

# Correctional Medicine

**American College of Physicians–  
American Society of Internal Medicine**  
Public Policy Paper  
2001



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A Public Policy Paper of the  
American College of Physicians–  
American Society of Internal Medicine

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How to cite this paper:

American College of Physicians–American Society of Internal Medicine. Correctional Medicine. Philadelphia: American College of Physicians–American Society of Internal Medicine; 2001: Public Policy Paper. (Available from American College of Physicians–American Society of Internal Medicine, 190 N. Independence Mall West, Philadelphia, PA 19106.)

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## Executive Summary

Public health officials, practicing physicians, and society have long ignored prisoners' health. The explosive growth of this population mandates attention and innovative approaches to health care. In February 2000, the U.S. jail and prison population exceeded 2.0 million persons (1). Further, it is estimated that 20 million individuals spend at least one night in a jail or prison annually in the U.S. The demographics of incarceration are well documented, (i.e., disproportionately poor, high-risk, underserved, and minority) (2-7). Correctional medicine is primarily the practice of adult internal medicine, with a significant amount of women's health practice combined with public health and epidemiologic principles.

The College issued a position statement on corrections in 1992 (8). The ensuing eight years have seen little reduction in the growth trend, which is predicted to continue, albeit at a slower rate. The total cost of incarceration is presently estimated to exceed \$41 billion, and associated health costs have grown substantially. Health care consumes approximately ten percent of correctional operating budgets, and presently is in excess of \$4 billion. Given these numbers and the nature of health problems encountered in this population, the issue of health care in corrections, the role of the internist, and more specifically, the role of the College, must all be addressed.

The position statement focuses on the most salient issues as related to the College and to internists. It is by no means exhaustive and, given current trends, will continue to require updating on a regular basis. Issues include:

- Corrections and Public Health
- Tuberculosis
- HIV and Hepatitis
- Qualifications of Practitioners in Correctional Settings
- Medical School Involvement in Prisons, Medical Experimentation, and Health Services Research
- Private Prisons and Private Medical Vendors
- Special Prison Populations, Women, the Elderly, Special Needs, and the Terminally Ill
- Accreditation of Correctional Health Care

Specifically omitted are issues such as physician participation in the death penalty, which has been addressed by both the College in its ethics publication as well as by the American Medical Association.

The Corrections population continues to expand and its health care needs will continue to increase. Internal medicine, its subspecialties, and the role of professional organizations such as the College are critical to addressing and solving the complex problems associated with this population.

## Correctional Medicine

This position paper updates the previous issuance by the American College of Physicians, published July 1992 (8). Since that time, the prison population has continued its dramatic growth (1). On February 15, 2000, the total incarcerated population of U.S. jails, state prisons, and federal detention facilities exceeded 2.0 million persons. Many of the concerns, predictions, and recommended solutions from 1992 have occurred while numerous new issues have arisen. Because of the “chronic” nature of internal medicine, this paper will almost exclusively address health care issues in prisons, which are long-term facilities rather than jails, which have rapid, short-term turnover.

Prison demographics continue to reflect a disproportionate number of minorities and underserved populations (2-7). Medical treatment presents both a daunting internal medicine challenge as well as a public health opportunity. The prison population is essentially male (93%), minority (38% African American, 11% Hispanic), and younger adult (mean age of 33.5 years). It is also disproportionately “high risk.” While estimates vary, most authorities accept that at a minimum, 80% of the prison population has at least one significant health risk factor, either related to drugs or other lifestyle habits. Women and older inmates represent substantial growth populations within prisons and provide their own unique challenges.

### I. Corrections and Public Health

*ACP-ASIM supports maximizing the collaborative efforts of correctional entities with state, county, and local health offices to best ensure the effective delivery of public health care. This should include direct involvement by health departments in the strategic planning, assessment, and the provision of clinical services when appropriate. The epidemiologic approach and management of infectious diseases, violence, and chronic diseases should be jointly addressed. Efforts should be made to assure timely and accurate disease reporting for epidemiological purposes and to assure the continuity of care for these conditions upon an inmate's release from a correctional facility.*

The corrections medical environment has been called a “public health opportunity” and its inmates characterized as a public health population (9). Numerous overlapping interests and opportunities exist between the two sectors, particularly for infectious diseases and contagious diseases. The unique nature of this confined population offers opportunities to ensure completion of antituberculosis therapy as well as treatment for sexually transmitted diseases and delivery of vaccinations.

