

Episode: Ethics Talk Videocast Transcript – Caring for Incarcerated Individuals During COVID-19 Pandemic

Guests: Brie Williams, MD, MS
Host: Tim Hoff; Audiey Kao, MD, PhD
Transcript by: Cheryl Green

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TIM HOFF: Welcome to another special edition of *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. This episode is an audio version of a video interview conducted by the journal's editor in chief, Dr Audiey Kao, with Dr Brie Williams. Dr Williams is a Professor of Medicine and the Director of Amend at the University of California, San Francisco. She joined us to talk about protecting those among us in and near correctional facilities during a public health emergency. To watch the full video interview, head to our site, JournalofEthics.org, or visit our [YouTube channel](#).

DR AUDIEY KAO: Good afternoon, Brie.

DR BRIE WILLIAMS: Good afternoon. Thank you so much for having me.

KAO: Well, it's actually morning for you, I think. Not quite afternoon.

WILLIAMS: That's true.

KAO: Yeah. Well, thanks for taking time, sharing your expertise on a topic that has arisen from this pandemic, which is caring for those who are in correctional facilities. But before we delve into the many challenges of caring for this vulnerable population, I think our audience would like to know a little bit about how you became interested in advancing the care and well-being of people living in jails and prisons.

WILLIAMS: Sure. Thanks for asking. You know, it really goes back to my medical training. As a third-year medical student in New York, I provided care in my training hospital to a woman who was incarcerated from Rikers Island. And then kind of dial forward several years later, as a resident in San Francisco, I took care of an elderly patient for a San Francisco County jail. And in each instance, I really learned about this incredible social, physical, and mental health vulnerability of the patient population and their extraordinary health needs. And when I became a Fellow in Geriatrics and Palliative Care, I worked with a legal services organization to describe some of the unique health care needs of older adults living in prison. And when I went to do some sort of background research on the area, as any good budding researcher would do, I was essentially shocked to find that there were only two articles on aging in correctional settings at the time. And one was over a decade old, and the other one was in French. So, these experiences really collectively showcased for me the extreme medical vulnerability of the incarcerated patient population and coupled with a startling and extraordinary lack of knowledge about their unique health care needs, especially older adults and people with serious illness, and it made me really determined to focus my career on the area. And so, now I'm a Professor of Medicine, as you said, at the University of California San Francisco, in the Division of Geriatrics in the Department of Medicine where I direct Amend at UCSF.

KAO: So, can you tell us a little bit about the program Amend and what its goals are?

WILLIAMS: Sure. Amend at UCSF is a program that works to transform prison culture, to bring dignity, humanity, and health to both staff and residents through a multi-year program that, really at its heart, is focused on reconceiving of the role of Correctional Officers. Instead of being just guards, they actually become trained in public health so that they can be motivational guides sort of on the front lines, help people who are incarcerated change their lives for the better. And really, Amend has now a very close national network of correctional administrators and health care leaders, but also front line officers and advocates and people who are incarcerated. And so, really, during this whole COVID-19 crisis, it has given us a very kind of unique but real responsibility to help support all these people who are working to abate the potentially devastating outcome of COVID-19 in prisons and jails.

KAO: Yeah, it sounds exciting and challenging to change a culture that most of us only see on TV shows and movies, which is not exactly how you describe what Amend is aiming to do.

WILLIAMS: Yeah. It's daunting, but extremely satisfying and interesting. You know, I worked for many years trying to improve the health and health care of older adults and people with serious illness and then really entire populations of people who are incarcerated. And it took about 10 years for me to realize that I was also dealing with another extremely medically-vulnerable and socially-vulnerable patient population inside prisons, and those were Correctional Officers. They are the unseen, kind of I would say, victims of our system of mass incarceration and criminal justice system. Which is essentially that officers have extraordinarily high rates of multiple medical conditions, some of the same multiple medical conditions that people who are incarcerated have: things like diabetes, heart disease, lung disease, etc. They also have extraordinarily high rates of suicide. And it's estimated that the average lifespan of a Correctional Officer is somewhere in their late 50s.

KAO: Wow.

WILLIAMS: So, basically, officers go to work every day for the state. They come home every day for the state. They work their tails off, they retire, and then they die.

