Incarceration: The Intersection of Emergency Medicine and the Criminal Justice System

20

Susi Vassallo

Key Points

- The public is required to provide health care for prisoners who by reason of their loss of liberty cannot themselves access such care.
- The US Constitution makes health care a right for prisoners, although standards of care in prisons can be difficult to enforce.
- Emergency medicine providers are not agents of the state, corrections officials, or police. While respecting security concerns and safety, the emergency medicine provider's loyalty is to the patient.

Foundations

Background

Prisons, jails, and detention centers are examples of spaces designed to incarcerate or deprive individuals of liberty based on existing law. Detention centers are most often established in jails and prisons. The term "correctional" facilities stems from the idea that these facilities are not only for the purpose of punishment, but also for rehabilitation.

There are 1,465,200 inmates in the prison population in the US, a 1.6% decline from 2017 to the end of 2018. County and city jails held an additional 738,400 inmates nationwide at midyear in 2018, with an average inmate length of stay of 25 days [1]. The number of people passing through jails in 2018 was 10.7 million, a decline of 21% since 2008. However, this decrease is within the context of a 500%

S. Vassallo (✉)
Department of Emergency Medicine, Bellevue Hospital Center and NYU Langone Medical Center, New York City, NY, USA
e-mail: Susi.Vassallo@nyulangone.org

H. J. Alter et al. (eds.), *Social Emergency Medicine*,
https://doi.org/10.1007/978-3-030-65672-0_20

increase in incarceration over the last 40 years. The United States is the world leader of incarceration [2]. The Black imprisonment rate has fallen 21% since 2006, yet people of color remain disproportionately represented in the prison system [3]: Black and Latinx individuals comprise approximately 28% of the US population in 2017 but accounted for 56% of incarcerated people [2]. Recent criminal justice reforms have resulted in further decreases in the numbers of incarcerated individuals [3]. In addition, during the COVID-19 pandemic some nonviolent inmates have been released as a means to decrease jail crowding and lessen the danger of viral contagion to staff, inmates, and the community, although these policies are inconsistent and have not been adequate to prevent severe outbreaks and mortality in prisons [4].

Jails hold individuals pre-conviction and those unable to post bond, as well as individuals who have been sentenced to less than 1 year. In general, city or county governmental authorities administer jails. Prisons are administered by state or federal entities and hold individuals sentenced to more than 1 year. Crowding and transfers result in movement among correctional facilities. This matters to emergency medicine providers because often, diagnostic workups and treatment plans do not follow patients from one facility to another. This means that many diseases and conditions go undiagnosed, or un- or under-treated for long periods. In view of these systemic weaknesses in the criminal justice system, an emergency medicine provider will often choose to expedite a patient's care, admitting patients for needed workups that may not be completed even if recommended at the time of discharge. There is no outpatient safety net for prisoners or guarantee that the correctional facility personnel will have the resources or personnel for whatever aftercare is recommended by the emergency department.

Prisoners have a Constitutional right to health care. In 1976, in the case of Estelle v. Gamble in the US Supreme Court, a prisoner in a Texas state prison filed a civil rights action against prison officials and the chief medical officer [5]. In Estelle, the Supreme Court ruled that deliberate indifference to a prisoner's serious medical needs was cruel and unusual punishment under the Eighth Amendment of the Constitution. The Eighth Amendment provides "excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." This amendment has been interpreted by the courts to embody "broad and idealistic concepts of dignity, civilized standards, humanity, and decency" [6]. Unlike the common emergency medicine meaning of the word serious, a medical, psychiatric, or dental condition does not need to be life or limb threatening to be serious. Under the amendment, a serious medical condition is one diagnosed by a physician as mandating treatment or is so obvious that even a layperson would easily recognize the necessity for a doctor's attention. Conditions are serious if they cause pain, discomfort, or a threat to good health.

Denial or unreasonably delayed access to care, the failure to administer treatment prescribed by a physician, and the denial of a professional medical opinion are actionable under the Eighth Amendment and Fourteenth amendments of the US Constitution [7]. The patient has a right to professional, timely access to care

ordered by a clinician. The Supreme Court, in *Farmer v Brennan* (Farmer v. Brennan 511 US 825 (1994)) clarified *Estelle* (Estelle v. Gamble 429 US 97 (1976)) [5, 8]. According to this decision, prison officials are liable when they know of a substantial risk of serious harm but fail to take reasonable steps to abate that risk. For example, if a prison doctor knows a patient has insulin-dependent diabetes and fails to prescribe insulin, this would be judged to put the patient at substantial risk of serious harm. Substantial means measurable or statistically significant. Holding prisoners in cells with a high heat index, for example, puts prisoners at substantial risk of serious harm [9] and violates the Constitution (Ball v. LeBlanc No 14-30067 (5th Cir. 2015)) [10].

