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ETHICS CASE

What Are Physicians' Responsibilities to Patients Whose Health Conditions Can Influence Their Legal Proceedings?

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Abstract

Correctional populations are disproportionately affected by conditions that affect cognition, such as psychiatric illness and head trauma. Honoring bioethical principles in the care of such patients can be particularly difficult in the correctional setting. However, the approach should not change markedly because a patient is incarcerated. That is, the same standards of respecting patient autonomy and confidentiality should be maintained, and the fact that correctional populations are already marginalized makes it all the more important for clinicians to honor these principles. Physicians should act in the best interest of their patients; in jails this might include disclosing information to and consulting with a patient's legal defense. However, this step should only be taken with a patient's consent or, in cases in which the patient does not have decision-making capacity, when it seems consistent with a patient's wishes.

Case

Dr. Obaje is a primary care physician who works at a county jail, where most of her patients are undergoing court processes. This afternoon, Jonathan, a 52-year-old man with a known history of poorly controlled type II diabetes and a 20-year history of opioid use, is brought to the jail's medical ward for a routine chronic care visit. This is the first time that Dr. Obaje has met Jonathan since his incarceration four weeks ago. Jonathan's blood sugars have ranged between 80 and 150 since his incarceration, and he does not currently seem to be experiencing any withdrawal symptoms. However, during the appointment, Jonathan struggles to provide a health history, shares tangential information, and repeats some information several times. After Dr. Obaje briefly leaves the room to answer a nurse's question, Jonathan does not appear to remember having met her when she returns.

Based on this memory lapse and Jonathan's history, Dr. Obaje worries that Jonathan could be exhibiting cognitive impairment. Jonathan reports that he has been transiently homeless during the past decade and that during several periods of homelessness he experienced violence, including blows to the head. She asks Jonathan about his mood,

and he confirms that he "often feels down" and states that "sometimes I get so angry, and I'm not sure why." On the Mini-Mental State Examination, Jonathan receives a score of 21 out of 30, and Dr. Obaje diagnoses him with mild cognitive impairment (MCI) [1].

Dr. Obaje refers Jonathan for mental health care not only for treatment but also to rule out reversible causes of cognitive decline. She also asks her mental health colleagues to evaluate how Jonathan's cognitive impairment influences his decision-making capacity and judgment. Dr. Obaje wonders whether information about Jonathan's cognitive symptoms could be important for his legal defense.

Commentary

Medical and mental health clinicians working in the correctional setting are likely to encounter scenarios similar to Dr. Obaje's encounter with Jonathan. Conditions that might be associated with cognitive impairment, such as aging, are common in correctional settings. Between 2-3 percent of people incarcerated in jails are over the age of 55, a proportion that is expected to increase as the population ages [2, 3]. More recent data shows that prison populations are aging, with about 10.5 percent of incarcerated people over the age of 55 [4]. While risk of cognitive impairment is highest for persons over age 65 [5], inmate populations might have more risk factors for dementia and other cognitive impairments, and their prevalence is likely higher in inmate populations than in the general population [3]. In 2002, 19 percent of people incarcerated in jails met criteria for substance use disorder; 15 percent met criteria for other mental health problems; and about half met criteria for both [6]. Any mental illness might have effects on cognition, particularly serious mental illness (SMI) that causes severe functional impairment—such as schizophrenia, bipolar disorder, or major depressive disorder [7]—which is estimated to affect up to 19 percent of men and 42 percent of women incarcerated in jails [8]. The prevalence of traumatic brain injury (TBI) in correctional settings is also likely higher than that of the general population. One study examining patients in prisons with a history of TBI found a prevalence of 35.7 percent [9]. Given that TBI is a risk factor for impulsive behavior [10], it is possible that the prevalence in jails is even higher. Thus, Dr. Obaje's meeting a relatively young patient with cognitive difficulties is not unusual, but it remains a practically and ethically complex situation.

What is key to Dr. Obaje's relationship with Jonathan is that she is his treating clinician, and therefore her primary responsibility is to her patient and his best interests. The same is true of the psychiatrist to whom she refers Jonathan for further diagnostic and treatment management. The concept of patient-centered care—the idea that clinicians should help patients be active, informed participants in their own medical management—is if anything more important in settings where patients are already marginalized. In the correctional setting, where the rights and freedoms of patients are

already severely restricted, fostering patient agency so that patients can make informed decisions (both medical and legal) about their care is essential.

