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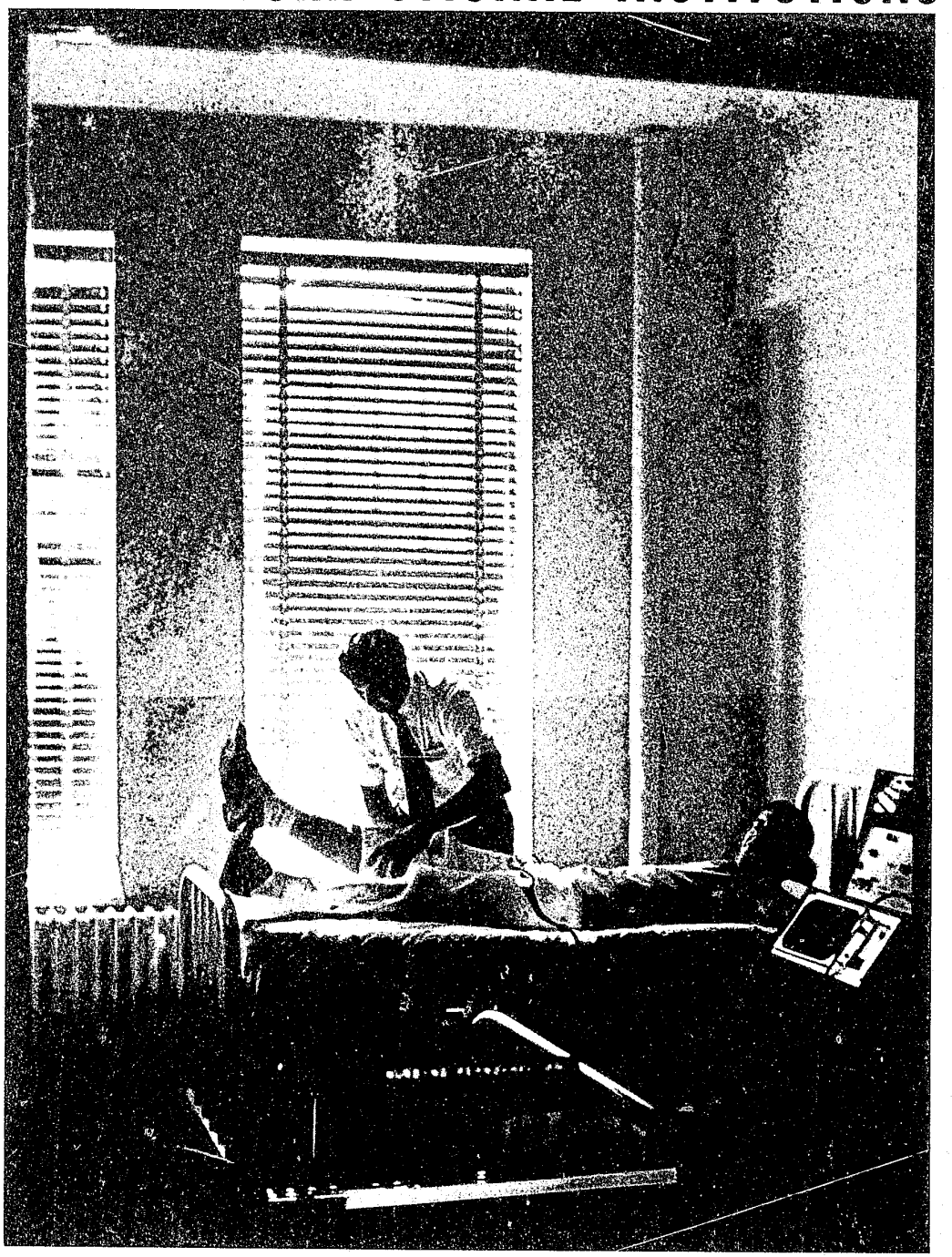
HEALTH CARE IN CORRECTIONAL INSTITUTIONS



NATIONAL INSTITUTE OF LAW ENFORCEMENT AND CRIMINAL JUSTICE
LAW ENFORCEMENT ASSISTANCE ADMINISTRATION
UNITED STATES DEPARTMENT OF JUSTICE

HEALTH CARE IN CORRECTIONAL INSTITUTIONS

By

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and

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FOREWORD

When a person is convicted of a criminal offense and is sentenced to a term in a correctional institution, he loses a number of rights. Access to medical care, however, is not one of the rights forfeited. This is even more obviously true for persons held pending trial or awaiting final adjudication of their cases. Correctional systems have a duty to supply not only medical care but dental care and other health services to all persons committed to their custody—and they recognize that duty.

But how, in a society where health care is annually becoming more complex and more costly, can that duty be carried out? How can correctional systems secure the facilities and the highly skilled manpower needed to provide adequate health care? Precisely what services must be included if "adequate care" is to be provided? How can these numerous health service components be organized into an effectively functioning system? How can wasteful duplication be avoided? How can appropriations or other sources of funds be secured to cover the high and rising costs of adequate health care?

This *Health Care Prescriptive Package* is concerned with these and related questions. It is addressed in part to the physicians, nurses, and others who are actually delivering health care in correctional institutions, but in even larger part to the legislators and the state and local officials who are responsible for organizing, planning, administering, and funding correctional health care services.

This manual does *not* seek to set minimum standards for correctional health care. It is not, except incidentally, a plea for higher standards of care. Rather, it is a "how to" guide. Assuming without argument that corrections officials would *like* to improve the quality and efficiency of the health care currently available to inmates, this manual offers a broad range of practical suggestions for achieving that goal.

GERALD M. CAPLAN
Director
National Institute of Law Enforcement
and Criminal Justice

September 1975

PREFACE

The American Correctional Association was indeed privileged to participate with the Law Enforcement Assistance Administration in the development of the Health Care Prescriptive Package. Health care as delivered to inmates in correctional institutions has been of major concern to administrators, wardens and health care professionals for a considerable period of time.

For the first time a joint effort to understand correctional health care was undertaken by the major components of both the public and private sector. All readers, whether professional, layman, or student, will gain a great deal of insight into this significant and critical area of service to inmates. The authors, Edward M. Brecher and Dr. Richard Della Penna, have done an outstanding job of defining the problems. State Correctional Health Care Administrators from throughout the nation and Canada critiqued the authors' work with the final draft, a combined effort of staff and professionals. The American Correctional Association is proud to have played an important role in this timely endeavor and commends this prescriptive package to all those who seek to understand the delivery of health care services to the clients of our correctional systems.

ANTHONY P. TRAVISONO
Executive Director
American Correctional Association
College Park, Maryland

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INTRODUCTION

The horse-and-buggy doctor, though long since vanished from the American scene, remains vividly alive in fiction and the cinema. He came to the patient's bedside when summoned, bringing with him in his black valise all of the equipment and medication he needed—indeed, all that was available to him. He was surgeon as well as physician, accustomed to operate in the bedroom or kitchen of the patient's home; nursing care and whatever other care the doctor recommended were supplied by the patient's family. In short, the horse-and-buggy doctor *was* the American system of medicine; his presence was assurance enough that whatever could be done would be done.

This was hardly the Golden Age of Medicine. The horse-and-buggy doctor "could do little but set bones, amputate limbs, pull teeth, vaccinate against smallpox, and assist births. The few drugs doctors prescribed were unspecific, and often given in debilitating doses." But that, plus relief of pain and and anxiety with opiates and reassurance, was all that patients expected.

Under such circumstances, supplying to the inmates of early correctional institutions the same health care available in the outside community was quite simple; the same physician who made the rounds outside also stopped off at the poorhouse and jailhouse when summoned. Nor was financing his visits a problem; for (at least in theory) the horse-and-buggy doctor was expected to support himself on the fees paid by his well-to-do patients, caring for the indigent and the institutionalized as a public service.

