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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

# How Should Surgical Care Team Members Protect Incarcerated Patients From Carceral Officers' Surveillance or Intrusion?

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**Abstract**

This commentary on a case considers surgeons' legal and ethical obligations to patients who are incarcerated and accompanied by carceral facility personnel.

## Case

BB is a 40-year-old woman who presented as a high-level trauma code to the emergency department after she was assaulted in her prison. BB is shackled, naked save for limited paper drape coverage, and accompanied by Officer G, an employee of BB's prison. Dr ED evaluates BB in the trauma bay, a large and accessible emergency department room stocked especially for acute trauma, with Officer G looking on.

BB is hypotensive and tachycardic, so Dr ED administers 2 units of packed red blood cells. BB's vital signs return to normal in response to the blood, so she is sent for emergent CT imaging, which reveals active extravasation from a grade 4 splenic injury. While still in the CT scanner, BB becomes hypotensive and is rushed to the operating room for an exploratory laparotomy by a surgical team led by Dr S.

Dr S asks Officer G to remove BB's handcuffs so they can utilize electrocautery and position BB properly for the procedure. Officer G responds, "I do not have clearance to remove cuffs," so Dr S uses bone cutters to break them. As Dr S and the team perform BB's operation, Officer G makes multiple requests for "status updates" on BB's condition. Upon completion of the surgery, over Dr S's objection, Officer G re-cuffs BB to her gurney rails. Officer G accompanies BB as she is transported to the surgical intensive care unit (SICU).

Dr S wonders what they should do to protect BB's privacy and dignity, at least while she is in the SICU.

## Commentary

As a surgeon, Dr S has a responsibility to care for BB like any other patient, regardless of her incarceration status. Dr S must ensure that BB receives the appropriate lifesaving care despite Officer G's demands. Patients who are incarcerated, excepting some circumstances, maintain autonomy in health decision-making,[1] which is a key value in

health care ethics, along with maleficence, beneficence, and justice.[2,3] Moreover, according to the American Medical Association (AMA) *Code of Medical Ethics*, it is the responsibility of the physician to provide "competent medical care, with compassion and respect for human dignity and rights" and to support "access to medical care for all people."[4] However, there can be many barriers to caring appropriately for patients who are incarcerated. Physicians and staff receive little dedicated training on working with patients who are in the justice system and might not be aware of relevant hospital policies, especially safety measures, such as shackling (a nonmedical form of physical restraints that controls a prisoner's body or limbs).[5] Clinicians might also be unsure about circumstances in which protected health information (PHI) can be shared with carceral institutions or officers, as authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) final Privacy Rule.[6]

Despite Officer G's claim that he did not have "clearance to remove cuffs," the removal of the handcuffs was necessary to position BB correctly and utilize electrocautery for safe, efficient surgery. Physicians should know that their decisions about how to care for a patient who is incarcerated may not be overruled or ignored by nonmedical prison staff if the officer is aware that doing so poses excessive risk to the patient's health and safety.[7] In the interests of beneficence, a physician is obliged to, for clinical reasons, request prison staff to remove handcuffs and ask for privacy for patient-physician communications.[8]

As an anesthetized patient, BB no longer needs to be shackled. Physical and chemical restraints, defined as measures that limit a person's freedom mechanically or pharmacologically, are generally used to prevent patients from harming themselves or others in clinical settings, although they are associated with increased morbidity risks.[9] It is important to note that shackling of prisoners differs from the use of physical and pharmacological restraints for agitated or combative patients. Shackles can limit the patient from being able to ambulate postoperatively to prevent venous thromboembolism risk and make it difficult for caregivers to position the patient during seizure management.[5,10] Overall, the use of handcuffs for BB while under general anesthesia is unnecessary and could be excessively harmful.

## Ethical Considerations

Although patients who are incarcerated retain autonomy over their own health care decisions and the right to consent to or reject medical treatment with some exceptions under the common law of informed consent, physicians and staff are faced with the unique ethical and legal challenge of providing equitable care while the patient is shackled to the bed with officer supervision. Often, clinicians receive little dedicated training and education on recommended care practices and health care organizational policies for patients who are incarcerated, and they might be uncertain about what the best practices are concerning shackling, privacy, and transitions of care.[5,11] Nurses' and other staff members' concern for their personal safety adds to uneasiness about caring for patients in shackles. For example, Brooks et al found in a survey of physicians and nurses that day-to-day care was more likely to deviate from standard of care for patients who were incarcerated than for those who were not.[11] Additionally, clinicians and staff may have concerns about incarceration and shackling infringing on patient rights as codified by the AMA,[4] creating cognitive dissonance. It is important to recognize the influence that incarceration has on patient care and to work with officials to ensure the safety of the patient and staff.[10,12]

