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Surgical Care of Incarcerated Patients

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FROM THE EDITOR

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

Monalisa A. Hassan, MD, MSc and Youmna A. Sherif, MD

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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Monalisa A. Hassan, MD, MSc is a pediatric surgery research fellow at the University of California, Davis.

Youmna A. Sherif, MD is a first-year independent plastic surgery resident at Johns Hopkins Medicine in Baltimore.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Physicians Manage Traumatic Injuries Sustained During Incarceration?

Wynne Q. Zhang, MD and Lucas A. Dvoracek, MD

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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Wynne Q. Zhang, MD is a fourth-year general surgery resident at Baylor College of Medicine in Houston, Texas, with an interest in access to care and health care

disparities. She is a graduate of the Baylor College of Medicine Care of the Underserved Pathway.

Lucas A. Dvoracek, MD is an assistant professor of surgery in the Division of Plastic Surgery at Baylor College of Medicine in Houston, Texas. He is also on the faculty at multiple institutions affiliated with Baylor, including Ben Taub Hospital, which serves as both a level 1 trauma center and a safety-net hospital for the greater Houston area.

Editor's Note

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

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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.

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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.

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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.

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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?

Anna Lin, MD and Mallory Williams, MD, MPH

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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Anna Lin, MD is a general surgery resident at Howard University Hospital in Washington, DC.

Mallory Williams, MD, MPH is the chair of the Trauma and Burn Surgery Unit at John H. Stroger, Jr. Hospital of Cook County in Chicago, Illinois.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Ethics of Learning Surgical Autonomy in Safety-Net Hospital Systems With Patients Who Are Incarcerated

Kala T. Pham and Rachel W. Davis, MD

Abstract

Safety-net hospitals care for patients who are incarcerated and are key environments in which surgical trainees learn to wield their professional autonomy. This article explores ethical questions raised by surgical trainees' participation in carceral care and canvasses possible responses to those questions.

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Surgical Trainees and Patients Who Are Incarcerated

Safety-net hospitals are crucial for serving vulnerable patients, such as those of low socioeconomic status; those who are incarcerated, unhoused, or victims of domestic violence; those with substance use issues; and minorities.[1] Public hospitals, in particular, care for patients who are incarcerated, along with academic safety-net hospitals. During the 1980s, US prison health care systems were strained by surging carceral populations due to changes in sentencing laws. Rising costs and limited resources further stretched prison health care systems.[2] To address this problem, Texas established a partnership in 1994 between academic medical centers and correctional facilities to serve this population.[2] Only 5 other states—Connecticut, Georgia, Massachusetts, New Hampshire, and New Jersey—have contracts between academic health centers and state carceral systems for inmate care.[3] As of 2012, 22 US academic medical programs offered varying levels of exposure to correctional health facilities for students and residents.[4] Resident training is rooted in the Halsted model of "see one, do one, teach one,"[5] and public hospitals remain key environments for trainees' learning of surgical autonomy.[6]

Despite the importance of resident autonomy, from 1998 to 2004, there was a 69% reduction in unsupervised surgeries by residents in the US Veterans Affairs system.[7] Contributing factors included increased patient safety concerns, emphasis on operating room efficiency, and work-hour restrictions.[7,8] This decline led some faculty to question the readiness of graduating residents for autonomous practice[8] and to growing resident concerns about inadequate preparation for independent practice. Between 1993 and

2005, the number of general surgery residents seeking fellowship training increased from 67% to 77%.[9] However, surgical residents in public hospitals, public and academic safety-net hospitals, and county hospitals typically have more surgical independence and unparalleled opportunities for ownership in patient care than residents training at private hospitals.[10,11]

The greater autonomy of residents in public and academic safety-net hospitals must be weighed against the ethical considerations in providing equitable care to vulnerable populations. Specifically, we address 3 key ethical questions: What is the extent of the autonomy of patients who are incarcerated? How can the risk of exploitation be mitigated? How should we distinguish equity responsibilities of surgeons and trainees from those of academic health organizations when they forge relationships with carceral facilities? This article will explore the role of surgical trainees in providing care—spanning emergent care to elective procedures—to patients who are incarcerated. Through an exploration of the benefits of trainee involvement in care provision and an examination of the ethical dilemmas associated with heightened trainee autonomy, particularly within high-volume centers, this article seeks to illuminate the complex interplay between surgical training, patient care, and ethical considerations.

Tensions and Equity

The intricate relationships among resident training, the incarcerated population, prison systems, and public and academic safety-net hospitals necessitate thorough scrutiny, particularly given the invasive nature of surgical care. Patients who are incarcerated are provided care by surgical trainees within institutional power structures that historically have neglected the health of such patients and exploited them as research subjects, anatomical teaching aids, and participants in academic clinical medicine.[11] Moreover, the characteristics of safety-net hospital systems and prison systems introduce potentially conflicting advantages for both surgical trainees and incarcerated patients, complicating ethical care. Trainees gain heightened surgical autonomy, exposure to complex patient pathologies, and enhanced patient compliance in the treatment of individuals who are incarcerated.[11] For patients who are incarcerated, safety-net hospitals are often the only option for health care.[12] They can provide expert physician evaluation, advanced diagnostics, and robust treatment that might not be available at their correctional facility.[2] Despite these advantages, it is imperative that surgical trainees ethically evaluate surgical care—encompassing initial consultation, surgical intervention, and postoperative management—provided to such patients.

Challenges of providing care to this population stem from the complex dynamics of treating individuals whose civil liberties are restricted but who remain entitled to the same standard of care as their counterparts in the community. Rule 24 of "The United Nations Standard Minimum Rules for the Treatment of Prisoners" embeds the principle of equivalence of care in stating that "prisoners should enjoy the same standards of health care that are available in the community … without discrimination."[13] However, the practical implementation of equivalent care remains difficult because patients who are incarcerated face institutional delays in accessing care and uncertain follow-up management.

Limitations of Autonomy of Patients Who Are Incarcerated

The perceived advantages of a liberated environment within safety-net hospitals are valued by surgical trainees, yet these advantages are intricately linked to the autonomy, or lack thereof, of patients who are incarcerated.[11] Patients who are incarcerated

encounter inherent obstacles regarding elective procedures, care transition, and clinician selection. Despite the distinctive constraints faced by patients who are incarcerated, they maintain the fundamental right to exercise autonomy in their surgical care, including the right to receive comprehensive treatment information and actively participate in decision-making processes. They thus must be informed about the role of trainees in providing care and consent to their involvement. Trainees must ensure that shared decision-making with patients who are incarcerated mirrors that for any other patient, free from bias and based on objective assessment.[14]

Patients who are incarcerated are unable to seek routine care from a physician of their choice outside the prison or obtain a second medical opinion.[14] This inherent limitation on autonomy necessitates the heightened significance of safeguarding any residual patient autonomy that remains within the correctional health care setting.

Mitigating Risks of Exploitation

The health care needs of people who are incarcerated are assessed by prison authorities who rule on the necessity of intervention.[11] The potential for nonmedical authorities to intervene in medical decisions and timing presents ethical challenges for what traditionally is a decision made solely based on patient autonomy. Resultant delays in accessing medical care contribute to the advanced disease pathologies often observed among individuals who are incarcerated.[11] Once such patients are able to access care, they demonstrate a high level of compliance with treatment.[11]

Surgical trainees must recognize the power dynamics between health care practitioners and patients, which are magnified for patients who are incarcerated, given the hierarchical power structure within prison environments.[11] Compliant behavior among such patients represents a double-edged sword. Although patient willingness to aid in training endeavors and accommodate requests can be advantageous for training, it also poses risks of exploitation.[11] The opportunity for surgical trainees to apply their training in practical settings can come at the cost of these patients, including compromised patient autonomy, absence of familial support networks, and diminished legal and professional accountability in the event of adverse outcomes.[11] Any requests made of individuals who are incarcerated by a person in a position of power, including medical trainees, has an inherent risk of situational coercion due to those individuals' lack of freedom.[11] Surgical trainees must ensure that patients with advanced pathologies fully understand and agree with the rationale for any proposed surgical intervention.

Equity Responsibilities

The culture within academic safety-net institutions typically affords surgical trainees greater autonomy in practicing surgical skills, particularly when caring for patients who are incarcerated.[11] One study of US Veterans Affairs medical centers showed that surgical procedures performed by surgical residents alone were not associated with worse mortality or composite morbidity than those performed by attending surgeons alone, although operative duration was longer for resident-performed than attending-performed cardiac or breast surgical procedures, with patient outcomes being comparable.[7] It is the role of surgeons and trainees to ensure adequate patient outcomes, given their direct role in patient care.

