

## ETHICS CASE

### How Should a Health Care Professional Respond to an Incarcerated Patient's Request for a Particular Treatment?

Commentary by Tom Peteet, MD, and Matt Tobey, MD, MPH

#### Abstract

Incarceration complicates the ethical provision of clinical care through reduction in access to treatment modalities and institutional cultures that value order over autonomy. Correctional care clinicians should expand their guiding principles to consider autonomy and health justice for their patients, which in turn should prompt development of processes and care plans that are patient-centered and account for the inherent restrictions of the setting.

#### Case

Dr. François is the medical director of a prison where more than 200 women are incarcerated. Over the past week, several nurses have contacted her both in person and through the prison's electronic health record to report that Jane, a woman with insulin-dependent type II diabetes who is incarcerated at the facility, has refused her insulin injections during the past week. Blood sugar measurements taken three times each day have been in the 300 to 500 range. Several of the nurses with whom Dr. François talks face-to-face report they feel anxious about the persistence of Jane's refusal.

Dr. François reads Jane's electronic health record and sees that she experienced a motor vehicle accident five years ago, which resulted in a two-week hospitalization. Jane has chronic neck and back pain as a result of the accident and reported that she was prescribed gabapentin by a primary care clinician in the community to control her pain. Clinicians at the prison are discouraged from prescribing gabapentin unless other pain control options have been tried due not only to this drug's risk for cultivating dependence, but also to the diversion risk within the prison [1]. As a result, Jane has not been prescribed gabapentin at the prison and instead has a prescription for ibuprofen.

Dr. François requests to speak with Jane to try to better understand her situation. When Jane arrives at the prison's medical ward, she tells Dr. François that her pain is unbearable and, specifically, that it keeps her from sleeping or moving comfortably. She states, "I need my gabapentin, this is torture!" When Dr. François asks her about her adherence to her insulin regimen, Jane tells her, "The only thing you people care about is whether I take my insulin. Why doesn't anyone care about my pain?" Dr. François tries to

clarify, "Treating your pain is important, but there are risks to continuing you for too long on gabapentin, so it's important that we work together to try something else for your pain." Jane insists, "I'm not going to take insulin until you give me gabapentin."

### **Commentary**

At any time, two million people are incarcerated in the United States [2]. Health care in correctional settings requires attention to features that might not be present in other health care settings: for example, vulnerable patient populations, custody-driven logistics in the facility, and matters of dignity and fairness [3]. Patients in the correctional setting experience higher rates of chronic medical illnesses, major psychiatric illness, and substance use disorders than their peers [4, 5]. Incarceration itself carries substantial risks to health, including a substantially reduced life expectancy [6]. As in this case, chronic pain is a common complaint managed by correctional health clinicians [7].

A frequently cited tension within clinical guidelines, including the National Commission on Correctional Health Care's guidelines on chronic pain treatment, is the prescription of medications with potential for diversion [8, 9]. The specter of diversion—like gabapentin diversion in this case—looms large over many clinical encounters in the correctional setting, determining the availability of medications, from sleep aids to medications for opioid maintenance to medications for pain. Consider one physician's blog post:

I was recently in a meeting with the commissioner of a certain state's Department of Corrections to give an update on medical services in his prisons and the very first question he asked was about gabapentin. Gabapentin! Think of all the things he could have been concerned about—Hepatitis C for example—and instead, he asked about the security problems caused by gabapentin diversion [10].

Despite the pervasiveness of concern for diversion, little data exists on the extent or health impact of medical diversion in correctional settings [1]. To take one example, in a randomized controlled trial of opioid agonist therapies at a large jail, 7 of 116 men were discontinued on the medications out of concern for diversion over a one-month study period [11]. The health impact of medication diversion is unknown: between 2000 and 2013, 4-9 percent of county jail inmate deaths and 1-2 percent of state prison inmate deaths were attributed to alcohol or drug intoxication, although the source of those substances is not reported, and many deaths are likely not due to medication diversion [12].

Although gabapentin has evidence of benefit in many conditions, including epilepsy and neuropathic pain [13, 14], it is a noncontrolled GABA-ergic medication with potential for diversion, which is central to this case. One early description of gabapentin diversion in a prison was noted in Florida in 2004 [15], and diversion of the drug is widespread in the

community for anxiolysis and euphoria [16, 17]. However, gabapentin, even in massively supratherapeutic blood concentrations, is unlikely to cause death [18], as only rare deaths have been definitively attributed to it [19], and its side effects are primarily related to drowsiness [20]. As an example of the degree of controversy around gabapentin prescribing, a lay publication described widespread diversion of gabapentin and then criticized the restriction of access to it in prisons for an off-label indication (anxiety) [21, 22].

