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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?

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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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