On an individual level, moral judgment plays a significant factor in the surgical care of patients who are incarcerated.[11] Trainees in academic safety-net hospitals often encounter such patients who are subject to moral scrutiny and negative stereotypes,

leading to bias.[11] Health care practitioners acknowledge the challenge of maintaining empathy when faced with patients "who trigger moral judgments."[11] Moreover, trainees may have a default suspicion regarding the validity of the medical conditions of patients who are incarcerated, suspecting them of malingering to obtain perceived benefits, such as transfer to more favorable locations, reduced work duties, or avoidance of legal responsibility.[11] Trainees often find themselves influenced by the perspectives of their supervising surgeons and may be discouraged from questioning ingrained biases within the medical hierarchy.[11]

Institutions also have responsibility for providing equitable care. Practical and ethical perioperative issues include the challenges of operating in the presence of armed guards and on restrained patients,[15] as well as coordinating postoperative management, including serial imaging, activity restrictions, and implementing specialized diets.[14] Follow-up care is further complicated by potential barriers to patients accessing transportation to follow-up appointments.[14] Moreover, surgical trainees may encounter limitations on patients' ability to obtain medication and coordinate follow-up services, such as physical therapy, occupational therapy, or primary care appointments. These logistical and institutional barriers require safety-net hospitals and carceral systems to take measures that allow patients who are incarcerated to have timely access to care, sufficient surgical intervention, and adequate postoperative care.

Responses to Key Ethical Questions

Surgical care for patients who are incarcerated should adhere to the principles of beneficence, justice, autonomy, and nonmaleficence.[14] Beneficence obliges trainees to act in patients' best interests, including managing pain and minimizing harm, regardless of legal status.[14] Surgeons should collaborate with accompanying officers to ensure that patients are positioned or restrained in a manner that facilitates surgical care without causing undue discomfort.[14] Justice demands equitable treatment and impartiality in surgical care delivery.[14] Autonomy involves allowing patients who are incarcerated to make informed decisions about their surgical care.[14] Nonmaleficence requires avoiding harm, prompting surgeons to express concern for increased susceptibility to infection and wound complications within prison environments.[14] These principles ensure ethical care for all patients, including those in carceral settings.

Providing ethical surgical care to vulnerable patients who are incarcerated requires specialized education and training,[11] as surgical trainees face challenges in managing the complex ethical issues of treating this population while avoiding exploitation.[11] As academic medical centers increasingly care for such individuals, specialized training programs are essential.[11] These programs equip trainees with the skills needed to handle patients' vulnerability to exploitation ethically and address power dynamics in the patient-clinician relationship.[11] Comprehensive training would ensure ethical and equitable health care for incarcerated populations.

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Kala T. Pham is a second-year medical student at Baylor College of Medicine in Houston, Texas. Her research interests include integrating innovative surgical techniques and evidence-based approaches to improve patient outcomes.

Rachel W. Davis, MD is the director of the Center for Global Surgery and an assistant professor of surgery in the Division of Trauma and Acute Care Surgery at Baylor College of Medicine in Houston, Texas, where she is also director of the Global Surgery Track of the General Surgery Residency Program. Her clinical work is based at Ben Taub Hospital, where she cares for incarcerated patients within the Harris Health System.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

What Are the Top 5 Things Surgical Trainees Should Consider When Caring for Patients Who Are Incarcerated?

Sophia Williams-Perez, MD and Chad Wilson, MD, MPH

Abstract

The US has the most individuals who are incarcerated worldwide. This article offers five recommendations for what surgical trainees should think about and know about when providing perioperative care for patients who are incarcerated.

Surgical Outcomes for Patients Who Are Incarcerated

Mass incarceration is defined as the extensive imprisonment of individuals in correctional facilities.[1] In the United States, an estimated 1.9 million individuals experience incarceration,[2] and the rate of incarceration is higher than that of any other country worldwide.[3,4] While incarceration affects individuals from any background in the United States, individuals from historically underrepresented and marginalized populations, such as racial ethnic minority communities, are inequitably affected.[1,3] Moreover, this population experiences an inequitably high rate of mental health illnesses and chronic diseases.[5] Importantly, adverse structural determinants of health experienced by individuals who are incarcerated have been associated with worse outcomes.[3,6,7]

While basic health care is provided to individuals who are incarcerated in correctional facilities, when their healthcare needs exceed the capacity of that facility, they must be transferred to a hospital system, often an academic health center or public safety-net hospital, that is under contract with the correctional facility.[6,8] Because academic health centers train students and postgraduates,[9] including those in surgical residencies, trainees often care for individuals who are incarcerated. Many trainees never receive formal training addressing the ethical challenges of caring for individuals experiencing incarceration that would help them be sensitive to inherent biases, discriminating language, and care inequities.[8,10,11] Moreover, Santry et al surveyed surgical trainees regarding their experiences caring for patients who are incarcerated and found that almost half of trainees observed differences in the health care provided for patients who are incarcerated and those who are not.[12] For these reasons, we provide 5 ethical considerations for surgical trainees when caring for individuals who are incarcerated to ensure the provision of equitable care.

Recognize Bias

Clinicians' explicit (conscious) and implicit (unconscious) bias towards underrepresented patients have been demonstrated in healthcare over the last several decades, particularly within the field of surgery.[13,14,15,16] Within the US carceral system, there is an inequitably large number of individuals from racial, ethnic, and socioeconomically underrepresented communities.[1,2] These communities are also those most at risk for implicit bias and worse health outcomes, such as impaired patient-clinician relationships and differences in treatment options.[17,18] Individuals who are incarcerated experience comparable discrimination and bias in health care delivery and poor outcomes.[3,19] Combine these 2 overlapping communities, individuals who are underrepresented and those who are incarcerated, and the disparate healthcare outcomes are remarkably amplified.

Unique to surgical patients who are incarcerated is the finding that surgeons' implicit bias can lead to disparities in who is offered surgery and in surgical outcomes such as worse morbidity and decreased care continuity.[18,20,21] Although the experience of bias is not unique to surgical patients who are incarcerated, bias can uniquely impact perioperative care, including the preoperative evaluation (eg, assessing complaints), intraoperative decision-making (eg, incision size and aesthetic outcome), and postoperative care (eg, adequate pain control and time to discharge).[10,15,19,21] Despite this evidence of bias, as mentioned previously, surgical trainees rarely receive training regarding care for patients who are incarcerated.[11] As such, the onus falls on trainees to recognize their inherent biases by considering the individual characteristics and needs of each patient with whom they interact. To combat expression of bias, we first encourage surgical trainees to practice using person-first language during communication. Person-first language, eg, "patient who is incarcerated" instead of "incarcerated patient," can help mitigate bias and persistence of negative attitudes toward patients.[22] In addition to oral communication, the vocabulary used to describe patients in written communication can lead to stigmatization and bias.[23] Vernacular describing a patient's demeanor or details of their incarceration within hand-offs, progress notes, or other health documents will reinforce biases not only of the author but of any reader participating in the care of that patient.

Privacy and Trust

Privacy is foundational for establishing trust between patients and clinicians.[24] Fostering an environment of trust is essential within surgical fields, as surgery is a markedly vulnerable experience for all patients.[24] The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 to regulate the use and distribution of protected health information (PHI) among healthcare entities.[4] Unique HIPAA exclusions exist for patients who are incarcerated, such as sharing PHI with the correctional facility if deemed necessary for care provision, for the safety of the individual, or for the safety of individuals at the facility.[4,25] Despite the regulatory protections provided by HIPAA, patients who are incarcerated remain increasingly vulnerable to unauthorized PHI sharing due to the persistent presence of corrections officers.

Patients who are incarcerated are often shackled and accompanied by corrections officers throughout their hospitalization.[12] Shackling limits clinicians' and surgical trainees' ability to perform comprehensive physical exams, while the constant supervision by corrections officers interferes with patient confidentiality in their discussions of PHI and with patient privacy in the operating room.[3,4,24] Trainees must ask patients for their consent when discussing PHI in the presence of corrections

officers, as patients can be less likely to discuss intimate health care details in the presence of others due to the risk for bias and discrimination.[4,26] While trainees should realize that discussions of PHI and sensitive material ideally occur privately with patients, security assessments and requirements for the presence of corrections officers might limit the ability to have conversations in private, and the trainee will need to work alongside officers to maintain a safe environment for all involved parties.

