The Status of Prison Health Care

A review of the literature

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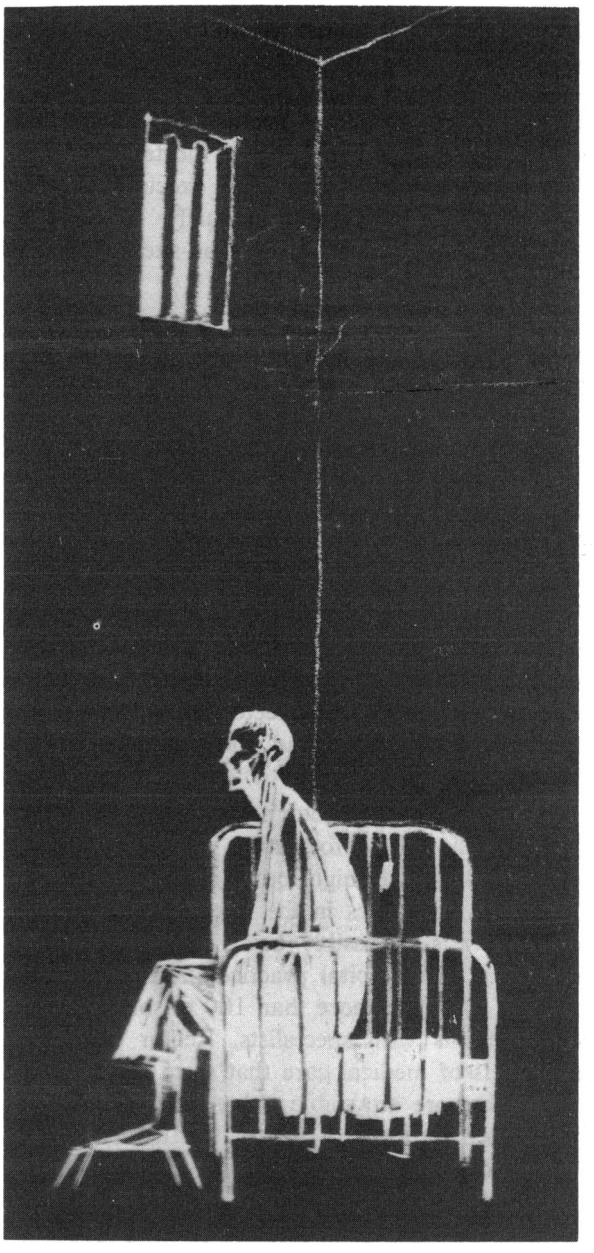

THE TUCKER TELEPHONE not only shocked the penises of the allegedly uncooperative and incorrigible prison-farm inmates of the Arkansas penal system, but it shocked the consciousness of the nation and awakened it to the atrocious conditions within its prisons. As reported by the superintendent of the Tucker Prison Farm, the convict doctor, a person with no medical or nursing training, was responsible for most of the primary care at Tucker, sold medical leaves of absence, ran an illegal drug program, and also functioned as the primary "Tucker Telephone" operator (*1*):

> The telephone . . . consisted of an electric generator taken from a crank type telephone and wired in sequence with dry cell batteries. An undressed inmate was strapped to the treatment table at Tucker Hospital while electrodes were attached to his big toes and penis. The crank was then turned, sending an electrical charge into his body. In "long distance calls" several charges were inflicted—of such a duration designed to stop just short of an inmate's fainting . . . sustained current not only caused an inmate to lose consciousness but resulted in irreparable damage to his testicles.

Describing the physical conditions of the medical department at Tucker, Murton (*2*) noted algae growing on the floor, condemned electrical wiring, poor sanitation, and unreliable flood protection that often resulted in fecal matter floating around and through the surgical and ward areas. Despite these defects and despite the availability of an acceptable medical facility in an adjoining building (but used only for post mortem examinations following State-ordered executions), the medical department was annually licensed by the State "without benefit of an on-site inspection" (*2a*).