The case implies that diversion and dependence are considerations; although gabapentin dependence has been described [23], we will focus in this commentary on diversion, as we believe the restriction of prescribing to limit diversion underlies the case and represents a central ethical quandary in correctional care. Moreover, we will not focus on the patient's threat of nonadherence as an attempt to bargain for gabapentin. We believe we see such brinksmanship occur in correctional care precisely because of problematic clinical environments and restrictions on liberty inherent in correctional environments, which can be addressed by changing policies to improve patients' experiences. Although we agree with published guidelines on the management of chronic pain in correctional health care [8], we acknowledge that clinical care need not be identical within and outside of correctional settings. Indeed, we argue that the lack of autonomy and frequent injustices in the setting of incarceration should lead clinicians to consider prioritizing principles such as *respect for autonomy* and *justice* over concerns about medication diversion and misuse.

### **Balancing Patient Considerations against Medication Misuse**

In the United States, although health care for incarcerated persons has been deemed a constitutional right [24], care is often explicitly rationed and difficult to access [25]. In the case above, the most salient ethical consideration is the clinician's unstated preference to mitigate the harm of medication misuse and diversion by following strict prescribing practices instead of trying to motivate continuity in the patient's care plan. As alluded to above, there can be legitimate safety and security concerns raised by prescribing medications known to be diverted. In exploring the ethical tradeoff, it is useful to consider how we might weigh [respect for an individual patient's autonomy](#) against the risk of harm to others differently within a correctional setting [26]. For example, given the lack of autonomy in prison, perhaps clinicians should offer medical care that prioritizes respect for patient autonomy (e.g., by keeping Jane on gabapentin). Or, perhaps given the injustices involved in care rationed according to unfair criteria, clinicians ought to have a higher threshold for withholding a treatment (e.g., by not stopping Jane's gabapentin upon admission). We propose two hypothetical questions to help us reach a conclusion in this case:

1. *Nonmaleficence versus respect for autonomy.* If gabapentin is known to have diversion appeal and diversion carries some risk of harm to prisoners, but if

continuing it for a single patient supports respect for her autonomy and is clinically appropriate, should gabapentin be prescribed?

2. *Health justice in an unjust setting.* If incarcerated persons often suffer injustices—from unfair rationing, for example—should individual clinicians be more inclined to honor patients' care plan preferences?

### **Nonmaleficence versus Respect for Autonomy**

Withholding Jane's gabapentin clearly denies her preference for treatment. At the same time, any single prescription of gabapentin carries risk of diversion and potential harm to others. Considered generally, how should clinicians approach the potential consequences of medication diversion and misuse in correctional settings?

We see no compelling argument for why the diversion of a medication should be demonstrably more problematic in a prison or jail than in a community setting. In fact, given how tightly monitored correctional facilities tend to be, prisons or jails might prove safer settings for the misuse of medications with diversion risk. One may disagree and posit a risk of violence associated with diversion in correctional facilities; however, violence associated with diversion could also occur in community settings. Notably, no data that we know of exist to suggest that diversion occurs at a higher rate or that it is more problematic in correctional settings. Using the numbers from the clinical trial cited above, over a month, perhaps 5 percent of incarcerated recipients diverted opioids [11]; national rates in the community setting in the US and France have been quoted as 0.08 percent and 20 percent, respectively [27].

If not from empirical evidence, whence the concern regarding gabapentin use in correctional settings? First, correctional settings might value order over autonomy. For example, correctional facilities typically are strongly risk averse to potentially fatal, if highly unlikely events, such as life-threatening gabapentin overdose, due to legal liability, although such risk aversion limits evidence-based treatment options for numerous patients [28]. Also, the effort necessary to prevent medication diversion and maintain order can be onerous for facility staff. Despite these concerns, we are troubled by the correctional system's strong tendencies against GABA-ergic medications and, for that matter, against other nonscheduled medications used for mental health care and other conditions. Second, a prescriber might be concerned about gabapentin's off-target effects, such as diminishing anxiety [29] or substance use cravings [30], and a patient's preferring it for that reason. However, it is not clear why such additional benefits could be construed as harmful. If a prescriber suspects that unspoken, off-target benefits might be the motive for a patient's care plan preference, a good solution is a strong patient-clinician relationship and appropriate mental health care. Such relationships might be difficult to cultivate if the focus of care is not patient centered and the clinician's primary concern is medication diversion.