KAO: Wow. Yeah, that's not anything that I think most physicians are aware of or the public at large. So, let's focus on the particular challenges that this pandemic has raised for both people living in correctional facilities and the staff who are there to take care of them. And so, as you know, the U.S. has more people in prison, over two million, and more people in prison per capita than any other country. And people in U.S. jails and prisons are disproportionately men, over 90 percent, in fact, and people of color. In light of the differences that we are currently seeing in COVID-19 case mortality rates based on sex as well as race and ethnicity, what do you think correctional facility leadership and medical personnel should be doing to address these potential health inequities?

WILLIAMS: I think it's important to take a step back to sort of pre-COVID days, although they may seem very, very long ago. Mass incarceration in the United States has been aptly described by some of our closest sociology and criminology colleagues as part of a new Jim Crow era in the U.S. For example, racial and class disproportionality and frankly, gender, disproportionality of policing and criminal justice sentencing mean that more often

than not, those people who end up being incarcerated also have had a lifetime of unequal access to health and social services in the communities before they even set foot in a jail or prison.

But fast forward to COVID-19. And the onset of the COVID-19 pandemic in the United States has really introduced, it really has not introduced new inequities so much as it's forced us to shine a brighter light on the vast inequities that already exist in our public health system. And an unfortunate but very large part of our public health system is the health care that people receive in the criminal justice system. Over two million people are incarcerated, but over 11 million people cycle in and out through jails every year. So, this is an enormous health care system that we're talking about. And it's become clear that this pandemic is exacerbating health disparities in the U.S. and further compromising the health of an already high-needs, medically-underserved patient population. And really, I think the most important thing to recognize right now is that the exceptionally large outbreaks of COVID-19 that we're seeing kind of day after day in correctional facilities right now show us that chief among the affected population of the COVID-19 disaster is going to be and will continue to be incarcerated people.

KAO: Yeah, it's good that you mention the outbreak clusters that we're seeing in correctional facilities, because here in Chicago where I live, there are more than 800 confirmed coronavirus cases in our county jail system. And as of today, April 22nd, there are over 2,100 confirmed cases in a single facility in Ohio. And you mentioned the cycling issue. And it's my understanding that about 200,000 people are booked into jails in a given week during normal circumstances, and about that same number actually leave the prison system in a given week. So, given that, how should we approach addressing the potential of correctional facilities being hotspots for virus spread among inmates, among staff, and frankly, the community at large?

WILLIAMS: It's a great question. So, I think before I answer the direct question about what can we do, it's first very important to review some of the reasons why there is exponential risk for accelerated transmission of COVID-19, and once people have COVID-19 in prisons and jails, why they're exceptionally high risk of poor health outcomes. We need that information before we can begin to really address what can be done.

So, in a nutshell, I'm going to kind of review three of the biggest concerns. First, prisons and jails house very medically-vulnerable patient populations who are living in relatively small spaces. So, it probably sounds like a strange analogy, but just like cruise ships, prisons and jails are communities that are enriched with very medically-vulnerable people: so, a lot of people of older age or with serious or at least chronic medical conditions. And these people are literally eating and working and recreating together in very close quarters, sometimes in dorms that hold 20, 40, 100, 200 people. This alone obviously translates into increased risk of the spread of disease. But this risk is then compounded by very old facilities, which often have inadequate sanitation. Many have inadequate ventilation. And this, coupled with very little space, makes social distancing in many facilities virtually impossible.

The second big problem is that medical treatment capacity is not the same as it is in a hospital. So, correctional health care centers, with very few exceptions, were never built to be acute hospitals. They're built almost like infirmaries, like the school nurse. [chuckles] That's what you can think of them as. They're built to treat relatively mild types of respiratory problems for a very limited number of people. They have doctors and nurses and other exceptionally good health care staff there, but they're designed to stabilize

people, and then if they cannot be stabilized, to triage them and send them out to the outside hospitals. So, many of our nation's over 5,000 correctional facilities are in rural communities. So, you can imagine the impact that an outbreak of a 3,000-person prison could have been a small community hospital that has just four ICU beds.

