

# Virtual Mentor

American Medical Association Journal of Ethics  
February 2008, Volume 10, Number 2: 84-87.

## CLINICAL CASE

### Assessing Demand for Wheelchair Use

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Mr. Franklin has been incarcerated for more than 5 years and underwent knee surgery a year ago. During his recovery he was provided with a wheelchair. After physical therapy he was able to walk on his own. When Dr. Wilson told the physical therapy technician to take the wheelchair back, Mr. Franklin blatantly refused to walk. During several follow-up attempts to get Mr. Franklin to walk on his own, he moaned and dragged himself around until he was allowed to get back into the chair.

On his next visit to Dr. Wilson, Mr. Franklin confided that having the wheelchair lowered his chance of being sexually assaulted, expressing relief that “everyone just leaves me alone.” Dr. Wilson sympathized with Mr. Franklin but knew that there were others who truly needed wheelchairs, which were in limited supply, and that spending his prison time in a wheelchair was not the best solution to Mr. Franklin’s fears.

### Commentary

Mr. Franklin is the infrequently encountered “patient” who tests the limits of prison medical and security practices and boundaries. These prisoners usually describe a long-standing but undocumented lower extremity neuromuscular condition, which required the use of a wheelchair while they were living in the free world. The etiology of the neuromuscular pathology is usually an antecedent stroke or spinal degenerative condition. Some patients, like Mr. Franklin, have been injured or have had back or lower extremity surgery while incarcerated and require temporary use of a wheelchair. At times, getting these inmates to return to the general ambulatory population can be a challenge, as we see in this case.

Upon intake into the prison system all convicted offenders give a complete medical history and receive a physical examination. Those in wheelchairs are assessed to determine what their true needs for ambulation assistance are. Wheelchairs are provided as medically necessary, but it is recognized that they pose security and safety risks. Most inmates who make this request can clearly demonstrate a need, but among a small group, the patient’s history and physical examination are less clear in determining the need.

When a prisoner comes from a county jail with a wheelchair and scant medical information, most medical personnel are reluctant to disallow the wheelchair before they take a complete history and perform a physical exam and before the patient has

been seen by a neurologist or other appropriate specialist. After the prison intake process, 30-90 days in most states, the inmate is classified and sent to his or her unit of assignment (UOA). If, during this time, the prisoner has established with both medical and security that he requires the use of a wheelchair, whether legitimately or not, he is assigned to a facility that meets ADA (Americans with Disabilities Act) requirements and is usually housed with other wheelchair-bound prisoners. Many seek out this environment because conditions are less predatory than those in the general population and because other conveniences related to meals and movement within the facility are provided.

Once at the UOA, the prisoner is evaluated for wheelchair need and sent for a physical therapy evaluation to ascertain baseline function. It is during this routine work-up and evaluation process that those feigning need usually become uncooperative with both medical and security staff. They refuse their specialist and imaging evaluations and make every effort to avoid physical therapy or participate minimally. They typically offer a multitude of reasons why they do not want anything further done and why they are content with their nonambulatory status.

With few exceptions health care treatment cannot be forced upon an offender. The exceptions are related to special clinical situations that involve acute mental illness and infectious disease (e.g., TB) treatment. Beyond that, prisoners have the right to consent to and refuse medical treatment. Consistent with most free-world practices, a signed refusal is obtained when an inmate declines care. Upon notification that someone is refusing further evaluation or is poorly participating in physical therapy, the medical staff should have the patient brought to the medical clinic to attempt to elaborate the real reasons behind the patient's uncooperativeness. Often, as in the case of Mr. Franklin, a fear for personal safety is at the heart of the behavior. Just as frequently, however, no valid reason is given, and it is clear that the patient is attempting to manipulate security and his environment. It is in these cases that the challenge of what to do really begins.

