AMA Journal of Ethics®
April 2025, Volume 27, Number 4: E249-256

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Surgeons Help Formerly Incarcerated Patients With Chronic Surgical Needs Maintain Care Continuity?

Christine Nembhard, MBBS and Kindha Nasef, MD

Abstract

Stoma care is very challenging, and, with the added hardship of incarceration, patients find it very difficult to navigate living with a stoma and having it reversed in a timely fashion. Incarceration history adds to the clinical and ethical complexity of surgical care for patients who require an ostomy, especially when secondary to trauma. This commentary on a case canvasses strategies for responding to long-term needs of formerly incarcerated patients with an ostomy who need good follow-up care as much as they need support reintegrating into communities.

Case

MM is a 24-year-old man who sustained 3-gun shots to his abdomen. MM was taken to the nearest hospital's operating room (OR) for an emergent damage control exploratory laparotomy. MM's planned return to the OR 3 days later resulted in bowel resection, primary gastrointestinal anastomosis, and temporary ostomy bag placement. One week after being shot, MM continues to recover. Dr S can no longer justify MM's stay on clinical grounds and discharges MM to police custody.

MM is jailed immediately on a felony charge of illegal firearm possession. MM is convicted of this charge, imprisoned for 3 months, and then released from prison. MM has few resources, struggles to care for his ostomy, and wonders how he will get the follow-up surgical care Dr S and nurses explained to him would be so important.

Due to his conviction, MM is unable to find steady employment or sufficient insurance to cover anticipated costs of the ostomy reversal surgery Dr S plans to do. MM does his best to manage his stoma but develops abdominal pain as well as pain around the stoma. His pain finally brings him back to the hospital's emergency department. MM is admitted with infected peristomal wounds, a peristomal hernia, and stomal prolapse.

Dr S and members of their clinical team resume MM's care and wonder what they should do to help MM continue to have access to the staged, longitudinal surgical care plan interventions that are regarded as standard of care for patients like MM.

Commentary

This case illustrates the vulnerabilities of patients who are, or were formerly, incarcerated and require ongoing surgical care. At the end of 2022, the US prison population in state and federal facilities was over 1.2 million, which represents a 2% increase from 2021, with Black men aged 18 years or older having the highest incarceration rate of any racial/ethnic group.[1] This manuscript aims to address some of the challenges faced by patients who are, or were formerly, incarcerated in seeking adequate, and timely health care resources. More specifically, it focuses on surgical patients and those with ostomies.

Health Concerns of People Who Are Incarcerated

Patients who are incarcerated are known to have numerous health concerns: from infectious diseases and psychiatric or substance use disorders to conditions acquired secondary to violent injuries (eg, orthopedic and soft tissue injuries, chronic wounds, infections, ostomies, chronic pain, and stress-related illnesses). Studies show that these patients have a decreased likelihood of having access to longitudinal care, such as follow-up post-injury, routine annual check-ups, screenings, and dental care.[2,3]

The patient in the case, MM, is the victim of multiple gunshot wounds requiring exploratory laparotomy and ostomy creation. This circumstance is not unusual, as one multicenter study of 513 patients who were incarcerated reported that 17% of surgical procedures were exploratory laparotomies.[4] Hashmi et al reported the rate of stoma creation in the overall trauma population to be around 9.6%, with same-admission reversal being performed in 0.7% of patients; 43% of all patients achieved reversal by 9 months.[5] Creating an ostomy dramatically alters the patient's quality of life and prolongs the length of time taken to return to normalcy after such injuries.[5]

Clinical Care and Discharge Planning

Challenges of providing care for patients affected by penetrating trauma, such as gunshots and stab injuries, start in the hospital trauma bay. After stabilization and disposition have been achieved, the presence of police officers to protect the safety of the patients and staff often hinders privacy for patients, which may demean their dignity during this vulnerable time.[6] As such, patients may be unwilling to disclose pertinent information or participate in their care. Additionally, delays in care occur due to logistical issues, such as transporting the patient to the operating room or procedure area, because multiple security escorts and hand-offs are involved. In our facility, we have noted that police officers require us to obtain approval from the jail warden to allow the patient to ambulate, which can sometimes take days. This delay increases the risk of complications, such as venous thromboembolism or respiratory complications, which can be preventable with early ambulation. Physician awareness established institutional protocols and better—and earlier—communication with the jail leadership would help to reduce these systemic delays and prevent prolonged hospital stays and unnecessary complications. Physical restraints also increase clinicians' difficulty in performing bedside procedures or physical examinations and patients' difficulty in learning how to adequately care for their stoma prior discharge.