Though prisoners have legal rights and protections, prisoners are not free to exercise these rights at will. For example, access to health care is dependent on the "sick call" system in place at a given facility. The prisoner must request health care either verbally or in writing. The written request is picked up from the cell side by either medical or security staff. The frequency of the gathering of these sick call requests (called "kites") differs in each correctional system but is usually once or twice daily. The level of training of the medical staff member who responds to the sick call request differs throughout the correctional system. Symptomatic treatment by licensed practical nurses is common, yet making a diagnosis is outside the scope of nursing practice. Treating only symptoms without a diagnosis can lead to serious complications for some patients. Sometimes staff may consider the patient's complaint a ruse to get a trip out of prison or believe the patient is complaining for other secondary gain [11]. Patients may present to prison sick call repeatedly for the same complaint and be treated only for their symptoms, without addressing their underlying disease process.

Another obstacle to care is the reporting structure. Rather than reporting to a health authority that is separate from security staff, medical staff is required to report to the warden on medical matters [12, 13]. The warden is almost never a medical professional and may have motivations or competing interests that result in failing to address gaps in medical care generally or for specific prisoners. There may be budgetary gaps or competing needs, such as the need to use prison transport vans for transportation needs other than outside appointments. The public is largely unaware of the everyday living conditions of confinement and the adequacy of medical care for prisoners [14]. Most recently, the COVID-19 pandemic has highlighted that correctional facilities are hot spots for the spread of the virus to correctional officers, inmates, and the surrounding communities [15].

Medical staffing of correctional facilities is difficult as the prestige and benefits are generally lower than medical jobs based in the community. Some staff are demoralized by staffing shortages and work conditions. There are few opportunities for continuing medical education or advancement. Staff may be disheartened by their inability to deliver a consistently high caliber of care due to resource limitations. In correctional facilities, security takes precedence over medical care, sometimes putting security personnel at odds with the mission of medical

staff [12]. Prisoners may not appear for medical appointments if they are locked down or there is no one to escort the prisoner to the clinic. Emergency providers do not know and cannot anticipate how follow-up care at the facility will proceed [16].

Evidence Basis

Each year 11.5 million prisoners are released from prisons and jails in America. Ninety-five percent of prisoners in state prisons will eventually be released. Prisoners have disproportionally high rates of infectious diseases, cardiovascular disease, asthma, tuberculosis, and mental health diagnoses compared with the nation as a whole [7, 17–19]. The stark racial disparities in the current American system of mass incarceration exacerbate existing racial health disparities that are already present in the non-incarcerated population [3, 20]. When correctional facilities or emergency medicine providers deliver substandard care, both the prisoner and the public can be impacted by the consequences. As an example, approximately 1.3 to 1.4 million prisoners infected with hepatitis C were released from prison in 1996 [17]. In July of 2020, a massive COVID-19 outbreak in the San Quentin prison in California resulted in many hospitalizations and also a need to provide testing for correctional officers via the emergency department due to a lack of preparedness and testing capacity on behalf of the prison system [21]. In addition, gaps in care can result in prisoners presenting to the emergency department with advanced illnesses. For example, cardiac or gastrointestinal symptoms are sometimes treated symptomatically for months without diagnosis or necessary specialty referral. These cases come to the public's attention in class action civil actions, news reports, and in the experiences of emergency medicine providers receiving patients from correctional facilities [15, 22–24].

The burden of physical and mental illness is higher in the prison population than in the community [19]. Suicide rates in jails are high. The suicide rate in jail is higher than in the general population [25]. In nonurban jail settings, most suicide victims are White men, intoxicated, and non-violent. White men are six times more likely to die by suicide in jails than Black men and three times more likely to die by suicide than Hispanic prisoners [26]. The risk of suicide appears highest early after initial incarceration: a quarter of suicides occur in the first 24 hours after incarceration and an equal number of deaths by suicide occur in the next 2 to 14 days. The majority of suicide victims in prisons die by hanging [27]. Because emergency physicians often assess prisoners just after arrest and before arraignment, suicidal ideation must be assessed and taken with great seriousness. Cynicism regarding the young intoxicated "just arrested" patient's suicidal ideation may be deadly [22, 28, 29]. Self-injurious behavior is also disproportionately prevalent among individuals in prison [30] and includes acts such as the ingestion of foreign bodies, self-cutting, overdose, and hitting the head purposefully. Foreign bodies include paper clips, razor blades, toothbrushes, and eating utensils. Sharp objects may or may not be wrapped in tape to render them less

dangerous. Many objects can be removed endoscopically. Worsening psychiatric illness is associated with increasing episodes of foreign body ingestion. The behavior of ingesting foreign objects often becomes more frequent and the number of objects ingested increases [30–32].

