INTRODUCTION

The American College of Physicians is developing a series of position papers addressing the health care needs of medically underserved populations. This paper identifies prisoners in correctional institutions as a medically underserved group, clarifies some of the causes of and possible solutions to the problem of providing adequate correctional health care, and focuses on the role of internists and other health care professionals in addressing the issues.

Awareness of the poor quality of health care in correctional institutions has only recently become widespread. A signal event was the revolt at Attica in 1972, where the list of grievances of the protesting prisoners included the need to upgrade the state of health care. This evaluation has since been confirmed by health care and correctional organizations--including the American Medical Association (AMA), the American Public Health Association (APHA), the American Correctional Association, and the National Sheriff's Association--as well as the US Supreme Court (1). Individual scholarly research provides additional confirmation that health care in prisons and jails has been improved since the early 1970s, but still too often, particularly within prisons, fails to meet acceptable standards (2-4).

DEFINITIONS

The term "jail" in this paper refers to a custodial institution designed to hold people for short periods of time. The main categories of jail inmates are people awaiting trial and misdemeanants serving short sentences. Most jails are usually located in convenient physical proximity to the local courthouse and are managed by a county official. A prison, on the other hand, is designed to punish convicted felons by long periods of incarceration. Most prisons are large institutions located far from urban centers and are under a centralized state administration. The term "corrections" will be used to designate both prisons and jails.

SUMMARY OF POSITIONS

1. The inadequacies in health care that have been documented in many correctional institutions are unacceptable and must be corrected.

2. The accessibility to and quality of correctional health care can be improved by a) increasing the numbers of health care professionals working in correctional settings; b) establishing training programs in correctional health care for physicians and other health care professionals; and c) improving the quality and quantity of physical facilities.
3. The American College of Physicians, in an effort to upgrade correctional health care, strongly supports the National Commission on Correctional Health Care and encourages College members to become more active and to take a leadership role in providing needed services in correctional institutions.

POSITION

1. The inadequacies in health care that have been documented in many correctional institutions are unacceptable and must be corrected.

RATIONALE

Access to medical care is a constitutional right for inmates of state and federal correctional institutions (5). Court decisions in the last decade have grounded this right in the Eighth Amendment's prohibition against cruel and unusual punishment and have further held that "grossly inadequate" or "callously indifferent" or "deliberately indifferent" medical care is a cruel and unusual punishment.

Newman v. Alabama (349 F. Supp. 278, 503 F2d 1320 [5th Cir. 1974]) was the first case to deal with medical conditions of a state prison system. The court upheld allegations that "unsupervised prisoners without formal training regularly pull teeth, screen sick-call patients, dispense as well as administer medication, including dangerous drugs, give injections, take x-rays, suture, and perform minor surgery."

The findings in that case—that the overall health care delivery system was constitutionally impermissible, on the grounds that the failure to provide medical care may result in pain and suffering that constitutes a cruel and unusual punishment—were found, by outside surveys, not to be unique to Alabama. In 1977 the AMA published a "Summary of the Jail Pre-Profile," reporting the results of a survey of 30 jails in six states, which stated that there was a "dearth of available health care facilities and services...less than 50% of the surveyed jails provided a regular sick call, and only 17% held sick call on a daily basis.... Only 10% of the jails were doing receiving screening or initial health assessment upon admission to detect communicable diseases and referring inmates to treatment who had acute illnesses."

The Supreme Court, in Estelle v. Gamble, (429 US 97 [1976]), confirmed this constitutional right to health care. The Court declared that "the deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain...proscribed by the Eighth Amendment." The Court further provided some guidance as to acceptable standards of medical care within correctional institutions by enumerating three examples of indifference that would clearly demonstrate a constitutional violation: "manifested by prison doctors in their response to prisoners' needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed."
The legal profession was not the only one involved in determining the deficiencies of health care in correctional institutions. In 1975 the APHA published, "Standards for Health Services in Correctional Institutions." These standards "were based on a philosophy that supported not special treatment but the assurance that incarceration did not compromise medical care" (5). In 1978 the AMA established a program for the accreditation of jails, after an evaluation of and efforts made to improve their health care systems, according to AMA-developed standards.

