JAILHOUSE MEDICINE—travesty of justice?

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Inmates of the Orleans Parish Prison in New Orlean, La., are, for the first time, well on the way to receiving first class medical care under a system that may be a model for the nation. Acting under Federal court orders, this county correctional institution and the City of New Orleans have contracted with Charity Hospital of Louisiana at New Orleans for the hospital to provide the inmates with medical care; the quality of the care is to be monitored by the city health department of New Orleans.

Scope and Sources of This Paper

Jailhouse medicine has traditionally been an area of considerable controversy and misinformation—controversy over legal and philosophical points such as prisoners' "rights" to medical care and misinformation as to the quantity and quality available. Finessing the first set of points to the lawyers and philosophers, this paper focuses on the organization, delivery, and quality of the personal health services that have, in the past, been available to inmates of Orleans Parish Prison and on the events which led to the adoption of a new system of providing such services.

The basic information for the paper came from the literature on prison medicine, from official reports and correspondence relating to the Orleans Parish Prison's medical system, and from interviews with State government officials, prison officials, prison medical and custodial personnel, and inmates. Additional data were taken from consultative reports written by a medical records librarian, two pharmacists, and a nutritionist; from a review of a sample of the medical records at the parish prison; from an epidemiologic survey of a sample of inmates at this prison—information which included detailed histories and the results of physical examinations; and finally, from systematic observation at the prison over a 2-month period.

Review of the Literature

The literature on jailhouse medicine can be classified as interesting, but usually worthless subjective discussions by physicians of their personal experiences in prison medical departments *(1–3)* and as reports of special one-time epidemiologic screenings in prisons for communicable

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diseases such as tuberculosis, gonorrhea, and syphilis or special studies of psychiatric condition (*4*). The most recent article I found that specifically focused on the medical problems of county jail inmates was published in 1962 (*5*) and described the health status of the overwhelmingly white (80 percent) inmate population of Albany, N.Y. I found no comparable data for any large urban jail that primarily incarcerated blacks. Several studies describing the organization of care for prisoners are useful for comparison but fail to go beyond the anatomy of the medical departments or to address crucial questions such as the quality of care afforded. Overall, the literature is disappointing in that it fails to provide substantive data on the process of medical care at correctional institutions or the quality and quantity of care available.

Class Action Suit for Inmates

The first in a series of events that led to the establishment of a new system of medical care at the Orleans Parish Prison was a class action suit (*Louis Hamilton, et al.* v. *Victor Schiro, et al.*). This suit was filed in October 1969 against the City of New Orleans, its mayor, city council, criminal sheriff, and the Orleans Parish Prison warden on behalf of the inmates at the Orleans Parish Prison. The court agreed with the inmates' allegations that conditions at the prison constituted cruel and unusual punishment in violation of the Eighth Amendment of the Constitution of the United States. Following are some of the important findings of fact by the judge that related to the medical care system of the prison (*6*):

> The danger of an outbreak of contagious diseases is great as a result of the unsanitary conditions in the toilets, the kitchen and sleeping equipment. Further, no medical intake survey is made to detect prisoners with contagious diseases. Although the incidence of gonorrhea is high, only sporadic blood tests for syphilis are done. As a result of the crowded conditions, there is no isolation or quarantine area for those with contagious diseases that are detected.
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> The combined effects of the fearful atmosphere and crowded and sordid living conditions has a severe effect on psychotics, often causing those transferred to the prison from mental hospitals to be returned to the hospitals. Disruptive psychotic prisoners are sometimes moved into a hallway by the main gate and shackled to the bars.
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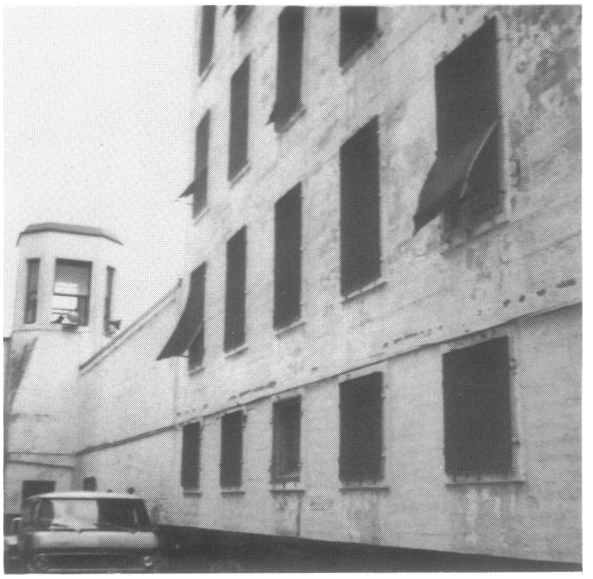
> Hospital facilities and medical attention are woefully inadequate to meet the needs of the inmates. Inmates who should be confined to bed with chronic diseases must be kept on the open tiers. Medication that is prescribed frequently never reaches the inmate or else is taken from him by other prisoners.