National Studies

While what happened in Arkansas in the Prison Medical Department in 1969 was extreme, the literature on prison medical care clearly indicates that the organization and delivery of health services within penal institutions is less than satisfactory and has been so for quite some time.

For example, in 1929 the National Society of Penal Information supported a study, under the direction of Dr. Frank Rector, that looked into the status of personal and public health services in prisons (*3*).

The objective of Rector's 13-month survey was the provision of information on prison health conditions "which might be of material assistance to prison authorities in the improvement of such conditions and possibly bring a standardization of health and hospital practices in penal institutions" (*3*). After more than 100 prison visits and consultations with specialists, Rector delineated standards of medical care that were attainable in 1929, that are attainable today, and that are yet unattained in a large part of the United States. The standards recommended included intake and pre-discharge or parole physical examinations for all inmates to be done by a "competent physician," including "a dental examination, distant and near tests for vision, blood tests for syphilis, urinalysis on all persons over forty years of age, and other laboratory tests as indicated" (*3a*). Other standards (*3b*) suggested by Rector and his group were (*a*) 1 physician per 500 inmates and an additional physician for each extra 1,000 inmates, (*b*) daily sick call to be held by a physician who would also dispense drugs, (*c*) complete dental care, and (*d*) complete optometric care.

What has happened since 1929? Most studies suggest that the prison health situation now is as bad as then. One research report, however, offers contrary findings (*4*). In this study, Aker mailed 110 questionnaires to State correctional department administrators of large State penitentiaries for men (average size was more than 1,000 inmates). Despite a response rate of 74.5 percent, Aker was confident enough about the results to conclude that (*a*) the capabilities of prisons in meeting inmates' needs are greatly improved over those in 1929, (*b*) the supply of medical facilities in prisons exceeds that for the nation as a whole, (*c*) the ratio of physicians and hospital beds to the population is greater for prisons than for the nation, and (*d*) medical care available in State prisons was as adequate as that found in the community hospital (*4a*).

A more recent national study on prison health was a mid-1972 joint undertaking of the American Medical Association and the American Bar Association. Their 4-page, self-administered questionnaire survey of more than 2,000 jails gathered information on available services, inmates' use of health services, staffing patterns, funding, physician reimbursement arrangements, operating procedures, and relationships with local medical societies. The survey revealed that there are general needs for more adequate funding, planning, and public support and specific needs for health services standards, improved facilities, more manpower, personnel to handle mentally disturbed inmates, drug control procedures, and facilities for severely disturbed psychiatric prisoners (*5*).

Unfortunately, the value of the Rector, Aker, and American Medical Association studies is in large part mitigated because of significant and similar methodological limitations. Specifically, both the Aker and American Medical Association studies asked a sample of respondents to fill out

questionnaires that were self-rating forms. With such a questionnaire, special precautions should be taken to insure that the data collected are reliable. No such indicators of reliability were apparent in either study.

The Rector study, certainly the most comprehensive of the three, also collected information by using a structured questionnaire but, "The same individual visited all the institutions and secured at first hand the data on which [the] report is based. By this method the influence of the human equation in the estimation of work being done has, it is believed, been reduced to the lowest point possible" (*3c*).

Is a 1-day visit a satisfactory indicator of the consistency and objectivity of data? Probably not. Numerous anthropological and managerial research projects have demonstrated that considerably more than 1 day of observation is necessary to realistically appraise the operations of an organization or a human being. Studies that fail to recognize this reality tend to legitimize data that are less than adequate; in the instance of prison health care, legitimized, but inadequate, data can be more dysfunctional than no data.

State and Local Studies

In the past few years a heightened concern about prison health care has resulted in numerous studies of medical care in county or State prisons. These studies are important because one can see emerging from them an obvious pattern of inadequate facilities and personnel and a probable need for medical services.

