Caring for the Incarcerated: An Orthopedic Perspective

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According to the 1976 Supreme Court case of *Estelle v Gamble*, the government is required to provide prisoners access to the necessary care for known, serious medical needs. Failure to do so violates the Eighth Amendment prohibiting the imposition of “cruel and unusual punishment.” Currently, more than 2.5 million Americans are imprisoned, the highest per capita rate in the world. In the current fiscal climate and with burgeoning health care costs for society as a whole, providing care for prisoners poses both moral and logistical challenges. From an orthopedic standpoint, caring for the incarcerated raises uniquely challenging issues due to the nature of this patient population and their types of musculoskeletal conditions.

**Care of Prisoners**

The responsibility of caring for prisoners varies from state to state. In approximately 20 states, health care operations have been shifted entirely or in part to private providers in an attempt to reduce costs. Some states have established geriatric units with medical capabilities and hospice wards to provide for an aging prison population. Elderly prisoners incur costs 9-fold higher than those of younger inmates and represent the fastest-growing incarcerated demographic. Approximately 40% of prisoners have a chronic medical condition. Due to rising societal health care costs, efforts to decrease expenses for inmate health care have been instituted. Although no prisoner can be denied necessary care based on ability to pay, in the authors’ state, a $3 copay is deducted from inmates’ personal accounts for each self-initiated request for treatment.

In the authors’ state, a managed care system has been implemented, including primary care physicians, standardized drug formularies, preauthorization of nonmandatory medical treatments, utilization review of hospital expenditures, capitated physician contract rates, and negotiated discounts on hospital services. Conditions have been tiered as acute or emergent, necessary but nonemergent, acceptable but not always necessary, limited medical value, and extraordinary. Orthopedic procedures such as joint replacement and anterior cruciate ligament reconstruction are classified as acceptable but not always necessary. With budget cuts, these semielective procedures are often eliminated in all but the most severe cases. Inmates are triaged by civil service and contract health care staff at infirmaries in each prison. Two skilled nursing facilities provide more intensive treatment as a step-down unit and a cost-effective approach for the long-term care of prisoners with serious illnesses and disabilities. Specialty outpatient clinics are held in one centralized facility and are also facilitated with telemedicine technology. For inpatient and emergent conditions, the state has partnered with the authors’ institution, which serves as a tertiary referral center and teaching hospital.

**Prisoners: A Unique Population**

Prisoners have a propensity to present with late-stage pathology for multiple reasons. First, prisoners are often from lower socioeconomic classes, are less educated, and have had less access to regular health care even before incarceration. Second, inmates are more likely to have engaged in high-risk behaviors and accumulated significant injuries over their lifetimes. Third, logistical hurdles within the prison health referral system and punitive measures such as solitary confinement frequently prevent inmates from being seen acutely after injuries sustained...
in prison. Fourth, prisoners have limited access to conservative treatment modalities while incarcerated. Due to security concerns, only certain types of braces, orthotics, or durable medical goods are allowed. Furthermore, there is limited access to physical and occupational therapy.

Most prisoners are grateful for medical care and are cooperative with physicians. The ride to the hospital can be onerous for inmates from distant locations, but the hospital stay and access to caring staff are usually considered a welcome change from the monotony of prison. Malingering must always be suspected. Drug-seeking behavior is common, and objective measures should always be used to confirm pathology before prescribing pain medications. Because inmates are not allowed access to high-strength narcotics, it is counterproductive to encourage reliance on narcotic regimens. Self-inflicted injury and self-inoculated infection are frequently encountered but nonetheless require treatment. Mental conditions such as psychosis, depression, and dementia are prevalent throughout the penal system. Prisoners are frequently reticent to provide the full nature of their injuries for reasons likely relevant to their status in jail. Of note, one situation that, perhaps surprisingly, has never been an issue in the authors’ experience is violence against health care workers. Although one must be cognizant of its possibility, inmates are always accompanied by 1 to 2 corrections officers and shackled.