The American system of health care has made revolutionary strides since then. The horse-and-buggy doctor has been superseded by platoons of specialists armed with new equipment, new drugs, and new techniques—family physicians, internists, obstetricians, pediatricians, neurologists, otolaryngologists, gastroenterologists, cardiologists, dermatologists, and practitioners certified in a bewildering variety of other specialties. The black valise of the horse-and-buggy doctor has been superseded by fully staffed and lavishly equipped clinical laboratories, radiological departments, pharmacies stocked with literally thousands of medicaments and medical supply items, and countless other back-up services for diagnosis and therapy. Finally, the *scene* of almost all health care has shifted from the patient's bedside to clusters of physicians' offices in medical buildings or neighborhoods where laboratory, X-ray, and other ancillary services are conveniently available—and even more commonly to hospitals and hospital outpatient clinics.

The time scale for health care has also shrunk through the decades. Patients before the telephone knew that it might take hours for a message to reach the doctor, and hours more for him to reach the bedside in his horse and buggy. In this day of telephones, automobiles, ambulance service and round-the-clock emergency services in hospitals, medical care must be prompt if it is to be adequate.

This expansion and elaboration of health care services has also given rise to the need for a wholly new profession, that of the *health services administrator,* whose function it is to mold these many disparate services into a smoothly functioning health care *system,* offering continuity of care to the patient. Thus, increasingly, the patient depends for his health care on an entire health care delivery system rather than solely on Dr. X or Dr. Y.

Each of these changes in the American system of health care has made it more difficult to deliver to the inmates of correctional institutions the many components of comprehensive health care that are currently taken for granted in the outside community. The correctional system today is thus confronted with a continuing dilemma: how to develop within each correctional institution, or within groups of institutions under common administration, the increasingly varied and complex services available on the outside; or, alternatively, how to arrange for inmate health care services outside the walls of correctional institutions. The major purpose of this study is to present in practical form both methods of modernizing correctional health care services.

Revolutionary changes have also occurred in the *financing* of health care services. Medicaid, Medicare, Blue Cross, Blue Shield, group health insurance plans, private health insurance policies, Veterans' Administration benefits, union and employee health benefit plans, group health and health-maintenance-organization (HMO) plans—each of these and other innovations in turn have made an increasingly broad range of health services available to an increasingly large proportion of the civilian population. Comprehensive health care is thus no longer a privilege of the few; it is rapidly on the way to becoming a right to which all are entitled. Proposals currently pending in Congress for a National Health Insurance Plan envision a still broader availability of services. We shall be concerned in this study with ways of organizing and financing comparable care for correctional institution inmates.

Many influences are at work both within the correctional system and on the outside to secure a broader range of health care services, a higher quality of care, and improved modes of organization. Among these influences is the flood of legal actions to which the correctional health system is currently being subjected. These actions arise out of the obvious facts that inmates are wards of the state, that the right to medical care is *not* one of the rights of which they have been deprived by judicial sentence, and that the only care available to them is the care provided by the correctional system. Literally hundreds of suits alleging inadequate or substandard health care have been filed in recent years—damage and malpractice suits, suits for injunctive relief, class actions, writs of mandamus and habeas corpus, and so on. Litigation has become so common that at least one correctional system retains a full-time lawyer on its correctional hospital staff and maintains a courtroom within the hospital's walls.

In some respects this litigation has been helpful, calling attention to the need for more and better health care resources. An unfortunate side effect, however, has been the need to practice "defensive medicine" in some correctional institutions—a brand of medicine concerned less with the health needs of patients than with the need for an adequate defense should a suit be filed. Defensive medicine is counter-productive; for it requires that scarce manpower and resources be used in ways which are dictated by legal considerations rather than the best interests of the patient. *The best defense against litigation is a system of health care which offers consistent service of good quality in adequate supply.* The suggestions made throughout this study should lead not only to an improvement in health care but also to a lessened vulnerability to legal attack.

In drafting this study, our first concern was to determine how correctional health care systems are currently providing for the needs of inmates. To find out, we visited a substantial number of state departments of correction and a broad range of individual institutions in all parts of the country. We believe that ours was the first such nationwide tour of correctional health care facilities.

On many of these visits we were accompanied by Kenneth B. Babcock, M.D., retired medical director of the Joint Commission on Accreditation of Hospitals and currently a consultant to correctional health care systems; we also had the benefit of Dr. Babcock's prior surveys of seven statewide systems and various local systems. Dr. Babcock's prior surveys provided a general review of current practices. In our site visits made specifically for this study, accordingly, we were not concerned to document shortcomings but concentrated on ways in which particular statewide systems and particular institutions are already engaged in remedying these shortcomings. We have tried to present here the best current practices in the field of correctional health care, based on these site visits.

We also interviewed a very broad range of personnel directly engaged in delivering health care, from statewide medical administrators to paraprofessional employees in outlying corectional institutions. Without exception, we found everyone involved in correctional health care delivery convinced that their institutions could do a better job than they are currently doing. This study incorporates a wide variety of suggestions for improvement which were offered us during these interviews.

Several state correctional systems have prepared or are currently preparing manuals for the guidance of their institutions and personnel; we have freely made use of these documents in drafting our own study. Thus the recommendations here made are not a flight of fancy or a projection of the authors' personal views; they are firmly anchored in present practice and in the views of experienced practitioners.

Before publication, a preliminary draft of this study was circulated to the men actually in charge of health care in 18 state correctional systems—the

medical directors, administrators, and coordinators in state departments of correction; for a list, see Appendix A. Their comments were presented at a meeting held in Alexandria, Va., on July 10 and 11, 1975*; and the manuscript was subsequently revised in the light of their suggestions.

Many others assisted at various stages in this project—in the research, the drafting, or the revision. Among those whose contributions went beyond mere helpfulness were the following:

- Kenneth B. Babcock, M.D., of Pompano Beach, Florida, whose broad experience and calm critical judgment have been outstanding guides throughout this project.

- Robert Brutsche, M.D., medical director of the U.S. Bureau of Prisons, his regional administrators, and health care personnel at all levels in the Federal institutions we visited.

- James Cicero, M.D., former medical director of the Minnesota State Prison, and Ivan Fahs, Ph.D., of Medical Coordinators, Inc., St. Paul, Minn. An unpublished study by Drs. Cicero and Fahs of correctional health care systems in Western European countries taught us in particular that the shortcomings of correctional health care systems are not limited by national boundaries but arise in considerable part out of the complex nature of the problem.

- Ruth Glick, Ph.D., of the National study of Women's Correctional Programs, Berkeley, Calif., and Iris Litt, M.D., of the Division of Adolescent Medicine, Montefiore Hospital and Medical Center, Bronx, New York, were particularly helpful with respect to our chapters on women's and adolescent institutions. Rita Judd Stokes, Ph.D., author of a comprehensive study of the San Diego (Cal.) jail system, was similarly helpful with respect to our chapter on local detention facilities.

Administration of this project was in the hands of Mary Ann Beck of the National Institute of Law Enforcement and Criminal Justice, the research arm of the Law Enforcement Assistance Administration; and Raymond S. Olsen of the American Correctional Association. Their contributions, however, went beyond mere administrative efficiency, and we are indebted to them for many forms of assistance as this study matured. Nick Pappas of NILECJ was particularly helpful in the role of independent and outspoken critic. Whatever the limitations and shortcomings of this study, they would have been far greater without the cooperation of these men and women.

We particularly regret the lack of a comprehensive consideration of *mental health* and *dental* services in this study. We hope that parallel studies in these areas will be undertaken soon, and call the need to the attention of the newly formed American Correctional Health Services Association.

We are hopeful that this study will be of interest and use, not only to health care personnel in correctional institutions but to all correctional personnel in a position to influence policies and procedures. We are also hopeful that correctional health care administrators will be able to use this manual in securing a better understanding of health care needs among legislators, state officials outside the correctional system, judges, lawyers, and the public at large. A wide gap exists between the quality and quantity of health care currently available to inmates at many correctional institutions and the care correctional officials themselves would like to see delivered. Making that gap known to the public and especially to appropriating bodies is a part of the correctional function—for it is a necessary first step toward closing the gap.

