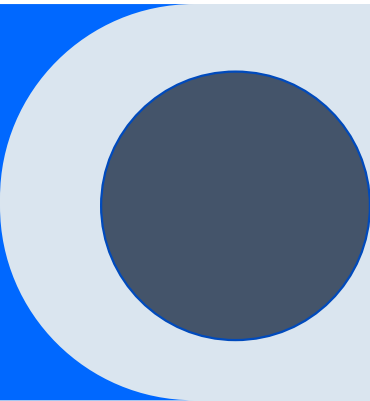
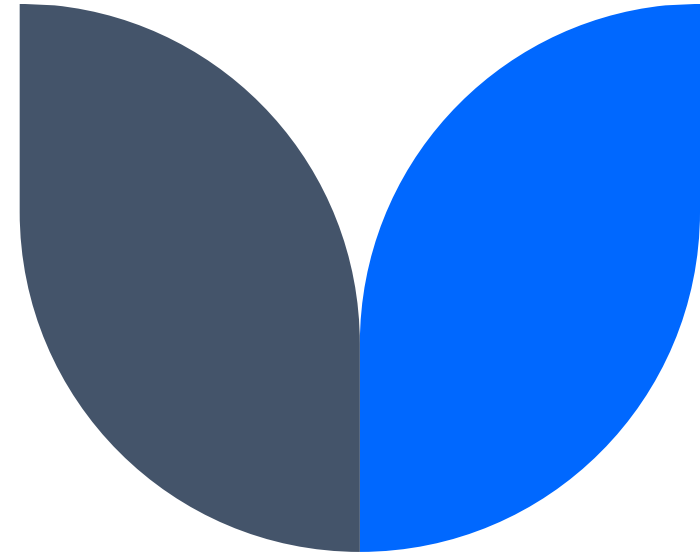





Everyday Clinical Ethics for Incarcerated Patients

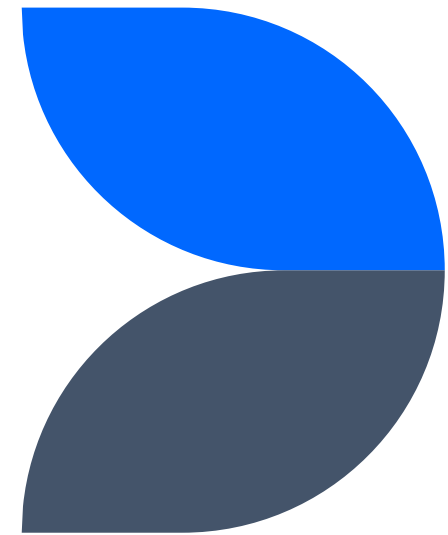


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Conflicts of Interest Disclosure

The presenters have no financial conflicts of interest to disclose related to this material.





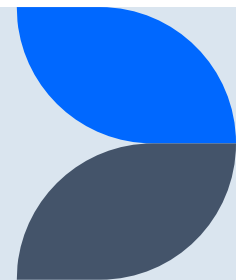
Agenda

- Local Context
 - Theoretical Overview
 - Case Types
 - Closing Thoughts, Questions, Discussion
- 
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Local Context

- Salem Hospital in Salem, OR is the main Acute Care Hospital serving Marion and Polk counties, and level 2 trauma center for surrounding areas
- Salem Hospital receives patients from several different institutions within its vicinity

Local Context



Institution	Description	Beds
Oregon State Penitentiary	Oregon's Maximum Security Prison, houses death row AICs	2200
Oregon State Hospital	The state's main Psychiatric Hospital, houses patients remanded for psychiatric treatment and evaluation by courts	700
Oregon State Correctional Institution	Medium Security Prison for men	888
Federal Correctional Institution Sheridan	Medium Security Federal Prison for men	1400
Coffee Creek Correctional Facility	Minimum and Medium Security, Intake center for all AICs, also houses women AICs	1684
Santiam Correctional Institution	Minimum Security, focused on rehabilitation and re-entry	440
Marion County Jail	Houses AICs awaiting trial or serving jail sentence for minor offenses	400

Broader Context

Having served at hospitals with similar relationships in Washington, Georgia, Montana, Washington DC:

