Caring for Incarcerated Patients: Can it ever be equal?

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Abstract

Background
Incarcerated patients represent one of the most vulnerable populations in the US healthcare system. Studying disparities in care they receive, however, has been difficult due to a history of abuse at the hands of medical researchers rendering this population excluded from most current medical research. Due to incarceration, these patients are frequently maintained in shackles and under constant guard when receiving healthcare. There is a paucity of literature on the influence these measures exert on healthcare workers and the care they provide. Our study aimed to measure surgical trainee's perception of health inequities and disparities in incarcerated individuals undergoing surgical care.

Methods
An anonymous cross-sectional survey was administered at our single institution to all general surgery trainees assessing perceptions in delivering care to incarcerated patients within our hospital system. The survey consisted of 10 items, nine of which were yes or no responses, and 1 open-ended text question. Survey results were averaged, and percentages were reported.

Results
Of all current general surgery residents (n=60), 40 (66%) completed the survey. Almost all respondents (n=39, 97.5%) have cared for a patient that was incarcerated or in police custody. Most respondents (n=25, 62.5%) have operated on an incarcerated patient with an armed guard present in the operating room. Similarly, most respondents (n=26, 65%) have cared for a patient intubated and sedated that was shackled to a bed. The majority of respondents (n=30, 75%) recalled incidents where a trauma patient was actively questioned by law enforcement during the primary/secondary survey during initial trauma evaluation. At the time of hospital discharge, a quarter (n=10, 25%) of respondents reported being unable to prescribe all of the medications that a non-imprisoned patient would receive with the same condition. In addition, 18 (45%) respondents felt they were unable to arrange outpatient follow-up with physical or occupational therapy and/or the patient's primary/consulting physician due to patient's incarcerated status. Strikingly, half of respondents (n=19, 47.5%) believed that the incarcerated patient received substandard care, and the majority of respondents (n=28, 72%) agreed that the holding areas for incarcerated patients in the emergency room provide substandard patient care.

Conclusions
The current status of caring for incarcerated patients within our system represents an urgent and needed area for quality improvement. Surgical trainees report difficulty caring for these patients, and they perceive these individuals receive substandard care. Though our cross-sectional study did not assess the origin of this disparity, the challenges trainees face in caring for incarcerated patients, from assessment to diagnosis and treatment, as well as in follow-up signals an area requiring further research and study.

Keywords: Disparities, Incarceration, Residents, Quality Improvement, Health Policy

Introduction

The United States (U.S.) has the highest incarceration rate in the world, accounting for a population of over 2 million people, four times higher than the world average.[1,2] Further, incarceration disproportionately affects minority communities, with African Americans and Latinos having six and two times the likelihood of being incarcerated compared to White Americans, respectively.[2] The U.S. also imprisons more women than any other country.[2] Due to the high incidence of incarceration in the U.S., healthcare workers have become accustomed to navigating the unique challenges posed by caring for individuals who are currently incarcerated or under police custody, however there is a lack of guidance on how to appropriately care and advocate for these patients.

Presently, incarcerated patients are among the most protected and understudied of patient populations. Review of the medical literature reveals a paucity of data describing the outcomes of patients incarcerated or in police custody, and a few current studies focus on palliative care in incarcerated people and obstetrical care for pregnant incarcerated women .[3-10] This paucity of research can largely be attributed to the historical abuses incarcerated people have endured in the name of research, including withholding treatment of infectious diseases, measuring responses to chemoradiation, and testing of pain tolerance.[11-15] In response to this precedent of mistreatment, current institutional review boards (IRB) enforce strict criteria in the study of incarcerated people.[16] These protections, however, have inadvertently limited the study of a multitude of aspects of care for incarcerated patients, including access, quality, and outcomes in the delivery of medical, surgical, and mental health care. This is cause for concern, given the vulnerability of this patient population.

Hospital and correctional protocols for caring for incarcerated people include maintaining shackles during their stay, constant armed guardianship at the patient's bedside, and segregation of incarcerated patients to separate areas of the hospital, but these policies and protocols vary across hospital and correctional systems.[17] No studies exist regarding the impact of these policies on the quality and type of medical care rendered under such conditions.

