily facilitate communication with a patient's next of kin, clinicians should contact the prison's medical leadership and, if necessary, the regional or state prison medical director. If similar issues adversely impact multiple patients from the same correctional institution, it may be helpful to involve the hospital's ethics committee to generate additional ideas, or to seek additional strategies and support from hospital leadership and counsel, legal advocates for incarcerated people, or correctional medicine experts.

As healthcare professionals, we must continuously press ourselves to safeguard the care and rights of our seriously ill patients. In the care of certain patients, such as those transferred from prisons and jails, we may not have the usual level of authority that is the norm to which we are accustomed. While COVID-19 rages on, and more incarcerated people become seriously ill, community healthcare professionals must take extra steps to advocate for this medically vulnerable

hospitalized patient population to receive ethically appropriate, humane care. Our incarcerated patients have already received their sentences—their freedom has been taken away. Our job is to ensure that they are not also sentenced to substandard or unethical care when they are seriously ill or dying.


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