Excessively hot temperatures in correctional facilities are dangerous to the health of prisoners, and facility staff. By a series of class action suits, excessive temperatures in prisons have been found to present a substantial risk of serious harm to prisoners and to be unconstitutional. The increasing morbidity and mortality associated with heat is extensively documented in the scientific literature. Heat stress rises with increasing temperature and humidity, and a quick guide is the heat index as published by the National Weather Service[1]. Morbidity and mortality increase with increasing heat index. Heatstroke is not the only danger. Worsening of underlying conditions including respiratory and cardiovascular disease and mental illness is well documented [33–35].

Emergency Department and Beyond

Bedside

Communication between the emergency department (ED) and correctional facilities is limited in many systems. Because of these gaps, emergency medicine providers must take extra care to educate their patients about medical findings, and listen to the patient repeat the goals of care to assure understanding. Prisoners are not normally provided with visit results, diagnosis, and follow-up treatment plans due to security concerns that preclude divulging the exact date of a follow-up visit to an inmate. In some cases, the patient will not receive a copy of the discharge instructions and the follow-up plan, which means he/she will need to understand and remember even more than a patient who does receive a written plan. Emergency medicine providers can clearly communicate all pertinent diagnostic and follow-up information back to the facility housing the patient and thoroughly document in the medical chart, especially in cases of trauma [36]. Emphasize the follow-up care recommendations to the officers transporting the prisoner, and document all results, medical decision making, and detailed plans for follow-up care (e.g., needed laboratory or radiography studies, medication that must be obtained/administered, need for specialist consultations) on the transfer papers and clearly define the time frame within which this follow-up must occur. Legal action by prisoners against prison officials will seldom result in acceleration or timely completion of a patient's care.

The Standard of Care

Emergency medicine providers should strive to provide the same standard of care for prisoner patients as for patients who are free. For example, national guidelines such as those promulgated by the Centers for Disease Control, the American College of Emergency Physicians, the American Academy of Emergency Medicine, the

[1] http://www.noaa.gov/

American Public Health Association, the American Diabetes Association [9], the Infectious Disease Society of America, the American College of Cardiology, and the American Heart Association, apply to prisoner patients as they would apply to free patients.

Request for Body Cavity Searches

Police may come to the hospital with a prisoner and ask the emergency medicine provider to obtain blood or do a body cavity (mouth, rectum, or vagina) search for legal purposes. Emergency medicine providers are not agents of the state and should not use their skills for nonmedical purposes [37]. No provider in a therapeutic relationship with the patient should do a body cavity search for contraband or other forensic reasons. Finding contraband results in punishment for the patient and goes against the first do no harm doctrine of medicine. The patient may be placed in a cell and observed for the passage of contraband if that is a concern. Police may come to the hospital with a prisoner and ask the emergency medicine provider to obtain blood toxicology testing for legal purposes. Many patients simply consent. For those who do not, it is assault to proceed. Police may provide their own medical provider from the police department to meet the forensic needs.

It is common for emergency medicine providers to "medically clear" prisoners so that they can leave a medical ED and transfer to a psychiatric facility, go to court for arraignment, or to return to a correctional facility. Sometimes transportation to another facility may be take hours to days and once a patient is discharged, the emergency medicine provider cannot control what happens to the patient. Consider the following scenarios. A patient with Type 1 diabetes receives a dose of insulin in the ED and is returned to jail only to receive no additional insulin and to return the next day with diabetic ketoacidosis [29, 38]. A patient taking benzodiazepines presents to the ED with tachycardia and signs of withdrawal. The patient improves with the administration of benzodiazepines in the ED. The patient may return to jail and receive no more benzodiazepines and start to act strangely and be put into a padded cell, become unstable, and die due to unrecognized benzodiazepine withdrawal. A patient with uncontrolled hypertension is prescribed a medication in the emergency department yet the medication is not continued in the correctional facility. A patient with asthma improves after receiving treatment with albuterol and is medically cleared. He complains of shortness of breath in the facility but receives no care, and dies of asthma.