In addition, shackles increase stigmatization and dehumanization of patients who are incarcerated, both of which are further exacerbated while patients are in the operating room in a heightened state of vulnerability.[3,19] Surgical trainees should advocate for the removal of shackles while patients are in the operating room to promote compassionate, equitable care, as the likelihood of patient escape is decreased in this environment, particularly after the administration of anesthetic.[19,24]

Patient Autonomy, Capacity, Consent

Patient autonomy includes an individual's ability to make decisions regarding their healthcare, free from influence or coercion.[27,28] Individuals who are incarcerated are inequitably affected by mental illnesses, which can limit their ability to adequately comprehend treatment options and execute true autonomy in giving informed consent.[25,28,29,30,31] Patient autonomy is critical for obtaining informed consent, which requires an individual's full decision-making capacity. Regardless of patients' underlying health conditions, assessing capacity occurs on an individual basis to ensure patients are afforded equivalent opportunities to exercise autonomy.[31] Excluding the case of court-initiated treatment,[32] if a patient who is incarcerated is deemed to have full decision-making capacity, they possess equal rights to autonomy and informed consent processes as do those who are not incarcerated.[25]

If a patient has inadequate decision-making capacity, a surrogate decision maker (SDM) must be identified. Batbold et al and Scarlet et al detail the ethical issues in designating SDMs for those who are incarcerated, including state-specific regulations for the use of prison staff as SDMs.[25,33] For example, Arkansas and Minnesota do not allow prison staff to serve as SDMs, while North Carolina does.[34,35] Furthermore, although most state regulations indicate that family members must be given first precedence as SDMs for patients who are incarcerated,[36] prison staff often limit physicians' abilities to communicate with family members.[33] To mitigate ethical issues when contacting SDMs who are family members, surgical trainees must remember their duty to serve the patient; however, they should work collaboratively with correctional officers to ensure that only relevant health information is shared with the family. Surgical trainees should also routinely employ advance care planning to identify SDMs, which has been shown to decrease challenges in later appointing these decision makers.[31,33] If a patient who is incarcerated becomes hospitalized and does not have a previously designated SDM, surgical trainees will need to actively assess if the state in which they are practicing possesses state-specific regulations for hierarchical alternate decision makers,[36] such as prison officials, clinicians, clergy, or court-appointed individuals. In these instances, a surgical trainee must consistently consider the values and desires of patient so that decisions best reflect the patient's goals rather than those solely of the appointed SDM.

Safety

Patient safety aligns closely with the ethical tenet of nonmaleficence, which is the duty of health care practitioners to do no harm.[37] For patients who are incarcerated, there are distinct safety considerations. Patients who are incarcerated are often frequently and

indefinitely shackled during hospitalization.[4,24,38] Haber et al have identified several patient safety risks related to shackling, including bone fractures, skin wounds, inability to reposition patients, and deconditioning, among others.[38] Persistent and indiscriminate shackling creates a uniquely disparate hospital experience for patients who are incarcerated. To mitigate the effects of prolonged shackling, surgical trainees must engage in a risk-benefit analysis to evaluate when shackles can be removed or changed. Specifically, trainees must consider strategic room allocation and supervised patient-clinician interactions, during which shackles can be removed.[38] Additional interventions include the use of soft, padded restraints when possible; frequent skin assessments for breakdown and wounds; and individualized analyses of patients' safety in conjunction with corrections officers to assess flight risk and harm to others so that, if the risk is deemed low, patients might experience periods of unshackling. surgical trainees

Patient encounters in the operating room also present special considerations in the care of patients who are incarcerated. Surgical trainees should advocate for limited maintenance of shackles while patients are in the operating room so that they can experience the same level of compassion and trust as patients who are not incarcerated.[19,24] Moreover, shackles limit postoperative activity and can lead to increased risk of postoperative complications, such as deep venous thrombosis and deconditioning.[38] Surgical trainees thus must consider the negative effects of prolonged shackling during the postoperative period. While following hospital policy and security requirements of corrections officers, trainees can place specific treatment orders to promote ambulation and activity, or they can conduct frequent assessments to ensure that patients who are shackled truly require the shackles.[38,39,40]

Transitional Care Planning

The transition of care is a critical component of patient care that benefits not only the patient but also the healthcare system. Poor transitional care planning results in worse outcomes for patients and increased readmissions for health care institutions, thereby increasing both entities' financial burdens.[41,42] Regardless of patients' carceral status, best practices for transition of care include complete discharge plans, medication reconciliation, patient and caregiver teaching, communication between sending and receiving facilities, and timely post discharge follow-up.[41] However, there are limited published data regarding best practices tailored to the needs of the carceral population.

Despite the lack of established guidelines, we recommend the following measures when planning transitional care for patients who are incarcerated. Surgical trainees must be sure to obtain therapy-based assessments for patients who are incarcerated to help with evaluation of safety for hospital discharge back to the correctional facility or to the community.[19] For patients returning to correctional facilities, surgical trainees must consider the resources that will be available to patients upon discharge. While most facilities possess health care practitioners, these clinicians might not be located on site at all times.[4] Additionally, specific services might not be available to individuals within correctional facilities, such as wound care, ostomy care, drain or line care, laboratory testing, rehabilitation and therapy, or adequate assistance with medications, all of which are key components of postoperative care for surgical patients.[4,43] Surgical trainees must familiarize themselves with the receiving facilities for patients who are incarcerated to actively determine available resources and anticipate challenges that can arise from limited personnel and supplies.[4] If personnel or services are deemed to be inadequate at a receiving facility, surgical trainees should consider that discharge

timing may need to be altered for patients being discharged to that facility if they cannot receive adequate care there.

Summary and Conclusion

To improve patient care for the vulnerable population of patients experiencing incarceration, we sought to provide 5 ethical considerations as a framework for surgical trainees to consider during the perioperative period. In sum, we recommend surgical trainees be formally trained to cultivate awareness of their biases, express respect for patients' privacy, build trust with patients, protect patients' participation in informed consent, ensure patient safety, and draw on best practices in transitional care planning.

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Sophia Williams-Perez, MD is a fourth-year general surgery resident at Baylor College of Medicine in Houston, Texas, who is completing 2 years of dedicated research in a National Institutes of Health-funded T32 research fellowship at the University of Texas MD Anderson Cancer Center and a master of education degree at the University of Houston. Her clinical interests include surgical oncology, and her research interests include oncologic clinical outcomes, surgical education, patient education, and health care disparities.

Chad Wilson, MD, MPH is a board-certified trauma surgeon and an associate professor of surgery at Baylor College of Medicine in Houston, Texas. He received his medical degree from Johns Hopkins University in Baltimore in 2001 and undertook his general surgery training at Massachusetts General Hospital in Boston. While there, he completed 2 years of dedicated outcomes research while also obtaining his master of public health degree from Dartmouth. Dr Wilson's current clinical and research interests include trauma quality improvement, trauma systems, and acute care surgery outcomes.

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AMA CODE SAYS: PEER-REVIEWED ARTICLE

Care of Patients Who Are Incarcerated

Amber R. Comer, PhD, JD

Abstract
This article considers AMA *Code of Medical Ethics* opinions relevant to the care of patients who are incarcerated.

Treating Patients Who Are Incarcerated

Clinical expectations for treating patients who are incarcerated present many ethical questions that have potential to influence a physician's ability to provide care.[1] From the moment patients present, they face potential for bias due to the impossibility of concealing their incarceration or other factors.[2,3] For example, when a patient is incarcerated, a representative of the carceral system, such as a corrections officer, is present during patient-physician encounters or posted outside of the patient's door.[3] Such patients, when treated in community health centers, will also often be shackled for reasons beyond what is medically indicated.[4] Further contributing to potential for bias is, in some cases, inquiry about reasons a patient is incarcerated.

Beyond potential for bias, incarceration restricts one's physical autonomy, which can exacerbate confusion about who is legally and ethically able to make health decisions for a patient who is incarcerated, whether the patient can have visitors during an in-patient hospitalization, and whether it is appropriate to have a representative of the carceral system present during examinations or procedures. This article examines guidance from the American Medical Association (AMA) *Code of Medical Ethics* on how to ethically engage care of patients who are incarcerated during clinical practice.