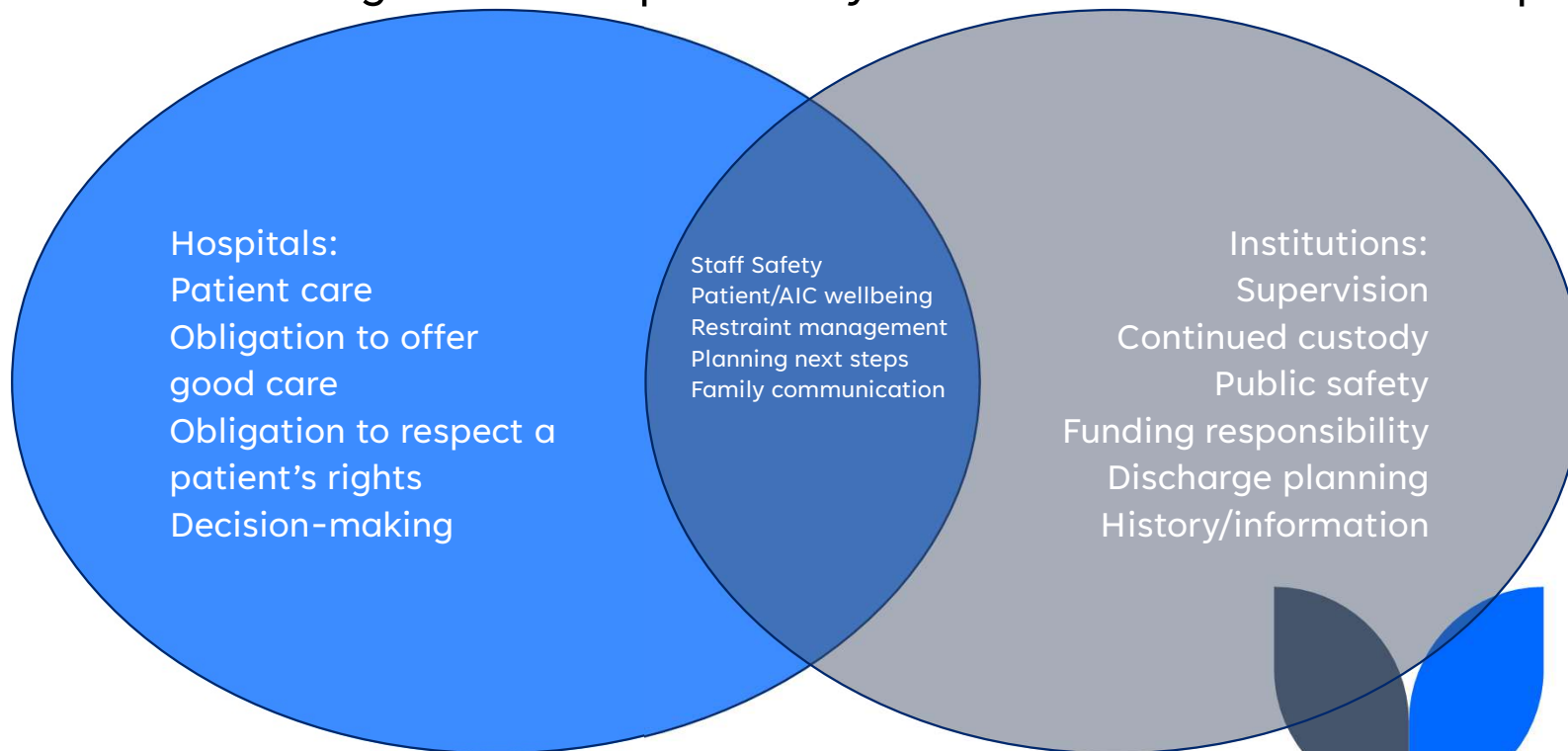
While the specifics of the systems are different, the situation is similar:

Carceral institutions can do some amount of healthcare themselves, but often in serious situations need to reach out to hospitals for additional care.