Every state prison system has policy and procedure that deal with threats against and intimidation of prisoners. Using a wheelchair to avoid harm is not the answer to threats from other prisoners. The medical director should discuss Mr. Franklin's case and concerns with the warden, and a full investigation of those complaints should be completed by security and reported to facility classification, the group responsible for assigning inmates to their units. If the classification staff believes the concerns are valid, they can move Mr. Franklin to either a different housing unit or facility to protect his safety. In parallel to security's efforts, the medical department needs to insure that allegations of physical abuse have been thoroughly investigated. Mr. Franklin should also be referred to the facility's mental health staff for evaluation. The transition from wheelchair use to being ambulatory is usually not difficult, once the personal safety concerns have been addressed. Most of those who feign need for wheelchairs have been walking in their cells at night or when not being watched and have adequate muscle strength to resume normal ambulation.

The preferred treatment and resolution of Mr. Franklin's case is reasonably straightforward and would be agreed to by all correctional health care professionals. But the subset of inmates who are attempting to manipulate the system requires a significantly different management approach. In these situations, the resolution takes a consistent, coordinated effort between medical and security personnel. The first and most important step in the process is to establish that the patient does not have any condition or pathology that demands use of a wheelchair. This typically involves subspecialty consultations and imaging studies. Physical therapy assessments and consultation with a physiatrist, ideally one accustomed to seeing correctional patients, are essential.

Once it is established that the patient can walk, the medical director of the facility must discuss these findings with the patient. Invariably, the patient asserts tenaciously that he cannot walk and will not walk and that any attempt on the part of the medical department to remove the wheelchair will result in the immediate filing of a lawsuit. (Convicted offenders have the Eighth Amendment constitutional right to be free from cruel and unusual punishment, and administration's deliberate indifference to their serious medical condition is a definite violation of that right. Not providing or removing a wheelchair from a prisoner who truly requires one would be a glaring example of deliberate indifference.) The threat of litigation, uncommon in general medical practice is, however, the daily reality in correctional medicine. Prison medical staff grow comfortable over time with this prisoner defense as they realize that the threats grossly exceed actual filings.

The medical director should create a multidisciplinary plan for Mr. Franklin's transition from the wheelchair despite his objections. This plan should include input from the physical therapy, medical, nursing, and mental health staffs, and from security. Ultimately it is the security classification system's decision where to house Mr. Franklin. If there is enough ADA space, they may decide to allow him to continue using the wheelchair, but, if they do so, Mr. Franklin must acknowledge, and the medical record must reflect, that remaining in the wheelchair is not in the patient's medical best interest. In most state prison systems, ADA space is at a premium and is reserved for those with true need. Moreover, allowing an inmate to have a wheelchair when it is not clinically necessary sets a precedent that encourages others to do the same.

Given the concerted effort by all disciplines to wean prisoners from unnecessary wheelchair use and return them to ambulatory housing, most prisoners do resume walking. But there is the occasional inmate who does not walk and who, during attempts to remove the chair, lies on the floor and crawls and creates a high level of drama for security and the other offenders. Managing these individuals demands even more time and effort. Consultation with the correctional department's legal office is usually standard practice in these cases. Cameras, hidden or obvious, may be installed in the cell or dorm to monitor and document movements. Most of these inmates invariably walk when they believe they are not being watched. All necessary

physical therapy and medical treatments should continue to be offered, with all refusals of treatment being documented in the medical record.

Ultimately, a decision must be made regarding continuation of the wheelchair. If it is taken away, accommodations can be made to move the prisoner closer to the chow hall or to provide meals in his housing area. Security staff should be made aware of the unique situation and given guidance on how to respond. Given time and the commitment of all personnel, even this outlier group will eventually walk.

Correctional medicine is rapidly becoming its own medical specialty, requiring primary care expertise, creative collaborative management, and leadership skills. Mr. Franklin and patients like him are a challenge to any prison or jail system. It is the creation of a coordinated consistent multidisciplinary approach to resolving this and other unique correctional issues that eventually leads to the best outcomes for the prisoner and the system.

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