*At this meeting, the statewide directors and administrators present also formed a new organization, the American Correctional Health Services Association, to foster improvements in correctional health care delivery. The ACHSA is the first nationwide association in this field. Affiliation of the ACHSA with the American Correctional Association is expected. For further information, write Mr. Cecil Patmon, acting secretary, ACHSA, Illinois Department of Corrections, 160 North LaSalle Street, Chicago, Ill. 60601.

PART I

MEDICAL ASPECTS

CHAPTER I. THE ELEMENTS OF SOUND HEALTH CARE

1.1. Chaos Confounded

To see correctional health care at its horse-and-buggy worst, it is only necessary to observe "sick call" at a correctional institution which has not yet modernized its services or organized its procedural routines effectively. If it is a small institution with 100 inmates, a dozen may be clamoring for the physician's attention during the half-hour he has to hear their complaints. In an institution with 1,000 inmates, 100 may have attended sick call yesterday, 100 more may stand in line today, and another 100 may be expected tomorrow. If there is no weekend sick call, the clamor and crowding on Mondays may be intolerable. There is no possible way for a physician to diagnose illnesses accurately and prescribe effective treatment during the few brief minutes he has for each inmate.

At one correctional institution a few years ago, a little more than one minute of the physician's time per inmate attending sick call was available on the average, and many inmates received only a few seconds of time:

"Most inmate contact with the medical services was through sick call, which began at 8:00 or 8:30 a.m. and lasted for 2 to 2½ hours, Monday through Friday. . . . Average attendance was 100 to 125. No examinations were given at sick call; there was not enough time and neither doctor felt it was necessary. A counter topped by a mesh screen which extended to the ceiling divided the pharmacy in two, and separated the doctor from the inmate. At sick call, the doctors asked the nature of the inmate's complaint and either sent him back to his assignment or to his cell after dispensing whatever medication he thought was appropriate. Only in rare cases, the doctors directed an officer to conduct the man to the examination room. The approach was very business-like, very direct, and very authoritarian, and usually took but a few seconds. The time and effort necessary to explain, to help provide insight, to gain acceptance, to achieve confidence, were absent. As is often true when the doctor-patient relationship is imposed, not chosen, there was no element of faith and confidence. . . .

"Inmates did use sick call to escape a boring job and see friends as well as to get treatment for illness, but the number of such 'malingerers' is not known. Both doctors claimed that the majority of those on sick call were not ill and that it was possible in a few seconds by 'looking into their eyes' to distinguish these from inmates with valid complaints. They also expressed the opinion that inmates make more demands for medical treatment than inmates would outside of prison. Inmates, however, complained that the doctors often didn't believe that they were sick and routinely dispensed a few drugs, such as aspirin, for almost all complaints.

"To conduct such a sick call, it is manifestly impossible for any doctor to spend more than a few moments with each inmate. Part of this time must be devoted to the process of weeding out those who need medical attention from those who simply desire a repeat of some previous drug or medication or from those who are faking their problems. Institutionalized persons also tend to develop vague symptoms, which though real, cannot be traced to a physical dysfunction, and the pressures under which inmates live give rise to emotionally based disorders. Ulcers and ulcerlike symptoms are common. Little is or can be done for them in this setting except for palliative therapy which most will eventually obtain through this sick-call process. The process nevertheless does provide a practical mechanism for finding and treating acute, urgent, or new clinical problems.

"In fact, there were often as many as 300 to 350 inmates on routine maintenance doses of various drugs, including tranquilizers. At sick call, only sick-call records, and not medical records, were available to the doctor, and his diagnosis was usually based on the inmate's description of the problem and a few moments' observation during the questioning. Specific drugs (sometimes placebos) were routinely dispensed for particular types of complaints and the routineness of the procedure undercut such confidence as inmates might have had." —*Official Report*

of the New York State Commission on Attica (Bantam Books, 1972).

Not all of the inmates appearing at sick call, of course, are sick. Some are just bored and have nothing better to do. Some want excuses from their work assignments. Some are in search of medication which will help pass the hours less disagreeably. Some are prey to anxieties which are real enough, and which give rise to psychosomatic symptoms. Nor do all who genuinely need medical care appear at sick call. "I was too sick to face that sick-call hassle," an inmate may remark.

Because so many attend daily, there is no waiting room in the medical area large enough to hold them comfortably. Often they will be found lined up impatiently along a corridor, or crowding around the door of the examining room. Tempers flare under such circumstances, so a correctional officer must be posted. If one is not enough, there must be two. Staff members are also competing for the physician's precious time during the brief sick-call period; they come and go with questions and problems, interrupting the physician-patient interviews. Privacy is necessarily sacrificed. Continuity of care is conspicuous by its absence. There is no time for the physician examination of each patient, no time to inquire into his medical history, no time to review his medical record—and no time to jot down more than the briefest note on what should be done. "Take an aspirin" becomes the common prescription.

Under these conditions, of course, inmates recognize that they are not receiving good medical care. They see the institution's medical service as just another instrument of oppression, and are alert for ways to "rip it off." The ways they find are innumerable.

The effects of this system (or lack of system) on the correctional physician and the health care staff are disastrous. Even a physician who takes a post in a correctional institution with a genuine concern for inmates, and with a determination to practice the same high-quality brand of medicine within its walls as he formerly practiced on the outside, soon "burns out." He may lose all empathy with the endless stream of inmates who parade through his office at three-minute intervals or less, openly voicing their disrespect for him and his medical skill, sullen and manipulaitve at best, hostile, and at times even threatening.

It doesn't have to be that way. In the sections that follow, we shall describe a pattern of health care organization which reduces to a minimum the pressures of the "sick-call hassle" on both health care personnel and inmates, making possible sound relations between them and raising the quality of the care provided.

1.2. The "Medical Evaluation"

An essential step in converting from a system of correctional health care based primarily or solely on sick call to a system with a capacity for providing quality care is to establish a series of procedures for the medical evaluation of each inmate. This evaluation cannot be performed under the hurried and harried conditions of the traditional institutional sick call. Four aspects of the medical evaluation are reviewed in the sections which follow, all designed to provide the health care staff with a knowledge and understanding of the inmate's condition *before* he appears at sick call.

1.3. The Preliminary Screening for Admission

For his own protection, for the protection of other inmates, and for the protection of the correctional institution, a *preliminary* health evaluation should be made immediately upon the arrival of a new inmate—before he is permitted to enter the inmate population. As many as possible of the following points should be checked:

- Does the new arrival report pain, bleeding, or any other symptoms suggesting need for emergency service? Are there any visible signs of trauma or illness requiring immediate care?
- Does the new arrival have a fever, a sore throat, swollen glands, jaundice, or other evidence of an infection which might spread through the institution?
- Does his general appearance suggest the likelihood of head lice, body lice, pubic lice, or other parasites?
- Does he appear to be under the influence of alcohol, barbiturates, heroin, or any other drug? Is he exhibiting withdrawal signs, or at risk of developing them?
- Is he so excited or elated, so depressed and withdrawn, or so disoriented as to suggest the possibilty of suicide or assault on others?
- Is he carrying medication, or does he report being on any medication which should be continuously administered or available—medication for arthritis, asthma, diabetes, seizure disorders, gastric

or duodenal ulcer, heart disease, high blood pressure, psychiatric problems, etc.?

- Is he on a special diet for any of the above (or other) conditions?
- Has he recently been hospitalized or seen a physician for any illness?
- Is he allergic to any medications or other substances?
- Does he have an unusual, recently acquired headache?
- Has he fainted lately or has he had any recent head injury?

A medical record folder should be prepared for each inmate on admission, and the pertinent findings of the screening examination, both positive and negative, should be the first entries in his permanent medical record.

The urgency of the preliminary screening varies from institution to institution and from inmate to inmate. It is most important in local detention facilities (jails) which receive most of their inmates directly off the street—and it is precisely in such institutions that screening on admission is most difficult and most likely to be neglected. (For a further discussion of this ubiquitous problem, see below, page 41). Even long-term institutions which receive many of their inmates from other institutions, however, should have an admission screening procedure for all inmates.

