more, the Court's finding that New York's restrictions were not narrowly tailored because there was no evidence of viral transmission in the petitioners' houses of worship and because other states had looser regulations suggests that states will not be able to act before super-spreader events occur or as long as other states take a more lax approach.

This development presents states with a dilemma. In the absence of a national pandemic policy or sufficient stimulus support, many governors have responded to the new surge in Covid-19 cases by imposing fine-tuned restrictions in an attempt to protect health without decimating the economy. Some of these measures have affected religious liberty in troubling ways; others are epidemiologically questionable.[5] For example, Rhode Island has banned all social gatherings in homes while allowing catered events.[5]

Unquestionably, courts must ensure that such measures do not serve as a pretext for discriminating against vulnerable people or quashing protected liberties. Nevertheless, the Court's approach in *Roman Catholic Diocese* devalues federalism and public health, making it difficult for states to rely on science and craft fine-tuned measures in response to local conditions. Although courts should not abdicate their role during a pandemic, they also should not rush to assume an expertise they lack.

Already, the case's effects have been felt. In December, the Court ordered a lower court to reconsider its rejection of a challenge to a California regulation that affects in-person worship. Beyond the pandemic, *Roman Catholic Diocese*'s most important legacy may be the dethroning of *Jacobson*. Gorsuch is correct that *Jacobson* was not a free-exercise case and does not control such claims. Still, for more than 115 years, *Jacobson* has been the key precedent supporting vaccine mandates and other public health laws. It has also served as a reminder of the importance of public health evidence and the fact that "real liberty" cannot exist in the absence of reasonable restraints to protect the public's health. With *Jacobson* apparently sidelined, the future of many public health laws, including and especially vaccine mandates, appears perilous.

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1. Roman Catholic Diocese of Brooklyn v. Cuomo, 592 U.S. (2020).
2. Jacobson v. Massachusetts, 197 U.S. 11 (1905).
3. South Bay United Pentecostal Church vs. Newsom, 590 U.S. (2020).
4. Calvary Chapel Dayton Valley v. Sisolak, 591 U.S. (2020).
5. Mull A. The logic of pandemic restrictions is falling apart. Atlantic. November 25, 2020 (https://www.theatlantic.com/health/archive/2020/11/pandemic-restrictions-no-logic/617204/).

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Incarceration and Social Death — Restoring Humanity in the Clinical Encounter

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Mr. S., a 28-year-old Black man, arrived at our emergency department (ED) by ambulance after exhibiting altered mental status and agitation in jail. While in solitary confinement for 4 days, he repeatedly and unsuccessfully sought the attention of the medical staff. He was brought to the ED after the jail staff noted that he was confused.

Mr. S.'s breathing was agonal, so he was intubated. He had a core body temperature of 26.8°C, multiple sacral decubitus ulcers, and sequelae of severe hypothermia. He was resuscitated, actively rewarmed, and admitted to the intensive care unit (ICU).

Mr. S.'s medical records documented previous ED visits for "medical clearance" after injuries sustained during multiple arrests: closed head injuries, contusions, abrasions, and Taser injuries. He was noted to be "belligerent" and "uncooperative" with police officers and ED staff. Some clinicians had speculated about possible substance use or underlying psychiatric diagnoses, though neither was confirmed by the patient or elsewhere in his record. Each time, he was deemed "safe for discharge" to jail. No further

information was recorded regarding his social situation, the reason for his anger, or the context of his arrests.

Debriefing with the ED team after Mr. S.'s ICU admission, the attending physician noted that the differential diagnosis for hypothermia is broad, but severe hypothermia and sacral decubitus ulcers were consistent with being kept in solitary confinement under inhumane conditions. Several team members countered that Mr. S. had probably been isolated because he was confrontational with jail staff. The attending noted that Mr. S.'s decubitus ulcers showed that he had needed medical attention for more than a day. In that time, he had no power or capacity to advocate for his own safety or health, let alone exacerbate his condition with "belligerent" acts.

In addition to highlighting the deleterious health effects of solitary confinement, Mr. S.'s case illustrates the condition of "social death," in which a person is not accepted as fully human and is treated as a "nonperson" and discounted in social terms.[1] Social death is ritualized — achieved through a set of structures, processes, and symbolic acts that govern the terms of exclusion from society. The result is a loss of one's social roles and, consequently, all significant components of one's identity. This loss of essential personhood is tied to one's perceived social value: the biologic death of a socially dead person is not considered a loss to society. Incarceration fundamentally enacts these processes by separating people from society and inflicting "a series of abasements, degradations, humiliations, and profanations of self."[2]

Solitary confinement, which deprives incarcerated persons of normal, direct, meaningful social contact and environmental stimulation, represents an extreme enactment of social death.[3] It occurs after someone has been rendered "rightless," granted theoretically inalienable rights or humane treatment only as a privilege or a conditional gift (e.g., for "good behavior").[4]

EDs — and hospitals more generally — may intersect with the carceral system and participate in processes of social death. When arrestees are brought to jail, they're evaluated by a nurse who determines whether an ED visit is needed for "medical clearance." If so, they are transferred to the ED with the arresting officer and undergo evaluation. They are "cleared" if they have no physical illness, exacerbation of a chronic illness, or medical condition requiring inpatient treatment. Once imprisoned, they may be taken back to the ED to be evaluated for serious illness or injury. Within these clinical interactions lie critical decision points for restoring social life and recognizing someone's humanity.