As a result of the litigation, a judicial order was issued directing the defendants to correct immediately the deficiencies enumerated in the suit. A year passed, however, without much discernible improvement in the parish prison.

Finally, in October 1971, 2 years after the original petition was filed, the Federal Court appointed a Federal special master to investigate and formulate a reasonable and effective plan for correcting the prison's deficiencies. (Special masters, usually attorneys, are judicially appointed; they serve the courts as fact finders or referees in complex civil cases, but their use is infrequent. Appointment of a special master in the type of civil rights case described was considered to be an important legal innovation.)

Because of the obvious health needs delineated by the judge, the Federal special master Robert Force made medical care his first area of concern. Since, however, health systems were not his area of expertise, I was appointed health care consultant to the project and was deputized with the same broad investigatory powers as the master. In this consultative role I prepared the medical care section of the master's report and formulated plans for changing the health care delivery system at the prison.

Process of Medical Care at Prison

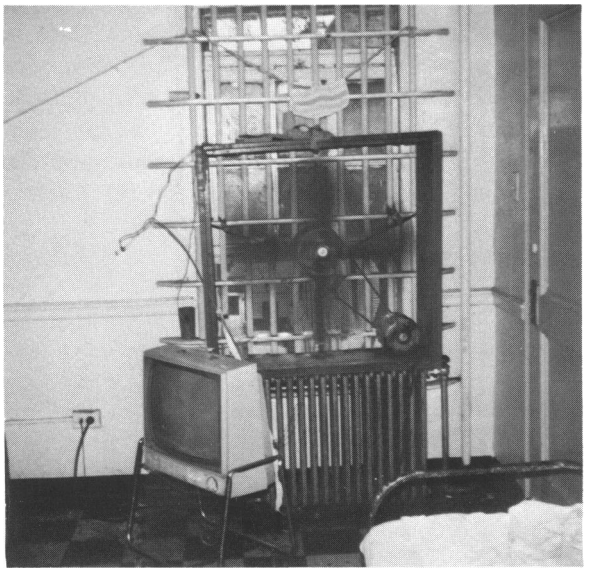
Conceptually, medical care in the 40-year-old dirty and poorly ventilated Orleans Parish Prison appeared to be rationally organized and reasonably operated. The breakdowns that occurred in

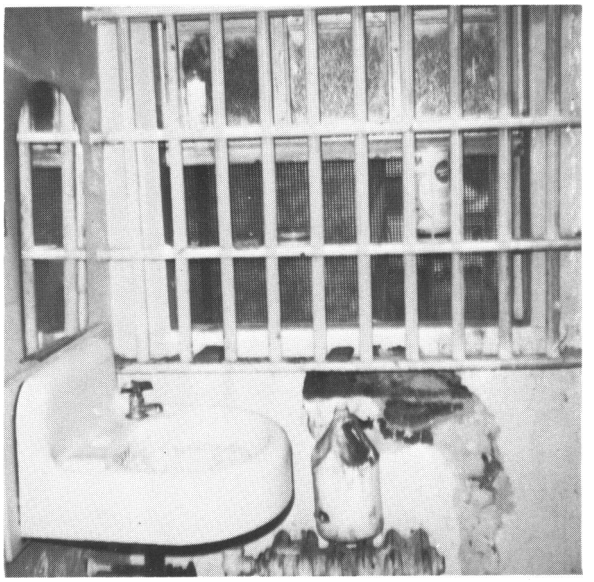
the system, however, suggested an alternative hypothesis.