This commentary will consider a number of ethical issues in this case. First, privacy and informed consent will be discussed. Then the application of standard bioethical principles in surrogate decision making and standards of surrogate decision making will be considered in relation to the case. Finally, how clinicians might interact with other third parties, such as legal counsel, forensic evaluators, and correctional staff, will be considered.

Privacy and Informed Consent

Although there are some differences in the care of patients in the correctional setting (such as the duty to inform custody staff about contraband), laws addressing health care communication and privacy, such as the Health Insurance Portability and Accountability Act (HIPAA) of 1996 apply in the same way [11]. In general, without a patient's consent, clinicians may only share medical information to a third party for treatment, payment, or health care operations; disclosure to legal counsel is not included in these criteria. The easiest thing for Dr. Obaje to do is to discuss with Jonathan the possibility of her informing his counsel of her concerns.

However, if Jonathan does not consent—or even if he does—things are a bit more complex. This is because the nature of his illness might impair his ability to give informed consent (either to permit or to forbid the doctors' speaking to his attorneys). What does not substantially change the importance of consent—or, in Jonathan's case, the assessment of his ability to do so—is the fact that Jonathan is incarcerated. There is no legal reason for incarceration to change the process of consent as it relates to medical care.

Assessment of Decision-Making Capacity and Surrogate Decision Making

Regardless of Jonathan's decision, any involved physician should determine if he has decision-making capacity. Capacity is a clinical term applied to a particular decision; a patient might demonstrate capacity by showing that he is able to make a clear and consistent choice, that he understands the situation and relevant information, and that he is able to rationally manipulate relevant information [12]. Determination of capacity is a clinical decision that may be made in any treatment setting and is distinct from determination of competence, which is made by a judge and relates to a person's longitudinal global functioning, although the exact legal definition is variable by jurisdiction [12].

If Dr. Obaje feels that Jonathan does not have decision-making capacity to consent to her communicating with his legal team about his MCI, she must apply the bioethical principles of beneficence and respect for autonomy in deciding what to do. A frequently

invoked standard for decision making in such cases is that of substituted judgement: the clinicians and family members—or the clinicians alone, in incarcerated settings in some states [13]—make a decision based not necessarily on what they feel is best for the patient, but rather on what they believe the patient would have wanted if able to make decisions. In the incarcerated setting, the patient's preference can be difficult to know, but obtaining collateral information from close contacts such as family members might be of use. In Jonathan's case, if close contacts are not available, Dr. Obaje might be in the position of having to decide (based on her own interactions with the patient) what decision he would have made, and acting accordingly. Some patients, for example, might be more averse to the idea of having a mental illness, or of being in a treatment facility that addresses mental or cognitive difficulties, than to a harsher criminal sentence; it is well documented that the stigma of psychiatric illness is magnified in the correctional setting [14] due in part to some correctional officers, who often receive little training in mental illness, treating incarcerated patients with psychiatric illness with disrespect or disregard for their vulnerabilities. If Dr. Obaje has no information about Jonathan's preferences and is unable to predict what decision Jonathan would have made, she cannot apply the standard of substituted judgment and instead should apply the best interest standard. For example, she might determine that she should inform his counsel of her concerns, given the benefits of this course of action to Jonathan (i.e., potentially getting Jonathan into a treatment environment rather than a correctional one).

In making this determination, Dr. Obaje has a potential source of assistance. Dr. Obaje was able to gain consultation from a jail psychiatrist, who might be able to provide additional perspectives as to Jonathan's decision-making capacity. Clinic leadership, such as a mental health director or a medical director in a correctional clinic can also be valuable resources for consultation. Getting information from multiple sources and perspectives might make Dr. Obaje feel more confident in her diagnosis or her course of action. It is worth noting, however, that diagnostic certainty is by no means a prerequisite to sharing potentially relevant information with a patient's legal counsel.