For example, a 1967 study of three prison hospitals in California indicated that although the beds were not conducive to rest, all the hospitals did give intake physical examinations, including X-rays, urine analysis, and psychological testing (*6*). The primary recommendation of this study was similar to that of Rector's (some 40 years earlier), that is, an appropriate staffing ratio for the penal institutions would be 1 physician per 500 patients.

Another California study, by Stokes (*7*), was focused on medical care at the San Diego County Jail. Based on a limited review of records, a health history and perception questionnaire, and 40 hours of observation, Stokes suggested that inmates were lacking medical care; for example, she noted that the average time spent by a physician with an inmate on sick call was about 40 seconds. Regarding inmates' health status, Stokes noted that based on the responses of approximately 100 inmates to a history questionnaire, inmates were indeed in poor health. Unfortunately, this information is of limited value because, as Stokes stated, "A correlation was not made between inmate perception of health status at admission and the 54 percent of inmates with mental health, drug and alcohol problems, plus the additional 29 percent of inmates with special health problems" (*7a*). Her conclusion that "the 31 percent who said they were not in good health at the time of their arrest constitute a minimum of the present people who should be seen by health care staff upon admission to jail" (*7a*) is probably reasonable from a crisis-planning perspective, but it does not provide the needed information on the health status of inmates.

Personal communications from Dr. Jules Frank, medical director of the San Diego County Jail, provide another picture of health care at that institution, a picture developed from the responses of 1,788 inmates to intake screening questionnaires. Although 19 percent of the inmates thought they were in need of medical attention, 87 percent said that they were not presently sick. Commenting on the Stokes' study, Frank questioned its statistical significance and relevancy:

> Anyone in medicine who has conducted any clinic, triage in nature, must recognize the fact that it takes very little time to order a liquid diet, to provide a Band-Aid if necessary or treat any number of minor conditions and minor complaints which constitute the majority of complaints found at sick call. In addition, with respect to her report, the San Diego County Jail has an average of 72,000 bookings per year and I hardly think the questionnaires given to one hundred random inmates have any statistical value whatsoever, particularly when the credibility of their answers was not further checked. This could have been done very simply by ascertaining if they had seen physicians outside the jail and simply calling those physicians and obtaining confirmation. It so happens that in the International Penal Digest, a journal written by ex-convicts, it was stated that out of 47 county jails in the United States, San Diego County Jail rated good, with the ratings being excellent, good, fair, bad or lousy. These ratings were done by prisoners themselves who were totally biased in this particular publication.

Washington State's 1972 study of jails (*8*) concluded that "sufficient medical and dental coverage is difficult to obtain in many jails. The problem is acute in some jails because of the doctor shortage in the community." A 1962 Massachusetts study revealed that medical care

for sick inmates was adequate and that emergency dental care was available, but "in no institution are all prisoners examined" (*9*). Eleven years later, the proceedings of a conference in and primarily about Massachusetts demonstrated the continued existence of those previously identified problems, the seemingly ever-present difficulties of providing health care in prisons and perhaps most significantly, how slowly change comes about in prison health systems (*10*).

Another addition to the literature, which demonstrates many of the problems of prison medical care, was the inquiry into Pennsylvania's prison health situation (*11*). This investigation began with the traditional unproved assumption that "People confined in prison commonly enter in poor health" (*11a*). The major recommendations stemming from this study are that the State should organize its medical care program for inmates, that standards for medical care be established, that appropriate facilities and staff be provided, and that the system be continuously monitored and evaluated (*11b*). The major contribution of this report is that it provides a good picture of the process of care in Pennsylvania's penal institutions. Unfortunately, little information or insight is provided on the health status of the inmates, the probable effect of intervention, and how one could best organize the system to provide comprehensive quality care. These critical questions are still unanswered.

