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Can There Be Acceptable Prison Health Care? Looking Back on the 1970s

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In 1974, when health care administrator Seth B. Goldsmith published his review of prison health care in *Public Health Reports*, 400 000 people were incarcerated in the prisons and jails of the United States, a number that would jump 5½ times during the next 40 years.[1] His views, described in more detail in his book *Prison Health Care: Travesty of Justice*, reflected careful consideration of the vast neglect and deliberately imposed suffering in what passed for carceral health care.[2] His findings demonstrated the difficulties of measuring happenings in the thousands of systems run by states, cities, and the federal government when no real statistics were kept and no oversight outside the correctional system existed. His analysis, given the lack of data, reflected what could be known about the conditions at the beginning of what is now labeled the mass incarceration era. This era of imprisonment began in the 1960s and grew as the War on Poverty became instead the War on Crime.[3-5] It expanded in the early 1970s after President Richard Nixon declared a war on drugs and the so-called Rockefeller Drug Laws in New York State began to be copied in other states, leading to life sentences for people who possessed just 4 ounces of narcotics. (Named after Nelson Rockefeller, governor of New York during 1959-1973, the laws put into place in 1973 drastically increased prison sentences for minor drug offenses.[6]) The deinstitutionalization of patients in the state mental hospitals that had begun in the 1950s affected incarceration by the 1970s, too, as the mentally ill were swept out of hospitals, into the streets, and then into jails and prisons.[7]

Concern with prisons was not a new issue, but the rebellions of the 1960s and 1970s put prisons and their multiplying populations on the societal radar. In turn, prison health care, as one of the key manifestations of the dehumanizing of incarcerated people, became a central focus of outcries and lawsuits.[8] It had always been a crucial issue, of course, as generations of incarcerated people and their families and allies tried to make sure imprisonment meted out in days, months, or years did not turn out to be death sentences through incompetence, ignorance, and intentional malfeasance.[9] If not death, as one researcher argued in the title of her article, the concern was that "incarceration [became] a catalyst for worsening health."[10]

Prison health care does not exist in a health care system vacuum. Our nation still treats health care as a privilege—not a right—outside the prison's gates, while concerns about control over prisoners and fiscal parsimoniousness in the carceral setting usually trumps care at almost every turn. Another assessment of prison health care, at the same time as Goldsmith's, by Brecher and Della Penna in 1975,[11] concluded that modernization in the provision of health care had eluded prisons and jails. Such care was still stuck in the "horse-and-buggy" era, this national report claimed, where the physician merely stopped by but could, or would, do very little.

It was not just the terrible level of care but the ways in which "sick call" (a request by the prisoner to ask to be seen by health care personnel) was viewed by wardens and correctional officers mainly as an opportunity for prisoner malingering, and suffering was believed to be part of punishment. Medical care was subordinated to the demand for control over the prisoners to remind them of the lack of freedom that underlies the prison rationale.[12] The Supreme Court finally dropped its hands-off approach to prison health care 2 years after Goldsmith wrote his assessment.[13] The court's justices realized the ways that substandard and cruel medical care violated the Constitution in their ruling in *Gamble v Estelle* in 1976: "deliberate indifference by prison personnel to a prisoner's serious illness or injury constitutes cruel and unusual punishment contravening the Eighth Amendment."[14]

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Although health care professionals and their organizations have tried to set standards for prison health care providers since the 1970s, and much has changed since Goldsmith wrote his critiques, it is ultimately the carceral system—in the name of security—that determines what will be paid for, to whom, and the kind of care incarcerated people can receive.[15] As then–federal prisoner and physician Alan Berkman and his epidemiologist colleague Richard Clapp told an American Public Health Association meeting in 1991, "there is a difference between prison health and prisoners' health care"—that is, between what the prisoner really needs and what the prison is willing to provide.[16] Looking back at Goldsmith's article, it is possible to see the issues then and to consider what has changed.[1]

"Barren Wasteland of Medical Care"

Goldsmith's assessment in 1974 came at a time when increasing attention was being paid to the failures in prison health care.[17] This attention intensified after prisoner organizing, especially in the aftermath of the state's murderous response to the Attica Prison uprising of 1971, where poor health care was a central concern.[18] In evaluating the evidence on the availability and quality of prison health care, Goldsmith pointed out the obvious concern of anyone who uses survey data: what you find often depends on your methodology and the kinds of questions you ask. He argued that self-rating forms and 1-day observations concluding that prison care is satisfactory are suspect.[1] Goldsmith gauged problems that had existed for decades: high inmate-to-physician ratios, incompetent (often unlicensed) health professionals, sick calls that lasted for 30 seconds, underreporting of needs, lack of follow-up, and lack of any preventive or primary health care. As Goldsmith questioned rhetorically in evaluating care in one prison, "[I]s a population of more than 1,000 inmates well served by one full-time physician with no technical assistance?"[1]