The AMA *Code* on Treating Patients Who Are Incarcerated

When faced with treating a patient who is incarcerated, physicians—even if they are aware or assume that the reason for incarceration is for morally reprehensible offenses—are called on by the AMA *Code* to provide the same quality of care to all patients regardless of personal characteristics and other nonclinical or nonmedically relevant factors.[5] The *Code* also calls on physicians to foster an environment of trust, which includes cultivating self-awareness of implicit bias, so that their patients feel comfortable disclosing information exchanged during clinical encounters.[6,7] The AMA *Code* requires that all patients be treated equitably, regardless of their status, unless there is a specific law or policy that otherwise directs the process of treating incarcerated patients.[8] Additionally, the history of state abuse of prisoners, including torture and nonconsensual experimentation, coupled with the plausibility of coercion due to the physical loss of autonomy, warrants classifying this population as

vulnerable.[9,10,11] Considering their patients' vulnerable status, it is important for physicians to recognize that the AMA *Code* provides additional ethical recommendations for ensuring the protection of patients who are incarcerated, including the prohibition of physicians engaging in torture and a call for physicians to exercise caution when asked to perform court-ordered medical treatments.[12,13]

Applying the AMA *Code* to Clinical Practice

Who makes medical decisions for prisoners or patients who are incarcerated? Treating patients who are incarcerated raises questions regarding their competency and capacity to make medical decisions because prisoners are wards of the state and, therefore, do not have custody of their own body, a concept which challenges the ethical principle of respect for autonomy.[14,15] *Competency* refers to the legal ability to engage in health decisions and is determined by a judge, whereas *capacity* is a clinical determination referring to a patient's ability to process information necessary to make informed health decisions and is determined for a specific decision at a specific point in time by the clinical team.[16] Once a patient is declared incompetent by a court, only a court can remove this standing; however, capacity can wax and wane.[16,17] While patients who are incarcerated are under the physical custody of the warden of their facility, they maintain their autonomy and the right of self-determination regarding their medical decisions.[14] Generally, when a patient is declared incompetent by a court, they are not able to consent or refuse specific interventions, or make broader medical decisions, as this responsibility falls to their court-appointed guardian.[18] It is a unique premise, then, that patients who are incarcerated can maintain capacity to make medical decisions and still not be allowed to do so because they are physically in the custody of the government.[18] While the carceral system maintains physical control of patients, patients' capacity to make decisions should be assessed and respected, just as it is for other patients.[14]

It is important to note that patients who are incarcerated have the ethical ability to engage in medical decision-making in the same manner as patients who are not incarcerated.[19] Therefore, an advance directive or advance care planning document should be considered in the same manner for patients who are and are not incarcerated.[20] When a patient who is incarcerated lacks capacity to make decisions, the patient's legally appointed health care representative should serve as their proxy decision maker. If a patient who is incarcerated has not appointed a legal representative, state law should be followed regarding the appointment of a surrogate medical decision maker.[21] When a patient who is incarcerated lacks capacity, assent should be sought, when possible, in the same manner as for a patient who is not incarcerated. Representatives of the carceral system—for example, the prison warden—should refrain from making medical treatment decisions for patients who are incarcerated and have capacity.

Is it appropriate to ask a patient why they are incarcerated or to search for information about the patient's reason for incarceration online? The patient-physician relationship is a covenant that requires physicians to provide high-quality care regardless of the social, political, or economic standing of their patient.[22] Whatever the background of the patient, physicians must put forth every effort to remain impartial regardless of *why a patient is incarcerated*, if known. Additionally, patients are entitled to privacy and confidentiality; therefore, seeking information about a patient outside of the information they provide within the context of the patient-physician relationship has the potential to violate the patient's trust in the physician, can harm the relationship, and should be avoided.[6,23]

Is a patient who is incarcerated able to decline the presence of a correctional officer during discussions or examinations? The ability to provide high-quality care is premised on the trust inherent in the patient-physician relationship.[22] Trust allows patients to feel comfortable disclosing their most intimate and private information, which is the foundation for providing effective treatment.[6] Part of confidentiality is allowing patients to determine to whom their personal health information is disclosed. Although patients who are incarcerated have restraints on their autonomy, their autonomy is not fully eclipsed by the carceral system. As such, outside observers of a patient's clinical encounter should only be permitted if the patient has explicitly agreed to their presence or if it is necessary to uphold the safety of the patient or physician.[23] In the event an examination involves a patient's sexual anatomy or is sensitive in nature, a properly trained chaperone should be offered to the patient in the same manner as a patient who is not incarcerated.[24] In the same way that a patient's family member or trusted companion is not qualified to serve as a chaperone, a member of the carceral system should not serve as a chaperone; this role should be filled instead by a trained member of the health care team.[24] A patient who is incarcerated may request to decline the presence of a representative of the carceral system, such as a correctional officer; however, a physician or the carceral system representative may determine that a representative of the carceral system is necessary in order to maintain the safety of the physician or the patient.[24,25] When an outside observer is present, whether that observer is a chaperone or representative of the carceral system, conversations regarding the patient's medical condition, including their history, should be minimized.[24]

Are hospitalized patients who are in the carceral system permitted to have visitors? Visitors of hospitalized patients play an underrated role in recovery by improving both well-being and satisfaction.[26,27] The same holds true for hospitalized patients who are incarcerated, as visitation is important for their emotional and psychological well-being. Additionally, visitation by a patient's surrogate medical decision maker has a direct effect on patient care, as the efficiency of the surrogate's communication with physicians increases the quality of medical decision-making.[26] Patients should be allowed to have their surrogate medical decision maker present to make or assist with making medical decisions. Although the literature has found negative effects on decision-making and patient well-being when hospital visitation is restricted,[27,28] there is no standard or consistent policy ensuring that patients who are incarcerated can receive visitors during their hospitalization. Visitation policies for hospitalized patients who are incarcerated are established by either the hospital or the carceral system whose jurisdiction the patient is under. Patients with a terminal diagnosis are generally permitted to have a visitor or visitors and ought to be able to engage in at least minimal physical contact with their visitor. Ethically, prisoners should have more extensive visitation rights than they are currently provided.

Should physicians comply with court-initiated or mandated medical treatments of patients who are incarcerated? There is a long history of state-sponsored abuse of persons who are incarcerated, including denial of treatment for punishment and using prisoners in medical experiments without their consent.[9,29] While incarcerated persons maintain their ethical right to medical decision-making, there are times when the court may mandate or initiate medical treatments for a patient who is incarcerated. Physicians must not participate in the administration of cruel, inhumane, or degrading treatments or punishments of such patients under the guise of medical treatment.[12] Importantly, physicians should decline to provide treatment when court-mandated medical treatments are not based on sound medical diagnosis and standards of care,

not therapeutically efficacious, or undoubtedly a form of torture, punishment, or mechanism of control.[12,13] Physicians should act in good conscience to ensure that the patient who is incarcerated has given their voluntary consent without coercion.[13]

Conclusion

Treating patients who are incarcerated evokes ethical challenges that, due to the restraint on their physical autonomy, are unique to this patient population. Despite this constraint, patients who are incarcerated are ethically entitled to autonomy regarding their decisions, including the appointment of a health care proxy of their choosing to make decisions in the event of their incapacitation.[20,21] Importantly, patients who are incarcerated should ethically be treated the same as other patients.

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Amber R. Comer, PhD, JD is the director of ethics policy and the secretary of the Council on Ethical and Judicial Affairs at the American Medical Association in Chicago, Illinois. She is also an associate professor of health sciences and medicine at Indiana University. Dr Comer is an expert in medical decision-making for patients with critical illness.

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When Should Surgical Human Subject Research Involve Patients Who Are Incarcerated?

Lubna Khan, MD and Marcus Hoffman, MD

Abstract

Surgical research involving patients who are incarcerated is fraught with ethical, logistical, and practical questions. This article first considers important moments in the history of research with people who are incarcerated and suggests how they have contributed to evolution in human subject research ethics and regulation. This article also examines the problem of limited data about surgical disease burden and describes barriers to enrolling individuals who are incarcerated in surgical clinical trials, including study exclusion criteria and clinician-investigator bias. Finally, this article recommends strategies for balancing human research subject protections with the need for equitable enrollment in surgical clinical trials, especially later-phase trials in which benefit is more likely than in early-phase trials.