A 1970 study performed by the Kearney consultant firm for the State of Nebraska Department of Public Institutions (*12*) considered the medical service staffing at the Nebraska Penal Complex by evaluating penitentiary records and interviewing penal staff. Their study indicated that physician availability at the penitentiary (1968 average monthly inmate population was 725) and the reformatory (1968 average monthly inmate population was 228) consisted of sick call 2 hours a day, 4 days a week—a total of 8 hours' medical coverage exclusive of emergency care. Additionally, one full-time dentist, one part-time X-ray technician, and one full-time medical technician (whose job was not defined in the study) were employed in the medical department. Based on their evaluation, the consultants recommended elimination of the medical technician's job and employment of a full-time physician. They noted in their report that "This medical coverage is less than what is suggested by the ACA [American Correctional Association] Manual, but it is sufficient for the needs of the Complex" (*12a*).

What are the needs of the penal and correctional complex? Is a population of more than 1,000 inmates well served by one full-time physician with no technical assistance? The arithmetic of the situation suggests that the Kearney evaluation is indeed reasonable, provided: (*a*) there is an efficient physician practicing full time (35 hours a week)—but in the Nebraska report half-time apparently meant 8 hours per week of scheduled time and availability for emergency care, (*b*) there is a normal population of 1,000 inmates generating between 4,000 and 5,000 physician visits per year, and (*c*) that the 900 annually admitted inmates present the physician with uncomplicated intake histories and have few problems on physical examination.

Clearly there are limits to the logic of this arithmetic. Does a prison population generate the normal number of patient visits? Who does the laboratory work? Who distributes and follows up on drugs? Who is responsible for medical records and medical administration? The Kearney recommendations do not adequately answer these critical questions, and therefore the general applicability of their staffing pattern must be approached with caution.

In another part of the country, New York, a riot in a prison located in a rural community, eventually resulted in death, destruction, and an investigation into the health program at Attica. In this study, it was noted that "medical care was one of the primary inmates' grievances" (*13*). Despite this finding, the report of the special commission noted that the "ratio of doctors to prisoners compares favorably with the norm in rural communities such as Attica" (*13a*). The staff for this 2,200-man prison included two full-time physicians, who were at the prison mornings from Monday through Friday, and were on call for emergencies; four nurses; one pharmacist; one laboratory technician; and one secretary. The process of medical care at Attica was characterized by rapid screening by physicians, few diagnostic tests, and little sympathy. Interestingly, the consultant firm that performed the study offered the hypothesis that despite what passes for unsatisfactory treatment, the inmates are physically healthy and the problems treated at the prison tended to be fairly routine and minor (*13b*). The solution offered by the consultants was that "of

some alternate system for the delivery of care in which [the] essential services are provided for the inmates of Attica by a larger well-staffed medical center or inmates in need of care are transferred to some facility with large enough volume to support more comprehensive staffing patterns" (*13c*).

The consultants who reported on Attica also reviewed the prison health situation at the New York State Prison at Clinton and the Manhattan Men's House of Detention (the Tombs). The review of the 2,000-man Clinton Correctional Facility, which has a prison hospital, included 2 days of visiting, interviews, and a review and analysis of medical records. In their study, it was found that hospital usage at Clinton was three times greater than would be expected from a general population and "The number of hospital days per 1,000 inmates was nine times greater than would be expected in an average male population with a median age under 30 years" (*14*). Several explanations are offered for this unexpectedly high usage: pre-existing health of inmates, convenience of medical staff, and need to isolate certain cases. The basic conclusion of the study was that "The present delivery of health care services is minimal, not because of the lack of dedication of the existing personnel, but because of the shortage of qualified personnel, needed technological equipment, and some needed physical renovation" (*14a*).