The new inmate's first encounter with the prison's medical system was in the docks, where between 15 and 35 men shared an open jail cell while awaiting the magistrate's arraignment. Here, using the daily intake report sheet, an inmate-trustee administered, without explanation, a tuberculin skin test (tine). If 1 to 2 days later the person tested was still in prison and could be located, the inmate-trustee would read the test. Positive results led to a chest X-ray's being taken, which was subsequently read by the tuberculosis control staff of the city health department. When the prison's X-ray machine was not operative (as was the case for the last 6 months of 1971), the health department sent over portable equipment and an operator on a weekly basis.

The inmate's second encounter with the medical system occurred in the booking room after his hearing when the booking officer asked each new inmate, "Is your health good?" or "Is your health good or bad?" The response was duly recorded on the back of the booking card. When a person was obviously in distress or stated a seemingly serious complaint, he was immediately referred to the nurse or physician for treatment.

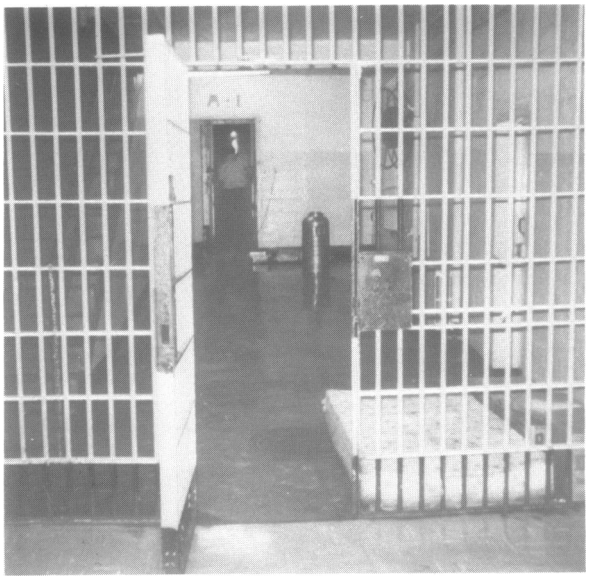
After assignment to a cell and tier, an inmate could request emergency treatment at any time and routine care at specified times through a variety of mechanisms. The most popular method of getting medical attention was to place one's name on the medical sheet that was circulated by an





inmate-trustee (hallboy) or deputy and transmitted to the nurse. A second popular way was to have a hallboy or deputy act as spokesman for the inmate seeking treatment and tell his "story" to the nurse, or in the case of the deputy, get him to actually bring the inmate down to see the nurse or physician. Writing a note or seeing the warden or associate warden, as well as bringing some outside pressure from the folks at home, would sometimes result in an inmate's getting medical attention. Finally, in an emergency or from utter frustration, the inmate could resort to the "beat down" or "knock down"—when the inmates on one or more tiers begin beating simultaneously on the bars—to attract attention.

Breakdowns in the medical care system with these methods were identifiable, numerous, and oftentimes horrendous. Specifically, my discussions with staff and inmates indicated that prisoners sometimes had to "pay off" hallboys and, indeed even deputies, to get their names on the list. Further, once the list got to the nurse, a determination as to whether to see or not to see the inmate would be made on the basis of a subjective assessment of the complainant and the nature of the stated complaint. Obviously, the more articulate and prison-wise the hallboy or the inmate, the more likely was the inmate to get medical attention. When deputies brought inmates for care, custodial problems arose; the tier was left unattended and staff relations became strained—the medical people thinking the deputies were trying to break the monotony of tier work and "goof-off"



by bringing someone to the prison hospital and the deputies thinking that if the medical personnel only did their job, the deputies would not have to waste their time bringing inmates to the hospital. Finally, the "knockdown" was used so often that everyone responded slowly to these calls, and the effectiveness of this emergency signaling system was thereby diminished.