One purpose of the screening on admission is to *identify very ill persons who should not be admitted at all* but should be transferred at once to a hospital, mental hospital, or other facility. In some cases, the police officer, marshal, or deputy sheriff who brings the person to the institution may be instructed to take him instead to the other appropriate facility. If this is not possible, the correctional institution itself must promptly make the transfer instead of admitting the new arrival to the inmate population.

If the new arrival is moderately ill on admission, or if he is intoxicated, he should be sent to the institution's infirmary rather than the general population. If he is in need of continuing medication, his medication should be taken from him but arrangements must be promptly made for dispensing appropriate doses through the institution's regular dispensing procedures (see page 23). The purpose of the screening on admission, in short, is not merely to make a paper record but to see that the immediate health care needs uncovered in the course of the screening are promptly met. A substantial body of litigation arises out of failure to identify and promptly care for medical needs present at the time of admission.

The preliminary screening on admission need not be performed by a physician. Indeed, one of the major distinctions between horse-and-buggy medicine and the modern practice of medicine is the use of physician's assistants, nurse-practitioners, medical technical assistants (MTA's) and other "physician extenders" to perform duties which the physician does not have time for and which would otherwise not be performed at all—thus leaving the physician free for duties consonant with his level of skills and training. Both the advantages and the limitations of care by physician-extenders will be discussed in subsequent sections of this study.

The screening should always be performed by a member of the health care (not correctional) staff.

Performing the initial screening in a thorough and efficient manner, and taking prompt care of the medical needs identified during the screening, is the first step in assuring the inmate that his health is in fact a concern of the health care system. This favorable first impression can and should be buttressed by handing new arrivals a leaflet explaining the screening procedure, the health services available in the institution, the inmate's right of access to those services, and his responsibility for his own health care.

The other three elements of the inmate evaluation—medical history, physical examination, and laboratory tests—should follow as soon as possible after this preliminary screening.

1.4. The Medical History

As in private medical practice, the medical history starts with inquiries into the patient's present health complaints, symptoms, and concerns, when they were first noticed, whether they are improving or getting worse, and so on. Next the patient may be asked about his family history, especially the presence in his family of diseases such as diabetes, tuberculosis, high blood pressure, and cancer. Childhood and adult illnesses, injuries, operations, immunizations, and hospitalizations are similarly inquired into. The patient is asked about his use of alcohol, tobacco, and other drugs. An affirmative answer to a question may lead to further explorations. The medical history provides a part of the base line from which future changes will be measured. The physician knows that

he will have numerous occasions to refer back to this initial history during the months or years ahead; and that it will alert him concerning points to check during the subsequent medical examination.

In the correctional health field, the initial medical history has other uses as well. It helps the physician determine, for example, whether any limitations should be placed on an inmate's work and recreational activities, or on his diet or housing. It may prove useful when the inmate is being prepared for parole or release. It also has medicolegal value: a condition recorded during the initial history-taking, for example, cannot subsequently be blamed on the correctional institution.

A medical history should be taken within 48 hours of admission if possible, and within a week in any event. It need not be taken by a physician. Where physician time is in short supply, the history can be recorded by a physician's assistant, nurse, MTA, or other health staff member—*provided the staff member is trained in taking medical histories.* The history should be reviewed by a physician, however, and he should then explore in greater depth any matters of concern recorded.

1.5. The Physical Examination

In correctional as in civilian medicine, the taking of the medical history should be followed by a complete physical examination. Indeed, history and examination can best be viewed as twin procedures which complement and supplement one another. The history is largely subjective; the examination provides objective data. The history guides the physician's physical examination, focussing it on the relevant organs and physiological systems.

Pertinent negative as well as positive findings should be recorded; for example, if there is a history of hepatitis, the record should show whether the liver is *or is not* enlarged or tender.

While the physical examination should be thorough, it should cover no more ground than necessary; if too many items are included, many of them will necessarily be slighted. For this reason, guidelines should be developed which minimize waste of time. Thus routine testing for glaucoma may be limited to inmates over 40; examination of the fundus of the eye may be similarly limited in the absence of a specific indication such as headache, diabetes, recent head injury, or a specific eye disease.

1.6. Additional Prediagnostic Studies

Using the medical history and physical examination as guides, the physician can then determine what additional studies are needed for evaluation of the inmate's health status and needs—an electrocardiogram, for example, if there is a history of heart disease or if the heart sounds suggest a problem; an examination by an ophthalmologist if eye disease is noted; and so on. A skin test for tuberculosis should be given all newly admitted inmates, and chest X-rays thereafter, if indicated. Other X-ray examinations may be ordered and blood or urine samples obtained for clinical laboratory tests as indicated. A serological test for syphilis should also be routine for all inmates.

A large correctional institution, as we shall note in subsequent sections, may find it both convenient and economical to have these additional prediagnostic services available within its walls. A small institution may instead send blood and urine specimens (or the patient himself) outside for further tests. The essential point for both large and small institutions is that a full range of prediagnostic services be available to the physician—and to his patients—when needed, either within or outside of the institution.

1.7. Problem Identification, Diagnosis, and Formulation of a Treatment Plan

Once a full medical history, physical examination, and additional prediagnostic tests have been completed and the findings recorded, the physician is in a position to record his medical evaluation of the inmate—identifying his specific health problems, diagnosing his illnesses, and drafting a treatment plan for him. It is essential at this stage to call in the inmate, review the record with him, advise him on the steps he himself should take (diet, exercise, etc.), and discuss future diagnostic and treatment measures, including medication if any. It is also highly recommended that the same physician who performed the physical examination make the evalution, and plan and discuss them with the patient. Tetanus immunization should be brought up to date, and other immunizations performed or ordered as indicated, in accordance with current public health guidelines.

Finally, prescriptions should be written, and (if indicated) a schedule of future appointments for periodic checkups should be set up. All diagnoses and treatment decisions should be recorded in suf-

ficient detail so that paramedical personnel can thereafter be clear on what should and should not be done. Subsequent medical audits should be concerned in considerable part with the extent to which the treatment plan recorded by the physician at this stage is in fact being implemented.

Whenever possible, the physician performing the inmate's medical evaluation should be the one responsible for his subsequent health care. This need for continuity of care and for a continuing physician-patient relationship will be further discussed in subsequent sections of this Manual.

1.8. Sick Call

Once these health evaluation procedures have been established in a correctional institution, "sick call" need no longer be an example of confusion or worse confounded by an occasion for solving most problems with aspirin tablets. Even though the physician has only a few minutes for each patient, he also has the patient's medical record with its findings, diagnoses, and treatment plan to guide him. Many inmates who would otherwise appear at sick call are now absent, for their needs are being met during periodic appointments outside the sick-call procedure. Having had an opportunity to discuss his health needs with the physician at the time of the evaluation, an inmate's health anxieties are at least in part assuaged and he need not come to sick call merely for information about his health status. His attitude toward the health care staff is likely to be much less hostile following the demonstration of competence and concern which the evaluation measures provide. There is no panacea for the shortcomings of "sick call"; but the measures described above, and others to be cited hereafter, can minimize those shortcomings.

It is essential that appearance at sick call be recognized as an inmate *right,* not a privilege. No member of the correctional staff, for example, should approve or disapprove requests for attendance at sick call. Denial of access to sick call is an open invitation to inmates to sue the institution—for it is *prima facie* evidence of denial of medical care.

Only one exception should be recognized. A physician, physician's assistant, nurse, or other qualified member of the *medical* staff should make the rounds daily to visit inmates in segregation or otherwise unable to attend sick call. Such a daily visit, *not made in response to a call but as a part of the institution's daily health care routine,* is the only acceptable alternative to allowing each inmate access to sick call. Assuring each inmate as a matter of right either access to sick call or a personal daily visit from a member of the health care staff is the only assurance a correctional health system (and the courts) can have that health needs are being met. Written orders should assure this access, and any violation should be deemed a serious offense.