In the 1973 Tombs study performed by E. D. Rosenfeld Associates, it was noted that the medical component of this 1,000-man institution was somewhat inadequate, not only in terms of physical facilities but also in terms of delivering medical care (*15*). For example, it was found that "insufficient physician time is being spent at the physical examination room and at the medical clinic to adequately examine, diagnose, and treat inmates" and that "sick call procedures do not permit adequate screening of inmates having medical complaints" (*15a*). Indeed, the following statement from the Tombs report rings true not only for the Manhattan House of Detention but for countless other penal institutions (*15a*):

> The overall organization of health care services at the Tombs Prison is weak and fragmented. There is little evidence of effective and imaginative leadership; nor is there any sense of control or accountability. The various programs function in a disconnected manner and have not been drawn together into a coherent and continuous framework.

Before the Rosenfeld report, the Tombs and the other jails in New York City had been investigated by various groups and individuals—all with similar conclusions (*16,17*). One report of such an investigation, by Richard W. Nathan (*17*), documented the medical care deprivation in New York City's correctional institutions and provided data on the massive expenditures required to operate the jails—more than $18 million was budgeted for fiscal year 1971. Nathan noted that:

> These resources currently provide approximately 7.9 physician hours per inmate per year. They permit sick call visits and initial admission inspections averaging two minutes apiece and specialty care when absolutely essential. . . . The mental competency examinations [provided in] inpatient psychiatric ward . . . cost per examination averages $1,770. . . .

Health Status of Inmates

With such massive expenditures as noted by Nathan, how sick are inmates? Some of the previously mentioned reports suggested that many inmates need medical attention, but how much?

In an attempt to quantify the health problems of inmates at the Tombs, Army reservists made three separate visits to the Tombs and performed physical examinations on three groups of inmates. The results of these examinations, which were reported in a memorandum of May 4, 1973 (table 1), indicate that a large percentage of inmates are in need of medical attention. However, even these data must be questioned for a variety of reasons; for example, the inmates volunteered for the examination, and each group was examined by

Table 1. Percentages[1] of health conditions requiring medical care among three groups of inmates, the Tombs Prison, New York City, 1973

Conditions	Group A (N=101)	Group B (N=70)	Group C (N=76)
None	72.2	70.0	71.0
Urinary tract infections	7.9	4.2	0
Chest diseases	4.9	4.2	0
Dermatological conditions	1.0	2.8	1.3
Eyeglasses needed	8.9	7.1	1.3
Ulcers and gastric disorders	1.9	4.2	2.6
Heart disease	2.9	1.4	0
Neurological conditions	0	1.4	0
Ear problems	0	2.8	7.8
Throat infections	0	1.4	1.3
Hypertension	0	0	9.2
Orthopedic conditions	0	0	3.9
Ophthalmologic conditions	0	0	1.3
Elbow infection	0	0	1.3

[1] Percentages do not total 100 because of rounding.

different physicians and technicians. One manifestation of these methodological limitations was the unexplainable inconsistency in the findings of hypertension in 9 percent of group C inmates but not in any of the inmates in groups A and B. Numerous other inconsistencies as well as the methodological weakness of this survey suggest that the validity and reliability of these findings are limited.

Another study (*18*) included a review of the medical problems of a predominantly white group of inmates in the Albany, N.Y., county jail in 1962. This study of 500 inmates found that immediate medical care, including hospitalization, was required for 113 or 22.6 percent, psychiatric hospitalization was required for 14 or 2.8 percent, and immediate medical care for a variety of conditions was required for 68 or 13.6 percent. Other psychiatric evaluations were required for gross personality disorders for another 8 or 1.6 percent of the population. Urine examinations were positive for sugar in 31 inmates; followup tests revealed that 8 were true diabetics and that 3 of these required hospitalization. Tuberculosis testing revealed four previously unreported active cases. Eight inmates were found to have syphilis, and one had gonorrhea.