1. A patient arrives accompanied by guard(s) for supervision
2. Hospital and institution need to coordinate over care
3. There is tension

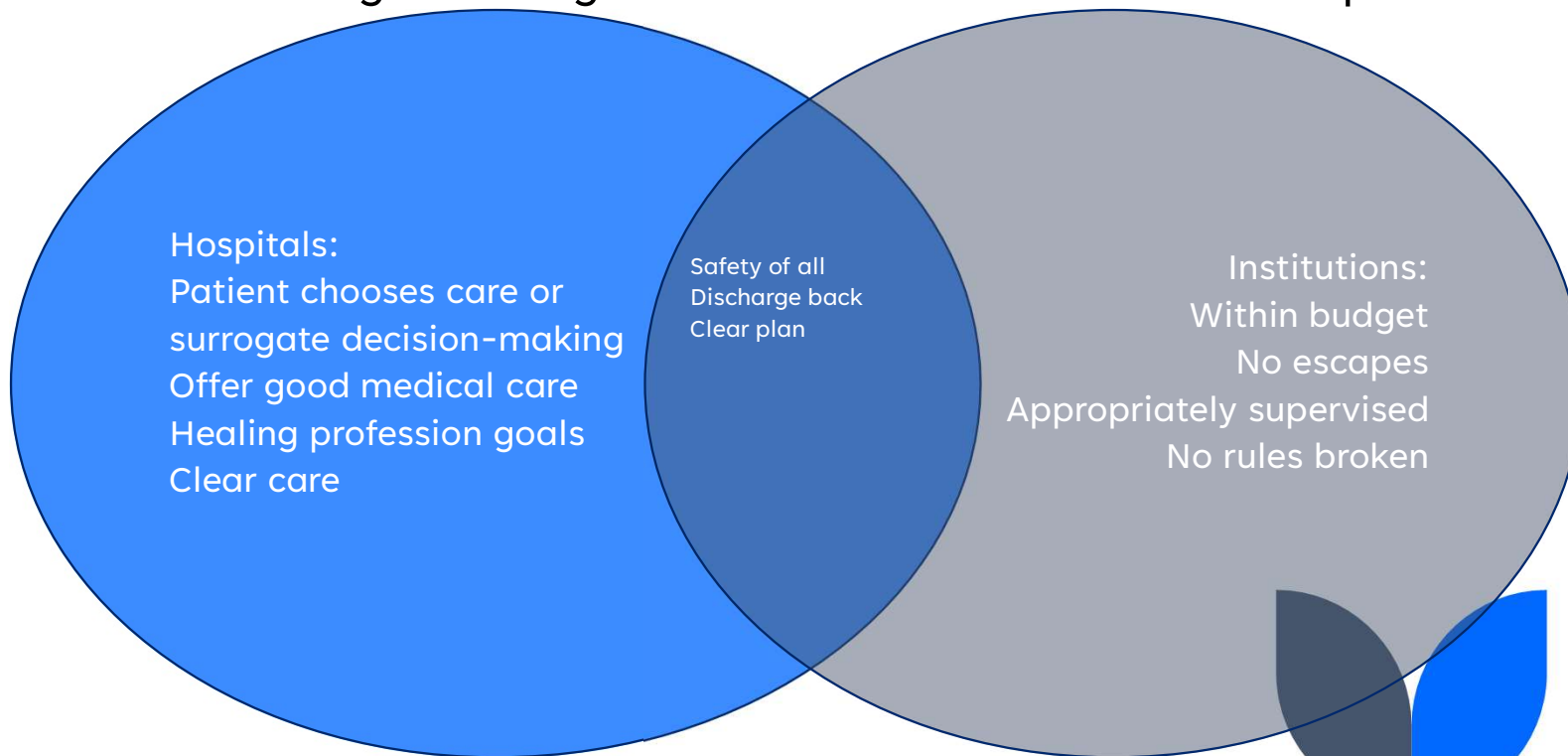
Broader Context: Ethical Issues

- Venn diagrams of responsibility of carceral institution vs hospital



Broader Context: Ethical Issues

- Venn diagrams of goals of carceral institution vs hospital



Obligations

- Patient focus: A main pillar of clinical ethics revolves around the patient and advancing their health and wellbeing. This consists in some mix of acting in the best interest of that person and/or respecting their autonomous choices.
 - "Patient First", "Patient centered care"
- Justice focus: The Criminal Justice system's theoretical interest in the person is in exacting what society believes is just in response to a criminal offense perpetrated by that person. The focus is societal first/the wellbeing of society.
 - In criminal cases, it is "The People vs. XXXX"