As his final witness to the vast indifference in what he called the "barren wasteland of medical care," Goldsmith called on no less an *éminence grise* than the infamous Teamsters president, Jimmy Hoffa. In his own words, Hoffa labeled the carceral health care he experienced as "unbelievably bad" and the "shame of our prisons."[1] (Hoffa was in the Lewisburg Federal Penitentiary between 1967 and 1971 but disappeared in 1975 and was declared dead in 1982. These statements were presented at an American Public Health Association meeting in 1972.) Although Goldsmith laid out the problems in "overutilized, obsolete, unsafe—in a word, unsatisfactory" prison health care, he saw some hope of reform in the involvement of outside professionals and their organizations and the upgrading of systems.[1] He could not have known what was ahead.

Separating Health Care From Corrections: The Solution That Did Not Work

By the early 1970s, prison health reformers began to call for the separation of prison health care from corrections, hoping that independent health practitioners, with more control than corrections officials over spending for prison health care and the reorganization of services, would make a difference.[19,20] In New York City in 1971, for example, Mayor John Lindsay set up a committee to investigate prison health care and recommend changes after inmate protests and revolts laid bare the worsening conditions for both physical health and mental health in the city's jails. The committee called for, and the mayor implemented, the city's Health Services Administration takeover of health services in jails from the Department of Correction. Several years later, however, reports demonstrated the ways in which the Department of Correction still maintained daily control. The Health Services Administration made an affiliation agreement in 1973 with the voluntary Montefiore Hospital to cover care at the multiple notorious city jails on Riker's Island as part of this effort to improve care. This use of public money to pay a nonprofit institution demonstrated the beginning of the privatizing of prison health care, with the hope that such actions would improve standards and quality of care.[21] Even though better trained physicians with more sympathy for the concerns of prisoners often did the work, the structural problems were not overcome. Similarly, in Chicago, newspaper exposés in 1973 on the health system in city jails led the Cook County Health & Hospitals Governing Commission to take over medical care in the city's jails and launch an experiment that used returning Vietnam War–era medical corpsmen to provide primary care.[22]

Health care professionals, accredited and supervised independently of prison officials and embedded in a staff hierarchy established by health care administrators, were supposed to be the answer to the perennial problems of systemic failure and incompetence. As one North Dakota prison health reformer argued in 1977, "It is the responsibility of public health and preventive medicine to assure that the widespread, inadequate, unconscionable, and unconstitutional prison health delivery system is relegated to the archives of history—never to return."[20]

Attempts to set standards for prison health care practitioners led the American Public Health Association, the American Bar Association, and the American Medical Association (AMA) to become involved in documenting the problems in prison health care in the early 1970s and the American Civil Liberties Union to form its National Prison Project in 1972.[23] It was not until 1977 that the AMA held its first National Conference on Improved Medical Care and Health Services, now the National Conference on Correctional Health Care, and in 1979, it published the first sets of health standards for prisons and juvenile confinement institutions. In 1983, the National Commission on Correctional Health Care was incorporated to set standards and

accreditation policies, and the peer-reviewed *Journal of Correctional Health Care* was established in 1989.[23]

The Rise of Mass Incarceration

Although higher standards and greater professionalization of health care providers improved care in some prisons and jails, they could not correct the problems that only multiplied as a result of the increasing numbers of prisoners and the growing fiscal restraints placed on government spending. The rise in the number of prisoners was especially steep for African Americans and other people of color, whose incarceration became out of proportion to their numbers in the population or their purported criminality. This massive increase in imprisonment led many critics to see it as a new embodiment of racism and a form of continued enslavement.[6,24] Thus, mass incarceration, or what some observers called hyperracialized imprisonment, made the attempts to provide decent prison health care more difficult.[25] In addition, the underlying tensions between control and care were exacerbated as lockdowns became more common, the prison population aged, and new demands were made by both mental health concerns and the HIV/AIDS epidemic. The racism implicit in the prison setting similarly increased as prisons were often sited in rural areas, away from major cities, with guards coming from mostly local populations.[26]

Much of the focus on prison health care changed with the growing realization that mass incarceration itself was a public health problem and that prisoners with various ills, especially HIV/AIDS, eventually return to their communities.[27] This realization transformed the sole focus on prison health care to a concern with the effect of incarceration and prison health care on populations beyond the prison gate. Public health literature during the early 21st century is replete with terms such as *epidemic* and *plague*.[28,29] An article published in 2017 observed that "peer-reviewed articles and government reports [suggest that] . . . excessive incarceration could harm entire communities and thus might partly underline health disparities."[30]

