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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Physicians Manage Traumatic Injuries Sustained During Incarceration?

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Abstract

Patients who are incarcerated experience severely restricted autonomy and are thus extremely vulnerable. This commentary on a case offers longitudinal, long-term postsurgical trauma-informed care recommendations and starts with a working assumption that, when injuries sustained during incarceration require surgery and hospitalization, patients' rights to evidence-based standard of care that would be given to any other patient should not be compromised. Yet surgical care of traumatically injured patients who are incarcerated can be ethically and clinically complex due to their status as wards of the state, which abrogates their liberty to make their own health decisions. Patients who are incarcerated also have preexisting trauma and are at risk for violence and persistent traumatic stress.

Case

CC is a 43-year-old patient who presented as a high-level trauma code to the emergency department after an altercation in his prison. Epidural hematoma was suspected immediately upon his arrival, and, during diagnostic imaging, CC became obtunded. A neurosurgeon, Dr N, was consulted and CC was taken emergently to the operating room for a craniotomy and transferred to the neurosurgical intensive care unit (ICU). A tracheostomy and percutaneous endoscopic gastrostomy (PEG) tube were placed for prolonged ventilatory support and enteral nutrition.

CC regains capacity to interact meaningfully with others after 2 months in the ICU. CC is weaned from the ventilator, continues to breathe room air via tracheostomy-mask; CC's central line is removed, but a PEG tube and Foley catheter remain in place. CC is anxious and agitated and does not remember why they are in the hospital. Dr R, a surgical fellow, wonders how to respond to CC's questions about their injuries, surgical recovery, and returning to prison.

Commentary

Care of the patient who is incarcerated is often complicated due to the decreased level of autonomy and privacy afforded to the carceral population. Patients who experience a physically traumatic event while incarcerated are often left with psychological trauma

from both the traumatic event and the subsequent care they receive due to unexpected exposure, procedures, and actions. In this case, Dr R tries to reincorporate CC into health decision-making and address their trauma and subsequent return to the carceral facility. The following sections review preservation of CC's autonomy, management of traumatic stress, and transitions of care for a trauma patient who is incarcerated.

Dignity

Patients who are incarcerated legally retain their right to make health care decisions, name a surrogate decision maker, and make advance care plans for contingencies in which they might not have decision-making capacity.[1] Accordingly, all carceral patients or their surrogates are entitled to the timely and accurate release of information necessary for the exercise of medical decision-making autonomy. If a surrogate is acting for a patient, certain information might be withheld for safety considerations or in compliance with institutional policies, including the patient's exact location. Therefore, the surgical care team needs to ensure carceral systems' release of appropriate information; any obstructions to obtaining information might require additional coordination with carceral leadership or involvement of hospital ethics, hospital leadership, and legal counsel.[2]

Several factors are more common among patients who are incarcerated: traumatic brain injury (TBI), less health literacy, and untreated psychiatric illness.[3,4] Each of these factors can influence communication but do not preclude a patient having decision-making capacity. To help maintain patients' dignity and autonomy, capacity determination should be a fluid process wherein a patient's cognitive status and desires are continually reassessed with empathic interviewing and open-ended questioning. For patients who have been determined to lack capacity, initial stabilization in a medical emergency can be performed with implied consent, but subsequent care requires a substitute decision maker. Selection of an appropriate surrogate might be complicated by the limited communication allowed once an individual is incarcerated. Similarly, friends and family might become estranged or might not be aware of the patient's most recent wishes or goals of care. In the absence of advance directives, surgical team members should become familiar with the surrogacy hierarchy set by state legislation.[5] While prison employees could be present during decision-making conversations, their involvement should be prevented as there is an inherent conflict of interest due to their competing obligations to the correctional system and the patient.[6,7] Observing these guidelines allows the carceral patient's autonomy to be respected during the consent process.

Trauma-Informed Emergency Surgical Care

Patients who experience traumatic injury while incarcerated are uniquely vulnerable to traumatic stress. Men like our patient CC have a high prevalence of exposure to traumatic events, including witnessed or direct violence, sexual assault, and childhood abuse.[8] Incarceration can create or worsen existing trauma due to the loss of autonomy, active isolation, lack of purpose and mental stimulation, and persistent prevalence of violence. Data from the 2004 Survey of Inmates in State Correctional Facilities indicated that 14.7% of individuals who were incarcerated had suffered violence-related injuries while imprisoned.[9] Yet such patients might not seek or receive care. The justice-involved population disproportionately includes persons from marginalized communities where current and historical abuses have led to medical mistrust.[10,11] Furthermore, in one study, 42% of patients who were formerly incarcerated expressed that they had

experienced health care discrimination as a direct result of their previous incarceration.[12]

In the setting of emergent surgical care, patients who are incarcerated might develop medical trauma or traumatic stress due to their experiences with the medical system. Following life-threatening traumatic injuries, patients might be placed in urgent situations wherein the primary goal is to ensure medical stability. This attempt to maximize possible medical benefits for a patient frequently occurs at the cost of consent processes because the patient is incapacitated. The aftermath of these medically necessary interventions could cause distress due to alterations in personal body image, feelings of helplessness or humiliation, decreased perceptions of autonomy, and altered levels of consciousness.[13]