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Human Subject Protections

During the mid-20th century, people who were incarcerated were subjects of medical experimentation without their comprehensive understanding, especially in drug development trials, possibly in exchange for leniency or parole reevaluation.[1,2,3,4,5,6] In response to Nazi human experimentation, the Nuremberg Code of 1947 established ethical standards for human experimentation, emphasizing informed consent, minimal suffering, and absence of coercion.[7] Although never formally adopted by any international agency, the Nuremberg Code became the foundation for subsequent ethical standards.[8]

During the 1960s, the majority of non-federally funded phase 1 pharmaceutical trials utilized individuals who were incarcerated as primary subjects,[9] raising significant concerns about exploitation.[9,10,11] Federal regulations were finally enacted after headlines broke in 1972 about the 4 decades-long US Public Health Service Untreated Syphilis Study at Tuskegee, Alabama, and at other locations; revelations about these studies also led to the creation of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.[12,13] The commission noted that

research in correctional settings presented problems related to coercion and autonomous consent.[14] The National Commission's report (published in 1976) led to the adoption in 1978 of regulations (45 CFR 46 Subpart C), which set specific protections for prisoners, including limited permissible research types, risk-benefit assessments, mandatory informed consent, and independent review by institutional review boards (IRBs), with the further requirement that an IRB member be a "prisoner" or a knowledgeable "prisoner representative."[15] Increased oversight of human subject research involving individuals who are incarcerated created a gradual shift from unethical research practices to the near exclusion of such individuals from potentially beneficial clinical research.[3,16]

The 1979 Belmont Report established ethical principles,[17] codified in 1991 as the Common Rule, which requires IRB review and approval for human subject research.[8,18] However, the additional safeguards of 45 CFR 46 Subpart C created regulatory barriers to the inclusion of individuals who are incarcerated in studies of carceral populations' health that, over time, led to gaps in incarceration-related health data.[19] Specialized IRB approvals and lengthy review and approval processes discourage researchers from enrolling individuals who are incarcerated, and the requirement to prespecify such participants discourages inclusion of those who are incarcerated during a study due to the need for additional IRB notifications.[20] These challenges lead to flawed estimates of racial and ethnic health inequity, especially given the disproportionate incarceration of minority groups.[21]

Determining the Surgical Disease Burden

Most national databases used for surgical outcomes research do not track incarceration status, which makes it difficult to extrapolate the surgical disease burden of individuals who are incarcerated.[22,23,24] Beyond complex ethical and regulatory challenges, conducting large-scale studies on individuals who are incarcerated presents considerable logistical difficulties. These include data-sharing agreements with individual state and federal corrections departments as well as privately run facilities, each with its own restrictions. In many cases, these institutions might be reluctant to cooperate with research that could reveal data potentially reflecting negatively on their institutions, making access and collaboration even more difficult.

Some researchers have suggested using a "don't screen, don't exclude" approach, which allows patients who are incarcerated to be included in studies whose subjects are not limited to this patient population without additional screening to meet regulations.[25] By not screening for incarceration status, researchers circumvent the extra regulatory requirements, which would otherwise delay the research process or necessitate special approvals. However, this shortcut also means that specific health issues related to incarceration might go unaddressed, thereby maintaining gaps in incarceration-related health data.

The only true data point regarding national surgical disease burden of individuals who are incarcerated came in the 1997 Bureau of Justice survey, which featured only one question regarding the need for surgery during incarceration and hence lacked specifics on diagnosis, procedures, or outcomes.[26] Rather than addressing these gaps in future surveys, the most recent Bureau of Justice survey from 2016 opted to exclude all inquiries related to surgery among the incarcerated population.[27] Without accurate data, advocacy to improve the standard of care proves more challenging.[28]

A few studies have attempted to estimate the local surgical disease burden of individuals who are incarcerated. In Florida's largest county, nearly a quarter of inmate deaths were attributable to acute surgical diseases or traumatic injuries, yet only a third of individuals who died received surgical care.[29] In California, the incidence of surgical disease in 2012-2014 among individuals who were incarcerated was comparable to the general population, but these individuals had high rates of complicated presentations and low rates of surgical intervention.[30] These studies highlight the disparities in access to surgical care and outcomes for individuals who are incarcerated, underscoring the need for a national review to address these issues.

Focusing federally funded research on issues affecting individuals who are incarcerated is essential to ensure that they do not disproportionately bear research burdens without receiving corresponding benefits.[31] While the necessary protections for ethical research involving this population are well established, the main challenge lies in securing the financial and personnel resources to implement these safeguards effectively. Doing so requires strong advocacy and political will, both of which are lacking due to the marginalized status of this population. We believe that the absence of consensus among researchers on the importance of improving health care and research in correctional settings leads policy makers to view these initiatives as controversial, resulting in a lower priority for funding and support.

One potential solution involves fostering partnerships among correctional facilities, academic institutions, and health care systems to create a framework whereby research is seamlessly integrated into the routine care of individuals who are incarcerated. This model could be adapted from research practices in veterans' hospitals, where health care and clinical research are closely aligned. This approach would ensure ethically conducted studies that are directly relevant to the surgical needs of the incarcerated population.

Ethical Distinctions in Surgical Research

Conducting surgical research involving individuals who are incarcerated presents several unique ethical challenges. The findings of one study suggest that the rate of health literacy among such individuals is low, which limits their understanding of procedures and treatment options, thereby complicating their ability to provide informed consent for research studies.[32] Moreover, surgical choices among patients who are incarcerated might be influenced by external factors beyond a mere assessment of risks and benefits.[33] For instance, individuals might opt for surgery or enroll in research studies primarily to avoid returning to prison. The presence of guards during surgical consultations restricts privacy and might intimidate patients, hindering open communication. Limited access to family members for support further deprives individuals who are incarcerated of valuable input during decision-making. These factors collectively impede their comprehension and ability to freely consent to surgical research participation.

Surgical research also necessitates postoperative assessments, but changes in imprisonment status can affect study eligibility. Individuals initially enrolled while incarcerated might be released or transferred, hindering follow-up appointments, while those previously ineligible to enroll might become eligible during follow-up. Researchers often exclude this population due to the challenges of meeting regulatory requirements, but this default exclusion raises costs and decreases the effectiveness of clinical trials, ultimately jeopardizing the interests of vulnerable individuals.[25]

In cases of trauma, "exception from informed consent" allows retrospective consent to be obtained from patients or their families. However, difficulties in contacting family members can result in the exclusion of individuals who are incarcerated from trials requiring immediate randomization and intervention, which might have been why such individuals were excluded from a trial of prehospital plasma administration.[34] This exclusion might contribute to worse outcomes in patients who are incarcerated, but data on the topic remain scarce.

Risk-Benefit Profiles for Patient-Subjects Who Are Incarcerated

While research participation might provide patient-subjects' access to specialized interventions, it also introduces unique risks at various stages of clinical trials (see Table). Early-phase studies can expose patient-subjects to undue risk without known benefits, while later-phase studies might offer novel treatments that have already been tested for safety. Inclusion of individuals who are incarcerated in studies not involving drug testing raises additional risk-benefit considerations. For example, enhanced recovery studies typically result in shorter hospital stay and improved outcomes,[35] with the trade-off that the few patients who develop complications will do so after discharge, and these complications might go unaddressed in the correctional setting. Similarly, longitudinal studies offer the benefit of consistent health monitoring and care for chronic conditions, but, for patients who are incarcerated, they also can be the cause of disruptions in access to care due to changes in custody status.

Table. Risk-Benefit Assessment of Enrolling Patients Who Are Incarcerated in Clinical Trials

Clinical trial phase	Brief description[a]	Benefits of involvement[b]	Risks of involvement[c]	Risk vs benefit assessment[c]
Phase 1	Small group (20-100) to assess safety, dosage, and side effects	• Monitoring by research staff	• Experimental treatments carry unknown risks, especially for vulnerable groups • Limited follow-up care for complications	*Risk outweighs benefit*. Early-stage trials carry high risks with limited potential benefit for vulnerable groups
Phase 2	Larger group (100-300) with disease/condition to assess efficacy and side effects	• Potential benefits for chronic conditions when treatments target common health issues	• Potential exploitation and ethical concerns over voluntary informed consent • Limited follow-up care for complications	*Risk slightly outweighs benefit*. Moderate risks, with some potential benefit, but ongoing ethical concerns remain
Phase 3	Large group (300-3000) with disease/condition to confirm efficacy, monitor side effects, and compare with standard of care	• Access to innovative treatments otherwise unavailable • Greater oversight of complications during participation	• Risk of coercion due to desire for better treatment or parole incentives • Limited follow-up care after trial, especially upon release	*Risk balanced with benefit*. Ethical and logistical risks exist but may be outweighed by access to proven treatments
Phase 4	Post-approval studies to monitor long-term effects, benefits, and risks	• Access to specialized care and new treatments. • Long-term health monitoring might improve overall outcomes	• Potential exclusion due to logistical challenges or changes in custody status • Long-term monitoring and informed consent issues	*Benefit outweighs risk*. Lower risks in post-marketing studies, with more benefits for long-term care and outcomes

[a] Step 3: clinical research.[36]
[b] Clinical trials information,[37] Benefits and risks of participating in a clinical trial.[38]
[c] These columns are derived from a synthesis of information from the text rather than any single source.