The fourth stage in the medical process was that of specialty care, which was provided at Charity Hospital. After a determination by the part-time physician at Orleans Parish Prison (12 hours per week) or the only full-time nurse (40 hours per week—no holidays, weekends, or nights) that an inmate needed some type of specialized care, the inmate and a deputy would go to the hospital and make an appointment. On the day of the appointment, the inmate (legs and hands shackled) and the deputy were sent to the hospital again for the visit. If possible, appointments made by inmates before their incarceration were kept. Generally, however, for security reasons, such as preventing the planning of an escape, inmates were not told in advance of their appointment dates. Since there was no prison ward at Charity Hospital, admission meant placement in the general ward. Security of an inmate who was an inpatient at Charity Hospital was handled by shackling him to his bed and thereafter having him checked by the three-man patrol of armed deputies that was assigned full time to the hospital. All inmates with serious medical problems which arose after hours and on weekends were transferred to Charity Hospital for care.

Dental care, consisting entirely of extractions, was provided one evening a week. Inmates requested this service by signing a dental sheet, and here again the logistics of assembling the inmates from two outlying buildings and the various prison tiers sometimes precluded their obtaining the necessary care.

Quality of Care at Prison

Although measuring the quality of medical care is difficult, there are some widely accepted minimal standards of good practice, such as those set by the Joint Commission on the Accreditation of Hospitals and by the Federal and State governments for Medicare and Medicaid facilities, as well as indeed the common standards of practice of most medical practitioners. Unfortunately, the work performed at the parish prison did not meet any of these standards.

For example, minimal standards of practice require the maintenance of adequate medical records that will provide information on a patient's medical history, health status, disabilities, diseases, treatments, and treatment results. The medical record is the narrative that documents the various encounters a person has with the health care delivery system and, if properly maintained, it has considerable medical as well as legal importance.

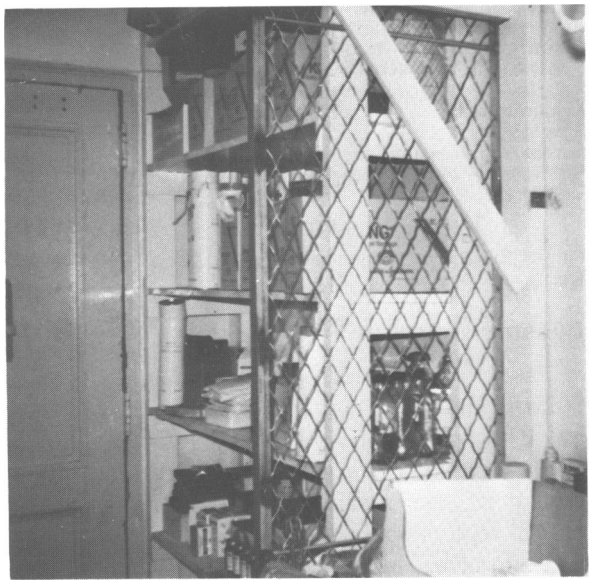
In a review of the medical records of the prison for September 1971, it was found that, in almost all instances, an adequate medical history had not been taken, nor had a physical examination or laboratory workup been done. Further, although the medical records indicated that a treatment had been given, almost 25 percent did not show a diagnosis; 42 percent of the records were not signed so that the person who had treated the inmate could not be identified. The most prevalent medical problems were minor traumatic injuries, dermatological difficulties, and venereal disease:

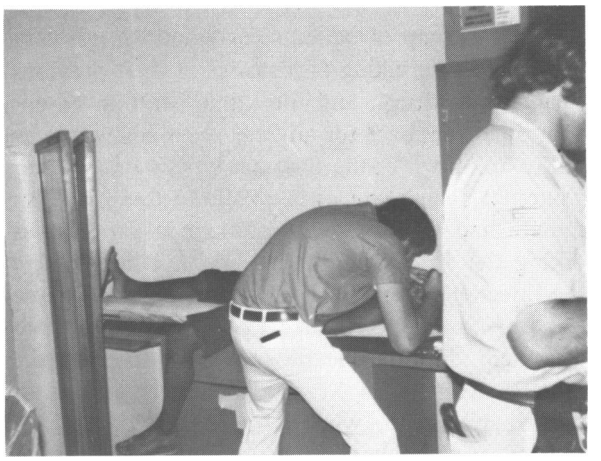
Medical problem	*Number of inmates*
Injuries, stabbings, lacerations	76
Dermatological conditions	25
Venereal disease	23
Stomach ailments	17
Colds	14
Nervousness	12
Eye irritation	11
Suture removal	10
Pregnancy	8

Under the system in force, it was not until an inmate had his first encounter with the medical system—possibly days or months after being

jailed—that his previous medical treatment was for the first time discussed and a request made for his records. It is perhaps of greater significance that, even when good historical data were available, they were not used. For example, during the course of my study, arrangements were made for community medicine students to take medical histories and perform routine physical examinations on incoming inmates under the supervision of a physician. Once these data were collected, however, and turned over to the prison medical department, they were filed and never used. The attitude of the medical department staff might be best characterized as that of a "quick fix" approach—responsibility for virtually any type of treatment that required followup or monitoring was abdicated.

Adequate quality care presupposes the existence of some minimal equipment, such as a scale and examining table—two basic pieces of equipment that the hospital did not possess. The total complement of reference books available to the nurse was one—the free give-away drug book, the PDR (Physician's Desk Reference). Nowhere in sight were such potentially valuable books for the nurse as the Merck Manual or a medical dictionary. Indeed, in terms of delivering adequate medical care, it would have been better to spend less money on the superficial accouterments of an office, such as a carpet, and more on needed basic equipment, reference materials, and first aid equipment—the hospital did not even have a plastic airway or Ambu-bag.





My observation of the physician's practice was limited. Clearly, while both he and the nurse were hamstrung by a lack of resources to examine and treat, they did not use the resources they had. For example, although agreements had been made with the health department and Charity Hospital to perform laboratory work, blood or urine samples were rarely sent out for examination, and only on rare occasions was urine tested by the "dip-stick" method.

Followup of patients is another basic element in care, and here again the prison medical system fell short of the mark. The major part of the difficulty was logistical, that is, the medical staff was never sure when an emergency might arise, when the physician would come in, or when an inmate would be able to get off the tier. Here there were really two problems—custodial functions superseded medical functions and the medical department was poorly administered, as exemplified by the fact that a great many inmates were told ". . . wait and we will have you see the doctor"—some medical records indeed bore the notation "to see Dr. X—" but the physician was never seen.

Next, there was the problem of drugs, legal ones. Fifteen percent of the prisoners were continuously on mood-changing drugs. Eighty-five percent of the inmates' contacts with the jail medical system during September 1971 resulted in their getting at least one of the following:

Item	*Times prescribed*
Tetracycline	87
Bacitracin, boric acid, Desenex ointment	64
Vanquish	37
Nasal spray, cough syrup	35
Phisohex	30
Multi-vitamins	26
Valium, Librium	17
Polysporin ointment	17
Percogesic	17