Each member of a trauma care team must be aware that the discussion of procedural interventions, physical injuries, postoperative recovery, and postoperative rehabilitation could lead to the patient's reexposure to traumatic elements. Clinicians should aim to follow tenets of trauma-informed care as defined by the Substance Abuse and Mental Health Services Administration. These tenets include the realization that trauma can affect families and communities as well as individuals, recognition of signs of trauma, and avoidance of the re-creation of interactions or environments that could lead to retraumatization.[14] This approach calls for ensuring appropriate psychiatric screening, respecting patient boundaries, reacting in a culturally sensitive manner, avoiding expression of judgment or intrinsic biases, and development of a relationship with the patient while reinforcing physical and psychological safety. Suggested benefits of integration of trauma-informed practices include improved outcomes in terms of treatment adherence, health care equity, and staff factors such as burnout.[15] Involving mental health services, screening for acute and chronic stress disorders, and treating preexisting mental health conditions starting as soon as patients present to the emergency department might allow patients to better recover from the psychological trauma of emergent surgical care.[16]

Importance should be placed on ensuring transparency by identifying all clinicians during each encounter, giving patients the rationale behind treatments performed or recommended, and providing patients with choices. Patients should also be allowed to self-identify their gender and ethnic or cultural background and should be encouraged to express preferences for their care. For more sensitive exams or evaluations of wounds, physicians should notify patients of the expected steps and provide as much privacy as can be afforded while maintaining clinician safety. Clinicians should be mindful of the signs of a stress response patients may demonstrate, such as decreased focus, hyperarousal, increased rate of breathing, sweating, or agitation, and offer empathy while assessing and addressing patient concerns. Especially for patients with existing medical trauma or mistrust, interactions should focus on the formation of rapport to strengthen the patient-clinician relationship and rebuild trust in the medical system.

Although the patient's final disposition might not be flexible, individuals who are incarcerated should be treated with evidence-based practices based on community standards of care. Despite limited research on enhanced recovery in trauma patients, in general, postoperative patients should receive interventions such as early mobilization, use of enteral nutrition, early removal of lines (including urinary catheters), appropriate pain control with multimodal regimens, and respiratory physiotherapy.[17] Yet, in a survey published in 2022 of 76 clinicians at a hospital servicing the local county jail, 29% of

clinicians (physicians and nurses) reported believing that patients who are incarcerated received fewer diagnostic tests or medical interventions than those who are not incarcerated and 79% of physicians agreed that they felt patients who are incarcerated received fewer ancillary services such as social work or physical therapy.[18]

While patients are in hospital, clinicians should not seek to limit treatment based on perceived resources that might be available to patients who are incarcerated following discharge. For example, use of narcotic pain medication in a multimodal regimen should be used cautiously but not avoided due to concern for opioid dependence or medication diversion, especially as uncontrolled pain in the peritraumatic time period has been associated with future development of posttraumatic stress disorder (PTSD).[19] Physicians should additionally advocate for alternative restraints for patients to be able to benefit from mobilization. Finally, the surgical team should minimize psychological disruptions during hospitalization by ensuring appropriate nutrition, facilitating good sleep hygiene, and decreasing unnecessary lab tests or studies.[20] In the above case, CC should be provided with speech therapy, respiratory interventions, catheter removal, physical and occupational therapy, and nutritional optimization, along with any other interventions deemed necessary to maximize his chances of returning to his prior level of capability.

Postsurgical Carceral Reintegration

Prior to discharge back to custody, the surgical care team must ensure that all active medical problems have active treatment plans capable of being continued in a prison setting, as well as appropriate follow-up. During their hospitalization, patients should be evaluated for psychopathology, including traumatic stress disorders, substance use disorders, and other mental health conditions. For patients with evidence of PTSD, providing trauma-focused therapies, including but not limited to psychotherapy, cognitive behavioral therapy (CBT), and counseling services, might help patients develop healthy coping strategies and avoid recidivism.[21] Screening for TBI, which can be associated with uninhibited or impulsive acts, attention deficits, and slowed or altered responses that could be misinterpreted by correctional staff or other incarcerated individuals,[22] similarly would allow for occupational therapy interventions in preparation for return to the carceral setting. Hospital social work coordination with prison social workers should allow for assessment of patient needs for planning not only for return to prison but also for subsequent reentry into the community. In severe circumstances wherein a patient who is incarcerated sustains debilitating injuries to the extent that their prognosis is limited or that they have medical needs unable to be met while imprisoned, clinicians should consider seeking medical clemency based on the eligibility criteria of the state of residence.[23]

Mental health resources available behind bars can be limited and variable depending on the institution, with most providing at least psychotropic medications and others expanding their offerings to include group therapy or even individualized psychotherapy.[24,25] Although research in the prison population remains sparse and is often focused on specific demographic populations, preliminary reports support the feasibility and benefit of implementation of trauma-focused interventions, most commonly CBT-based standardized group programs.[25,26] Health care practitioners must advocate for their patients who are incarcerated to have access to these stabilizing interventions in addition to transition to community care upon reentry to the general populace. Other avenues for endorsement include the promotion of trauma-informed correctional services through training correctional staff to respond to trauma symptoms

in both individuals who are incarcerated and coworkers.[27] A positive perception of corrections staff among adolescents who are incarcerated was associated with a decrease in the odds of perpetrating violence within this population,[28] suggesting that educational programs targeting carceral workers might help develop desirable cultural changes.

Recommendations

For patients who are incarcerated, medical care following incapacitating acute traumatic injury involves special considerations. Patients who are justice-involved retain their basic rights to humane health care and medical dignity realized through development of a therapeutic relationship. This relationship might require clinicians to address patients' underlying traumatic stress from their experiences not only prior to incarceration but also within corrections facilities and within the health care system, especially in the case of emergent surgical intervention. The surgical team must pursue implementation of trauma-informed care principles within both hospitals and prisons and advocate for increased mental health resources being made available to patients in carceral settings.

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Editor's Note

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Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

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