For surgeons who act as both caregivers and researchers, when patients look to them for advice on the best treatment options, it is crucial to ensure shared decision-making in which a clear distinction is made between clinical advice and research-related information. The inherent limitations on autonomy within carceral settings are compounded by power imbalances between individuals who are incarcerated and surgeons, raising concerns about coercion during treatment selection.[39]

Surgical researchers must also studiously avoid undervaluing potentially beneficial studies due to preconceived biases regarding the ability of patients who are incarcerated to adhere to treatment regimens and follow-up protocols.[40,41,42] These biases often originate from assumptions about the challenging correctional environment and concerns about patients' access to ongoing medical care after the research is concluded. Additionally, there might be apprehension about the logistical complexities involved in coordinating follow-up appointments. This reluctance can perpetuate the underrepresentation of such individuals in surgical research, further exacerbating disparities in health care access and outcomes.

Conclusion

While attempting to prevent exploitation of individuals who are incarcerated, the extra federal protections currently in place limit their access to research benefits. Regulatory and logistical barriers to research perpetuate unaddressed gaps in access to surgical care. However, lowering these barriers risks compromising protections for patients experiencing incarceration, who are particularly vulnerable to exploitation and coercion. Despite limited data, regional studies have revealed surgical care disparities among such individuals, necessitating national attention. Ethical considerations for surgical researchers include ensuring informed consent, addressing power imbalances, and mitigating biases while prioritizing patient autonomy. In order to promote equity in surgical research, researchers must safeguard the rights of those who are incarcerated through ethically sound protocols while fostering trust and informed decision-making.

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Lubna Khan, MD is a general surgery resident in the Global Surgery Track at Baylor College of Medicine in Houston, Texas. Her research focuses on access to trauma care in post-conflict and post-disaster regions of the greater Middle East.

Marcus Hoffman, MD is an associate professor of surgery in the Division of Trauma and Acute Care Surgery at Baylor College of Medicine in Houston, Texas. His research interests include the influence of frailty and debility on outcomes in trauma and critical illness. Dr Hoffman also has a strong interest in medical student and resident education.

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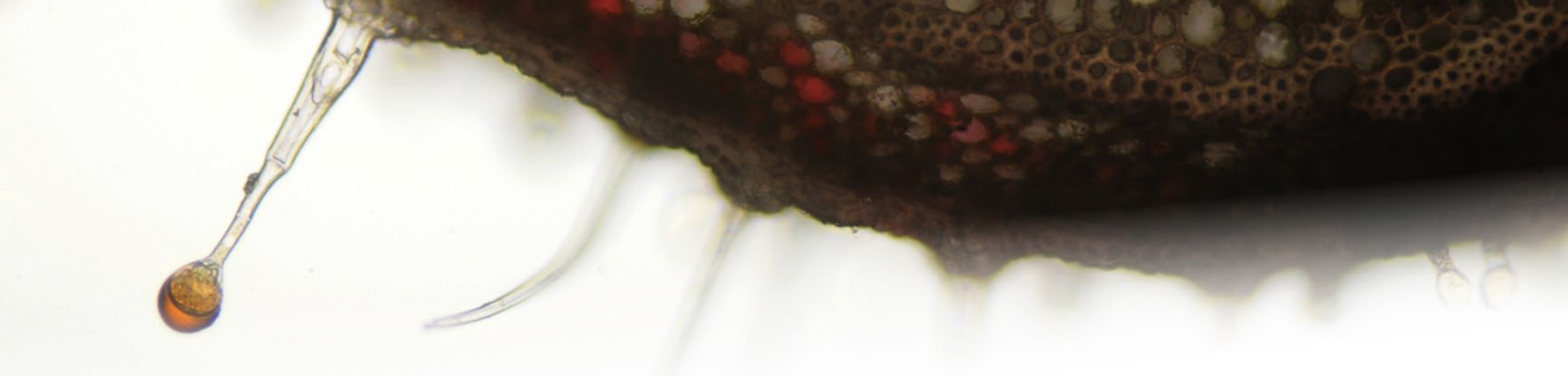

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HISTORY OF MEDICINE

How Foundations of Carceral Health Care Came From a Right to Sue

Jorie Braunold, MLIS

Abstract

The focus of the American Medical Association (AMA) on health care for persons who are incarcerated was in response to the US Supreme Court's 1964 *Cooper v Pate* holding. This article summarizes key points from AMA work during the 1970s that led to further development of carceral care standards by the National Commission on Correctional Health Care.

Carceral Facilities as Sites of Physicians' Obligations

When the American Medical Association (AMA) was founded in 1847, its goals included promoting public health, in part by defining the nature and scope of physicians' professional roles. It is unsurprising that one of its first tasks was to enumerate physicians' duties to the public, including to persons who are incarcerated. Article I, Chapter III of the first *Code of Medical Ethics* explicitly acknowledges ties between AMA work and carceral settings as they pertain to public health.

> As good citizens, it is the duty of physicians to be ever vigilant for the welfare of the community, and to bear their part in sustaining its institutions and burdens: they should also be ever ready to give counsel to the public in relation to matters especially appertaining to their profession, as on subjects of medical police, public hygiene, and legal medicine. It is their province to enlighten the public in regard to quarantine regulations, - the location, arrangement and dietaries of hospitals, asylums, schools, prisons, and similar institutions,- in relation to the medical police of towns, as drainage, ventilation, &c.,- and in regard to measures for the prevention of epidemic and contagious diseases; and when pestilence prevails, it is their duty to face the danger, and to continue their labours for the alleviation of the suffering, even at the jeopardy of their own lives.[1]

It is notable that "prisons" are named explicitly. Victorian-era America was awash in ideas about prison reform, with some of the most notable and notorious systems designed during that time, including the Auburn System and the Pennsylvania System.[2]

Carceral Health Deficiencies

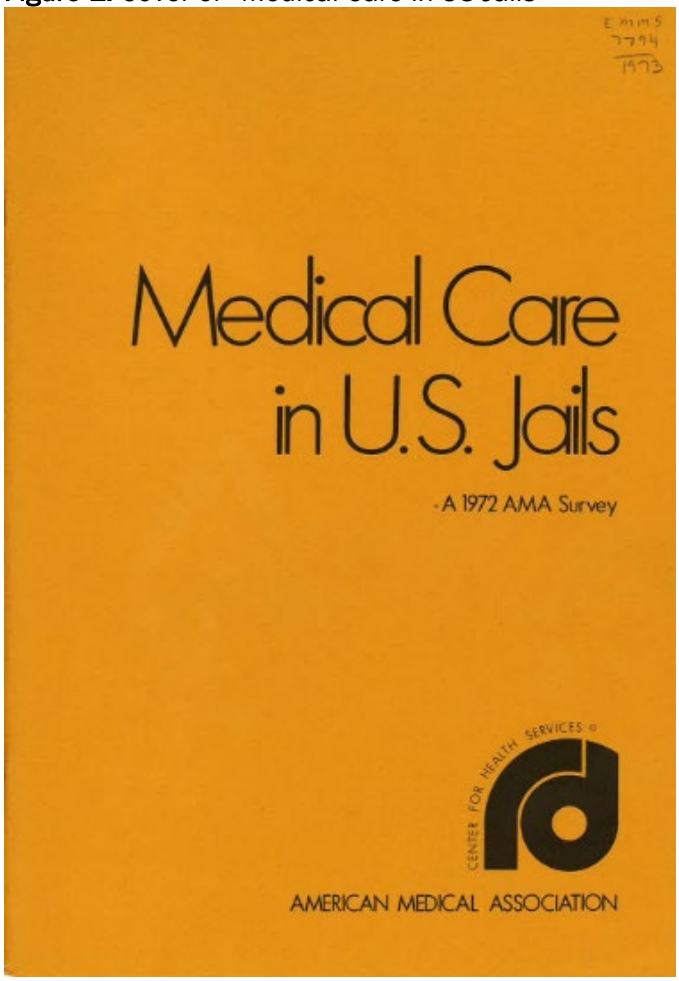
The AMA did not take a leading role in carceral health care until the 1970s, after *Cooper v Pate*,[3] a 1964 US Supreme Court case, ruled that state prison inmates have standing to sue in federal court to address grievances. The formation of the Law Enforcement Assistance Administration (LEAA) in 1968[4] also created an environment in which prison conditions could be scrutinized. An early task of the LEAA was a national jail survey, which was completed in 1970. A goal of the survey was to provide answers to "such fundamental questions as the number of jails, the number and type of inmates … the

operating costs, and the presence or absence of selected facilities."[5] The results revealed that health services delivered in infirmaries, for example, were dismal: only about half of jails either at the county level or located in municipalities of 25 000 or greater population had "facilities" for their inmate populations.[6]