And then the third big issue is that prisons and jails actually aren't isolated from our community. So, this is the part where they're not like cruise ships. They're not actually sealed off from the outside world. They're not in the middle of the ocean. Hundreds of thousands of Correctional Officers and health care staff enter and exit the facilities every day. So, even if we stop the 200,000 people booked into jail, even if we stop the 200,000 people exiting prisons and jails every week, the staff go in and out, go back to their communities, back to their families, bringing back and forth from families, communities, and prisons and jails, anything that they were exposed to during their workday or during their home life. And so, this is why people in the correctional health care field say correctional health is public health. Decreasing risk in prisons and jails must happen in order to decrease risk of spread in our communities.

So, then the next question—and this is a long answer, and I apologize—but the next question then that you asked is so then, how do we decrease risk? What do we do? And now that we have a sense of these are the three main issues, I think it's a little bit easier to break down what we can do. And the first is the hardest. It's that we have to take a rational public health approach to the problem. And a public health approach to overcrowding in old systems where there's no capacity to socially distance means that we have to decrease the institutionalized patient population. This means, from a public health perspective, we have to decarcerate. So, there's a few things that we can do.

We can develop emergency multidisciplinary task forces that assess people who are older with serious medical conditions for their suitability for release. Which basically means having an access-to-health care plan on the outside, having a home or at least a non-overcrowded institution like a halfway house where they can practice social distancing and follow local shelter-in-place-mandates. The second is that we should use the multidisciplinary task force also to identify anyone, even those who aren't ill, who are suitable for release, basically anyone deemed not an immediate threat to the community. Because reducing the overall patient population means that then medical professionals inside prisons and jails can spread their clinical services throughout the remaining population more efficiently. And they can also help them to have more space to socially distance among the remaining population. And then the third—and I'm almost done—

KAO: [chuckles]

WILLIAMS: —is that we need to create social distancing plans in prisons and jails for the people who remain, who cannot leave. Basically, the goal is that with decarceration of absolutely anybody that we can get out safely, we have a smaller population left and that health care and correctional leadership can come together and institute shelter-in-place and medical isolation and quarantine protocols for those who remain.

One idea that our team has is to develop mini communities where basically we have eight to 10-person groups that almost function like a household. And there's correctional staff that are specifically assigned to that group, and they have staggered recreations, staggered meal times. But it also, having this group allows officials to identify and isolate and then immediately quarantine a small group if there's a confirmed case so that they can keep the rest of the prison moving and not locked down while they quarantine sort of mini

group by mini groups. So, these are some sort of examples of what people are talking about.

KAO: Yeah. Let me follow up on that. You mentioned that one of the solutions was to decarcerate, which basically would reduce the population density in these correctional facilities. And about a year and a half ago, you wrote an article in the *AMA Journal of Ethics* on the topic of compassionate release of incarcerated patients with serious illnesses. And the recently passed \$2,000 trillion, actually \$2 trillion+ Pandemic Relief Act expanded the number of federal inmates who would be eligible for home release. And like you were saying, you and other experts have advocated for decarceration and more release of prisoners, including those, for example, that are convicted of non-violent offenses. That being said, few states, if any, have meaningfully done so. Given that, what do you think are the barriers for implementing these types of recommendations, and why haven't states been more proactive about it?

WILLIAMS: I have three answers. Also an exceptional question. The first, I'm only going to say this because this is the *AMA Journal of Ethics*. [laughs] I feel like your listenership and readership can handle this. But one problem is this idea of non-violent offenses. The people who are most elderly, who are most sick, who are most frail, some of those people are people who, in the 1950s, 1960s, were sentenced for a murder charge. Some of those people are women who are 80 years old, who were sentenced to murder for murdering their abusive spouse who was a police officer. There are people who are there who are incarcerated for violent offenses, who had an offense that has been kind of the time, they have paid time. They have paid time. They have made amends. It has been decades and decades and decades. And at some point, we do have to look at the people who are there for quote-unquote "violent" offenses and not ask what was the offense, but ask, are they still a threat to society? And if they're not, then we also have to include people with violent, so-called violent, offenses. Because people with non-violent offenses can be a threat to society, and people with violent offenses are not necessarily a threat to society. It depends on what happened in terms of the sentencing and what they were sentenced for, etc. So, the first question is, to help the advocacy, the lawyer advocacy community weigh in a little bit more on what does that mean to have a violent offense five, six decades ago and now to be 90 years old? Are you still a threat to the community?