Thus, both lawsuits and research studies have helped determine that the system of health care delivery in correctional institutions needs improvement. Major shortcomings of correctional health care include the following:

(a) denial of access to care (including total denial and long delays),
(b) denial of ordered care (e.g., special diets),
(c) denial of medication needed on a regular and continued basis (e.g., anticonvulsants),
(d) incompetent and poorly trained health care personnel,
(e) disease-inducing environmental conditions,
(f) faulty equipment and facilities.

Some specific examples of the general inadequacy of correctional health care include an increase in infectious diseases and body parasites among the incarcerated population (2), the overuse of psychotropic drugs for security purposes without regard to long term and interactive effects (7), and the tendency to assume that all chronic complaints are indications of malingering, with consequent failure to treat (6-8). There is an abundance of individual case studies demonstrating these deficiencies.

The need for upgrading the quality of jail health care is justified not only by the rights of inmates, but also by its public health aspects. Jails have a very high turnover, and thus the amount of interaction of inmates with the general population is great (6). The demographic profile of inmates closely resembles that of the social stratum with which they interact, i.e., the urban poor (4). A characteristic of this class is poor health, due in part to nutritional deficiencies, failure to observe sound health practices, and poor health care resources and services. Efficient medical screening and treatment of the inmate population, as well as educational programs in proper health care, can thus influence the general population in terms of reduced incidences of infectious diseases, such as tuberculosis and venereal disease, and of asymptomatic conditions and traits, such as sickle cell anemia and hypertension (9). The motivation to improve public health can result in a more comprehensive service to inmates as well as a related improvement in public health. In fact, the National Institute of Law Enforcement and Criminal Justice (NILECJ) recommends changing the basic philosophy of jail health care to include some responsibility for community health care via case finding (6).

POSITION

2. The accessibility to and quality of correctional health care can be improved by a) increasing the numbers of health care professionals working in correctional settings; b) establishing training programs in
correctional health care for physicians and other health care professionals; and c) improving the quality and quantity of physical facilities.

RATIONALE

The difficulties inherent in establishing and administering adequate health care programs in correctional institutions arise from some basic factors that are generic to all correctional systems. Five of these are: (i) attitudes towards criminals and the institutions that process them, (ii) financial incentives, (iii) conflicting institutional goals, (iv) work-related stress, and (v) inadequate training programs. The American College of Physicians believes that these difficulties can be overcome or significantly improved upon.

(i) Attitudinal Problems

As discussed above, despite legal mandates for improved health care services in correctional institutions, there remain public attitudes that adequate health care for prisoners is not appropriate, particularly if that care is perceived as better within jail or prison than that received in the community. This attitude makes it difficult to attract physicians and other health care professionals to work in correctional settings and adds to their conflicts when working with inmates.

(ii) Inadequate Financial and Other Incentives

The low priority of health care in correctional institutions is manifested in budget allocations. Most correctional institutions do not have sufficient resources to offer competitive salaries or to provide other incentives, such as modern equipment, to attract well-trained health care personnel. There are few, if any, financial incentives to attract well-qualified physicians to work in a correctional setting. Salaries and other compensation are often a major problem. Although systematic data are not available, some estimates are known (e.g., current annual salaries in Texas are reported to range from $45,000 to $65,000, and housing and other benefits are added). Given the undesirable working environment, these salaries are not considered competitive.

(iii) Conflicting Institutional Goals

A major factor in the undesirable working environment is conflicting goals. The primary goal of any correctional institution is custody, and medical staff are obliged to accommodate their functions and procedures to this goal (10). Therefore, all medical personnel who work within the institution are subject to serious role conflicts. Many authorities have thus advocated the system of "contracting out," where the health care system is administered by an autonomous medical administrator in the surrounding community (11). However, as it is not feasible for all sick inmates to seek outside care, no jail can dispense with the traditional internal sick-call, and many jails retain an infirmary where more serious cases are treated.