### II. Tuberculosis

*ACP-ASIM supports the aggressive identification and assurance of treatment completion for actively identified tuberculosis (TB) cases and tuberculin reactors in correctional settings. CDC guidelines and collaboration with public health departments for testing and treatment are appropriate for this setting.*

Though the epidemic of tuberculosis (TB) in the United States is increasingly coming under control, it remains an important public health problem. Prisons present a unique setting and chance to ensure that treatment of both TB dis-

ease as well as latent infection (tuberculin positive reactors) can be completed. Tuberculin reactivity and TB disease have been reported to be up ten-fold-higher in corrections than the general population (10). Given the large number of high-risk individuals who are incarcerated, prisons provide the opportunity to intervene, which can serve as a major contributor to the further control and reduction of TB.

### **III. Human Immunodeficiency Virus (HIV)**

*ACP-ASIM supports aggressive testing programs to identify all HIV-infected inmates to allow for early intervention, treatment, and education. Up-to-date therapy must be utilized. Experienced clinicians familiar with the treatment of HIV and its complications must oversee and direct patient care. Following discharge from the correctional setting, continuity of care should be maintained through appropriate community referrals.*

Although recent advances in therapy and more aggressive treatments have reduced morbidity and mortality, HIV remains a serious public health disease with a high prevalence in prisons (11). Despite treatment gains, however, correctional systems have not uniformly countered this epidemic. This is reflected by the high variation in testing and treatment policies among states.

### **IV. Hepatitis C (HCV)**

*ACP-ASIM supports aggressive testing programs to identify HCV-infected inmates and ensure appropriate counseling concerning necessary lifestyle changes related to both disease progression and spread. Recognizing that clinical outcomes and predictors of response are still in the evaluation phase, and that local community standards may vary substantially, ACP-ASIM supports the development of correctional policies that reflect the prevailing clinical approach and standards of the communities served.*

HCV infection has a significant prevalence in correctional populations, undoubtedly far exceeding that of HIV (12-14). While accounting for only a small percentage of reported deaths, HCV is increasingly responsible for a high proportion of prison morbidity. The mere scope of the problem makes it the most significant public health disease in prisons. Treatment candidates, guidelines, and measures of clinical outcomes are presently in evolution. Reflective of these uncertainties, there is a substantial degree of variation in practice among communities. State corrections departments and public health officials must jointly address this issue, and arrive at the policy that best meets the needs of their local populations. Once consensus is achieved among experts and clear guidelines are established, public health epidemiologists must make this disease a priority to best guide future policy and treatment guidelines.

## V. Qualifications of Practitioners in Correctional Settings

*ACP-ASIM strongly opposes licensure provisions that enable physicians otherwise deemed unqualified to practice in the community for practice privileges in correctional settings. Prisoners by virtue of their incarceration do not forfeit their right to community standards of care that must be adhered to by those rendering care to this population.*

Recent disturbing reports published in both the medical and lay press have revealed the approval of “restricted” licensure, whereby physicians not certified to practice in community receive restricted licensure for the prison setting (15). Otherwise stated, they are not licensed for practice in the community, nor can they be granted hospital privileges, yet are deemed acceptable to treat the prison population.

## VI. Medical Schools Involvement in Prisons, Prisoners as Experimental Subjects, and Health Services Research

*ACP-ASIM supports medical and academic institutional involvement in the delivery of correctional health services. The quality and level of care should be consistent with that provided to other segments of the populations served by these providers.*

*All consideration for access to experimental treatments and involvement in medical research must be reviewed and controlled by Institutional Review Board oversight. Informed consent and right of refusal must be rigorously respected and assured. No laxity of standards applied to research projects with prison subjects is acceptable. Ethics committees must provide input and oversight to ensure appropriate protocol implementation.*

*ACP-ASIM strongly supports health services research in the field of correctional health care. The same scientific rigor applied in academic centers, HMOs, and community-based clinics must be utilized in the prison populations. Opportunities for health interventions and priorities for health expenditures must be based upon sound scientific knowledge and evidence-based medicine.*

Within the past five years, four states (Connecticut, Georgia, Mississippi, and Texas) have awarded the medical care of their prison populations to state medical schools. This link of public entities and sharing of state resources is a natural and cost-effective one, benefitting both sides of the partnership. Advantages of this partnership include improved quality of care, exposure of students and residents to an important high-risk population, and the linkage of the academic community to underserved and rural populations. Health services research and certain specific treatments for highly prevalent diseases in prisons may be considered for this population. Unfortunately serious abuses in the past have essentially halted all medical research in corrections since the mid- to late 1970s (16-18).