A *physician* need not see all inmates appearing at sick call. A physician's assistant, nurse, MTA, or other qualified member of the professional health care staff (but not the correctional staff) may see inmates initially, handle minor conditions, and refer to the physician only those inmates requiring his care. Standing orders, signed by the physician in charge, should specify in adequate detail those conditions which paraprofessional personnel may care for themselves and those which should be routed to the physician. "If in doubt, call the physician" should be the universal rule. (For other limitations on the use of non-physicians, see Section 2.2, below.)

Privacy is an essential feature of adequate sick call service. Hence a suitable waiting room or waiting area with seats should be provided, along with separate examination or interview rooms for the screening and the physician interviews. The elements needed are not "budget breakers"; the essentials are merely that the medical area be clean, well lit, well ventilated, appropriately equipped and supplied—and large enough for its functions.

An inmate's medical record should be at hand *and should be checked* whenever he appears for sick call or for any other procedure. This should be true whether the attendant is a physician, a nurse, or any other staff member. All health staff members should be required to add a brief note to the inmate's medical record following *any* procedure, however minor or routine.

If a condition is such that it cannot be diagnosed or treated during sick call, an order, referral slip, or appointment for further diagnostic tests and for a return visit should be written at once and recorded in the inmate's medical history. Medication should be prescribed only *after* all other measures have been taken, thus impressing upon the inmate the truth that the purpose of sick call is to provide health care rather than merely medication.

Even after the system of medical evaluation and treatment planning described above has been established, the number of inmates appearing at sick call

is likely to be excessive—a serious waste of health staff time and facilities. Limiting access to sick call, however, is *not* an acceptable method of curbing this waste; for the inmate deprived of access may be the one in urgent need. Some inmates are hypochondriacs who come again and again; but even hypochondriacs are in serious need of medical attention on occasion. Numerous ways of cutting down attendance at sick call *without* depriving inmates of access can be instituted.

- First and foremost is the image projected by the institution's health care service. As noted above, inmates rip off their friends less frequently than their enemies. A health care service which is perceived as operating in the inmates' interest will have unnecessary appearances at sick call—but it will be less heavily burdened with them.

- A high proportion of appearances at sick call are for medication rather than medical care. A health care service which relies excessively on medication thus *invites* excessive use of sick call. When inmates perceive the health care service as a source of needed health care rather than a source of wanted medication, sick call attendance goes down. This does not mean, of course, that inmates should be deprived of medication needed as a *part* of their medical care (see page 23).

- The routine dispensing of medication (the "pill line") can be separated in time and space from sick call, thus reducing sick call congestion.

- Many common home remedies that are readily available over-the-counter in pharmacies (such as mild analgesics, antacids, Vaseline, and skin lotions) can be provided without the need for inmates to appear at sick call. (For details, see page 27).

- All forseeable occasions for care can be scheduled outside sick call hours, thus limiting sick call to self-referrals requiring immediate attention. Inmates can be offered the alternative of a future appointment in lieu of sick-call appearance today if their need is not urgent; many will prefer the appointment.

- Inmates attend sick call because they are interested in and worried about their health. *Health education classes* (see page 77) are an alternative way of meeting these interests and assuaging these worries. So are explanations given the inmate by the time of diagnosis or treatment.

- Inmates attend sick call, as they attend other institutional functions, because they are bored and need something to do. The richer the institution's activity program, the fewer inmates will rely on sick call attendance as an antidote to boredom. In one correctional institution, the introduction of television was promptly followed by a marked reduction in sick call attendance.

- The *hour* for sick call affects attendance. Scheduling it during working hours provides an incentive to attend instead of going to work. Scheduling it at an hour when other popular activities are available tends to reduce its use to combat boredom. This tactic, however, should not be carried to extremes; that is, attendance at sick call should not require a sacrifice sufficient to tempt individuals in need of medical care to forego it.

- One common motive for appearing at sick call is to secure a medical excuse from work assignment. Some correctional institutions minimize this motive for attendance by a "sick leave" system—allowing each inmate a limited number of one-day absences from work for illness without a medical excuse. While this sick-leave system may result in a modest increase in the number of unjustifiable one-day absences, as it does in private industry, the benefits to the sick call system may more than compensate for this loss.

1.9. Continuing Clinical Services

Because sick call is even at best a hurried procedure, and an unsatisfactory procedure for both physician and inmate, every effort should be made to schedule regular appointments outside of sick-call hours for all *forseeable* medical needs. In addition to relieving the "sick call hassle," a regular schedule of appointments makes for better doctor-inmate relations and for a higher quality of health care.

1.10. Periodic Health Examinations

The usefulness of an annual physical examination for all inmates is a controversial issue—in correctional as in civilian medicine. No one doubts that conditions which might otherwise be missed will be identified during an annual examination, or that the examination offers an opportunity to re-evaluate each patient and to audit the care he has been receiving. The issue is whether the same time and effort will produce an even greater benefit if utilized in other ways. Various alternatives may be cited:

- Annual health evaluation only for inmates over 40, or over some other age.

- Biennial or triennial health evaluations for all patients, plus annual tests for tuberculosis and syphilis.
- Quarterly or semi-annual health evaluations for those patients with chronic conditions requiring followup.
- An annual health evaluation only for those inmates who request one.

A "one-shot" comprehensive physical examination for all inmates in a correctional institution or system may be of very great value in the course of converting from a "sick call" system of health care to a system based on medical evaluation and scheduled followup appointments.

A health interview, and physical examination if indicated, is recommended for all inmates prior to release.

1.11. Medical Records

The conversion from a sick-call or horse-and-buggy model of medical care to the organized system of health services here described will collapse if a comprehensive system of medical records is not established along with the other changes. A modern system of health care is as dependent on good records as a bank or insurance company. It is for this reason that the Joint Commission on Accreditation of Hospitals, for example, places as much emphasis on good medical records as on sterile conditions in the operating room. The Joint Commission lists six purposes of a medical records system:

- To serve as a basis for planning and for continuity of patient care;
- To provide a means of communication among the physician and any professionals contributing to the patient's care.
- To furnish documentary evidence of the course of the patient's illness and treatment. . . ;
- To serve as a basis for review, study and evaluation of the care rendered to the patient;
- To assist in protecting the legal interests of the patient, the hospital [in this case, correctional institution] and responsible practitioner; and
- To provide data for use in research and education.

What should the medical record contain? The Joint Commission's requirement is all-encompassing:

> All significant clinical information pertaining to patient shall be incorporated in the patient's medical record. The record should be sufficiently detailed to enable:
>
> - The practitioner to give effective continuing care to the patient, as well as to enable him to determine, at a future date, what the patient's condition was at a specific time and what procedures were performed;
> - A consultant to give an opinion after his examination of the patient; and
> - Another practitioner to assume the care of the patient at any time.

Though they refer to a hospital's medical records, these requirements are at least equally applicable to the records of a correctional institution.

A medical record for each inmate should be opened, as noted above, at the time of his initial screening. It is a major convenience and saving of time if a numbered checklist of the inmate's health problems is filed at the opening of the record, so that all subsequent entries can be numbered and titled by problem. If the inmate subsequently comes to sick call with a stomach ache, the physician, physician's assistant, or nurse can at a glance determine whether a gastrointestinal problem is already included in the problem checklist. If it is not, the problem should be added to the list. If it is already there, a quick thumbing of the record will turn up all of the *relevant* entries without the need for mastering the entire record. Problems which have been resolved or which have become inactive can be so marked on the checklist. In such a "problem-oriented record system," the problem checklist serves as a time-saving index or table of contents.

Following the evaluation summary, each subsequent contact of the inmate with the medical service should be entered in the form of progress notes, nursing notes, lab reports, consultants' opinions, and so on. Each entry should be appropriately numbered and titled in terms of the problem checklist, and should be signed or legibly initialled. Diagnoses, orders, treatment plans, impressions, and other special types of entries should be labeled as such.