The dual goals of custody and treatment cause a dilemma--how to apply the medical model in a penal setting--and place the correctional physician in a state of role conflict. Even where medical care is on a contracting out system, "the bottom line is, of course, that every prisoner is ultimately
the responsibility of the Department of Corrections" (12) or, in the case of jails, of the sheriff. The medical model's requirements of confidentiality, consent, and freedom of choice are of necessity precluded by the need for custody. The "power relationships dictated by most prisons preclude (the contractual model of modern medicine with collaboration of patient and physician).... When one of the individuals in the doctor-patient relationship lacks basic rights of autonomy, the relationship can never conform to a model in which equal participants take part in the decision-making process; it can never be a relationship of one who informs and one who consents" (13).

Role conflict has several results. Brecher and Della Penna (6) state that "health care personnel in such an organizational structure are at the same time impotent to foster improvement and free to tolerate deterioration." Inmate perception of this process can exacerbate their negative perception of the doctor and further damage the therapeutic relationship.

(iv) Work-related Stress

Role conflict is but one cause of work-related stress. Another major stress-causing factor is the high use inmates make of the health care system. There are several causes of over-use, e.g., the physical environment increases the incidence of infectious diseases; problems are caused by lack of adequate nutrition and exercise; and there are many symptoms of anxiety. In addition, in order to further the custodial goal, inmates lack access to self-help cures and must approach the health care system for such simple needs as aspirin, bandages, and cough syrup. Some women's facilities even require inmates to apply to the health care system for sanitary napkins and tampons (2). Another cause of over-use of the health care system is secondary gain. Inmates can use sick call to avoid a work assignment, meet friends, break the boring routine, and obtain medicines that can be bartered later for other needed goods (14).

A further major cause of stress is the inadequacy of facilities. Often space is very limited, a quiet and private working environment is not possible, supplies are limited, and technical aids are old and faulty, if they exist at all.

Reactions of health care personnel to stress fall into two major categories. One is the high attrition rate. Another is the reduction of the quality or amount of care provided.

(v) Inadequate Training Programs

Clearly, there do not exist at present many incentives for physicians and other health care professionals to work in correctional settings. Nevertheless, because much of the poor quality of health care in most correctional settings is a result of the paucity of trained personnel, physicians and other health care professionals must be encouraged to provide adequate quality health care in correctional institutions. To achieve this goal, it is necessary to overcome the disincentives discussed above. A major way to accomplish this is to establish training programs that will educate health care professionals about their roles in correctional settings.
It is possible that orientation programs may help physicians establish rapport with the inmate/patient, thereby reducing stress by increasing inherent rewards (15), but few such programs exist. Some states have programs in which medical residents can spend a day or two observing in the correctional setting, but the utility of these programs in terms of attracting people to work in corrections is said to be doubtful (15).

Training should focus also on the group of health problems revealed by epidemiological research to predominate among incarcerated populations. It has been noted that many of the health problems listed below are typical in not only correctional institution populations but also the poor and minority groups that they resemble demographically. For example, "higher rates of dental disease, diabetes, certain heart ailments and hypertension are reported among blacks than whites" (2). Other problems, such as venereal disease (especially among women) and drug and alcohol abuse, are related to the criminal lifestyle. The medical problems that have been found to predominate among prisoners are drug and alcohol abuse, tuberculosis, acquired immune deficiency syndrome (AIDS), venereal diseases, hypertension, psychosomatic and stress-related illnesses, hepatitis-B, and epilepsy.

Although there is little doubt that the problems listed above are frequently found among incarcerated populations, no systematic forms of treatment or prevention exist. The failure to treat effectively, together with the problems of overcrowding and stress, not only places the individual sufferer in more danger and/or discomfort than necessary, but also has serious public health implications. Treatment of these (and other) health problems by internists and other health care professionals would alleviate the situation considerably. The possibilities for prevention, especially with respect to young offenders, beg for increased attention.

It is of particular importance to consider the role of the nonphysician health care professional in upgrading the quality of care rendered in correctional settings. The development of increased training programs for physician assistants, nurse practitioners, and other health care professionals is of paramount importance. Many reports document the increased use of these health care professionals in correctional health care. Reports from Florida (16), Tennessee (17), and Maryland (18) indicate that one aspect of the success of their use lies in relieving the physician of many of the stress-causing factors discussed earlier.