There is nothing in the scientific literature setting a standard for the emergency medicine provider with regard to medical clearance in the ED. Therefore, the threshold for holding an incarcerated patient in the protected environment of the hospital must be low.

The Right of Refusal of Care

Prisoners have the right to refuse medical care. This right is protected by the liberty interest of the Fourteenth Amendment and common law [39]. Refusal of care is accompanied by the clinician's assessment of the patient's mental capacity to refuse. As competence is a legal determination made by a judge in court, a clinician's

assessment refers instead to "capacity" [40]. Medical treatment without the consent of the patient may constitute an assault and battery. Prisoners have the right to make "bad" or" wrong" decisions [41].

However, the right of a prisoner to refuse medical care is not absolute. When there is a strong public health reason to administer treatments, such as the treatment of active tuberculosis or other infectious diseases such as SARS-CoV-2, the right of refusal may be overridden [39]. In addition, the patient may have a severe medical condition and refuse emergency care, but the person may be hospitalized if the risk of death is considered too great to safely return to the general prison environment. An example is a patient with end-stage kidney disease who refuses dialysis; if the patient is deemed to have capacity to refuse care, he/she cannot be forced to receive dialysis but can be hospitalized. Additionally, the Supreme Court ruled that prisoners with serious mental illness may be involuntarily medicated with antipsychotic drugs if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest [42]. There are frequently extenuating circumstances that lead a prisoner to refuse care. An approaching court date or visitation by family may play into the prisoner's refusal. Emergency medicine providers must address these concerns for the patient to accept needed care.

Withholding a specific treatment in order to compel or coerce the prisoner to submit to a medically desired treatment plan (e.g., withholding pain medicine unless the prisoner agrees to a blood draw or wound closure) is unethical and may constitute deliberate indifference. The patient has a right to refuse. Fundamentally, the right of refusal is part of informed consent and the Constitution protects prisoners' right of informed consent. An informed and detailed review of the law surrounding the right of refusal is available elsewhere [39].

Privacy

Emergency medicine providers recognize that patient privacy is frequently violated in the ED [43]. This happens because of the organization of the ED, the nature of emergencies, crowding, and thoughtlessness. Information is power in correctional facilities. It may endanger the patient when another prisoner or a correctional staff member overhears private medical or other information about the prisoner during the ED stay. Such knowledge may be leveraged for the patient's disadvantage. For example, intelligence concerning sexual orientation, mental health, medical history, HIV status, or allegations of wrongdoing by police may subject the prisoner to discrimination or violence.

Indirect transmission of the type of sensitive information listed above from the provider to the correctional officer is unethical without a patient's consent or knowledge. Correctional officers do not have a right to know the patient's medical information [44]. However, with the patient's consent, in some circumstances, shared medical information provides an additional level of patient safety when correctional officials know to be alert for the symptoms of the patient's medical condition. For example, a patient's behavior that is due to an underlying medical condition can influence the responses of corrections officers and police and may be helpful

information in their management of an inmate. For example, conditions that result in altered behavior and an inability to follow orders such as head injury, seizures, hypoglycemia, substance withdrawal, pain, fever, and mental illness are conditions that can result in altered behavior and an inability to follow orders, which can be dangerous in the correctional system environment.

Hospital/Healthcare System

When incarcerated individuals present to the ED repeatedly, it is usually a sign of an undiagnosed or missed condition. However, in prison, repeated presentation for the same complaint, particularly after a trip to the ED, may elicit disbelief [11]. This mindset means that an ED provider's common "come back if you get worse or develop additional symptoms" is not a realistic discharge instruction. Unlike an individual who is not incarcerated, there is no guarantee that a prisoner will be allowed to return, particularly for a subtle or ill-understood patient complaint.

Understanding the systemic limitations of access to health care must influence ED decision making for prisoner patients. It is a good rule of thumb that once the patient leaves the emergency department, the patient will be perceived by prison staff as "medically cleared." While medically clearance from the ED is a term that has no definition or standards, it is intuitively understood to mean that the patient has been evaluated and is "safe for incarceration." This highlights the responsibility emergency medicine providers have to assure that a thorough workup is completed and that specific discharge instructions are provided. As mentioned above, it is often safest for the patient to be admitted to the hospital if the natural history of the disease process is ill defined or has a significant risk of recrudescence [45]. For example, individuals withdrawing from alcohol will not have access to continued pharmaceutical treatment after being stabilized in the ED and their symptoms can recur upon discharge, so a lower threshold for admission may be appropriate in such cases.