Pocket tape recorders or other equipment for dictating medical records to save the time of doctors and nurses should be considered.

Inmates should *not* be used to transcribe entries into medical records, or have access to medical records for any other purpose. Rather, all transcribing and filing should be done by a trained *medical records technician.* This is neither so formidable nor so costly as it sounds; correspondence courses are available. A statewide correctional system may also find it advantageous to employ a qualified medical records administrator to supervise the records system in all of the state's correctional institutions. Alternatively, a state system may employ a medical records administrator temporarily as a consultant, or borrow one from another state agency, for the purpose of setting up a modern medical records system and for reviewing it periodically.

Maintaining a uniform medical records system for all the correctional institutions in a state has two major advantages: an inmate's medical record can accompany him as he is transferred from institution to institution, and auditing of the records to determine conformity with statewide policies is greatly simplified.

Even the most comprehensive medical record, of course, is useless if it is not available when needed. Records should therefore be filed immediately adjacent to the treatment areas where they will be used. They may be stored elsewhere following an inmate's release—but should be held for reactivation in the event of his return.

Medical records, in correctional as in civilian practice, are confidential. This means they should not be available to *anyone* except the medical staff concerned with the inmate's health care.* They should be kept in locked files and surrounded by other safeguards as indicated. They are the property of the institution and should *never* be taken out of the institution except (a) for transfer to another correctional institution when the inmate is transferred, or (b) when required by a court order.

One exception to the confidentiality rule is that data from the records may be made available to outside persons—for example, a physician, hospital insurance company, or parole officer—on the inmate's written authorization. A blanket authorization is not sufficient. Each authorization should specify the person to whom the inmate wishes information released and precisely what information he wishes released. The release form should be filed with the medical record, together with a note of the date on which the information was forwarded.

Establishing a uniform and comprehensive problem-oriented medical records system is not an easy undertaking. Physicians, nurses, and other health care personnel are set in their ways. They resist and may resent any effort to alter the methods of record-keeping to which they are accustomed. "I designed a uniform records system for this state's institutions, and spent two weeks explaining it to the staff," one health care administrator recalls. "Then I gave up. I estimated that it would take six months of my time, full time, to achieve the changeover." The effort is worth while even though it does take six months of someone's time. To facilitate the changeover to an improved records system, we have two major recommendations:

First, a new medical records system should not be devised in a vacuum at the state headquarters level and then handed down by decree from on high. Rather, meetings of the health care staff in each institution should be held at which record problems can be aired. Almost certainly, these meetings will reveal that the operating staff itself is annoyed and dissatisfied with the shortcomings of the present records system and has many suggestions for change. A preliminary plan for a new system can then be drawn up incorporating the suggestions of those who will have to operate the new system. The preliminary plan can next be brought back and explained to the health care staffs, and over a period of time a final plan evolved which will have the assent of those concerned. The services of an experienced medical records administrator throughout these planning stages —an administrator who has dealt with staff resistances before—can be invaluable.

Our second suggestion is that as soon as a new system has been instituted, a substantial effort be made to review the new medical records—not from the point of view of the health care delivered but from the point of view of the record keeping itself. A random sample of inmate records can be drawn and reviewed monthly. Here is an order for an electrocardiogram not followed by an EKG report; why not? Here is a new problem not added to the numbered problem list in the front of the record—and so on. Such a review will reveal, of course, that some of the shortcomings are due merely to staff sloppiness; but it is also likely to turn up inconveniences

*Information *from* the record, of course, may be transmitted to the warden or correctional staff in situations where this does not violate physician-patient confidentiality.

or shortcomings in the records system which can then be corrected.

1.12. Summary

While the pattern of health care here outlined may seem formidable at first glance, a brief review will indicate that very little is required beyond what a competent and conscientious physician in private practice customarily performs when he first accepts a new patient. The system here recommended differs from the traditional sick-call system of institutional care in only three major respects:

- The initial medical evaluation of each inmate (including screening, history, physical examination, lab tests, and briefing of the inmate). This is *a one-time procedure* for each inmate, and requires no costly or elaborate equipment.
- The substitution of followup appointments and scheduled clinics for sick call to the extent feasible.
- A sound medical records system.

Making these three changes need not increase the number of hours of physician time. On the contrary, by providing a framework in which physician's assistants and other allied medical personnel can be effectively used (see Section 0.0 below) the health care model here described can free up some of the time a physician now devotes to routine tasks, making that time available for tasks requiring his level of training and competence.

The correctional health care system in the United States is under heavy pressure today from the courts, legal aid groups, prisoners' organizations, and in some states from the public and legislators. One possible response to these pressures is to hire more physicians, build costly new hospitals, buy costly new equipment, and so on. The reorganization of health care services along the lines here described will meet much of the demand for improvement, and will accomplish more for inmate health, than spending far larger sums for buttressing an outmoded system of medical care.

CHAPTER 2. THE SUPPORTIVE MEDICAL SERVICES

2.1. Why Supportive Services are Needed

The patient in civilian life whose personal physician is engaged in solo private practice may believe that it is his physician alone who is responsible for his health care. Except in very atypical situations, however, the personal physician is merely the visible tip of the iceberg. Less visible are the wide range of supportive personnel and services—the specialists with whom the physician consults and to whom he refers patients whose problems are beyond his expertise, the pharmacy, the clinical laboratory, the X-ray service, and the hospital, including both its surgical and non-surgical inpatient facilities. The same comprehensive range of backup services can and should be available when needed by the correctional physician and his inmate patients—even inmates in small outlying institutions.

This does *not* mean, however, that every correctional institution must house a major medical center within its walls. On the contrary, a small institution can provide comprehensive health care with only a part-time general practitioner, a nurse or two, and the simplest of equipment—*if it has communication with and access to a full ranges of supportive services on the outside.* In principle, a correctional institution should duplicate within its walls as few as possible of the services economically and conveniently available on the outside. Adding a supportive service to an institution's internal capabilities is warranted *only* where there is some affirmative advantages (such as greater economy or availability for emergency use) over patronizing outside health care resources.

The supportive services to be reviewed in this chapter are highly relevant to the problem of recruiting fully qualified physicians and other qualified health personnel for correctional institutions (see page 53). A competent physician experiences deep frustration when the tools he needs to do his job well are not available; the supportive services here reviewed are at least as essential to his work and his sense of accomplishment as his stethoscope or blood pressure cuff. Given a choice, a competent physician will almost invariably choose to practice in a setting where supportive services of satisfactory quality are available—and so will a competent physician's assistant or nurse. A correctional institution which fails to provide access to adequate supportive services can expect to attract only those physicians and allied health professionals who have no choice.

Access to supportive services is also essential in protecting the correctional system from litigation. A substantial volume of litigation arises out of claims that some supportive service was not available which would have been available had the inmate not been incarcerated.

In this chapter, accordingly, the major supportive services essential to adequate correctional health care will be reviewed—with emphasis on those factors which determine whether a particular service should be established within the institution or should be made made available in other ways.

2.2. The "Physician's Assistant"

In the American system of health care, the person immediately responsible for a patient's health is almost always a physician—commonly a family physician, internist, or pediatrician. Few correctional institutions, however, have available an adequate number of hours of physician time to enable physicians to play this role satisfactorily. The result is that inmate health services in many institutions are limited primarily to attendance at sick call, where a physician may have to see 20 (or in some institutions more) inmates per hour. Under such circumstances, emphasis must inevitably be placed on the inmates' complaints rather than their health needs, and on medication rather than medical care.

In a growing number of state and local correctional systems, this problem is met in part by providing personnel who are capable (a) of handling many of the duties which a physician ordinarily handles, and (b) of recognizing and referring those conditions which lie beyond their personal competence. These personnel are called by many different names:

Physician's associate
Physician's assistant

Nurse clinician
Nurse-practitioner
Medical technical assistant (MTA)
Etc.

The term "physician-extender" is sometimes applied to these allied health professionals. In this study, the terms "physician's assistant" and "nurse-practitioner" will for convenience be used to apply to all such personnel.