## Legal Considerations

At the end of 2022, over 1 million individuals were incarcerated in US prisons, with the number of females in state or federal prison increasing almost 5% between 2021 and 2022.[13] The right to health care for those in prison was established by the 1976 Supreme Court case *Estelle v Gamble*.[14] In the case, J.W. Gamble, who suffered from and reported a back injury while in the Texas prison system, was required to continue working. He claimed his care was a violation of the Eighth Amendment, which protects criminal defendants from unduly harsh punishments.[14] The case set the precedent that "deliberate indifference to the serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain'" [*Gregg v. Georgia*],[14] violating the Eighth Amendment. However, this case sets a high bar as to what "deliberate indifference" means. For example, prison guards purposely denying patients' requests for medical care or interfering with a physician's treatment can be considered "deliberate indifference," but negligent care or malpractice would not meet that standard.[14]

Globally, the rights of prisoners have been codified in the Nelson Mandela Rules,[15] which detail the obligation to treat all prisoners with "the respect due to their inherent dignity and value as human beings" and to prohibit "torture and other cruel, inhuman, or degrading treatment or punishment." Regarding health care, Rule 24 explicitly states that prisoners should have equal access to necessary care and "should enjoy the same standards of health care that are available in the community."[15]

HIPAA was enacted to set standards for the electronic exchange, privacy, and security of health information.[16] Patients, including those who are incarcerated, have the right to the privacy of their PHI, the disclosure and sharing of which is limited without patients' authorization.[16] However, this right would be difficult to for any person to actualize when in custody. Due to the need for correctional facilities to use and share inmates' PHI without authorization, the HIPAA provisions regarding permissible uses and disclosures of PHI effectively exclude inmates from the right to receive notice of or provide authorization for possible uses and disclosures of PHI.[6] The Privacy Rule also excludes people who are incarcerated from the right to obtain a copy of PHI if it would jeopardize the "health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the inmate."[16]

## Care of Patients Who Are Incarcerated

Education of the health care team about implicit bias and hospital rules for the care of patients who are incarcerated is essential. Physicians should be aware of their role in care for the patient while ensuring the safety of the patient and staff. They should recognize that the internal conflict between prison safety measures, such as shackling, and professional codes of ethics, such as the four ethical principles of beneficence, nonmaleficence, autonomy and justice, affects their relationship with the patient.[3] Ultimately, clinicians should maintain clear communication with the patient and officials to ensure that the patient's rights are upheld. Below we review further clinical care considerations.

For physical examinations, it is important to maintain the physical privacy of a patient. Physicians are justified in making requests of prison staff, such as to adjust or remove handcuffs to perform an examination, provide the necessary positioning for surgery or seizure management, and prevent burns during electrocautery use during surgery; to stand where they cannot view the exposed patient; and to appropriately drape patients

for sensitive examination such as genitourinary.[8] By doing so, physicians continue to express respect for the dignity of all patients who are incarcerated.

Ensuring the safety of the patient and staff through shackling can be difficult for clinicians, especially nurses, to navigate. Clinicians need to recognize when care will be interfered with by the presence of shackles. If the clinician deems that appropriate care cannot be provided with physical restraints in place, the responsibility of custody officials is to determine an alternative method to ensure the safety of the patient, with or without restraints, so their care needs are met.[5] If there continues to be disagreement, clinicians can confer with colleagues or consult hospital legal counsel or an ethics consultant or committee for further guidance.[8]

To maintain the privacy of the patient, a toolkit created by the Working Group on Policing and Patient Rights of the Georgetown University Health Justice Alliance to protect patient's PHI from being seen and heard by third parties offers recommendations, include protecting PHI when asked for by officers, asking officers to step out of earshot, and maintaining patients' autonomy to make decisions about their care.[17]

## Conclusion

In this case, BB should be treated like any other patient to enter the emergency room. When BB initially presents to the ED, having Officer G accompany her to the hospital is justified for the safety of the staff. However, BB has the right to privacy during her medical evaluation, and Office G should not be looking on but ensuring that BB and staff are safe. Dr S can ask Officer G to stand outside the room and out of earshot of BB to protect her physical privacy as well as her PHI. Prior to surgery, Dr S should ask Officer G to remove her handcuffs so as not to interfere with her lifesaving surgery because she will be chemically restrained under general anesthesia and the handcuffs pose a physical threat to her safety when utilizing electrocautery. Regarding Officer G's multiple requests for status updates, Dr S is not obligated to share details of BB's condition unless it threatens her own safety and that of others. Overall, BB should be treated like any other patient, and Dr S should clearly state BB's needs to Officer G to ensure her patient rights are maintained throughout her treatment.

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## Editor's Note

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


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## Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

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