These results worried members of the Commission on Correctional Facilities of the American Bar Association, so they contacted their frequent collaborators on medical-legal issues, the AMA. According to Dr Herbert C. Modlin of the AMA:

> In 1971 representatives of the Commission on Correctional Facilities of the American Bar Association expressed their concern to the AMA about the poor quality of medical services in correctional institutions, particularly in jails. Discussions with members of the National Sheriff's Association and the American Correctional Association clearly showed that the problem was serious. To acquire more accurate data than any available, staff members composed and submitted to 2,900 sheriffs a four-page questionnaire on medical services.[7]

Figure 1. Cover of "Medical Care in US Jails"



Courtesy of the American Medical Association Archives.[8]

The questionnaire, sent to sheriffs across the country (though only 39.6% of jails responded[6]), excluded administrators of federal and state prisons or other correctional institutions; institutions exclusively for juveniles; jails located in Connecticut, Delaware, Rhode Island, New Hampshire, Vermont, Hawaii, and Alaska that were not operated on a county level; and overnight lockups. Questions posed included the following: "What is

the average number of inmates receiving medical care per month?" and "What type(s) of medical facilities are available in the institution?"[8] The survey's results were published[5] and sent to various stakeholders, including the AMA's Board of Trustees, which promptly allocated $50 000 for further study and planning of a program to improve medical care in the nation's jails.[7]

Bleak results quickly emerged: a picture of outdated facilities, inadequate staffing, limited funds, and disinterested clinicians. Fewer than 40% of facilities had physicians regularly available and 66% had only first-aid facilities.[5] Moved by the findings, the LEAA joined with the AMA in 1974 to begin a 3-year pilot project that began on April 1, 1976.[7] Notably, 1976 was also when the Supreme Court ruled in *Estelle v Gamble* that jails and prisons have an "obligation to provide medical care for those whom it is punishing by incarceration."[9,10]

Creating Standards

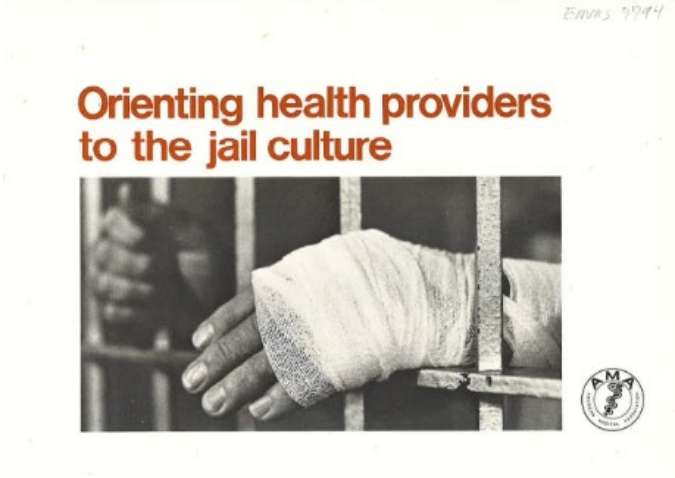
The AMA and LEAA sought to develop "model health care delivery systems for jails," construct minimal standards and implement a national certification program for jails, and create "a national clearing-house of information on jail health services."[7] Six pilot states were chosen, and, by mid-1977, a much-revised draft of the medical standards for jails was nearing its final form.[7] It included 83 guidelines for minimum standards for medical, dental, and mental health and for alcohol and drug addiction services offered to inmates. It also set procedures for keeping medical records and prescribing medications and called for physical examinations for inmates.[11]

With approval from the AMA's Board of Trustees and House of Delegates, the standards were distributed to jails in the 6 pilot states, along with invitations to apply for certification.[7] As Modlin explains: "A survey team evaluated each applicant jail. The National Advisory Committee then granted or denied certificates on the basis of results and recommendations from its accreditation subcommittee."[7] Once approved by all relevant parties, this set of standards was sent to participating states in order to prepare them for accreditation. That same year, the AMA also hosted the first-ever National Conference on Improved Medical Care and Health Services in Jails.[12] By 1979, 20 more states had joined the program and sought accreditation.[7]

AMA Materials on Carceral Health

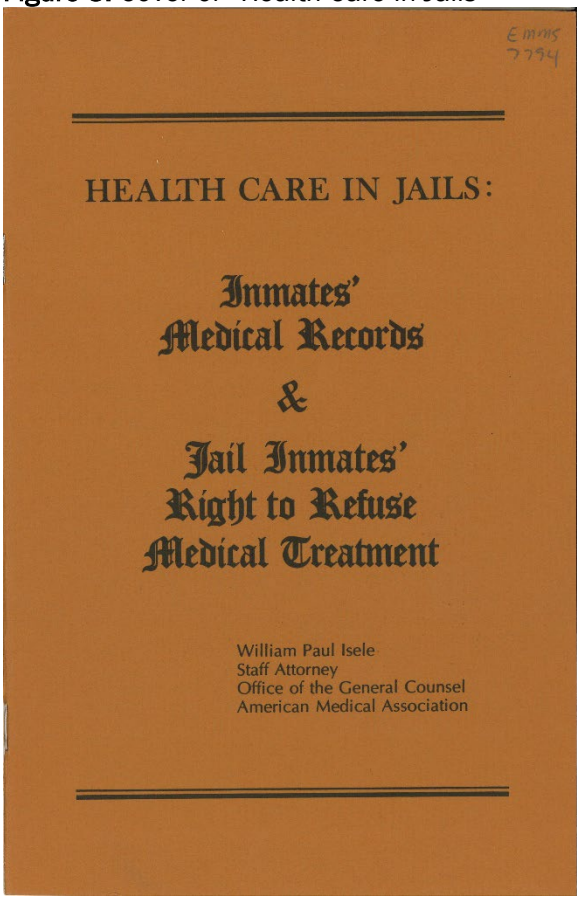
The pamphlets whose covers are displayed in Figures 2 to 5 represent just a fraction of the materials created by the AMA to advise carceral institutions on specific issues related to health care for inmates. They are largely undated but were all created in the late 20th century.[13]

Figure 2. Cover of "Orienting Health Providers to the Jail Culture"



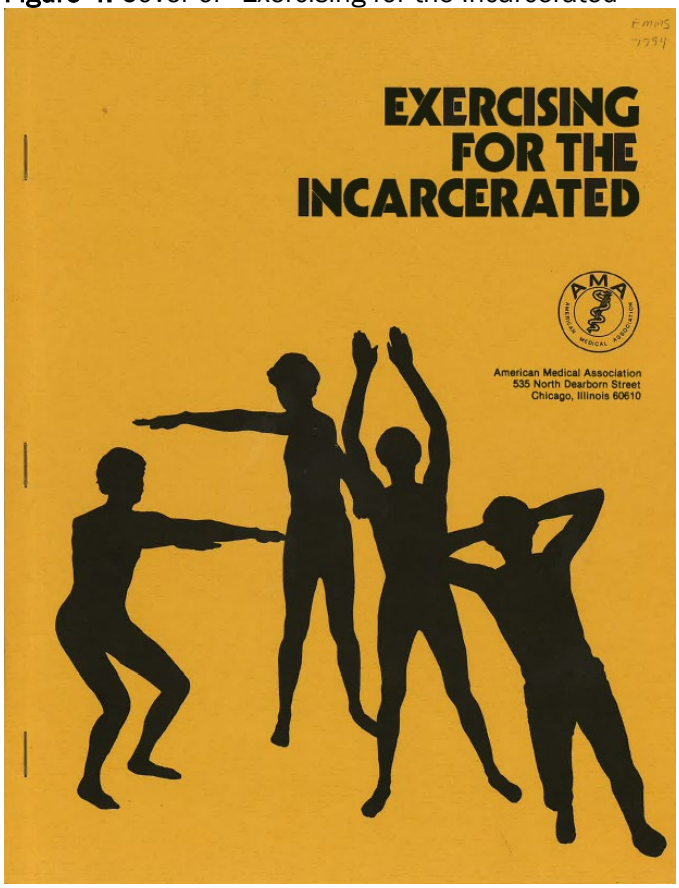
Courtesy of the American Medical Association Archives.[12]

Figure 3. Cover of "Health Care in Jails"



Courtesy of the American Medical Association Archives.[12]

Figure 4. Cover of "Exercising for the Incarcerated"



Courtesy of the American Medical Association Archives.[12]

Figure 5. Cover of "Guide for the Care and Treatment of Chemically Dependent Inmates"