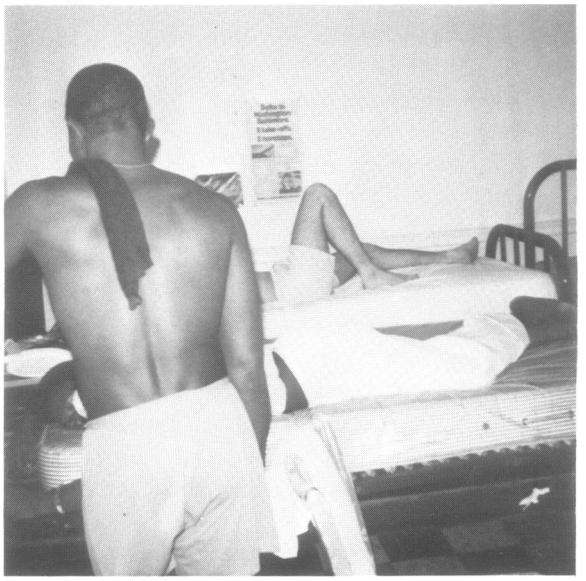
The followup of patients for whom drugs were prescribed, the taking of histories of their previous reactions to drugs, and the administration of appropriate treatment for adverse reactions were virtually unknown at the Orleans Parish Prison. For example, during one of my visits to the prison an inmate had a grand mal seizure because he was taking the wrong drug. The prison did not have the injectable drugs needed to treat him after the seizure; nor did the nurse know the appropriate treatment. In fact she did not plan to treat the inmate at all, but was prodded into action by an outside physician, who happened to be touring the jail at the time.

The nurse's answer to the problem was that "Charity Hospital is only 3 minutes down the street." While her statement was indeed correct, 30 minutes to an hour were lost in getting the inmate from the fourth floor prison hospital ward to the first floor examining room, onto a stretcher, into a vehicle, and to Charity Hospital. More important, perhaps, the whole difficulty might have been avoided had a proper workup been done initially. The man had been booked into prison on a Thursday with only one complaint listed in respect to his physical condition—"bad eyes." His medical abstract was not sent for until the following Monday, when he had come to the prison medical department to complain of head pains.

Finally, there was the question of psychiatric care for the inmates. It was essentially nonexistent. Inmates with serious psychiatric problems were sent to Charity Hospital. Sometimes they were kept there; other times they were sent back to the prison, where they were either tranquilized with drugs or shackled to bars near the main entrance.

In summary, while the limited resources circumscribed the medical department's ability to provide the highest quality care, the resources that were present were poorly used, and the result was care that was not even minimally adequate. Fortunately for all concerned, the inmate population of the parish prison—while great complainers—was basically made up of healthy young people who seemingly could stand being incarcerated without proper medical care.

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—syphilis, 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

Quantity of Care at Prison

There was considerable discrepancy between the officially stated amount of medical care available at the parish prison and the amount revealed by observation, interviews with inmates, and a review of the medical records. According to official reports and statements of the prison nurse and physician, an average of 800 inmates per

month were seen by the nurse and 500 by the physician. The other sources, however, clearly indicated that only 500 inmates per month were seen by the nurse and 180 by the physician.

The total staff available to deliver the care was comprised of one physician working approximately 12 hours per week on an unscheduled basis; one full-time nurse; three deputy sheriffs, who delivered and dispensed drugs and provided inmate transportation to Charity Hospital but rarely provided first aid or medical assistance; several inmates who performed recordkeeping functions and general "runner" activities, such as escorting other inmates back and forth from locked tiers; and a full-time salaried pharmacist, who worked 10 to 15 hours per week filling prescriptions. Care was provided in the one-room medical department, a room which was used for both clerical work and physical examinations. An eight-bed prison hospital ward located four floors away was used as a self-care unit for convalescing inmates. The patients on this unit, who were basically under the control of a hospital trustee-inmate, were rarely checked by the nurse or physician more than once every several weeks.

Dental care, consisting almost entirely of extractions, was also available at the prison. Once a week a dentist came to the prison to extract teeth. Officially, an average of 17 extractions were performed each week, and an average of 46 inmates per week were seen under the dental program (exclusive of referrals to Charity Hospital for extractions of wisdom teeth). One dentist reported, however, that approximately 20 patients per week were seen, and worksheet reports indicated a weekly average of 11 visits and 9.2 extractions—significantly below the officially reported 46 visits and 17 extractions. The reported working hours of the dentists, of between 2 and 3 hours per week, appeared to be accurate. The fee for these 2- to 3-hour sessions was $100, or $35 to $50 per hour (net).