Theoretical Overlap

Shared Obligations towards the patient/AIC due to the law and ethics (ie. right to health care)

- Depriving an AIC of adequate health care violates the Eighth Amendment's prohibition against "cruel and unusual punishment"
- Pretrial detainees are protected under the Fifth and Fourteenth Amendment's due process clause against the state's deprivation of "life, liberty, and property" without due process of law. Deprivation of adequate health care is included.
- These rights apply to all "persons" in the United States, not just citizens
- Ethics: Argument from justice (everyone should have equal access regardless of social standing) and argument from dignity (all people have inherent worth and deserving of dignity, and tending to the sick and injured is part of recognizing that)

Broader Context: Ethical Issues

- Social situation of the patient limits care availability, a common thing to encounter by a very specific and limiting way in this case.

Resources in facility

Ability to choose own lifestyle

Followup care

Access to supports/surrogates

What is 'covered'

Broader Context: Ethical Issues

- This is an unusual situation for everyone, so ‘policy lore’ and heightened anxiety is common.

New situations for LEOs and clinical staff mean heightened tension

Disagreement on policy leads to worse outcomes

Example misconceptions: “the warden is the surrogate!”, “guards are never allowed in the room!”

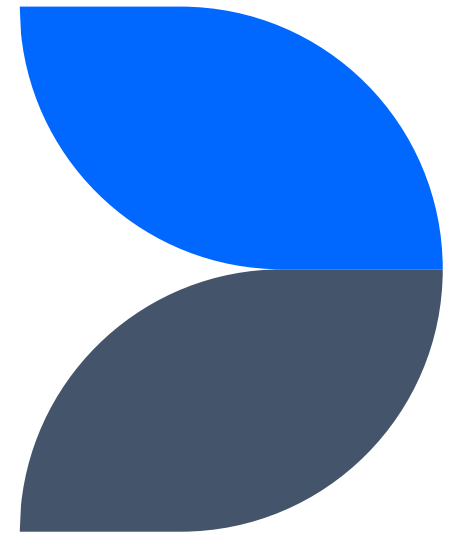
Example lore: “this patient is a murderer!”, “this patient harmed their family/surrogate!”

Clarity on: what is appropriate, what our role is, how we can educate/update our partners

Same Space, Different Roles

- These two systems meet when an AIC becomes ill and requires medical care beyond what can be provided at the incarceration institution
- In the shared space of the hospital/medical clinic, the roles of the system representatives differ in how they relate to the patient/AIC
 - Guards as custodian of the AIC
 - Secure the AIC (escape, harm to and from others)
 - Medical team as caregiver of the patient
 - Heal the patient

Case Studies





Case 1

JL is an AIC who was brought to the hospital from the State Penitentiary after being found down in his cell by guards. CPR was initiated on the scene after they found his heart had stopped. By the time JL was transported to the hospital, medics were able to restart his heart. He was admitted to ICU for further treatment and placed on a ventilator. Due to his medical condition, JL was in no condition to make his own medical decisions. Who would be in line to make decisions on behalf of JL?

Guiding Concepts

- The incarcerating institution and conflicts of interest
 - Perceived right of an institution to make decisions vs actual right to do this
- Surrogate Hierarchy
- Navigating contact of next of kin
 - Right to have a surrogate decision maker
 - Are they victims of the patient? Also incarcerated?
 - Hypervigilance over security of AIC, restricting access
 - ROIs on file at incarcerating institution?
 - How much information and access can the surrogate decision maker have?



Case 2

W is a 60 year old man currently incarcerated at the state penitentiary. He was taken to the hospital after suffering a stroke in his cell. While his care team at the hospital was able to save his life, the stroke has left W with cognitive and physical deficits. For W to have any chance of regaining something close to his previous level of functional ability, standard of care dictates extensive rehabilitation involving PT, OT, and ST. Without those services after acute hospitalization, W's post stroke deficits will become permanent.