It is important to ensure that the patient is psychologically ready and adequately equipped to care for their stoma prior to discharge from the hospital to reduce the risk of stoma-related complications. Toward this end, some surgeons advocate for early stoma reversal prior to discharge from the hospital. A meta-analysis showed early stoma reversal (within 4 weeks of stoma creation) to be safe in comparison with routine stoma

closure (8 weeks after stoma creation), with lower rates of small bowel obstruction albeit higher rates of wound complications.[7]

We make the following recommendations for discharging a patient with a stoma to a carceral setting:

- Patient is clinically ready for discharge.
- Patient understands how to care for stoma (ie, changing appliance, cleaning, and protecting skin).
- Patient understands how to recognize potential complications, such as dehydration, hernia, and prolapse.
- Closed-loop communication is documented between physician and custody officials or the facility infirmary regarding patient needs for stoma care and supplies, plan for follow-up and stoma reversal, and any other ongoing medical care (eg, medications, wound care, or nutrition).
- Surgeon considers early stoma reversal prior to hospital discharge.

Carceral Continuity of Care

Some of the challenges that patients who are incarcerated encounter after discharge are access to adequate supplies, difficulty with pouching the ostomy, and appliance leakage.[8,9] Patients' psychological challenges (depression, anxiety, posttraumatic stress disorder) often go unaddressed, compounded by their having to share a living space, like a prison cell, and deal with the embarrassment and frustration of odor and exposing the ostomy to empty it (particularly in those with a high output). These factors undermine the patient's quality of life.[9] Unlike the general population, patients who are incarcerated have limited access to resources that would allow them to research their condition, better care for their ostomies, and join online support groups.

Patients who are incarcerated have been found to have low clinic postoperative follow-up rates.[4] One barrier is that patients depend on a coordinator to schedule the appointment with the appropriate surgeon. Sometimes this person does not have enough information on the patient's medical history and ongoing needs to do so. This lack of information, which can arise from suboptimal documentation from both health care facilities and the department of correction infirmaries, and lack of health care education, contributes to disruptions in continuity of care. Another barrier is the logistics of transportation and the need to involve hospital security to prevent patients who are incarcerated from eloping and to maintain the safety of other patients and staff. We tend to see a lot of "no shows" in our clinic and for elective procedures scheduling, as well for nonelective procedure follow-up, preoperative testing and bowel prep instructions not being followed. These issues can be mitigated with appropriate communication and processes to streamline follow-up.[10]

Patients' ongoing frustrations and inability to follow up or see their surgeons when needed affects care continuity. Patients may try to find a way to return to hospital for care, even resorting to self-harm to do so.[2] An estimated 22% of trauma patients who are incarcerated will return to the emergency room (ER) within 90 days, 10% of whom will require readmission.[4] In our institution, people often return to the ER for supplies and for purposes of follow up to address concerns that could have been addressed at their routine clinic visit. This practice creates unnecessary costs and misuse of the

system. In our practice, these patients anecdotally complain of poor medical care in jail, not receiving their medications in a timely fashion, poor pain control, and lack of privacy.

We make the following recommendations for care of a patient with a stoma while in jail:

- Provide the patient with adequate supplies and document use of supplies.
- Make available a nurse educator trained in ostomy care to provide instructions (in person or by video conference) on how to care for stoma and to monitor for complications.
- Provide the patient with access to online stoma educational resources.
- Ensure patient privacy and respect so as to maintain patient dignity and enable the patient to feel safe in speaking up regarding a stoma-related concern.
- Make available psychosocial support, such as support groups.
- Ensure that physician documentation on stoma care instructions, follow-up, and plan for stoma reversal, as well as other documents, are sent with the patient in the event of a transfer or given to the patient upon release from jail.
- Coordinate care with jail personnel to arrange follow-up and ensure that necessary appointments are kept.

Continuity of Care for Patients Reintegrating Into Society

Upon release from custody, patients have found it difficult to establish follow-up care for several reasons. There will be competing priorities, such as finding housing, employment, and food. Patients might not have any information provided to them upon release from jail regarding medical procedures they underwent, their insurance status, recommended follow-up, and care instructions. The aforementioned information is handed directly to custody officials and not to the patient. It can also be especially difficult to attend to medical needs without health insurance or adequate knowledge of self-care. Most patients would have lost their prior health insurance, including Medicaid coverage, upon incarceration, and they will lose the health coverage provided by the jail upon release. They might require assistance with the application process to obtain Medicaid near the end of their sentence to help bridge the gap in health care coverage upon their release. If patients do not obtain Medicaid by the time of their release, they can be directed to resources at healthcare.gov to apply for other health insurance plans under the Affordable Care Act.[11,12] A 2012 simulation estimated that 34% of people who were formerly incarcerated would be eligible for Medicaid and an additional 24% would be eligible for health insurance subsidies,[13] although coverage varies by state.[2]

