

POLICY FORUM

Surgery in Shackles: What Are Surgeons' Obligations to Incarcerated Patients in the Operating Room?

Sara Scarlet, MD, and Elizabeth Dreesen, MD

Abstract

Incarcerated patients frequently require surgery outside of the correctional setting, where they can be shackled to the operating table in the presence of armed corrections officers who observe them throughout the procedure. In this circumstance, privacy protection—central to the patient-physician relationship—and the need to control the incarcerated patient for the safety of health care workers, corrections officers, and society must be balanced. Surgeons recognize the heightened need for gaining a patient's trust within the context of an operation. For an anesthetized patient, undergoing an operation while shackled and observed by persons in positions of power is a violation of patient privacy that can lead to increased feelings of vulnerability, mistrust of health care professionals, and reduced therapeutic potential of a procedure.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

Hippocratic Oath [1]

We are men: We are not beasts and we do not intend to be beaten or driven as such.

L.D. Barkley [2]

Introduction

Providing health care to patients within the criminal justice system presents unique challenges. This is especially true for incarcerated persons requiring surgery outside of the correctional setting. Under these circumstances, the privacy at the core of the physician-patient relationship must be balanced against the need to control the incarcerated patient for the safety of health care workers, corrections officers, and society at large. For incarcerated patients requiring surgery, this tension between privacy and control exists throughout all phases of surgical care—from the office, where corrections officers observe the history and physical; to the operating room, where

patients are, in our experience, sometimes shackled to the operating table and observed throughout the duration of a procedure.

Respect for [patient privacy](#) is critical to the development and maintenance of trust in one's physician. The belief that sensitive information will remain confidential can enable patients to reveal disturbing and painful information that might be essential to the physician and the patient during the decision-making process. The patient's willingness to reveal information and subsequently to believe that the physician is accurately representing medical problems, treatments, and alternatives are all based on trust. Conversely, patients who distrust their clinicians might be more reticent to discuss personal information. In turn, decision making based on inaccurate or incomplete information might contribute to inappropriate tests, ineffective treatment plans, and costlier care [3]. Patients who distrust their clinicians are less likely to adhere to treatment plans, seek medical care, or consent to undergo a surgical procedure [3]. Surgeons recognize the heightened need for gaining a patient's trust within the context of an operation, in which patients lack the ability to protect themselves and must completely depend on the "knowledge, skills, and professional integrity" of the surgical team [4]. Without trust, the potential benefits of surgical intervention can be outweighed by the fear and vulnerability that such interventions engender.

In the United States, a patient's right to the privacy that enables trust is not solely upheld by ethical values—the Constitution also affords citizens a legal right to privacy. For example, the 1973 ruling in *Roe v Wade* upheld a person's right to privacy, justified by the First, Fourth, Ninth, and Fourteenth Amendments [5]. Additionally, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 specifies requirements for maintaining patient confidentiality for health care professionals, insurance plans, and health care systems [6, 7]. The creation of HIPAA reflects recognition of the sensitive nature of patient health information and the need to protect this information in order to prevent harms. Of note, the HIPAA regulations specifically state that inmates' individually identifiable health information is not excluded from the definition of protected health information (PHI) [8]. It thus must be kept confidential, with the exception of situations in which covered entities, such as prison clinics, can disclose PHI to a correctional institution or to law enforcement officials for the provision of health care or if the safety of the patient, other inmates, corrections officers, or the correctional facility is jeopardized [8].

Issues of privacy and trust are particularly acute for incarcerated persons. Incarcerated persons are often from medically underserved populations and include ethnic minorities, who tend to have higher levels of [distrust](#) in the health care system [3, 9, 10]. Many incarcerated persons have experienced physical violence and sexual assault [11]. Mental illness is also common [9]. These types of experiences can heighten incarcerated persons' feelings of vulnerability and hinder the development of the mutual trust

between physicians and incarcerated patients that is required for treatments to be accepted and effective. Unfortunately, providing health care to incarcerated patients presents additional obstacles to building mutual trust. Unlike the general population, incarcerated patients are unable to choose their physicians and freely contact them with questions or concerns, and they are afforded few opportunities to interact with health care professionals in the clinical setting without observation by a corrections officer or without being in the presence of physical barriers. In this paper, we explore the tension that exists between trust and safety when incarcerated persons require surgical care.

The Need for Trust during Surgical Procedures

Undergoing an operation is one of the most vulnerable patient experiences in all of medicine. Patients agree to be naked and unconscious in front of strangers and to be cut open. During this period of unconsciousness, patients trust surgeons to honor their wishes and act in their best interest when presented with the unexpected. Afterwards, they accept reduced strength and functionality for the length of recovery or even permanently. For patients alert to the potential danger of postsurgical effects that might render them unable to protect themselves in their lives as incarcerated persons, these vulnerabilities are significant. In contrast, in noncorrectional settings, the therapeutic goals of surgery and the respect, care, and confidentiality provided by the surgical team can help mitigate this sense of vulnerability.

The authors have cared for incarcerated patients in the operating rooms of multiple hospitals and have frequently witnessed these patients, for the duration of their anesthetic and operation, either attended by armed guards or shackled to the OR table. In the authors' current home institution, the level of security for incarcerated patients within the hospital is ultimately the responsibility of the prison agency. In the operating room, security is maintained by accommodating hospital stipulations agreed upon by the custodial agency, hospital police, and clinical personnel. Frequently, two armed guards are present observing the entire surgical procedure. It is difficult to know the extensiveness of such practices; however, evidence suggests that they are not unique to the authors' institution [12, 13].