The aim of this study was to assess the perception of care delivery to incarcerated patients by surgical trainees within the emergency and inpatient hospital environment. The ACGME requires that residents engage in quality improvement activities, including activities aimed at reducing health care disparities.[18] Residents frequently provide care at the front lines, and often witness inequities in care to vulnerable populations. This study gives a voice to residents recognizing the challenges of providing medical care to incarcerated patients. In addition, this study aims to provide a framework to better understand and describe how disparities in the care of incarcerated patients may exist using the World Health Organization framework (Figure 1).[19] Lastly, this study will discuss strategies for improving the care of incarcerated patients.

Materials and Methods

An anonymous cross-sectional survey was designed and administered at our institution to all Indiana University general surgery trainees as part of a quality improvement initiative. Although specific demographics were not collected on individual respondents, the general surgery program consists of 63 residents (6 residents per year), almost equally consisting of males and females (Male = 51%, Female = 49%). 62% of the residents identify as White/Caucasian, 17% Asian, 8% Black/African American, and 8% Hispanic/Latino. The survey was distributed online to the trainees through Survey Monkey. The survey consisted of 10 items,

nine of which were yes or no responses, and 1 open-ended text question (Table 1). Aggregate data was gathered and analyzed. Thematic analysis of qualitative responses was conducted. Questions were designed to describe the resident experience in different aspects of care for the incarcerated patient.

Results

Of all general surgical trainees, forty residents (66%) completed the survey (Table 1). Overall, 97.5% of respondents have cared for a patient who was incarcerated or in police custody. Most trainees (62.5%) have operated on an incarcerated patient with an armed guard present in the operating room. Similarly, 65% have cared for an intubated and sedated patient who was shackled to a bed. The majority of trainees (75%) recalled incidents where a trauma patient was actively questioned by law enforcement during the primary/secondary survey in the initial trauma evaluation. At the time of hospital discharge, 25% of trainees reported being unable to prescribe all of the medications that a non-imprisoned patient would receive with the same condition (including opioid pain medication). In addition, almost half (45%) of trainees felt they were unable to arrange outpatient follow-up with physical or occupational therapy and/or the patient's primary physician due to patient's incarcerated status. Strikingly, half of respondents (47.5%) believed that the incarcerated patient received substandard care, and the majority of respondents (72%) perceived that the separated holding areas for incarcerated patients in the emergency room provide substandard patient care.

Sixteen respondents included free text responses regarding personal experiences caring for incarcerated patients (Table 2). General themes included inequities in care, availability of social support, and loss of privacy due to presence of law enforcement. Specifically, several trainees described experiences in which incarcerated patients did not receive timely care for

surgical emergencies due to delayed presentation from jail or segregation in a separate holding area. Trainees expressed concern that hospital or law enforcement policies that prevent notification of next of kin by the incarcerated patient or healthcare provider severely affected the social support required for adequate care and convalescence. According to trainees, the presence of law enforcement was often felt and at times was invasive, directly impeding their ability to care for the patient. A few trainees commented on moments in which they had to request officers to leave the room in order to adequately care for the patient.

Discussion

Survey results from 40 general surgery residents reveal concerning disparities in the delivery of care for incarcerated patients. Trainees attested to observing incarcerated patients receiving substandard care compared to non-incarcerated patients. Trainees also reported significant challenges with getting these patients necessary medications upon discharge and outpatient follow-up. In addition, designated holding areas for incarcerated patients, or those under police custody have been recognized by a large proportion of residents as being understaffed and providing lower quality healthcare. Trainees listed a multitude of anecdotes where they felt law enforcement was invasive in patient care contributing to delivery of inadequate care. In addition, several responses highlighted the lack of healthcare personnel necessary to care for patients in emergency department (ED) holding areas. What remains unknown is whether these observations by residents have yielded poorer outcomes for this patient population.

Currently, it is difficult to assess the quality of care and outcomes of incarcerated patients due to the restrictions in place meant to protect them as a result of previous atrocities committed upon incarcerated individuals in the name of science. Research involving incarcerated individuals is complex due to the individual's compromised ability to make an informed and

voluntary decision to participate in research. [16] Due to this, these research projects often require review and approval from multiple agencies as well as meet a number of additional requirements, rendering research projects difficult to undertake.[16] While these strict guidelines protect the incarcerated population from malfeasance, they may be masking inequities in care. More research is necessary to identify health disparities in the large population of incarcerated individuals in this country, as well as the social determinants of health that perpetuate them.

