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FROM THE EDITOR

How Should We Better Express Respect for Surgical Patients Who Are Incarcerated?

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With roughly 2 million individuals who are incarcerated, the United States has the largest prison population in the world and accounts for more than a fifth of the total global prison population.[1] In 2004, 12.7% of people who were incarcerated underwent invasive procedures,[2] with the likelihood of undergoing surgery while incarcerated increasing as time in confinement increased (from 0.2% at 1 week or less to 3.5% at 1 year or more).[2,3] The population of people who are incarcerated is also aging: 15% are 55 years or older.[2]

Patients who are incarcerated lack timely access to safe, quality surgical care. In the high-cost, often acute field of surgical care, this lack of access manifests as an inability to receive surgical care from specialists and delayed presentation for surgical pathologies.[2] Postmortem reports for Miami Dade County, Florida, indicate that only 33% of individuals in the sample who died from surgical pathologies received surgical treatment; this finding suggests that these patients are dying from surgical pathologies that have not been diagnosed.[4] Moreover, patients who are incarcerated also face barriers to postoperative follow-up and experience higher rates of complications.[2] This inequity in surgical care generally stems from poor health service infrastructure in carceral environments. Surgeons, policy makers, and caregivers have ethical responsibilities to work toward providing equitable care.

Numerous historical violations of biomedical ethics have been studied within the American carceral system, including in medical experimentation and in the provision of substandard care.[5] Many of these violations were surgical in nature and included nonconsensual sterilization and surgical transplantations using organs from individuals who were incarcerated.[2] These violations occurred, in part, because the biopolitical approach to individuals within the prison system has been characterized by devaluation of the these individuals' well-being, dignity, and physical health.

There are legal obligations for government to provide people who are incarcerated with medical care; the Supreme Court established that "deliberate indifference to serious medical needs" violates the Eighth Amendment's prohibition against cruel and unusual punishment.[6] Nonetheless, multiple barriers to providing equitable surgical care for patients who are incarcerated remain. These barriers include (1) enforcement of

stigmatizing policies that limit the patient autonomy, (2) the presence of law enforcement during patient care, (3) incomplete understanding by health care professionals of patients' rights in health care decision-making, (4) minimal care continuity with clinicians, (5) lack of care equivalency, and (6) absence of inclusive ethical research.[7] These challenges particularly affect Black people, who experience disproportionately high rates of policing and incarceration relative to White people.[8,9] Patients who are incarcerated tend to experience deep mistrust of health care institutions.[7]

Attempts to mitigate barriers to the ethical surgical care of patients who are incarcerated must occur at the clinician, institutional, and policy levels. At the clinician level, surgical care teams who work in hospital systems that are partnered with carceral institutions will frequently encounter patients who are incarcerated. They are positioned to foster meaningful patient-physician relationships to ensure dignity, promote privacy, and encourage respect. Health care organizations are starting to standardize education on ethical surgical care of patients who are incarcerated.[10] Finally, eliminating punitive policies that restrict these patients' autonomy in health decision-making and facilitating access to surgical care during and after incarceration is critical to eliminating inequity. Intervention at all levels must consider these patients' physical and emotional vulnerabilities during surgical care.

This issue explores ethics questions unique to surgical patients who are incarcerated. First, it is important to understand the working infrastructure—in particular, the historical relationship between safety net hospitals and prison systems—to provide ethical care. Second, contributors aim to explore the nuances of maintaining patient privacy, dignity, and autonomy for medical decision-making. Contributors also discuss the inclusion of patients who are incarcerated in ethical medical research and in education of surgical trainees.

With a deep and intentional understanding of ethical questions arising during surgical care and follow-up, surgical communities can provide more equitable and dignified care for imprisoned populations. We hope this issue will open a forum for members of health care and law enforcement teams to promote humanistic, equitable surgical care of patients who are incarcerated.

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