Courtesy of the American Medical Association Archives.[12]

Before 1980, this work had begun to bear fruit. The American Correctional Association and National Sheriffs' Association incorporated the medical standards proposed by the AMA into "their general standards for correctional institutions," and, in overseeing a lawsuit against the Los Angeles County jail for insufficient medical care by inmates, the presiding judge asked the AMA's survey team to investigate using its newly created standards as criteria.[7]

Expansion

"Reasonably satisfied" with the standards it had created in jails, the AMA in 1978 turned its focus on prisons and juvenile institutions, where the standards were field-tested and modified as necessary. Additional specifications for mental health were studied and incorporated as well.[7] In 1982, with funding from the Robert Wood Johnson Foundation, the program was subsumed under a larger advisory body, with the AMA as one participant among many.[12] It evolved into the National Commission on Correctional Health Care, which is still active to this day.[12]

After it relinquished control of the program, the AMA occasionally waded into the discussion of health services for people who are incarcerated. Since 2016, the House of Delegates has been refining and modifying its policy on "Health Care While Incarcerated." Some of the measures advocated for include programs and training to address distinct health service needs of women and girls who are incarcerated and state Medicaid agencies' acceptance and processing of Medicaid applications from adults and children who are incarcerated.[14] Most recently, in 2023, the House of Delegates voted to collaborate with relevant parties to advocate for quality care and oversight of care for people who are incarcerated by ensuring that staff and administrators meet the same standards as those in community-based health care with similar roles.[15]

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Jorie Braunold, MLIS is the archivist for the American Medical Association in Chicago, Illinois. She has an MLIS in library and information sciences with a focus on archives from Dominican University.

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PERSONAL NARRATIVE

Alone, Handcuffed to a Bed Awaiting Surgery

Amber R. Comer, PhD, JD

Abstract

Hospital inpatients who are incarcerated spend most of their time alone, are not permitted to have visitors while hospitalized, and are handcuffed to their beds. This story describes an ethics consultation about one such patient's surgical care.

Stepping Into the Unknown

As I grabbed the cold steel handle of the hospital room door, the sheriff guarding the patient's room glanced at my badge hanging from the lapel of my collar. Without provocation, I said, "I am with the hospital ethics committee." The sheriff silently nodded his approval to proceed, but, before I entered, I heard a voice from behind me whisper, "Good luck. He is aggressive, belligerent, and just plain rude.... But I am glad you are here; we are all at our wits end." I was not surprised to hear this from the nurse who was caring for this patient because I had already been warned by the surgical team when it requested an ethics consultation that this patient was "impossible." I gave a slight smile and responded that I would do my best to help. I felt a twinge of fear in my stomach as I opened the door.

When I entered, I could hear the patient screaming profanities. As our eyes met, the man, who was in his late twenties, screamed at me, "Who the hell are you?" I took a deep breath before responding so that I could assess the situation. I noticed that the man was handcuffed to the bed, and I immediately knew that the patient was incarcerated and that the guard posted outside of the door was there not to protect the patient, but to protect everyone else. I also noticed that, in addition to his prison-mandated handcuffs, the patient was restrained by straps attached to his ankles and wrists in a way that made it impossible for him to move. Although it is typical for patients who are incarcerated to be handcuffed to their hospital bed, his restraints went beyond the norm. I wondered if his restraints were for his own or the staff's physical safety. After allowing several moments of silence to pass, I responded with my name and that I was from the hospital ethics committee. "What's that?" he asked. I explained that I was there because his care team was very concerned about him refusing a surgery that had the potential to save his physical function and likely his life. "They don't give a ____ about me!" he screamed. "They do care, or I would not be here," I said. I asked him if I could sit next to him, to which he quipped, "Do what you want."

To avoid engaging with me further, the patient began to sing loudly and aggressively, using many profanities. The song was not memorable, but the way he used verbal aggression as a coping mechanism was. I watched him as I sat down and pondered the story that the surgical team had told me. The patient, M, was jumped in the prison yard by several other inmates and during the beating sustained a C-4 spinal cord injury. Ethics had been consulted because M was adamantly refusing surgery and the surgeons were very concerned that if he moved the wrong way, he would sever his spinal cord, which would result in either quadriplegia or death. I was further informed that while the patient had full capacity, he was "difficult" because he mostly responded during interactions by singing and screaming profanities before eventually yelling at everyone to get out of his room.

I continued to silently watch M as he sang. Eventually, he stopped to angerly ask me why I was still there. "I am here because people care about you," I said. "You do not even know me," he yelled. "I do not need to know you to care about you," I replied. M said nothing and began watching TV. I said nothing and sat silently with him for a long time before asking if he wanted to talk. He screamed "No!" and told me to get the _____ out of his room. I told him I was happy to give him some space and that I would be back later. He mumbled something to the effect about his disbelief that I would return.

Second Encounter

Two hours later I came back to see M, as I had promised. I asked him if I could just sit with him for a while and said that we did not have to talk. He said, "Whatever." We watched *SpongeBob SquarePants* for about 15 minutes before the nurse came in to take his vitals. I watched silently as he verbally abused the nurse and refused to comply with anything she asked him to do before yelling at her to get out. We silently continued to watch *SpongeBob*. Eventually, I broke the silence by making a silly joke about Patrick, the starfish in the show. M chuckled. I continued to talk about the show. Slowly, M's responses went from one word to a sentence, and from a sentence to something that resembled a conversation. After a long while, I told M that I needed to go but that I would come back the next day.

Developing a Relationship

I came back the next day, and the next, and our interactions were mixed. Some days I was screamed at and told to leave before I even had the chance to say hello, and, other days, I was permitted to sit beside him while he watched TV. No matter how M treated me, I kept coming back, and eventually he asked me why I kept returning. I reminded him that I was there because people care about him. This time, M did not respond, and I took his silence as an opportunity to bring up his surgery. I told him everyone was worried that if he did not have surgery, he would end up as a quadriplegic or dead. I then mentioned that I could not imagine how scared he must be and how hard it must be that he could not have any visitors due to his incarceration.

Tears welled in M's eyes. We spoke for a while about what it was like to be in prison, and, eventually, I asked him why he was refusing surgery. M responded in a way that I never could have anticipated. M said he was scared and that all he wanted was for his momma to come visit him but that he was told that he was not permitted to have visitors. We spoke for a while about how he felt alone and scared. Eventually, M said he just wanted to see his mom so that she could tell him that everything was going to be okay. That day, I was able to arrange for M to talk to his mother on the phone, although he was not permitted to have her visit. I was told that patients who are prisoners can

only have visitors in the hospital if they are actively dying. I found this response incredibly frustrating because though he wasn't actively dying, the surgical team had said that M could die at any moment "if he moved the wrong way," not to mention that he was facing a potentially life-changing surgery that he was not guaranteed to survive.

A few hours later, I asked M if he felt ready to have the surgery, and, to my surprise, he said yes. The surgeons quickly seized the moment, and, later that day, I held his hand as the surgery team obtained consent for surgery, and I continued to hold his hand until they wheeled him away to the operating room.

Lessons Learned

I met M several years ago, and, even as I write this story today, I am brought to tears by the notion that this patient, who had been seemingly impossible to treat, was just reacting to his immense fear and that all he wanted was his mother. I cannot help but think that had this patient not been incarcerated, his hospital stay and journey to surgery would have been very different. The inability of M to be with his mother while he suffered through this extraordinarily difficult experience created a situation that was incredibly strenuous for him and the medical team.

Although M eventually consented to the surgery, he had to hold the hand of a stranger instead of the hand of his mother during what was likely one of the scariest moments of his life. While I recognize that M committed a crime and that prison was the consequence, I cannot help but feel that withholding the ability for someone to feel love and support while they are facing extraordinary hardship is a punishment that goes beyond the individual's criminal sentence. Not to mention the irony that M was permitted to have his mother visit him in prison, but she was not allowed to visit him in the hospital when he needed her the most.

I am grateful to the surgery team and nursing staff because they showed empathy and compassion for someone who very easily could have been dismissed as belligerent. Instead of giving up on M, even though giving up would have been easier, the entire medical team kept trying to help him. When I first walked into his room, I could never have guessed that the solution to this surgical dilemma would reside in any person's very human desire to have his mother present while he was scared.

Amber R. Comer, PhD, JD is the director of ethics policy and the secretary of the Council on Ethical and Judicial Affairs at the American Medical Association in Chicago, Illinois. She is also an associate professor of health sciences and medicine at Indiana University. Dr Comer is an expert in medical decision-making for patients with critical illness.

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