The World Health Organization (WHO) framework for understanding and addressing social determinants of health can be used to describe how disparities in incarcerated patients arise.[19] It has been well established that socioeconomic factors including low socioeconomic status and non-white ethnicity are strongly associated with incarceration.[26-28] Unfortunately, those from low socioeconomic backgrounds are often entangled in cycles of poverty, crime, and incarceration that are difficult to escape. These cycles are perpetuated by public policies and services that maintain disenfranchisement and exacerbate a lack of access to gainful employment, quality education, and safety in their environment.[29-32] These external environmental factors often stress marginalized groups to adapt behaviors that enable survival.[27,28] Not only does this influence their physical and mental well-being but also embeds them in communities where others must do the same. Social stigma and blatantly discriminatory policies toward criminal offenders has led to further disenfranchisement of those who are incarcerated.[29-30, 32] This stigma often translates to hospital policies which leads to substandard care in prison infirmaries and isolates incarcerated patients to segregated ED holding areas with constant armed guardianship.[9, 21-25] Because the system of mass incarceration imprisons discriminately more African American and Latino people this further perpetuates the health disparities that already exist in these communities.[2, 28]

A conceptual framework for disparities research published by Kilbourne, et al describes three phases of disparities research: detecting, understanding and reducing.[33] This study can be categorized into the detection phase of disparities research, at the beginning of identifying vulnerable populations, defining health disparities that may exist, and postulating the factors that may perpetuate those disparities (Figure 1).[33] Resident trainees are at the forefront of and are integral to disparities research. Often, they are the frontline workers who will first identify inequities in care. Trainees and faculty work together through research to understand the determinants involved in the health disparity of interest, create strategies, and engage in policy to reduce them.

In order to address the disparities observed from trainees in the care of incarcerated patients, action must take place on a hospital and correctional system level to more closely assess policies related to four key areas: staffing of segregated holding areas, patient privacy during evaluation by a healthcare worker, social support for discharging incarcerated patients, and real-time communication of a patient's health status with next of kin. Best practices of care for incarcerated patients should be studied and universal practice management guidelines created to implement across healthcare and correctional systems. Guidelines should include algorithms for prompt identification and triage of severe illness, as well as standards for staffing of segregated ED holding areas. Case managers and social workers should be utilized to provide adequate communication with families, discharge planning, and post-acute care follow-up for incarcerated individuals. Policies that protect incarcerated or in-custody patients during a healthcare evaluation should be enacted to limit law enforcement interference until full evaluation, imaging, and necessary tests are completed. On a larger scale we must address the social determinants which increase the likelihood of incarceration (socioeconomics, ethnicity, racist policies) and

prevent ease of reentry to society post-incarceration. Changing societal values and attitudes towards incarcerated individuals will impact how we govern and care for them.

This study is limited in that it is a qualitative survey study of a small subset of the healthcare workforce population. In addition, certain survey questions could be perceived as leading, or non-neutral. The survey was initially created for quality improvement purposes without survey design experience, after analysis the present authors found the results to be an opportunity for education and advocacy. Additionally, we could not find reliable data to quantify the number of incarcerated patient encounters each resident sees annually, nor can we speak to the number of incarcerated patient encounters respondents have had throughout their training. Our residents rotate at a county hospital that serves the Marion County Jail population, as well as two level 1 trauma centers that serve the state and federal incarcerated patient populations.

Nonetheless, the results of this survey demand a revisiting of health and correctional system policies in providing healthcare for incarcerated patients. Assessing local policy with the goal of quality improvement could positively impact health outcomes and therefore address the inequities observed by surgical trainees. Furthermore, this study serves as a call to increase research for this vulnerable and underserved population to uncover and address the persistent inequities in their healthcare. Provisions should be made to study these patient's outcomes, and further research is required to identify and address incarcerated patient healthcare disparities. Future studies evaluating trainee's perceptions of incarcerated patient care should include semi-structured interviews to fully capture resident experiences in the care of this marginalized patient population.

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Figure 1. Application of the disparities research agenda as described by Kilbourne et al to this study.[33] This study serves to detect and begin to understand health disparities in incarcerated patients' access to healthcare.

Table 1 Caring for Incarcerated Patients Survey Results, listed are 9 yes/no questions and 1 open ended question posed to the general surgery residents.