Emergency medicine providers have an opportunity to effect improvement in the care of prisoners by reporting back to prison officials and health care providers when they identify lapses in quality of care. Most hospitals' electronic health records are not accessible by correctional facility personnel. Some correctional facilities have no electronic records for patients; others rely on a patchwork system. For example, the pharmacy medication administration record may be electronic but clinic notes may not be. In New York City's Rikers Island Jails [12], one of the largest jails in the US, the system of communication between the hospital and jail is a handwritten form that is filled out in pen, put in an envelope, handed to the corrections officer and carried back to the jail. These forms include notations such as "CT head and abdomen done" and "Medically cleared." The information contained on the form is invariably limited, with no medical decision making recorded. There is little space in which to write and most emergency

medicine providers do not receive training on these forms or the limitations of the jail health care system. Hospital-based emergency medicine providers rarely have an opportunity to tour jail health care facilities, much less spend time shadowing a prison-based clinician.

Upon release from prison, individuals often face difficulty with continuity of care and obtaining necessary prescription medications. For example, they may be released with only a limited supply of medications and without a clear plan for obtaining more. This issue may be exacerbated if they lose their insurance coverage while in prison. Patients may therefore present to the emergency department, where they can be assisted in reestablishing health care in the community. In some communities, special Transitions Clinics exist to help people as they transition from incarceration to the community [46].

Societal Level

National health care guidelines apply to prisoner patients as they would apply to free patients, yet in practice, the aforementioned barriers faced by prisoners regarding timely and high-quality health care and preventive medicine make this difficult. Each year nearly 10 million prisoners are released from prisons and jails in America, and often the ED is their only clear path by which to receive follow-up care [47]. Reducing the epidemic of mass incarceration is a top priority for many policy makers, and there are also many other steps that society can take to improve care for individuals who are incarcerated. A number of cities have or are piloting innovative programs that offer access to medication-assisted treatment for prisoners with substance use disorders, social services in jail to help smooth re-entry via connection to ongoing social services, and relationships with local outpatient clinics that provide specialized care for those who have been recently released from jail or prison. In addition, most prisoners who are insured by Medicaid experience discontinuation of coverage if incarcerated for more than 90 days, and renewal can take 3 months, leaving already vulnerable individuals without insurance after release. Social services providers within prisons can restart benefits from within prison prior to release and avoid this issue.

The *Prison Litigation Reform Act (*PLRA) presents additional barriers for prisoners. PLRA is a federal law that makes it more difficult for prisoners to pursue legal claims in federal court. Before the claim will be heard, prisoners must exhaust requests to prison officials for administrative remedies. The exception occurs when the prisoner is in imminent danger such as if denied treatment for an ongoing serious medical problem or is subjected to environmental conditions that cause or aggravate such problems. In some cases, the risk of future injury may be sufficient [39]. Thus, even in a societal context, often the most expeditious and realistic means for an emergency medicine provider to improve medical care for a prisoner patient is to initiate the care of the patient [45].

Recommendations for Emergency Medicine Practice

Basic

- Similar to stroke care, sexual harassment prevention, privacy and security, and countless other required trainings, emergency medicine providers need formal training regarding key principles of the care of prisoners, including information on the system of incarceration, recidivism, and jail and prison-based health care.
- Emergency medicine providers should familiarize themselves with the standards of screening for and treatment of infectious agents that can present a substantial risk for correctional facility spread given the congregate living environments.
- Use the opportunity for one to one interaction with your patient to educate them about their diagnoses and advocate for them by assuring detailed and clear follow-up instructions are provided to their facility at discharge.

Intermediate

- Emergency medicine providers can educate themselves with books about health and incarceration. Examples include Clinical Practice in Correctional Medicine (Michael Puisis editor); Public Health Behind Bars: From Prison to Communities (Robert Greifinger editor); multiple publications from the National Commission on Correctional Health Care concerning Standards for Health Service in Prisons, Jails and Juvenile Detention Centers; the American Correctional Association (ACA) Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions; and Life and Death in Rikers Island by Homer Venters, M.D.
- Interested clinicians and learners can find opportunities to learn about specialized care and models for prisoner health services provision including hospice and palliative care transitions clinics linking prisoners with health care upon release, care for and prevention of infectious diseases, mental health of juveniles, immigrant detention centers, prisons, federal, state and city authorities, civil rights organizations, security personnel and specialists, and the intersection of law and medicine.

Advanced

- The National Commission on Correctional Health offers certification in correctional health care. (CCHP, Correctional Care Health Professional).
  - Certification is a good introduction to correctional health care for emergency clinicians and can aid in understanding correctional health care standards.