The clinical encounter may either reinforce or resist the process of social death. Mr. S.'s case highlights the important role that physicians who work outside the carceral system can play as patient advocates in the carceral process and the role of clinical documentation in humanizing patients. Clinical documentation is intended to "objectively" record patients' symptoms and physical findings and to communicate treatment plans, but it also incorporates subjective judgments and observations that may humanize or dehumanize a patient, shaping future clinical interactions and the treatment course.

The ED team read Mr. S.'s chart, for example, when he was too ill to provide a history or advocate for himself. Although he received the standard of care for severe hypothermia, the documentation describing him as "difficult" and "belligerent" led some clinicians to overlook the sacral decubitus ulcers and conclude that the delay in treatment was understandable or justified. Mr. S.'s social death was thereby reinforced.

Social death — in which patients are considered "as good as dead" — also applies to entire groups of people who are treated as nonpersons. This concept can help clinicians recognize the importance of clinical encounters and medical records to the processes by which vulnerable populations are abandoned. Clinicians have the power to intervene or interrupt these processes by recognizing and acknowledging patients' humanity.

Physicians can recognize their own biases and resist participating in processes of social death. By empathizing with and advocating for patients, clinicians can humanize them and resist their social abandonment — necessities for providing high-quality care. Bourgois et al. suggest that clinicians ask themselves questions such as, "May some service providers (including me) find it difficult to work with this patient?" and "Could the interactional style of this patient alienate some service providers, eliciting potential stigma, stereotypical biases, or negative moral judgment?"[5] These questions provide useful starting points for mitigating blame and dehumanization

within clinical interactions. If an interaction seems difficult, physicians should consider the underlying reasons: Does it make the physician uncomfortable? Demand time that's in short supply? Challenge ethical norms or complicate clinical decision making? These questions may help physicians identify and overcome potential biases.

In clinical notes, physicians can avoid stigmatizing or dehumanizing language (e.g., "belligerent" or "malingering") that implies fixed personality traits, places blame on patients, and negatively influences future caregivers. They should understand that anger is often a product of a situation or context and shouldn't be readily dismissed as a consequence of personal shortcomings, substance abuse, or psychiatric conditions. Physicians can incorporate humanizing information about patients and their stresses, struggles, and frustrations. They can ask open-ended questions and note patients' fears, anxieties, or fraught relationships with institutional authorities owing to experiences of violence or other difficulties. Empathetic interactions impart humanity and help ensure delivery of equitable, high-quality care.

Second, physicians are well positioned to bear witness to the physical and mental consequences of incarceration and solitary confinement and to advocate for patients' welfare. Although advocating for incarcerated patients may seem daunting, it's important to clearly delineate their medical needs, communicating that information to patients themselves and detailing it in discharge or transfer records. In addition, medical–legal partnerships offer patients access to legal expertise for navigating concurrent medical and legal difficulties.

Finally, physicians can lobby for carceral reform. The United States has the world's highest incarceration rate, and Black people are disproportionately targeted for incarceration. These disparities result from structural inequities within the legal system and are intertwined with pervasive racism. Incarceration not only has devastating effects on individuals and communities, but it also threatens public and individual health, fueling chronic disease and mental illness. Though people must receive medical care while incarcerated, treatment usually stops when they're released, especially if they lack insurance, as most do. After release, the risk of requiring emergency care or hospitalization and the risk of death are high. Thus, the carceral and mainstream health care systems are interrelated.

Physicians can leverage their social capital and moral authority to improve health care quality within and after release from the carceral system, while recognizing the fundamental differences between the ethical frames of carceral and health care systems. They can, for example, invite previously incarcerated patients to help educate trainees and colleagues about the conditions of incarceration and their health consequences. Physicians can participate in efforts to redistribute public funds toward mental health, housing, and other social services. They can advocate for professional societies to issue policy statements on prison reform and for legislatures to improve transitional care programs for people released from incarceration. Incarceration's processes of social death strip prisoners of their rights. Doctors can restore social life through interactions and documentation that recognize the humanity of people who've been rendered socially dead.

After a protracted hospitalization, Mr. S. was discharged back to jail. His functional status, however, was worse than that before his incarceration.

Identifying details have been changed to protect the patient's privacy.

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