A New Approach

My study demonstrated that the Orleans Parish Prison's medical department was unable to deliver a minimally acceptable quantity and quality of health care to inmates. This result was not completely unexpected. The job entrusted to the medical department was frustrating and, indeed, oftentimes unstimulating. The atmosphere was difficult, and the relationships between the professional staff of the medical department, the group of jail deputies, and the prison administration was strained at best. This conflict was natural and to be expected since the custodial goals of a jailhouse conflict with the therapeutic goals of a medical department.

Who suffers because of the problems described? —inmates, 80 to 85 percent of whom are in jail not because they have been convicted of any crime but rather because they are awaiting trial and cannot afford bond.

The solution to these problems that I proposed was to contract for medical services outside the jail. I recommended, and the court ordered, that the Orleans Parish Prison enter into a specific performance contract with an appropriately qualified medical group to deliver medical services to Orleans Parish prisoners. Under this plan, administrative authority was to be retained by the criminal sheriff; professional responsibility was to be placed in the hands of the contracting group; and the City of New Orleans Health Department was to be given responsibility for monitoring the quality of medical care provided. Basically, the contractor agreed to perform routine intake physical examinations and conduct routine sick call for all inmates on a 24-hour basis. Additionally, the contractor agreed to provide comprehensive backup consultative services—medical, surgical, obstetrical, and psychiatric—and, also, emergency medical services; medications were to be ordered on a cost basis. The contractee (the Orleans Parish Prison and the City of New Orleans) agreed to provide appropriate physical space, equipment,

and supplies and to reimburse the contractor for services of medical and nonmedical personnel and supplies.

This approach, while drastic, seemed to me to be necessary if a reasonable quality and quantity of care was to be delivered to the parish prison inmates. Clearly, the medical department and the inmates' medical problems were a headache for the prison administration. This approach for the first time caused the payers of care and the providers of care to sit down and spell out what they wanted from each other. Further, with a clear delineation of responsibility and authority, everyone for the first time knew what his job was vis-a-vis medical care.

To Charity Hospital (or indeed to any other medical group such as the medical schools of Tulane University or Louisiana State University), the contract would mean primarily an excellent clinical experience for its house staff and, secondarily, a way to make some money.

Such a program is expensive at $138,000 per year. Its cost represents an increase of 100 percent over the medical department's previous budget. This added money, however, will provide 24-hour instead of 8-hour coverage; 50 hours of physician time per week instead of 12; and complete laboratory workups, including SMA 12 (AutoAnalyzer) determinations and urinalyses, instead of no laboratory work—in short, comprehensive medical care where relatively little has previously existed.

Charity Hospital is now delivering the medical care to the Orleans Parish Prison inmates. The task of the Federal Court with respect to the prison is not yet finished; still to be addressed are the significant questions of the organization and internal management of the prison and the workflow of the criminal courts. Finally, the Federal Court, the City of New Orleans Health Department, and Charity Hospital must engage in a careful evaluation of the new medical system, but it appears to be an important positive step toward alleviating the abysmal medical conditions uncovered by my study.

REFERENCES

(*1*) Robinson, T. A.: Prison medicine. Mississippi Doctor 36: 118, 119, November 1958.

(*2*) The patients are prisoners. Hospitals 36: 53–58, Dec. 1, 1962.

(*3*) Men behind bars. Med World News 12: 27–35, June 11, 1971.

(*4*) Fink, L., et al.: Psychiatry's new role in corrections. Am J Psychiatry 126: 542–546, October 1969.

(*5*) Whalen, R. P., and Lyons, J. A.: Medical problems of 500 prisoners on admission to a county jail. Public Health Rep 77: 497–502, June 1962.

(*6*) *Louis Hamilton, et al.*, v. *Victor Shiro, et al.* U.S. Dist. Ct., Eastern Dist., La., New Orleans Div., Case No. 69–2443, pp. 3–5.