Lack of Information on Surgical Care for Incarcerated Persons

With 2.2 million incarcerated people, the United States imprisons more people than any other country in the world.1 This mass incarceration is recent, arising from the war on drugs and punitive sentencing policies that began in the 1970s.1 Ethnic minorities and the poor have been disproportionately affected by this increase: more than half of the incarcerated people in the United States are black or Hispanic race/ethnicity.1 Mandatory minimum sentences have ensured that the incarcerated population has aged as it has grown; between 1992 and 2012, the prevalence of incarcerated people aged 55 years or older increased by 550%.2

Some of the health needs of the incarcerated population are known. The prevalence of human immunodeficiency virus, hepatitis C, and tuberculosis among incarcerated persons is well documented and much higher than in the general population.1,2 Predictably, as the incarcerated population ages, the prevalence of diabetes, hypertension, and hyperlipidemia is also increasing.2 Compared with the general population, incarcerated persons are more likely to have mental illness or previous traumatic brain injury.2

A growing body of literature addresses management of these medical conditions during incarceration. Some conditions are better controlled in the corrections setting than beyond its walls, including human immunodeficiency virus.1,2 Mental illness, however, is often untreated in prison.1,2

After noting the literature on chronic medical illness in prison, we searched for data on surgical disease; however, surgical disease among the incarcerated is poorly documented. Data collected by individual correctional facilities or state systems are often unavailable publicly. The Bureau of Justice Statistics intermittently surveys a sample population in state and federal correctional facilities to assess their health problems. While the survey primarily focuses on the prevalence of chronic medical conditions, the most recent version (2004) had a single question addressing surgical care. Of the 3686 individuals who responded, 12.7% reported having surgery while incarcerated. Beyond this, however, no data regarding diagnosis, operative procedure, practice setting, or outcome were reported.3

In 2016, the Centers for Disease Control and Prevention published the National Survey of Prison Health Care, which evaluated the availability and location of specific health care services for the incarcerated population.4 The questions targeted the availability of ophthalmology, obstetrics, and orthopedics, and the availability of general surgery was not addressed.4 The provision of these surgical services was largely located outside the corrections setting.4 This diversity of location would make data difficult to aggregate and may contribute to the dearth of information on surgical care for the incarcerated population.

In further attempts to understand the surgical care of incarcerated persons, we performed a PubMed search using Medical Subject Headings terms prisons and surgical procedures, operative, and the search terms surgery, prisoner, jail, and imprisonment. We did not use the search term incarcerated, as this term, when used in the surgical literature, primarily refers to herniorrhaphy. The bulk of the 817 citations that we identified addressed ethical issues associated with performing psychosurgery, surgical sterilization, organ transplantation, and plastic or reconstructive procedures. Many reports described the care of incarcerated persons outside of the United States. No citations focused on the incidence and outcomes of acute care surgery diagnoses other than injury. Most investigations were single-institution studies.

We speculate that the lack of research on surgical care of incarcerated persons is multifactorial. Surgical disease is likely to be less common than acute or chronic medical illness among the incarcerated population. Correctional surgery is not recognized as an area of interest in surgery, although it is in medicine.5 Finally, many of the large national databases used in longitudinal studies and surgical outcomes research (including HealthCare Cost and Utilization Project, National Cancer Database, and National Surgical Quality Improvement Program) do not track incarceration.

As surgeons, we have cared for incarcerated patients in a variety of settings. In the absence of robust literature, we have had to rely on our experiences in developing our practice. We have observations, however, that we would like to share.

We frequently see delays in the identification and care of incarcerated persons with surgical diagnoses. At presentation, many of their chronic medical conditions are poorly controlled. Surgeons with whom we work are frequently unaware of the increased prevalence of traumatic brain injury, mental illness, sexual abuse, and other comorbidities among incarcerated persons.

Incarcerated persons often have limitations placed on their perioperative care. Corrections officers are frequently required to be present in operating rooms, challenging patient privacy. Patients may be required to be shackled to both the operating table and their hospital beds, limiting mobility. There are arbitrary limitations to diet, which influence postoperative nutritional status. Visitation is limited, reducing personal support from which all ill persons benefit. Limited visitation may also affect the quality of care, as the families of nonincarcerated patients often act as advocates and assist with simple tasks, including reorientation during delirium.
At the time of discharge of incarcerated persons, we often know little about the availability of rehabilitation services in the facilities to which our patients return, complicating discharge planning. Postoperative follow-up is often dictated by prison resources and policies, rather than patient needs. Transfers within the corrections system often limit long term follow-up.

We acknowledge that these are anecdotal observations, but they raise concerns about whether the surgical needs of incarcerated persons are adequately met. Addressing these concerns will require an understanding of the needs of this population that is built on data—not anecdote—as well as an examination of the relationship between incarceration and surgical outcomes. If disparities in surgical outcomes related to incarceration exist, might they be due to factors such as ethnicity or socioeconomic status, which are already identified as sources of surgical disparities? Alternatively, are there unique aspects of incarceration, including those observed above, that contribute to disparities?

Academic and professional organizations have recognized the growth of the incarcerated population and the paucity of research, guidelines, and policy in this area. In 1982, the American Medical Association founded the National Commission for Correctional Health Care to develop policy and programs in the field of correctional health. In 2012, the Academic Consortium on Criminal Justice Health Care was founded as an academic home for criminal justice health researchers and clinicians. No major surgical organization, however, has joined the National Commission for Correctional Health Care. With the exception of a single ophthalmologist, none of the 25 members of the Academic Consortium on Criminal Justice Health board of directors are surgeons.

We urge the surgical community to embrace this challenging work. The American College of Surgeons should join the many professional organizations supporting the National Commission for Correctional Health Care. Interested individuals can join the Academic Consortium on Criminal Justice Health Care. Surgical educators should develop a curriculum on care of incarcerated patients. Incarceration must be explicitly included in surgical databases. Surgeons must work to develop partnerships within the justice system to facilitate shared use of existing health data for research as well as informed policy creation. Only with robust research and collaboration can we ensure health equity for the incarcerated population.

In 1976, the Supreme Court ruled in Estelle vs Gamble that “deliberate indifference to serious medical needs of prisoners” constitutes cruel and unusual punishment, which is proscribed by the 8th amendment. If surgeons continue to care for incarcerated persons without rectifying the dearth of data on the access to and outcomes of this care, our profession is in danger of deliberate indifference.