  - Seek professional development in the specialty of correctional medicine: The American College of Correctional Physicians is dedicated to the professional development of physicians in the specialty (the American Board of Medical Specialties does not yet recognize correctional medicine).

    Join The Academy of Correctional Health Professionals (correctionalhealth.org), a membership partner of the NCCHC. Members receive the Journal of Correctional Health Care and the Academy Insider, a weekly e-news brief.
- Examine whether your ED or institution can develop contracts with health authorities in specific local correctional facilities that refer patients, so that a hospital-based emergency medicine provider can serve as a formal liaison.
  - The correctional health liaison must be a certified correctional health professional by the National Commission on Correctional Health Care. (NCCHC.org) and must actively practice emergency medicine.
  - The liaison physician must undergo clearance at the correctional facility, and can attend warden and health care authority meetings, facilitate communication between the correctional facility and the emergency department and create educational goals and curricula for emergency medicine clinicians.
  - The liaison has the authority to work with correctional staff to arrange for hospital-based emergency medicine providers to observe health care delivery monthly. This could include observing the chronic care clinics, sick call, pill call, pharmacy operations, and talking with prisoners.

Teaching Case

Clinical Case

A 55-year-old male prisoner presents to the hospital emergency department with a chief complaint of multiple seizures over the last 6 months, increasing in frequency. The past medical history is significant for a history of seizures secondary to a traumatic brain injury, and diabetes. He normally has only one seizure every 6 months. The patient has been compliant with his levetiracetam and metformin medication regimen. He has occasional headaches that are thought to be residual from the traumatic brain injury. In the emergency department, the patient's vital signs are normal and the neurological exam is normal. A CT scan of the brain is normal. Laboratory testing is unremarkable. The neurology service is consulted and recommends an increase in the levetiracetam dose and clinic follow-up in 1 week.

The recommendation for increasing the levetiracetam reached the prison medical staff the day after the emergency department visit. A physician assistant ordered the increased dosage from the prison pharmacy. The pharmacy technician entered the new order into the records such that 3 days later the patient would have received the

increased dose at pill call. However, a weekend intervened, causing delay. The patient did not receive the new dosage. (Pill call is the distribution of medicine to prisoners at their cell or dormitory. In some instances, prisoners walk to the window of the pharmacy to receive medications directly at the window.)

Two days after the emergency department visit, the patient had another seizure in the prison. The patient was awake but nonverbal after the seizure. Officers believed the prisoner was malingering in order to get a "trip out of jail." Officers told the prisoner he was "just at the hospital" and did not need to go back. Officers called the medical team and the nurse practitioner determined the patient was fine as he was talking and interacting. She called the doctor at home and the doctor said there is no indication for the patient to go back to the hospital as his neurology appointment is rescheduled for the following month, he has already been to the emergency department at the hospital, the levetiracetam dose was increased, and the patient has had seizures and headaches for years. The doctor has no way of knowing over the phone, and does not ask for the nurse to confirm, whether the prisoner is receiving the increased dose of levetiracetam.

The next morning the patient submits a sick call request stating that he is having more seizures, and he needs a refill for Tylenol. The sick call request is reviewed and the patient is assigned to see the physician assistant holding clinic two mornings later. Two mornings later there is a brief scuffle in the dorm and the prisoners are locked down. No patient gets to sick call in the morning. Every patient is reassigned to the afternoon sick call clinic. In the afternoon, the patient refuses to come out of his cell for sick call. He tells officers that he is scheduled for family visitation. He refuses to sign a refusal form that he is refusing sick call clinic evaluation. He states he is not refusing, he just needs to make his family visit. He explains to officers that his wife has come to see him on the bus. She comes once every 2 weeks. It a four-hour bus ride each direction and they have three children at home.

The patient does not get up for breakfast in the morning. Officers bang on the bars and there is no response. A call for back up goes out over the radio and 10 minutes later several officers have arrived and enter the cell. The patient is warm to the touch and 911 is called. Officers start chest compressions. No officer has brought the automated external defibrillator to the scene. The ambulance arrives at the front gate of the prison grounds. Because it is not possible to simply open all the gates and doors, it takes the ambulance another 10 minutes to get from the front gate of the prison to the patient. Paramedics find that the patient is in asystolic cardiac arrest and begin advanced cardiac life support and transport the patient to the emergency department of the hospital. Resuscitative efforts are unsuccessful.

