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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

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

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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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