The expanded use of allied health care in correctional health care was recommended by the NILECJ as early as 1975, and studies bear out the validity of the recommendations (5). A federally funded program for the education of nonphysician health care professionals has been established (9).

POSITION

3. The American College of Physicians, in an effort to upgrade correctional health care, strongly supports the National Commission on Correctional Health Care and encourages College members to become more active and to take a leadership role in providing needed services in correctional institutions.
RATIONALE

Currently, many jails and prisons are making efforts to improve their health care systems. One major effort is through accreditation by the National Commission on Correctional Health Care, an outgrowth of the Jail Accreditation program initiated by the AMA in the mid 1970s and originally funded by the Law Enforcement Assistance Administration and the Commonwealth Fund. The purposes of the National Commission are (i) to promote and encourage educational and research activity in correctional health care, (ii) to devise and implement programs that will improve the health care provided for inmates, (iii) to provide a program for accreditation of correctional facilities and state-wide correctional systems that meet standards for health care promulgated by the commission, and (iv) to maintain an effective clearinghouse of correctional health care information. The American College of Physicians is one of 22 organizations that have named members to this commission's Board of Directors.

The accreditation of an institution's health care program is based on meeting the AMA's "Standard for Health Services in Prisons," which contains 69 separate standards addressing the technical capabilities required of health care personnel and rights and responsibilities of both the inmate-patient and the correctional institution-health care provider.

Evaluations of the commission indicate remarkable success in improving the quality of care in the areas of intake screening, accessibility of care, equipment, environment, and autonomy of health care personnel (11). A continued increase in the number of jails and prisons applying for accreditation is also indicated (11). In the first year of operation (1982) the commission accredited 43 facilities, and an additional 90 were accredited the following year.

The College believes that the commission would be even more successful if it had sanctions that could be applied for noncompliance and if its accreditation standards were enforceable.

A remarkable factor in the history of the accreditation process appears to be its dependence on the support of organized medicine. Evaluating the earlier AMA effort, Anno, Hornung, and Lang emphasize, "The single most important factor influencing the extent of improvements which occurred in these jails' health care systems was the amount of support and cooperation received from the medical community, whether inside or outside the facilities" (11). They referred to state medical associations' support, both material (that is, supplying manpower to help the jails achieve the required standards) and symbolic, and alleged that "without the strong support of organized medicine, the program will fail. The progress of this effort hinges on the willingness of local physicians to become involved" (11).

There are incentives--albeit not financial--for involvement by physicians in correctional institutions: the intangible rewards of contributing to one's community and of personal accomplishment. As the past president of the Washington State Medical Association stated, "professionalism in medicine depends on our ability to provide quality care to the least of us" (19).
As the number of physicians who work in correctional settings increases, the stigma attached to the position decreases, and thus a powerful disincentive is removed. Although it would be unrealistic to expect physicians to select correctional institutions as their primary work setting, the encouragement of physicians to volunteer some time for correctional work may well function to reduce the stigma and thereby to increase and improve the health care provided inmates. Volunteer physicians can act as an information source for their peers concerning the need to upgrade correctional health care, and they may act as role models in encouraging more health care personnel to volunteer their time in corrections. An example of such work is a small group of members of the Empire State Medical Association (the New York Chapter of the National Medical Association). These physicians spend four hours each week working on non-routine cases at Rikers Island. The College encourages local initiative for such volunteer programs.

CONCLUSION

The state of correctional health care today is far below the quality of care to which the inmate population is entitled. Resolving the problem by increasing the quality of care will require educating both the public and health care professionals in order to overcome prevalent negative attitudes toward correctional institutions as a professional environment. Any increase in the numbers of health care professionals stimulated through such attitude change would need to be supplemented by training programs in correctional health care for physician and nonphysician health care professionals, and by improvements in physical facilities for these purposes.

Another way in which the number of health care professionals working in corrections may be increased is by encouraging volunteer work. Although the work of volunteers provides a valuable contribution to an overburdened system, it must be emphasized that volunteer work in corrections is in no way the sole solution to the problem. The obstacles to acceptable correctional health care identified elsewhere in this paper must be the major focus of efforts made to improve the situation. For these reasons, the American College of Physicians continues its support of the National Commission on Correctional Health Care.
NOTES