Teaching Points

1. Although it is the prisoner's constitutional right to care that is ordered, there are many barriers to receiving this care. The non-medical functions of prison life

influence the nature of the medical care. The delivery of medical services in the nation's prisons and jails is beset with problems and conflicts which are virtually unknown to other health care services [46].
2. Emergency medicine offers an opportunity to provide high quality, expeditious care for prisoners.
3. Do not be reassured that "someone is watching the patient." The teaching case illustrates that both a lack of both physical supervision and an assumption that a prisoner is malingering can lead to ruinous outcomes.

Discussion Questions

1. What might the emergency providers have done differently at the initial visit that could have potentially resulted in a different outcome for the patient?
2. Emergency medicine providers may voice that the patient was "just there for a trip out of jail" or is malingering for secondary gain. What techniques can help guard against this bias?
3. What are the opportunity costs to engaging in health care from the patient's perspective?

References

1. Institute for Crime and Justice Policy Research. World prison population list. 12th ed. https://www.prisonstudies.org/news/icpr-launches-12th-edition-world-prison-population-list. Accessed January 9, 2021.
2. Criminal Justice Facts | The Sentencing Project, 2020. https://www.sentencingproject.org/criminal-justice-facts/. Accessed August 16, 2021.
3. NAACP | Criminal Justice Fact Sheet, 2020. https://naacp.org/resources/criminal-justice-fact-sheet. Accessed August 16, 2021.
4. Widra E. and Wagner P. 2021. Jails and prisons have reduced their populations in the face of the pandemic, But not enough to save lives. Prison Policy Initiative. https://www.prisonpolicy.org/blog/2020/08/05/jails-vs-prisons-update-2/ accessed Aug 13, 2021.
5. Estelle v. Gamble 490 US 97 (1976).
6. The Legal Information Institute of Cornell Law School. https://www.law.cornell.edu/supremecourt/text/429/97. Accessed August 13, 2021.
7. Wilper AP, Woolhandler S, Boyd JW, Lasser KE, McCormick D, Bor DH, et al. The health and health care of US prisoners: results of a nationwide survey. Am J Public Health. 2009;99(4):666–72. https://doi.org/10.2105/AJPH.2008.144279.
8. Farmer v. Brennan 511 USA 825 (1994). *Oyez*, www.oyez.org/cases/1993/92-7247. Accessed August 16, 2021.
9. Diabetes management in correctional institutions: position statement. Diabetes Care. 2007;30 Suppl 1:S77–84. https://doi.org/10.2337/dc07-S077. Accessed August 14, 2021.
10. Ball v. LeBlanc No 14-30067. (5th Cir. 2015).
11. Greifinger RB. The acid bath of Cynicism. Correct Care. 2015;29(2).
12. Venters H. Life and death in Rikers Island. Baltimore: John Hopkins University Press; 2019.
13. US Immigration and Customs Enforcement: Performance-based national detention standards, 2011. https://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf.