A trend toward the increased use of physician's assistants and nurse-practitioners (in this broad sense) is beginning to appear in hospitals, in medical group practice, and even in solo medical practice; thus a physician maintaining his own private office may employ a physician's assistant or nurse-practitioner to handle a part of his load. We see no reason whatever to discourage this trend in correctional institutions. Indeed, the realities of staffing and budgeting *dictate* an increased dependence on physician's assistants and nurse-practitioners, both as "primary health care providers" and in other roles.

In the health care service of the U.S. Bureau of Prisons, the allied health professionals who assist the physician are known as medical technical assitants. The broad range of duties which MTA's perform in Federal correctional institutions is indicated in the following MTA job description:

1. Assists the physician in accomplishing a wide variety of medical procedures. (a) Participates in conducting the daily sick call. Interviews patients, establishes preliminary diagnosis, records symptoms and vital signs, requests appropriate laboratory procedures, prescribes treatment and medication for routine illnesses and assists the physician in performing more exhaustive diagnosis and treatment. (b) Provides emergency medical care to inmates injured in prison fights or accidents; subject to emergency callbacks after hours or on weekends to provide medical care in absence of physician or until the physician has arrived. (c) Serves as scrub or circulating nurse for a variety of surgical procedures. Sets up operating room with needed supplies and materials as required. Provides pre-operative and post-operative care. (d) Provides comprehensive nursing care to patients in general or psychiatric wards. Supervises charting of temperature, pulse and respiration. Administers prescribed treatment and medication. Maintains close surveillance over psychiatric patients, monitors any unusual behavorial changes, ensuring the safety of the patient, and exercises trained judgment in calling for psychiatric assistance. Makes appropriate entries in medical records for inpatients and outpatients.
2. Performs a wide variety of technical services essential to a medical care program. (a) Serves as a clinical laboratory technician; performs red and white blood cell counts, differential blood counts, urinalysis, fasting blood sugar determinations, sedimentation rates, tuberculosis smear examinations, feces examination, and other routine laboratory procedures. (b) Operates hospital radiographic equipment, exercises skill in the methods of positioning patients, processes the development of X-ray film, and identifies any obvious abnormalities. (c) Responsible for the pharmaceutical disbursement of medication, which requires knowledge of the expected action, side effects, and toxic nature of such medications, and maintains records in accordance with Federal regulations. (d) Assists the dental officer in preparing materials and equipment for restorative dentistry and oral surgery, takes and develops dental X-rays and performs dental prophylaxis. (e) Performs physical therapy treatment, treats patients with ultra-violet lights, hydrotherapy, short wave diathermy, infra-red light and ultrasound.
3. Penological responsibilities. Exercises supervisory custodial control over assigned inmate-workers and inmate-patients. Responsible for the safeguarding of narcotic drugs and general hospital security in a correctional setting. Maintains constant alertness to conditions which might endanger the security of the institution, personnel, and inmates.
4. Performs other duties as assigned.

An increasing number of states have recently passed laws recognizing and regulating the role of the physician's assistant or nurse-practitioner; correctional institutions should of course conform their procedures to state law.

If a physician's assistant or nurse-practitioner is to be effectively used in a correctional health care system, four prerequisites must be met:

- *He or she must be appropriately trained.* The bulk of the MTA's in the Federal correctional

system secured their initial training in the Armed Forces medical services; some state correctional systems are also beginning to employ MTA's separated or retired from the Armed Forces. Other physician's assistants and nurse-practitioners are currently being trained in a number of medical schools and medical centers. The training includes rules on what such personnel should *not* do as well as what should be done; the physician's assistant and nurse-practitioner are trained to recognize situations in in which a physician should be consulted or summoned.

- *He or she must be under a physician's continuing supervision.* This is accomplished in part by personal interaction during the hours when physician and physician's assistant or nurse-practitioner are on duty together; equally important is the role of medical record in assuring adequate supervision. The physician's assistant or nurse-practitioner finds in the medical record orders and indications of what should be done. He or she then notes in the record the actions taken; and the physician subsequently reviews those actions.
- *The physician's assistant or nurse-practitioner must have standing orders* governing what should be done in the physician's absence when special orders are not found in the medical record.
- *A physician must be available at all hours;* in case of doubt or need, the physician's assistant or nurse-practitioner can either consult with him on the phone or summon him.

In some correctional institutions today, wholly untrained and unskilled inmates (falsely labeled "inmate nurses") are performing medical functions which only a physician should undertake—while simultaneously, physicians in the same institutions are spending much of their time on chores which do not require their extensive training and skills. The physician's assistant or nurse-practitioner simultaneously relieves the physician of necessary chores and relieves the sick inmate of reliance on unskilled attendants.

It is sometimes alleged in litigation that a particular service was performed by someone lacking an M.D. degree. In most cases, the person performing the service was another inmate or some other untrained person. The use of a fully trained physician's assistant or nurse-practitioner, functioning under a physician's orders and supervision, in accordance with state law and with the other prerequisites noted above, is unlikely to be condemned by any court.

In the system here described, the "primary health care provider" to whom the inmate turns for continuing care may be either a physician, a physician's assistant, or a nurse-practitioner. To the extent possible, the inmate should have access to the *same* primary health care provider throughout his stay in the institution. Also to the extent possible, he should have a *choice* among the primary health care providers employed in the system, much as there is a choice in outside health care delivery systems. These principles of continuity and choice are necessarily limited in the institutional setting; but to the extent that they can be followed, they will almost certainly yield dividends in terms of quality of care and inmate satisfaction with the system.

Should an inmate have access to his personal civilian physician when he is ill? Policies on this point differ. Some institutions forbid access to outside physicians altogether, in part on security grounds and in part because such access sets up a privileged group of inmates who can afford outside medical care. A less stringent policy admits an inmate's civilian physician as a consultant, with a proviso that he file a report for the inmate's medical record, and that any orders or prescriptions he may recommend be agreed to and countersigned by a staff physician. Cases have arisen in which inmates have secured court orders specifying consultation with their personal civilian physicians.

2.3. Consultants

Even a very small correctional institution may have occasions in the course of a year when an inmate's illness will require the services of a specialist consultant. Arrangements with consultants in the major specialties *should be made in advance of need.* Except for the minor specialties and subspecialties which are rarely needed, the search for a specialist consultant should *not* be delayed until a need for his services arises.

The arrangements between a correctional system and consultant may be either an informal understanding or a written contract and may take a variety of forms:

- A statewide correctional system may employ a consultant full-time or part-time to serve all of its institutions.

- A large or very large institution may employ a consultant full time or part time.
- A consultant for whose services a regular need can be anticipated may be employed to hold a clinic at the institution at weekly or other regularly scheduled intervals.
- Arrangements can be made with a nearby teaching hospital, medical center, medical school, clinic, or group practice plan to draw on all of its specialists as consultants when needed—either for an annual fee or on a fee-for-service basis.
- A correctional institution may "contract out" a specialty (such as radiology) to a specialist or partnership of specialists who agree to provide all needed services both within and outside the institution.
- Finally, for small institutions and for seldom-used specialties, the institution may simply call in a specialist or bring an inmate to his office when the need arises, in accordance with a pre-existing standby understanding.

A consultation generally consists of at least three elements: (1) a review of the patient's medical record, including test findings, by the consultant; (2) physical examination by the consultant, and (3) the filing of a consultant's note, including diagnosis and treatment plan. All three elements should be included in a formal consultation within the correctional system.

Whether the consultant should be brought to the institution or the inmate brought to the consultant depends in part on relative costs, relative delays, and the inmate's custody level. It may also depend in some cases on whether the consultant needs costly non-portable equipment. In general, it is more economical to bring the consultant to the institution if several inmates can benefit from his services on the same visit. Consultants are for the most part heavily scheduled and loath to make the trip; arranging for their attendance at a time convenient to them (including evenings or weekends) may constitute an inducement.