The public health consequences of mass incarceration began as the social welfare programs of the 1960s were withdrawn, community health programs in urban settings were eliminated, and state budgets were imploded by fiscal conservatism in the 1970s. Among the consequences were that the incarcerated sometimes came to prisons sicker than they did before mass incarceration. They were especially beset with mental health and drug addiction problems, received little attention to chronic conditions while imprisoned, and had low levels of linkage to care after imprisonment.[31-33] And to cut down on overuse of health care services, prisons began to collect copayments, which did little to increase state budgets and much to keep prisoners from accessing care.[34]

Criticisms of prison health care exploded from time to time in newspaper exposés, lawsuits, and even congressional hearings.[35,36] In 1991, prison health care was the topic of a *60 Minutes* episode.[37] But in response, prison officials and the physicians in charge of providing the medical care would often stonewall, promise that the problem was just a few bad apples or that things were getting better, or blame the penuriousness of state budgets, which resulted in never being able to hire enough practitioners or improve the quality of those they already had.[38] Over and over, when questioned, physicians in federal prisons would fall back on assuring their critics that they were meeting "community standards," even when no community would sustain this kind of care, care that bordered on obvious malpractice.[36,39] And yet in an ironic twist, it was sometimes true that medical care was better for people in prison than it was for people in the community, as prison officials often claimed.[40]

From Professionalization to Privatization

When the affiliation agreements with voluntary hospitals and medical centers did not provide needed improvements or improvements were not possible to make, many governmental entities turned toward transferring both prison control and prison health care to private companies. During the 1980s, this privatization expanded. Thirty years later, judgments on the success of such privatization are, as one study put it, "polarized." Anyone watching the Netflix series *Orange Is the New Black* can see the dramatization of what privatization has meant.[41] Private prisons are criticized for their cost-conscious approach, but government-controlled prisons often operate under fiscal restraints as well.[42,43] Others have seen this form of privatization as another aspect of "carceral capitalism"—where money is transferred from the poor into both municipal and private hands.[44]

All of the solutions that Goldsmith thought possible—better affiliations, increased standards for professionals, more quality control—are often mitigated in the privatized setting.[45] Physician Robert (Bobby) Cohen, a long-standing prison health care administrator and expert in correctional medicine, has been appointed by courts in many states, including Florida, Michigan, and New York State, to monitor medical care in legal cases that challenge the provision of medical care in prisons.[46] His examples of mistreatment, denial of care, and horrible outcomes are painful to read; he argued that these experiences were worse than what was seen in photos of the sadistic treatment of prisoners at Abu Ghraib.[47] In his written testimony for a lawsuit in 2013 against the Arizona Department of Corrections related to privatized medical care in its prisons, Cohen wrote that the system was "disorganized, under-resourced, understaffed, and completely lacking in the capacity to monitor itself and correct the systemic dysfunctions that currently exist."[47] The American Civil Liberties Union argued the case in the US District Court for the District of Arizona and won in 2015. Two years later, the same court found "pervasive and intractable failures to comply" with the settlement and began to hold the Arizona Department of Corrections in contempt for its failure to improve private care for prisoners.[48]

Conclusion

Before the rise of mass incarceration, the HIV/AIDS epidemic, and the increase in the number of people with mental illness in US prisons, Seth Goldsmith published his critique of the failures of carceral health care. Physician Alan Berkman, a federal prisoner for almost 10 years, testified and wrote in the 1990s about the systemic failures in carceral health care that he observed and experienced. He almost died of cancer twice while imprisoned because of the horrendous care he received. For Berkman, the systemic failures originate in the belief that all prisoners lie or are violent (or both), are not capable of giving a factual medical history, and must be controlled above all else. Moreover, all incarcerated people were perceived as prisoners, not patients. As he concluded in testimony before the US House of Representatives in 1991, "Security concerns are the context in which prison medicine is practiced, but it is disastrous if they become the overwhelming content."[49]

Decades later, many incarcerated people still face the same kind of cruel and unusual punishment that Goldsmith, Cohen, and Berkman described. Goldsmith grasped some of these problems, but he could not predict the expansion in the number of people incarcerated, the HIV/AIDS epidemic, the fiscal restraints, or the privatization of prisons and prison health care. His solutions—better monitoring, more staffing, and the upgrading of health personnel credentials—have barely been implemented over the years, as Cohen's recent testimony made clear. Berkman's argument—that control rather than care underlies the medical rationale in prison health care—still undermines humane treatment of incarcerated people. In the national prison strike that ran for 19 days beginning on August 21, 2018, incarcerated strikers made this their first demand: "immediate improvements in the conditions of prisons and prison policies that recognize the humanity of imprisoned men and women."[50] Reforms proposed by the prison health care critiques should be implemented, but until the "humanity of imprisoned men and women" is a priority, I fear that whoever reviews prison health care decades from now will see the same problems that we see today.

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