Undergoing surgery in the presence of persons in positions of power while physically restrained has the potential to limit trust between surgeons and patients. Corrections officers able to observe an operation might purposefully or inadvertently reveal private information gleaned during the procedure. If corrections officers who are insensitive to issues of privacy purposefully reveal these details to others in the correctional setting, stigmatization or even abuse of incarcerated patients might result. For those who learn of privacy violations, mistrust will replace any trust they might have established with their surgeon.

The Need for Safety during Surgery

Restraints and surveillance are sometimes appropriate in clinical settings, when patients pose a risk to the safety of others or might attempt to escape. Neither rationale seems particularly applicable to the intraoperative period. While it is possible that a patient could escape from the operating room before or after a general anesthetic, it is unlikely that this would occur once a procedure is underway. Anesthesiologists, with their armamentarium of paralytic and sedative medications, are well versed in treating a heightened level of consciousness during an operation. Nearly all perioperative staff members are accustomed to treating patients who develop “emergence delirium,” a state “characterized by transient agitation, confusion, and violent physical and verbal behavior” [14]. It is likely that an incarcerated patient attempting to commit a violent act or escape during the intraoperative period while still under the influence of anesthesia would behave similarly and could be easily chemically restrained by anesthesiologists.

It is feasible that an accomplice could assist an incarcerated patient in escaping from the operating room; however, correctional facilities avoid informing incarcerated persons of the location or timing of health care encounters in an effort to reduce the likelihood of this occurrence. Additionally, allowing corrections officers to guard any entry points to operating rooms would protect against this threat without privacy violations.

Precedents and Paradigms

The Prison Rape Elimination Act (PREA) is a federal law passed in 2003 with the intention of preventing sexual abuse within correctional settings [15]. Recognizing that vulnerabilities of incarcerated persons can result in an increased risk of victimization and abuse, PREA national standards prohibit certain procedures that might lead to abuse [16], including cross-gender pat downs of females in facilities with a maximum of 50 inmates “absent exigent circumstances” and cross-gender strip searches and cross-gender body cavity searches “except in exigent circumstances or when performed by medical practitioners” [17]. Additionally, inmates are allowed “to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks” [17].

Should the principles and language of the PREA national standards—created to reduce victimization and sexual abuse of incarcerated persons by corrections staff—be extended to and used in the OR? In the OR, the majority of patients undergoing surgery will have their clothes removed, as they would in a prison shower or changing room. Patients might undergo procedures on the breast, buttocks, or genitalia, during which these areas are exposed for the entirety of the procedure. It is possible that patients would regard other operations not involving these areas to be considerably revealing as well. The PREA exception to the cross-gender viewing prohibition raised privacy concerns [16]; similar violations of privacy within the health care system can reveal

patient vulnerabilities and might translate into abuse and victimization of incarcerated persons within the correction setting. Thus, preventing corrections officers from viewing a patient's surgery, irrespective of which body part it is performed on, would be an appropriate extension of the PREA. Extending the PREA protections to incarcerated patients undergoing surgery would help preserve the trust between these patients and their physician that is part of a true therapeutic relationship.

Crafting Policy to Balance Trust and Safety

According to feminist ethics theory, a "rich empiricism" should inform decisions and policy [18]. In our opinion, policies directing care of incarcerated patients in the surgical setting should reflect the prevalence of events that breach safety. While it is essential that appropriate safety precautions be taken when caring for incarcerated patients outside of the correctional setting, little data exists regarding actual safety breaches during these episodes of care. It is unclear, for instance, how often incarcerated patients attempt to escape from the surgical setting. Going forward, observational data regarding safety breaches should be collected and used to develop policy related to guards and the shackling of incarcerated patients in the OR. At present, it is unclear whether current policies are justified in protecting safety given their questionable effectiveness and propensity to erode trust between surgeons and their patients.

Recommendations for Surgeons

In light of our conclusions, we set forth several recommendations.

1. Surgeons should discuss institutional practices regarding corrections officers and shackles during [informed consent](#) discussions with incarcerated persons, thereby allowing incarcerated persons to factor the potential implications of these practices into their decision-making process.
2. Surgeons should work with correctional staff to remove shackles while a person is fully anesthetized.
3. If correction officer presence during an operation is required, corrections officers should be positioned in operating rooms in locations where they are unable to observe elements of the procedure.
4. Operating room staff should not discuss patient health information in the presence of corrections officers or, at minimum, avoid discussing information irrelevant to the operation being performed.
5. Surgeons, health care systems, and correctional institutions should rely on data to guide policy creation. Minimally, efforts should be made to compile epidemiologic data regarding safety breaches during the perioperative period.

Conclusion

The experience of incarceration is one of social isolation and loss of control. Incarcerated patients, however, still have autonomy in medical decision making, as demonstrated by their ability to consent to medical and surgical treatments. Incarceration therefore

should not include unnecessary violation of a patient's privacy or dignity since it can contribute to distrust in the clinician-patient relationship and interfere with autonomy in medical decision making. All patients with decisional capacity, regardless of whether they are incarcerated, have the right to make medical decisions free from coercion and have adequate information to make choices. Within the context of surgical care, autonomy depends on trust in one's surgeon to honor one's preferences in the operating room.

Although legislation such as the PREA is demonstrative of incremental attempts to recognize and protect the privacy of incarcerated people, there is much progress to be made. We contend that shackling a person to the operating table in the presence of armed corrections officers is an inappropriate means of exerting control. There is no evidence that we know of indicating that incarcerated patients have threatened the safety of corrections officers, operating room staff, or society at large during the intraoperative period. In contrast, the potential harms of this practice—violations of privacy, victimization of incarcerated persons, and undermining of the clinician-patient relationship—are considerable. Providing high-quality surgical care to incarcerated patients necessitates the development of trust between physicians and patients. We must unlock the shackles as we unfurl the drapes.

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