14. MacDonald R PA, Venters H. The triple aims of correctional health: Patient safety, population health and human rights. J Health Care Poor Underserved. 2013;24(3):1226–34.
15. Goldensohn R. 2014. City renewed contract with Rikers health provider despite 4 inmate deaths. DNA info. https://www.dnainfo.com/new-york/20140924/east-elmhurst/state-renewed-contracts-with-rikers-health-provider-despite-4-inmate-deaths/ Accessed August 14, 2021.
16. Lewis v. Cain, CIVIL DOCKET NO.: 3:15-CV-318 (M.D. La. Mar. 31, 2021).
17. National Commission on Correctional Health Care. The Health Status of Soon to Be Released Inmates: A Report to Congress. Volume 2; Document No. 189736. September 2004. https://www.ojp.gov/pdffiles1/nij/grants/189736.pdf.
18. National Commission on Correctional Health Care. The Health Status of Soon-To-Be-Released Inmates: A Report to Congress. Volume 1; Document No. 189735, September 2004. https://www.ojp.gov/pdffiles1/nij/grants/189735.pdf.
19. Binswanger IA, Krueger PM, Steiner JF. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. J Epidemiol Community Health. 2009;63:912–19.
20. Gramlich J. Black imprisonment rate in the US has fallen by a third since 2006. Pew Research Fact Tank, May 6, 2020. https://www.pewresearch.org/fact-tank/2020/05/06/share-of-black-white-hispanic-americans-in-prison-2018-vs-2006/. Access date 1/9/21. 2020.
21. Cassidy M. San Quentin officials ignored coronavirus guidance from top Marin County Health Officer, Letter Says. San Francisco Chronicle. 2020. https://www.sfchronicle.com/crime/article/San-Quentin-officials-ignored-coronavirus-15476647.php. Accessed August 14, 2021.
22. Rohde D. City Board Members Fault St. Barnabas Hospital over prison care. New York Times. 17 September 1998.
23. Novick LF RE. A study of 128 deaths in New York City Correctional facilities 1971–1976; implications for prisoner health care. Med Care. 1978.
24. White K. Thirty -two short stories about death in prison. 2019.
25. Noonan ME. Mortality in Local Jails 2000–2014 [database on the Internet]. Bureau of justice statistics. Washington, DC: US Department of Justice 2016. Available from: BJS.gov. Accessed August 14, 2021.
26. Pope L. Delany-Brumsey A. Creating a Culture of Safety. Vera. 2016. https://www.vera.org/publications/culture-of-safety-sentinel-event-suicide-self-harm-correctional-facilities/culture-of-safety/overview. Accessed August 14, 2021.
27. Hayes LM. National study of jail suicide: 20 years later. J Correct Health Care. 2012;18(3):233–45. https://doi.org/10.1177/1078345812445457.
28. Greifinger RB. Public health behind bars from prisons to communities. https://www.springer.com/gp/book/9780387716947. Springer-Verlag New York, 2007.
29. Gill GV, MacFarlane IA. Problems of diabetics in prison. BMJ. 1989;298(6668):221–3. https://doi.org/10.1136/bmj.298.6668.221.
30. Dalal PP, Otey AJ, McGonagle EA, Whitmill ML, Levine EJ, McKimmie RL, et al. Intentional foreign object ingestions: need for endoscopy and surgery. J Surg Res. 2013;184(1):145–9. https://doi.org/10.1016/j.jss.2013.04.078.
31. Knoll IV, JL. Suicide in correctional settings: assessment, prevention, and professional liability. J Correct Health Care. 2010;16(3):188–204. https://doi.org/10.1177/1078345810366457.
32. Evans DC, Wojda TR, Jones CD, Otey AJ, Stawicki SP. Intentional ingestions of foreign objects among prisoners: A review. World journal of gastrointestinal endoscopy. 2015;7(3):162–8. https://doi.org/10.4253/wjge.v7.i3.162.
33. Cole V. Livingston. CIVIL ACTION NO. 4:14-CV-1698, S.D. Tex. Judgment Law, 2020.
34. Gates v. Cook, 376 F.3d 323 (5th Cir. 2004).
35. Roth A. Do Heat Sensitive Inmates Have a Right to Air Conditioning? NPR. July 24, 2014. https://www.npr.org/2014/07/24/334049647/do-heat-sensitive-inmates-have-a-right-to-air-conditioning. Accessed August 14, 2021.
36. Strote J, Verzemnieks E, Walsh M. Emergency department documentation of alleged excessive use of force. Am J Forensic Med Pathol. 2013;34(4):363–5.

37. Physicians for Human Rights. Dual loyalty and human rights in health professional practice. 2003. Accessed Feb 15, 2021: https://phr.org/wp-content/uploads/2003/03/dualloyalties-2002-report.pdf.
38. Keller AS, Link RN, Bickell NA, Charap MH, Kalet AL, Schwartz MD. Diabetic ketoacidosis in prisoners without access to insulin. JAMA. 1993;269(5):619–21.
39. Boston J. Prisoners' self-help litigation manual. 4th ed. Cary: Oxford University Press; 2010.
40. Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. N Engl J Med. 1988;319(25):1635–8. https://doi.org/10.1056/NEJM198812223192504.
41. King, K. Martin Lee, LM. Goldstein S. EMS, Capacity and Competence. Stat Pearls Publishing. 2019. https://www.ncbi.nlm.nih.gov/books/NBK470178/ Accessed August 15, 2021.
42. Washington v. Harper, 494 U.S. 210, (1990).
43. Lin YK, Lin C-J. Factors predicting patients' perception of privacy and satisfaction for emergency care. Emerg Med J. 2011;28:604–8.
44. Baker EF, Moskop JC, Geiderman JM, et al. Law enforcement and emergency medicine; an ethical analysis. Ann Emerg Med. 2016;68:599–607.
45. Hurst A, Castaneda B, Ramsdale E. Deliberate Indifference: Inadequate Health Care in U.S. Prisons. Annals of internal medicine. 2019. https://doi.org/10.7326/m17-3154.
46. Transitions Clinic. San Francisco, 2020. Transitionsclinic.org. Accessed on August 15, 2021.
47. Incarceration and Reentry. Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/topics/human-services/incarceration-reentry-0. Accessed August 16, 2021.