While the state penitentiary reports rehab therapies are available to AICs, those services are in reality quite limited. There is a PT/OT/ST that comes once a week to tend to the needs of the entire population of the penitentiary, and appointments are dependent on what they have time for. How should the team planning of W's hospital discharge navigate the situation?



Guiding Concepts

- Mass Incarceration and Prisons as Public Health Crisis
 - Prisons and jails are not a healthy environment
 - Incarceration harms the physical and mental health of the incarcerated and their families
 - Per the Prison Policy Initiative, about 2 million people were incarcerated in the US in 2025 (<https://www.prisonpolicy.org/reports/pie2025.html>)
- AICs often lack of access to resources and supports
- Role of advocacy for AICs?
 - Finding options beyond what is usually offered at the institution

Case 3

TM is a 65 year old AIC brought to the hospital from the State Penitentiary, is Covid positive and has had a left sided stroke. Experiences partial paralysis of the right side of his body, confusion, partial vision loss, confusion, difficulty with speech. As he is treated, the team indicates they would like to start physical therapy as soon as possible to maximize recovery. However, according to the guard monitoring him, TM is in an elopement risk category which requires four-point non-medical restraint due to an elopement attempt 10 years ago.

This becomes even more complex as he begins to experience respiratory failure for which bipap is indicated, but in order to self-rescue he would need his left hand free.



Guiding Concepts

Dual AIC/ Patient status:

- Care team obligations vs custodian/guard obligations
A Tension that may be unavoidable
- The AIC's receive health care in the context of their judicial legal status
What does it mean to be an extension of a carceral institution when you do not work at one?
- We maintain an obligation to offer good medical care: can this ever override AIC status?
If so, is this based on medical urgency or changed AIC status? Which matters?
- Can changed medical picture change AIC picture?
Compassionate release suggests 'sometimes'

Hospitals/Clinicians taking on security concerns:

- Security defaults in hospital vs carceral settings
Discussion with the guard about the aggressive and disoriented patient next door who is *not* restrained.
- Who has the expertise to evaluate changed status?
Experts in medicine vs security, clinicians at the impact morally and physically

Case 4

LM is an AIC who is currently receiving outpatient care relate to a cancer diagnosis. As part of his treatment plan, LM is scheduled to have a number of imaging appointments. At his first appointment, LM arrived shackled and in the company of two guards. Due to concerns about interference with the imaging equipment and safety, LM cannot be shackled during his MRI.

Staff at the imaging clinic feel uncomfortable around LM citing the way he watches people leaves them feeling unsettled. They have concerns about LM being unshackled during care. Staff report that they would like to find out more about LM criminal background in the interest of their own safety.



Guiding Concepts

Curiosity

- Doesn't always come from a bad place (e.g. concern for safety, establishing rapport)
- However, circumventing the patient to find out information about them may damage the therapeutic relationship

Staff Bias

- There may be a natural assumption that one's status as an AIC implies they are a "bad" or dangerous person
- Learning of the AIC's crimes may affect a clinician's ability to maintain neutrality

Professional Ethics

- Social Work Code of Ethics: "Social workers should avoid searching or gathering client information electronically unless there are compelling professional reasons, and when appropriate, with the client's informed consent."





Case 5

SC is a young man who was injured when he was taken into custody by ICE agents during an enforcement action. He was brought to the Emergency Department for treatment by the agents. During the intake process, SC appears reluctant to share his personal health information with care team members due to the constant presence of the ICE agents at his side. The agents present insist that their close proximity to the SC at all times is non negotiable.



Guiding Concepts

Vulnerable Population

- AICs lack many of the rights other members of society enjoy, and they are disadvantaged in the power structure they exist in

Doctor Patient Confidentiality

- Patients/AICs need to be able to speak freely and truthfully about their health issues to their medical team without fear of consequences or retaliation
- Disclosure without the consent of the AIC may be allowed to the incarcerating institution under the category of operational considerations and safety

Role for Advocacy

- Working with institutional partners even when it appears we are at odds
- When the situation is extreme, looking for other external avenues



Questions and Comments?

Thank you!