Obtaining health insurance is also closely linked to obtaining employment. About 65% of people who were formerly incarcerated were unemployed within 4 years of their release in 2010, whereas the unemployment in rate of the general population in 2010 was 9.6%.[14] Lack of skill, limited job opportunities, negative attitudes, and lack of motivation contribute to difficulty obtaining employment and reintegrating into society. There are several reentry programs that people who were formerly incarcerated can use for help with job or skills training, housing, and employment assistance.

Other types of support are available. Social support groups, mentoring programs, and mental health resources are important to prevent substance use relapse, reincarceration, and loss of health and financial benefits. Government financial support resources and transportation aid services make it easier for patients to attend follow-up appointments regularly and obtain supplies to prevent disruption in the care plan. Social

workers, care coordinators, and probation officers can assist patients in obtaining insurance and continuing care while transitioning from the department of corrections to release.

There are also many resources that patients can take advantage of to obtain supplies, such as online ostomy patient assistance programs. These programs donate excess stoma supplies to those in need, and free samples can also be obtained by request from most appliance manufacturers. Obtaining free supplies or samples requires knowledge of resources, internet access, and a shipping address. In-person resources can be sought via local institutions, such as shelters, the Salvation Army, the American Red Cross, and Goodwill Industries. United Ostomy Associations of America also assists with finding free supplies, in-person and online support groups, and educational resources. These support groups and community programs, along with support from social workers, family, and friends, are all important to bolster the psychological fortitude of the patient, which is needed to navigate life with an ostomy.

Below are recommendations for facilitating continuity of care upon patients' release from prison:

- Direct the patient to obtain assistance from a social worker or care coordinator with enrolling in a health insurance plan (eg, Medicaid, healthcare.gov) prior to release from jail to avoid gaps in coverage.
- Ensure that the patient receives their medical documents from the jail, including stoma care instructions, information on how and where to obtain supplies and how often supplies were used and will be needed, follow up instructions, information on how to obtain appointments with their clinicians, and a plan for stoma reversal.
- Assist the patient in connecting with reentry community programs, which provide job or skills training and housing and employment assistance.
- Assist the patient in finding in-person or online social support groups, mentoring programs, and mental health resources.
- At follow-up appointments, social services workers or physicians should give the patient resources on how to access ostomy support groups and free supplies.

Physician Responsibilities and Ethical Considerations

During the entirety of the patient's care, the physician is responsible for maintaining patient privacy, trust, and dignity with empathy, respect, and cultural awareness. Trust must be built and maintained, and the patient must be encouraged to participate in their care and learn how to advocate for themselves and when to seek help. Patient autonomy is sometimes overlooked in patients who are incarcerated, as their circumstances belie this fundamental ethical principle. Direct lines of communication need to be set up and clear discharge instructions given to both the patient and relevant jail personnel. A discussion should also be had with the patient regarding the purpose of the ostomy, timing of reversal, planning for supplies, health insurance, and follow-up once released. There may be a benefit in more frequent follow-up for patients who are incarcerated to address the challenges of caring for an ostomy in the department of corrections in a timelier fashion, as well as to provide support to which they might otherwise not have access.

The physician should also uphold beneficence by ensuring proper transition planning to help prevent complications. Adequate stoma care education has always been the cornerstone of preventing stoma complications. Every effort should be made to ensure the patient understands how to care for the stoma prior to discharge. A stoma nurse is invaluable in this regard. Physicians should educate patients on how to recognize complications early and when to seek help, as dehydration, denuded irritated skin, infections, stoma dissociation, prolapse, hernia, and stenosis can occur during stoma care. Written educational materials and follow-up instructions should have been placed in the patient's file and be given to the patient upon release. The patient should understand their medical condition, including the procedures, new medications, follow-up appointments, and wound and stoma care. A tracking system with coordination by a patient navigator or social worker helps to ensure adequate follow-up, including that the patient attends follow-up appointments. Physicians should collaborate with other health care practitioners, such as primary care clinicians, stoma nurses, wound managers, and nutritionists, to coordinate visits and diminish the frequency of patients' trips and time off. Physicians volunteering within correctional facilities and community centers can help to provide education and increase health literacy.