We argue that—in general—clinicians should be circumspect in overriding an incarcerated patient’s autonomy even if upholding respect for autonomy carries risk for medication diversion. Specifically, in this case, we believe that a risk of harm from medication diversion or misuse should probably be assumed in order to express respect for this patient’s autonomy. We suggest that Dr. François consider prioritizing respect for her patient’s autonomy over her concern about diversion and possible harms to others.

### **Health Justice in a Setting of Liberty Restriction**

Jane’s case highlights a larger question regarding a clinician’s duty to provide [just care](#) within a system known for its shortcomings in the care of patients with chronic illness [31]. The barriers to high-quality, patient-responsive care in jails and prisons are endemic in the United States: for-profit health care companies, care rationing, formulary restrictions, restricted access to exercise and nutrition, among others. In such a challenging setting, ethical principles of beneficence, respect for autonomy, and justice often require nuanced evaluation. For instance, a correctional facility might in good faith opt to segregate a person at risk of harming others, although paradoxically, over time, that person’s declining mental health due to seclusion might generate more harm than it prevents. In many cases, in our experience, what seems beneficial and expedient in the short term might prove to be harmful over the long term.

When clinicians practice in such an environment, we believe that they must seek a higher standard of upholding beneficence, respect for autonomy, and justice in their patient interactions. Simple rules such as, “gabapentin is not on formulary,” are not satisfactory in a setting in which patient concerns about preferred care plans should be approached with nuance and care. The gold standard of just care has been argued to be shared decision making [32]. We suggest here that shared decision making or a similar standard should be employed in every correctional clinical encounter in which there is not a clear-cut care plan. In the final section, we offer recommendations for clinical practice.

### **From Ethics to Clinical Practice**

In this case, Jane reports chronic back and neck pain after a motor vehicle accident. She says that her pain has been improved with gabapentin. In her case, with chronic back and neck pain without an obvious neuropathic component, gabapentin is not recommended as a first-line option, largely due to lack of evidence of benefit [33]. However, at times it is used [off label](#). Other pharmacologic measures (e.g., anti-inflammatories, topical therapies) and nonpharmacologic alternatives (e.g., massage therapy, cognitive-behavioral therapy, physical therapy) might be more effective [34]. However, in our experience, nonpharmacologic measures, in particular, are typically unavailable in correctional settings.

As we have described, arguments exist for prioritizing respect for patient autonomy and health justice in the correctional setting. We therefore suggest that correctional clinicians

openly consider requests like Jane's for continuity in the preferred care plan and work collaboratively with their correctional institution both to distribute medications in ways that reduce the risk of diversion and to offer appropriate, attentive clinical assessment and follow-up.

We wish to conclude by encouraging clinicians to consider several factors that we have witnessed cloud decision making in correctional settings. First, clinicians should be aware of their possible cognitive biases, such as the attribution bias of stereotyping incarcerated patients and the "bandwagon effect" of following restrictive prescribing practices from previous clinicians or other facilities. Second, clinicians should confront their fear that if medication diversion is uncovered, it could reflect poorly on them. Third, because US correctional settings' cultures are typically risk averse and focused on order, clinicians should consider the impact that these factors play in their decision making. Or, stated more positively: How might one's decision making differ in a correctional environment that allows inmates to sunbathe, cook with knives, form a band that performs at music festivals, and play darts [35, 36]?

### **Conclusion**

We propose an ethical test: if prescribing patterns and standards of care differ between community and correctional settings, clinicians and facilities should reflect upon the reasons for the difference. If differences are due to another goal being valued above patient welfare (e.g., decreasing drug diversion, limiting costs, or limiting staff burden), then clinicians should consider whether a change to a more patient-centered approach during clinical encounters or at the facility level could better express respect for patient autonomy and promote health justice.

We acknowledge the difficulties of managing locked facilities safely and the challenges that correctional clinicians face in trying to offer just health care to patients whose liberties are so restricted. However, as we've argued, at minimum, facilities and clinicians should commit to making constant improvement in their care systems to motivate more just care for incarcerated patients.

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