Prisoners as Patients Questionnaire	Yes (%)	No (%)	N/A (%)
Q1: I have cared for a patient that was a prisoner or in police custody	39 (97.5)	1 (2.5)	0 (0)
Q2: When caring for a patient that was a prisoner or in police custody, I feel they received substandard care	19 (47.5)	20 (50)	1 (2.5)
Q3: I have cared for a patient that was shackled to the bed	39 (97.5)	1 (2.5)	0 (0)
Q4: I have cared for an intubated/sedated patient that was shackled to the bed	26 (65)	12 (30)	2 (5)
Q5: At the time of hospital discharge of a patient that was a prisoner or in police custody I was unable to prescribe all the medications that another patient with the same condition would have received.	10 (25)	28 (70)	2 (5)
Q6: At the time of hospital discharge of a patient that was a prisoner or in police custody I was unable to arrange outpatient follow-up with physical therapy, occupational therapy, or primary/consulting physicians	18 (45)	20 (50)	2 (5)
Q7: I have cared for a trauma patient in which the police/detectives were actively questioning the patient during the primary/secondary survey	30 (75)	10 (25)	0 (0)
Q8: The holding areas in the emergency room (for patient in police custody) provide substandard patient care (compared to a regular ER patient room)	28 (71.8)	11 (28.2)	0 (0)
Q9: I have operated on a patient in which an armed guard was present in the operating room	18 (45)	20 (50)	2 (5)

Table 2 Caring for Incarcerated Patients Survey Results, thematic analysis of open-ended response.

Question	Responses
Q10	
	Inequities in Care
	"I was consulted on a patient in the holding area of the ED at [*redacted*] the morning after he had been brought in. Patient reported being assaulted by police and complained of abdominal pain all night without getting an evaluation. CT just prior to my evaluation showed a pancreatic transection and he was taken emergently for ex-lap/distal pancreatectomy. The patient had a serious injury due to police assault and his complaints were ignored by officers and ED physicians overnight."
	"There was a prisoner with end stage liver disease who decompensated after emergent surgery for incarcerated hernia. He was already residing in an "infirmary" at the prison prior to his admission, so this likely made a difference, however the prison staff worked with me to get him discharged to a hospice situation which was his wish as his illness progressed. I was impressed with how well the transition went for this patient given his incarceration."
	"there is a severe disparity in nursing to patient ratios for our trauma patients in some locked units in the ED - likely a result of the variety of acuity that is avoided in other parts of the ED." "We are told they get therapy at the prison, so a lot of time discharged to prison for therapy and not an actual rehab center."
	Availability of Social Support
	"I think it's highly unfair that prisoners don't get to discuss major medical decisions with their family members like any other patient has the right to."
	I think it is absolute bull**** that patients who are prisoners are unable to contact their family and that we as health care providers are also unable to contact their family with any updates. I once had a patient who was newly arrested upon admission who just wanted to make sure her daughter was with her grandparents and she wasn't allowed to do that. Another gentleman left AMA so that he could call work and if he left the hospital he could make a phone call from the police station."
	"Mostly the ER holding areas. Unmonitored by proper clinical staff and moved there before surgery team would have liked. Getting supplies over there is real hard. As for police trying to question a trauma patient in the trauma bay during initial physician evaluation or during procedures I kick them out as we have a right to do that but I don't think all residents know that."
	Lack of Patient Privacy
	"I once operated on a prisoner who was under sedation for a CEA. He was getting fidgety and we were telling him the usual "you're okay" "you're in surgery, stay still". The armed guard took it upon himself to come up and grab the patients leg (over the sterile drape) to tell him to quiet down. As if his behavior was due to him being a prisoner and not because he was a patient under sedation."
	"On call recently, I took care of a patient in a single car MVA who had a traumatic arrest upon arrival. After CPR, epi, bilateral chest tubes, lines, multiple transfusions, the patient stabilized enough for CT. An officer, inside the cramped trauma bay, demanded a blood sample for EtOH prior to transport "because it HAD to be within a certain time from the accident." This person later died. I took care of an imprisoned person with multiple significant comorbidities who was transferred in for surgical care, however on arrival surgery was deemed futile. We were not allowed to call this persons kids or spouse to say goodbye, they died alone with a guard outside their room."
	"For questions 4-6 I answered NA because I do not clearly remember those experiences with patients who were prisoners. Regarding question 7, I have not had a police officer question a patient during a primary or secondary survey, but I did kick one out once for questioning and agitating a patient while I was trying to suture their laceration. I believe the biggest injustice I have noted is the segregated holding area at [*redacted*]. It is understaffed with nurses in comparison to the rest of the ED, increasing the risk for errors in the management of those patients."