Nonmaleficence responsibilities lie with the jail personnel and include not putting the patient in a harmful situation. Jail personnel should ensure the patient has adequate resources to cleanse the ostomy and change the appliance, and there should be appropriately trained staff to pick up on problems early and escalate them appropriately. Justice is ensured by not discriminating against patients with a stoma—specifically, by reassuring them that they can report issues they are having with the stoma and by educating jail staff so that they will be understanding of any limitations and needs the patient may have. Although changes can be made to health care systems to better support surgical patients who are incarcerated, addressing disparities in care of this group of patients should be made legally, and department of correction protocols should be reviewed to provide appropriate health care to an often-neglected population that is at high risk for health care inequities.[4,15]

Conclusion

The surgical treatment of patients who are incarcerated continues to pose unique challenges. More research should be done to identify how surgeons can provide adequate patient care while also considering the unique social determinants of health of this specific patient population. Surgeons need to be more proactive about providing quality care to patients, and patients need to be educated, given the necessary resources, and feel empowered to advocate for themselves, especially when they need help.

References

1. Carson EA, Kluckow R; Bureau of Justice Statistics. Prisoners in 2022—statistical tables. US Department of Justice; 2015. Accessed November 25, 2024. https://bjs.ojp.gov/document/p22st.pdf
2. Bryant MK, Tatebe LC, Siva NR, et al. Outcomes after emergency general surgery and trauma care in incarcerated individuals: an EAST multicenter study. *J Trauma Acute Care Surg*. 2022;93(1):75-83.
3. Zhao J, Star J, Han X, et al. Incarceration history and access to and receipt of health care in the US. *JAMA Health Forum*. 2024;5(2):e235318.

4. Dhimal T, Cupertino P, Ghaffar A, et al. Systematic review of surgical care in the incarcerated population: identifying knowledge gaps for future research. *Ann Surg Open*. 2024;5(2):e434.
5. Hashmi ZG, Dalton MK, Sheikh SS, McCarty JC, Salim A, Haider AH. National estimates of intestinal ostomy creation and reversal for trauma. *J Trauma Acute Care Surg*. 2021;90(3):459-465.
6. Scarlet S, Dreesen E. Surgery in shackles: what are surgeons' obligations to incarcerated patients in the operating room? *AMA J Ethics*. 2017;19(9):939-946.
7. Guo Y, Luo Y, Zhao H, Bai L, Li J, Li L. Early versus routine stoma closure in patients with colorectal resection: a meta-analysis of 7 randomized controlled trials. *Surg Innov*. 2020;27(3):291-298.
8. Zewude WC, Derese T, Suga Y, Teklewold B. Quality of life in patients living with stoma. *Ethiop J Health Sci*. 2021;31(5):993-1000.
9. Davis D, Ramamoorthy L, Pottakkat B. Impact of stoma on lifestyle and health-related quality of life in patients living with stoma: a cross-sectional study. *J Educ Health Promot*. 2020;9:328.
10. Martin RA, Couture R, Tasker N, et al. Emergency medical care of incarcerated patients: opportunities for improvement and cost savings. *PLoS One*. 2020;15(4):e0232243.
11. Bainbridge AA; Bureau of Justice Assistance. The Affordable Care Act and criminal justice: intersections and implications. US Department of Justice; 2012. Accessed September 30, 2024. https://www.criminaljustice.ny.gov/opca/pdfs/aca/aca-cj-whitepaper.pdf
12. Health coverage for incarcerated people. HealthCare.gov. Accessed September 30, 2024. https://www.healthcare.gov/incarcerated-people/
13. Ejike-King L, Dorsey R. Reducing ex-offender health disparities through the Affordable Care Act: fostering improved health care access and linkages to integrated care. *AIMS Public Health*. 2014;1(2):76-83.
14. Wang L, Bertram W. New data on formerly incarcerated people's employment reveal labor market injustices. Prison Policy Initiative. February 8, 2022. Accessed November 25, 2024. https://www.prisonpolicy.org/blog/2022/02/08/employment/
15. Incarceration and health: a family medicine perspective (position paper). American Academy of Family Physicians. April 2017. Updated January 2022. Accessed May 16, 2024. https://www.aafp.org/about/policies/all/incarceration.html

Christine Nembhard, MBBS is a colon and rectal surgeon at Howard University and an assistant professor at Howard University Hospital in Washington, DC. Her area of interest is outcomes research, with a focus on systems processes and mitigating health care disparities.

Kindha Nasef, MD is a second-year general surgery resident at Howard University Hospital in Washington, DC. She plans to pursue a trauma and critical care fellowship after residency. She has a special interest in health care disparities, quality improvement, and trauma systems, with the goal of improving patient outcomes.

Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2025;27(4):E249-256.

DOI

10.1001/amajethics.2025.249.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

ISSN 2376-6980