The Botterell enquiry report from Ontario, Canada, is one of the most comprehensive on a prison health system (*19*). This investigation of jails, adult correctional and training centers, forestry camps, and training schools provides a detailed description of diseases and symptoms found among Canadian inmates in a sample of institutions. This information (table 2), provided from intake examinations and sick call records, indicates that two conditions are common and prevalent in the sampled institutions—the common cold (acute nasopharyngitis) and drug dependence. Other conditions that contributed significantly to medical care in four of the jails were alcoholism, sleep disturbance, and nervousness, which also were prevalent conditions in five adult institutions. Other prevalent conditions in the adult centers were skin rashes and headaches. In the training schools, contusions, lacerations, and abdominal swelling were the third, fourth, and fifth most prevalent conditions. It should be noted that although all these diseases cause discomfort, few are disabling or lead to imminent death, and most are treatable within the context of primary care.

Table 2. Health status of inmates in selected correctional institutions, by percentages of selected conditions, Ontario, Canada, 1972

Condition	4 jails (N=700)	5 adult correctional and training centers (N=640)	3 training schools (N=237)
Alcoholism	9.8	4.0	0
Acute nasopharyngitis	7.8	10.2	11.3
Drug dependence	6.5	4.1	7.9
Disturbance of sleep	5.3	3.0	0
Nervousness and debility	5.3	3.4	0
Rash, skin eruption	2.8	5.4	3.7
Headache, pain in head	2.2	3.4	3.7
Abdominal swelling	0	3.4	4.1
Lacerations and open wounds	2.8	2.9	4.6
Contusions	2.5	3.9	6.6

SOURCE: reference 19.

Finally, brief mention should be made of my report in 1972 of the Orleans Parish Prison, which revealed that neither the quantity or quality of medical care at the jail was adequate (*20*). One aspect of the Orleans study was an epidemiologic screening of 50 inmates, and as previously reported (*20a*):

> In a special study of 50 inmates in December 1971, no major medical problems were found on gross physical examination, although as can be seen in the following table, a large percentage of the 50 inmates complained of a variety of conditions. Basic laboratory workups, moreover, presented information suggesting that 14 percent might have had an active venereal disease and that 14 percent might have had a urinary tract infection. A review of the available medical records of these inmates showed that none had been seen previously for either of these infections. Perhaps of greater significance was the observation that 2 weeks after the abnormal results of tests had been returned to the prison hospital, none of the inmates to whom they pertained had received either followup laboratory work or treatment.

Medical condition	*Percent*
Frequent trouble sleeping	69
Dizziness or fainting spells	57
Nervous trouble of any sort	53
Depression or excessive worry	51
Pain or pressure in chest	45
Frequent or severe headaches	45
Venereal disease—syphillis, gonorrhea, and so forth	45
Leg cramps	41
Head injury	37
Severe tooth or gum trouble	37
Shortness of breath	35
Fractures	35
Eye trouble	31
Chronic or frequent colds	31
Palpitation or pounding heart	29
Recurrent back pain	29

Conclusion

Probably one of the best-known prisoners of the 1960s who has written about prison health conditions is James Hoffa. In a paper prepared for an American Public Health Association meeting (*21*), he noted that prisons are "unbelievably bad for those who enter their gates either with incipient physical or mental health problems, or even for those who have no more than average resistance to physical or mental health problems, or even for those who have no more than average resistance to physical or mental stress."

Are his observations an overstatement? Certainly not! It is obvious from this review of the published literature as well as my personal experience as a consultant to many jails and prisons that a significant number of health facilities and programs are overutilized, obsolete, unsafe—in a word, unsatisfactory. Indeed, they are simply a reflection of a prison system that appears to be in violation of the eighth amendment to the Constitution which forbids cruel and inhuman punishment.

Is the situation changing? Yes, but very slowly. For example, in New Orleans the new system is reportedly a considerable improvement over its forerunner. In New York, the quality of professional and nonprofessional staff and facilities is being upgraded and the quality of medical care is now being continuously evaluated by a group of health care professionals from outside the penal system.

These changes are encouraging, but much more remains to be done in this barren wasteland of medical care.

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