

VIEWPOINT

Surrogate Decision Making for Incarcerated Patients

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When patients are too ill to make their own health care decisions and lack a previously designated decision maker, identifying the appropriate surrogate can be a complex process. For example, clinicians may use surrogacy ladders (hierarchical lists of individuals who could serve as decision makers), which are delineated in state statutes.¹ Although patients with incapacitating illness are inherently vulnerable, there are additional considerations for people who are incarcerated, and these may not be addressed in state laws. We discuss the selection of surrogates for incarcerated patients and who should or should not serve in this role.

In the United States in 2017, approximately 2.1 million people were incarcerated in jails or prisons, and the median age is increasing.^{2,3} The prevalences of infectious diseases, traumatic brain injury, and severe mental illness are high.³ Some people may lose decisional capacity at some point during their incarceration, either temporarily or permanently.

Guidance for Surrogate Decision Making

There is little guidance in the medical literature on how best to care for incarcerated patients who lack decisional capacity. According to a 2014 statement from the Department of Justice, "the authority, parameters, and procedures for creating [proxies] are governed by the laws of the state in which the institution operates."⁴ Nonetheless, we are aware of only 2 states with health care surrogate statutes containing specific language regarding decision makers for people who are incapacitated and incarcerated—Vermont and Mississippi.^{5,6} In Vermont, corrections employees cannot act as a decision maker unless "related to the principal by blood, marriage, civil union, or adoption."⁵ In Mississippi, "the department may petition the chancery court of the county of residence of the offender to appoint the commissioner [of the Department of Corrections] as guardian for an offender who lacks the capacity to make a health care decision and who does not have a relative or other person available to make the decision."⁶

Challenges for Selecting Surrogates

The selection of surrogates for incarcerated people is challenging. For security reasons, direct communication with family and friends is often prohibited by correctional policy. The correctional facility may control communications. Clinicians may be unable to disclose where and when health care will be provided. They may incorrectly infer that family or friends are unable to act as surrogates and thus follow decision-making practices that they would not use for patients outside correctional facilities. If a patient has no available family or friends to serve as a surrogate (a so-called unrepresented patient), corrections staff may assert that they can act as decision makers without being formally designated as such.⁷

When employees of correctional facilities assume health care decision-making authority for incarcerated people, however, ethical conflicts can arise. The primary duty of correctional staff is to maintain custody and control of incarcerated people. A surrogate's duty, however, is to respect and advocate for a patient's preferences and best interests as they relate to their health. When correctional staff act as surrogates, they have to balance their loyalty to the corrections system against their responsibility to promote the patient's health, a concept called *dual loyalty*.⁸ These competing loyalties can bias medical decisions. In some circumstances, however, a correctional employee may be the best individual to make decisions on a patient's behalf. For individuals with limited contacts outside correctional facilities, their relationships with corrections staff, clinicians, and caregivers may supersede those with acquaintances before incarceration.

Recommendations

Advance care planning can prevent some dilemmas related to surrogate decision making for incarcerated patients.^{9,10} Primary care physicians should engage in advance care planning for all patients, not just those with life-limiting illness. At a minimum, these discussions should elicit preferences for potential surrogate decision makers. If an individual cannot identify a decision maker outside the correctional setting, a trusted individual within the correctional setting may be selected, if such a choice is permitted under state law.

Incarceration, however, creates unique barriers. Advance care planning discussions may generate "feelings of uncertainty, distrust, and frustration," and there may be suspicions of the motivations of clinicians and corrections staff.⁹ To facilitate communication, clinicians should directly address these concerns.

Some patients will have previously participated in advance care planning, which may lead to uncertainties about the validity and durability of preferences expressed before incarceration.¹⁰ Nonetheless, decisions already made during advance care planning discussions should be upheld and, if necessary, modified to suit health changes that occur after incarceration.

In the absence of advance care planning or when such planning does not identify a surrogate decision maker, clinicians should use state statutes to identify potential surrogates, as they would for patients who are not incarcerated. Engagement of surrogates is essential even if correctional staff filter communications. Typically, the warden should be contacted to facilitate communication; the correctional facility's medical director can also be an important resource. If corrections staff prevent communication without offering an explanation, involvement of a hospital institutional ethics committee or legal counsel should be considered. For

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unrepresented patients for whom long-term loss of capacity is anticipated, such as those with age-related cognitive impairment or severe mental illness, a court-appointed guardian may be needed.

Paper records, including advance care planning documents, are usually sent with incarcerated patients to health care facilities. Advance directives should be scanned into institutional medical records. If existing advance care planning documents are modified or completed, this information should be shared with the correctional facility. Direct communication with clinicians and other medical personnel at the correctional facility can help avoid confusion or the potential for misplaced documents. Information sharing and collaborative policy development can strengthen relationships between clinicians at other hospitals and corrections staff

and clinicians, an important prerequisite for delivering high-quality health care to incarcerated patients.

At correctional facilities, institutional policies should include specific language related to decision making for incarcerated persons, particularly those who are unrepresented. Medical associations should address these situations in their ethical codes and guidelines.

When needed, incarcerated patients should have a surrogate decision maker who can advocate for their preferences, values, and previously expressed wishes or, at a minimum, act in their best interest. Although incarceration is designed to strip away many rights of individuals, values-based medical decision making should not be one of them.

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