One ubiquitous and highly concerning risk when operating on prisoners is the extremely high rate of bloodborne disease such as hepatitis B (approximately 20%), hepatitis C (25%-30%), and human immunodeficiency virus (2%).\(^9,10\) At a teaching hospital where students are involved with patient care, the relatively higher risk of a needlestick injury for less-experienced trainees may outweigh the benefit of participating in educational activities such as suturing or administering injections. Surgeons must be mindful that unexpected objects such as fracture shards, glass fragments, or buried self-inflicted shards may be present and could cause injury. The infectious status of prisoners is often known prior to surgery and all team members should constantly be vocally reminded intraoperatively, but extra vigilance for universal precautions and handling sharps should be taken for all prisoners.

Abscesses and other infections have especially high titers of viral particles in the purulence. Electrocautery and blunt instruments should be used whenever possible.

Incarcerated patients represent one population with a high methicillin-resistant Staphylococcus aureus (MRSA) rate. Prevalence varies by region but can be as high as 94%.\(^11\) Combined with poor hygiene, sharing of soap, overcrowding, and self-draining of abscesses, a high proportion of prisoner complaints are associated with MRSA-related infection. Appropriate contact isolation and antibiotic choice must be followed. Although MRSA does not pose as great a communicable threat to health care workers as viral disease does, it could potentially expose nonincarcerated patients treated in the same hospital facility or operating room to colonization or infection.

**ETHICAL ISSUES IN PRISONER CARE**

The majority of prisoners are eventually released back into society.\(^12\) Although performance of purely elective procedures on criminals can easily be morally refused, borderline medically necessary care is controversial. While millions of uninsured or working-poor citizens forgo medical care due to financial hardship, taxpayers shoulder a massive burden for infirm inmates. For example, in 1 year in a single state, 6 prisoners with potentially fatal illnesses incurred more than $3.9 million in hospital charges.\(^13\)

On the physician level, several ethical issues can arise. First, the most obvious is the ability to humanize and provide equal care to a potentially heinous criminal. Rarely do prisoners volunteer their crimes and, for the most part, physicians avoid inquiring lest it cloud their judgment. However, tell-tale tattoos and prison security officers occasionally may reveal the nature of prisoners’ backgrounds. Second, use of prisoners as teaching cases for surgical education can be questioned. The amount of intraoperative resident involvement is largely unappreciated by the general public, and although few patients object to the idea of medical education, many hesitate at the idea of a junior resident performing the procedure.\(^14,15\) The extent to which this matter should be included on the informed consent and in the preoperative discussion has been the subject of some debate. It has been noted previously that prisoners’ drug use, lower social status, older age, and unconsciousness have contributed to supervisors’ willingness to shift responsibility to trainees during surgery.\(^16\) Private citizens can choose a surgeon and specify the involvement of trainees within a teaching hospital, whereas prisoners are generally not given an alternative. Nevertheless, the informed consent process should have the same elements: that the patient has the capacity to make a decision, that the patient has freely consents. Resident participation has been associated with higher morbidity rates in some studies,\(^17\) and physicians are held to the same medicolegal standards even for prisoners. Is it fair to use prisoners, who in most instances implicitly consent to being teaching cases? Finally, there is the overall ethical question of caring for this protected, vulnerable, and disempowered population. Although this issue is fairly well defined for experimental research,\(^18\) it is not as clear in the teaching setting.

**CONCLUSION**

Providing care to prisoners gives rise to numerous unique surgical and ethical considerations. Historically, it has been an area largely unappreciated in the orthopedic literature. Not all orthopedic surgeons encounter prisoners in their everyday practice.
However, for those who do, developing strategies to effectively and efficiently care for prisoners is ethically imperative and essential to control costs and manage resources. In several important ways, prisoners differ from regular patients, and it is crucial to understand these differences. Caring for inmates can be challenging. The proper, conscientious care of inmate patients serves the public at large by promoting a humane criminal justice system.

REFERENCES