Despite the growth and the overall expenses associated with health care delivery<sup>1</sup>, little is known definitively about the prison population, besides demographics and “point prevalence.” To convince policy makers to allocate necessary funding, for both prison-based health services research as well as care, it must first be demonstrated that public funds will be well spent in terms of cost-effectiveness, clinical efficacy, and the overall benefit to society.

<sup>1</sup> National prison average 7-15% of prison operations costs.

## VII. Private Prisons and Private Medical Vendors

*ACP-ASIM advocates that all aspects of medical care, inclusive of level and quality, provided by private, for-profit prisons or by private medical vendors, must be at least equivalent to that provided in public facilities. States contracting for these services must provide the necessary oversight and maintain the technical ability to ensure the appropriate delivery of services in terms of type and quality.*

Private prisons are increasingly assuming an important role in housing inmates (19). Many provide their own health services with little oversight or direction from the public sector with which they contract. Currently 29 states subcontract to private, for-profit companies to provide medical services. The scope of services varies substantially among states, depending upon the coverage in a particular contract. Quality and access to care have been identified as potential problems when all services are provided by for-profit corporations with capitated costs. However, states have shown varying interests and abilities in overseeing these services to ensure that this model of delivery does not lessen quality and access to care (19).

## VIII. Special Prison Populations: Women, the Elderly, Special Needs, and the Terminally Ill

*ACP-ASIM advocates that corrections systems address the specific needs of the special populations they incarcerate. Screening and prevention guidelines should follow nationally accepted parameters. Provision of special services to inmates should be determined by medical necessity. Hospice programs should be provided in the correctional setting within the security constraints of the environment.*

Mandated sentencing, “three-strike” laws, and other components affecting sentencing and length of incarceration have contributed substantially to the growth of these population subgroups. The female population is growing much faster than its male counterpart, presenting unique health care challenges. These include high-risk pregnancies, increased screening requirements, and differential utilization patterns, all which increase costs. The aging of the population<sup>2</sup> means more advanced internal medicine diseases and a growing need for more high technology-secure units. Increasingly, inmates are suffering from prolonged terminal illnesses in prisons, which creates an increased need for hospice and palliative care (20).

<sup>2</sup> 7.2% greater than 50 years old.

## **X. Substance Abuse and Mental Illness**

*ACP-ASIM supports identification and voluntary treatment of inmates with substance abuse problems. Specifically, prisons should identify and offer services to addicted inmates six months prior to their discharge into the community. Continuity of such treatment begun in prison should occur upon discharge. Mentally ill inmates must receive care consistent with the community standard of care and protection including specialized units as needed within the prison environment.*

Substance abuse significantly affects the health of inmates. It also has a profound impact upon medical interventions in this population (21). Internists are frequently the first to identify these problems and should appropriately refer inmates for treatment, both inside and outside of the correctional setting. Mental illness, which is estimated at 16% of the prison population, contributes significantly to the overall medical morbidity and mortality of this population (22).

## **XI. Accreditation of Correctional Health Care**

*ACP-ASIM supports the accreditation of medical care provided in correctional settings. Specifically, the College encourages acceptance of medical care consistent with community standards. Accreditation entities uniquely focused on corrections, such as the National Commission on Correctional Health Care (NCCHC), are best qualified to ensure these standards (23). The standards for accreditation should reflect those of the community, and use evidence-based medicine as the standard against which to measure outcomes assessment.*

Prior to the incorporation of the NCCHC in 1983, no independent organization existed that was specifically dedicated to improving health care in correctional settings. Since its founding, this independent nonprofit agency has served a pivotal role in improving the standard of care for inmates and ensuring that correctional agencies have the infrastructure in place that to provide necessary medical and quality care.

## **CONCLUSION**

The College has multiple reasons (scientific, ethical, and policy issues) for its involvement in the policies and care of prisoners. Long ignored by mainstream medicine, correctional health care is rapidly emerging as a unique discipline, if not a subspecialty of internal medicine. It requires an expansion of the combination of adult medical skills and public health knowledge, which has historically focused on maternal and infant care. The chronic diseases of the population are the mainstays of our medical discipline. It is clearly a primary care venue, and exemplifies the future challenges posed to internal medicine (the prioritization of funds and expenditures in a capitated setting, public health options, health services research, and teaching opportunities). Finally, if one accepts that societies may be judged by how they handle their most vulnerable populations, ensuring quality health care delivery in prisons clearly belongs among the College's missions.

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