The second problem is that many medical doctors honestly have not been well trained to prognosticate. And because our team has been working on how to achieve improved evidence-based compassionate release for many years, we actually developed a video resource for correctional clinicians on prognostication in the setting of COVID-19 outbreak. And we're hearing from correctional clinicians on the front lines this is the first time that they've ever really learned—

KAO: Hmm. Interesting.

WILLIAMS: —about the science and the clinical rationale around prognostication. And so, that's available on our website.

And I'll just finally say that it is way past time to bring health care professionals into decision-making around public health-driven decarceration. Because the main problem, the main problem is that although releases have increased in some places, most efforts are focused on reducing overcrowding by releasing people who are awaiting trial or who have exceptionally minor charges or violations of their parole (they haven't even done something illegal). But these are extremely modest, I mean, tiny reductions, and they do

almost nothing to harness the knowledge of medical experts about how to meaningfully reduce risk for older and seriously ill incarcerated people and those with chronic diseases. So, what we need is actually public health-focused response, public health-focused decarceration, which is honestly led by medical and public health professionals. Because doctors and our allied health professionals, we cannot help decarcerate the prisons if the policy makers won't let us help them.

KAO: Do you want to plug that website you were mentioning just a moment ago?
[chuckles]

WILLIAMS: Oh, I would love to: www.Amend.us/COVID.

KAO: Well, thank you. I think that that would be a very valuable resource for many of our physician audiences listening to this interview.

So, we're getting close to the end of our interview. But I wanted to give you a chance to speak to what you think health professionals should understand and be doing to support their colleagues working in correctional facilities across the country during this pandemic.

WILLIAMS: Yeah. That's a great question. There are a number of things. I'm just going to, because we are kind of almost at our time limit, I'll just leave you with a few thoughts. First, I think health professionals and public health agencies should proactively reach out to correctional health care professionals, our colleagues in correctional health care facilities who are working day and night overwhelmed. There are a lot of correctional physicians that are like Chief Medical Officers that I know at prisons that haven't slept in two months. They are doing absolutely everything that they can to prepare their facilities for an oncoming plague. And they need partnership from public health. They need partnership from epidemiology. They need thought partnership to help ready their correctional facilities as best as they can and to respond to an outbreak once it occurs. And those are things like identifying appropriate places in the prison to develop a medical isolation or quarantine wing, to help think about how to create places where patients can socially distance, to figure out where to put people who are exceptionally ill or older who can't get released.

The second thing that public health agencies need to do is to be working together to factor the correctional facility into the county's pandemic planning. So, again, patients are going to be transferred to local hospitals for serious disease. And if you've got four ICU beds and 3,000 prisoners—

KAO: Right!

WILLIAMS: —in a nearby community, you're going to get overwhelmed.

KAO: Talk about supply and demand there.

WILLIAMS: Exactly.

I think another issue is that local public health departments and county hospitals can be thinking about how to deal with nearby correctional health workforces that may fall ill. And so, developing emergency credentialing plans for health care providers if there's an outbreak. I mean, tragically, in Louisiana, a couple days ago, a Warden and a Chief Medical Officer and a patient all died in a Louisiana prison.

KAO: Mm.

WILLIAMS: This was two days ago. So, suddenly you have not just an outbreak among correctional staff and among patients, but you also have an outbreak among the physicians and the other health care professionals. That local community needs to think about how can we get some clinicians in there to quell this outbreak?

And then finally, I would make a plug for my fellow geriatricians and palliative care doctors. You know, even geriatricians and palliative care doctors in academic centers and those who are working sort of in the hospitals, in the communities, we have a real opportunity to support our correctional colleagues. This is a geriatric health care emergency.

KAO: Right.

WILLIAMS: And we have a responsibility to bring the knowledge and the training that we have to support our colleagues in correctional systems so that we can help to bend the curve of this devastating pandemic.

KAO: Well, Dr Williams, thanks again for being a guest on *Ethics Talk*.

WILLIAMS: Thank you.

KAO: And thank you again for sharing your insights and enlightening our audience on a topic that I think needs to have more light shown on it.

WILLIAMS: Thank you so much for having me. I really applaud you for thinking about this topic as worthy of your listeners. And thank you so much to all of you for listening.

KAO: Yeah. So, for more COVID ethics resources, please visit the AMA JournalofEthics.org. And to our viewing audience out there, be safe, be kind, and be well. We'll see you next time on *Ethics Talk*. [bright theme music plays]