Sharing Protected Health Information

The benefit of Dr. Obaje sharing her concerns with Jonathan's counsel is so that his defense team can argue that his MCI should be taken into account during his trial. One way that a lawyer (or the judge) might introduce this information is through the use of a forensic evaluator. The explicit role of a forensic evaluator is to opine on how the patient's illness or limitations might affect his charges or mitigate sentencing. The roles of treating clinician and forensic evaluator are intentionally kept separate whenever possible to avoid conflicts of interest [15]. Jonathan's attorneys, however, were they made aware of his MCI, might respond by obtaining an independent forensic evaluation to strengthen the legal case that his MCI should be taken into account. It will probably ultimately be the role of someone appointed through his lawyers or the judge—namely,

a forensic evaluator—to determine the appropriateness of any diagnosis and how it should impact legal proceedings and decisions.

While there are no laws requiring clinicians to disclose protected health information to a patient's counsel, the American Bar Association requires that the attorney act as a "zealous advocate" for his or her client [16]. As with any sharing of medical information, Dr. Obaje should reveal the minimum amount necessary to achieve the purposes of the communication. Details that would not affect an attorney's decision to get a forensic evaluator, or which would not be relevant to such an evaluation, should not be shared. Although there is no obligation for her to speak to the defense counsel in this situation, she could disclose information that might help Jonathan if she has his permission; or, in the event that Jonathan lacks decisional capacity, Dr. Obaje should obtain consent from a surrogate decision maker or make a decision based on substituted judgment or his best interests. On the other hand, his council is obligated to consider if involving a forensic evaluator would be in Jonathan's best legal interest.

Finally, there is an additional consideration in decisions about sharing information about Jonathan's mental state. Separately from sharing this information with his defense team, should Dr. Obaje's concerns be shared with the correctional staff? There is reason to believe that her concerns about Jonathan's mental status warrant his being treated differently from other inmates. This is particularly true if any jail or medical staff members believe that Jonathan's condition puts him at increased risk of victimization from other inmates. Mental illness and cognitive impairment are risk factors for being victims of violence from both other inmates and correctional staff [5, 17]. In many correctional settings, this risk of violence can be mitigated by putting the inmate in a different setting (either in the same facility or in a different facility). If this is not possible, Dr. Obaje might explain to correctional staff that Jonathan's condition warrants his receiving extra protection. There is little legal guidance on how she should balance her concerns for her patient's privacy and well-being in her discussions with correctional staff, although some professional guidelines have been proposed [18]. However, the jail itself is legally obligated to afford Jonathan additional protections if he is at increased risk of victimization. The Eighth Amendment of the US Constitution protects incarcerated persons from "cruel and unusual punishments" [19], and in the 1994 case, *Farmer v Brennan*, the US Supreme Court ruled that prison officials' "deliberate indifference" to the risk of harm violated the constitutional rights of incarcerated persons [20, 21]. (The Due Process Clause of the Fourteenth Amendment has been interpreted to extend these rights to pretrial detainees [22].) In other words, if Jonathan is at increased risk of victimization—even if only from other incarcerated persons—failing to protect him from this increased risk of harm is a violation of his constitutional rights.

Conclusion

This is a complex but realistic scenario similar to situations that physicians working in the correctional setting are likely to encounter. From a legal perspective, a clinician's ethical obligations to a patient with a mental illness or cognitive impairment do not change markedly because he or she is in correctional custody. However, the implications of incarceration should still be considered. Some clinicians might have a tendency to partition the lines between the legal and medical systems as much as possible to avoid overstepping their bounds; this compartmentalization might make physicians in the correctional setting less likely to take actions that might be considered effective advocacy for their patients. However, the alternative must also be considered: patients in correctional custody are stripped of so many of the rights and comforts afforded to our patients in the civilian world that going the extra mile to advocate for an incarcerated person's care might have significant benefits for his or her health care, legal situation, and overall well-being.

In this scenario, Dr. Obaje should explain to Jonathan her belief that he has MCI and that this knowledge could help his legal counsel in defending him. She should ask his permission to share this information; whether or not he provides permission, she should also assess his decision-making capacity to do so. If he has capacity to give consent, his preference should be honored. If he does not, she should try to make a decision based on substituted judgment and tell his attorney that this is what he would have wanted were he not impaired. If he lacks capacity and she is unable to make a substituted judgment due to lack of available information, she should do what is in Jonathan's best interest—which, in this case, means informing his defense counsel.

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