Where a correctional system or institution often takes inmates to a particular hospital or clinic for consultation, it may be advisable and economical to set up a secure waiting room there. The Minnesota Department of Corrections has such a waiting room at St. Paul Ramsey Hospital.

Consultants should be subject to the same rules governing the prescription of psychoactive drugs as staff physicians; and access to consultants should be only through referral by a staff physician, physician's assistant, or nurse-practitioner. In one institution where these rules were not followed, two major abuses followed. One consultant, a dermatologist, flooded the institution with tranquilizers; and his dermatological clinic as a result became the most popular in the institution, resulting in enormous bills for his services—rendered on a fee-for-service basis.

In addition to formal consultations based on a personal examination by the consultant, it is often helpful for a physician to be able to phone a consultant for advice. Physician's assistants and nurse-practitioners as well as physicians should have telephone access to consultants in situations where they need advice but where a formal consultation is unnecessary or there is insufficient time for one.

An institution's medical records should be audited to assure the proper utilization of consultant services. Three questions in particular should be explored:

- Were there situations where a consultation was indicated but where the medical staff failed to seek it? (Litigation may arise out of such a failure.)
- Were there situations where a formal consultation was indicated but where the medical staff relied instead on a mere "phone consult"? (This may also give rise to litigation.)
- Is the medical staff referring inmates to consultants unnecessarily? (Medical audit in one institution turned up inmates who repeatedly saw a number of consultants—with almost no care by the institution's medical staff.)

After a consultant has reached and recorded a diagnosis and treatment plan, much of the inmate's subsequent continuing care can and should be provided by the institution's staff, in accordance with the plan recommended by the consultant.

2.4. The Pharmacy

The function of an institutional pharmacy is in principle very simple: to stock prescription drugs and dispense them on a physician's prescription. In practice, however, maintaining a sound pharmaceutical system in a correctional setting involves many considerations:

- The need to maintain the security of pharmaceutical stocks.
- The need to resist inmate pressures toward over-prescription, especially of mood-altering and mind-affecting drugs.
- The need to keep medication as a component in medical care rather than as a substitute for good care.

All of these problems are soluble. In many of the institutions we visited, however, health care personnel were frank to concede that their existing procedures left much to be desired. The reason is that a pharmaceutical system in a correctional institution is only as sound as its weakest link. Unless the system is well-planned and well-managed from the initial ordering of drugs from outside suppliers to the ultimate dispensing of individual doses to inmates, an institution's drug problems are not solved.

The pharmacist. Under state law, a pharmacy must operate under the continuing supervision of a registered pharmacist. We see no reason why correctional pharmacies should not abide by this law. They should also, like civilian pharmacies, be inspected periodically by the state's pharmacy-licensing agency.

A licensed pharmacist need not be continuously present in the institution. One alternative is a part-time pharmacist. Another is a pharmacist with responsibility for two or more correctional institutions. Yet another possibility is the "contracting out" of an institution's pharmacy service to a community pharmacy which maintains stocks, fills prescriptions, and makes daily or twice-daily deliveries. But whatever the procedure, a registered pharmacist, fully qualified under state requirements, should have overall responsibility for the correctional pharmacy service.

One or more pharmaceutical clerks may be employed to assist him; *but inmates may not be used in this or any other pharmacy capacity, and should not have access to pharmaceutical supplies under any circumstances.* The pharmacy itself should be a secure area, with access limited to authorized professional personnel. It should be large enough and well enough lit for convenient storing, handling, and dispensing supplies and recording all transactions. It should not be subject to extremes of temperature or humidity.

The Pharmacy and Therapeutic Committee. Each statewide correctional system should have a statewide Pharmacy and Therapeutic Committee composed of correctional physicians, nurses, pharmacists, and the statewide administrator; and this committee should have as advisers recognized authorities from the state medical school, teaching hospitals, the state pharmacy board, the state pharmaceutical association, or other sources outside the correctional system. The two major functions of this committee should be to prepare and periodically revise a statewide formulary; and to audit drug utilization throughout the correctional system.

Similar committees may be established within each correctional institution.

Need for a formulary. Literally thousands of prescription drug products—antibiotics, hormones, tranquilizers, sedatives, analgesics, anticonvulsants, and many more—are available under an incredible array of brand names. No correctional institution can, or should, maintain a complete stock. Rather, the correctional pharmacy should stock only those drugs which are listed in the correctional system's formulary; and physicians should (with exceptions to be noted below) prescribe only the listed drugs.

From the hundreds of antibiotic preparations available, for example, the Pharmacy and Therapeutic Committee can select half a dozen or a dozen for inclusion in the formulary—enough to provide for the full range of therapeutic needs, but no more than enough. Similar selections can be made from the vast numbers of available sedatives, tranquilizers, and so on. Under a formulary system, the individual physician gives up his right to prescribe whatever he pleases; but in return he gets the assurance that the drug he prescribes will in fact be promptly available.

A statewide correctional formulary has advantages over separate formularies for each institution. An initial draft should be prepared by the Pharmacy and Therapeutic Committee. Before final adoption, however, the formulary draft should be circulated for comments and suggestions to all of the physicians in the system who will be bound by its limitations. The Pharmacy and Therapeutic Committee should also be charged with the periodic revision of the formulary—again with input from the physicians who must use it.

While a particular institution should stock *only* drugs listed in the statewide formulary, it need not stock all listed drugs. It should select from the statewide formulary those drugs which are in fact prescribed by the institution's physicians and which are

appropriate to the levels of care available in the institution. For example, general anesthetics need not and should not be stocked in an institution which has only an infirmary rather than a hospital.

Where a statewide system fails to provide a formulary, there is no reason why the physicians, nurses, and pharmacist in a particular institution should not prepare their own, perhaps in consultation with a hospital pharmacist familiar with the drafting of a formulary.

Drugs should be listed in the formulary, purchased, and prescribed by generic name rather than brand name—except in cases where differences in potency or "biological availability" can be documented. Substantial savings can be achieved in this way.

There should be an emergency mechanism for procuring drugs not included in the formulary; but orders for non-formulary drugs should be periodically reviewed by the Pharmacy and Therapeutic Committee to guard against unwarranted departures from the formulary list.

Liquid preparations, to the extent available, should be listed in the formulary in preference to tablets or capsules, since they are less subject to hoarding and trafficking.

In recent years, pharmaceutical suppliers have been making available an increasing range of drugs in "unit dose" form—each tablet, capsule, or liquid dose individually prepackaged and labeled in its own container. The cost per dose is higher; but in a correctional setting the added cost is more than justified by the numerous advantages: no waste due to spillage, fewer medication errors, ease of administration, lesser likelihood of contamination, and better inventory control.

Drug purchasing. In most circumstances, drugs and pharmaceutical supplies should be purchased on a statewide basis, both to take advantage of volume discounts and to ensure adequate inventory control. Correctional purchases may be consolidated with state health department purchases and the purchases of other state institutions—*if* the state system is efficient enough to ensure the continuous availability of all needed products. As a backstop for a statewide procurement system, there should be a provision for the local purchase of emergency supplies when the statewide procurement system breaks down.

Drugs have a limited shelf life. Whatever the procurement system, it should avoid stocking any drug in quantities which will not be exhausted before the expiration date of the product. Drug expiration dates should be monitored, and overage drugs destroyed. A first-in-first-out procedure in the stock room will minimize the need to destroy overage drugs.

In addition to prescription drugs, the pharmacy should stock and dispense certain over-the-counter remedies available without a prescription on the outside. For a discussion of policies respecting these non-prescription drugs, see below section 3.1.

A very wide range of drugs are valued in the inmate community for their mind-affecting or mood-altering properties. Stimulants, sedatives, tranquilizers, anesthetics, and analgesics are obvious examples—but they are *only* examples. The majority of drugs in the formulary, it seems likely, have some value on the contraband inmate market; hence prudence should be exercised when prescribing *any* prescription drug.

No physician, physician's assistant, or nurse who has not worked in a correctional institution can envision the pressures and "gimmicks" inmates will resort to in their continuing effort to secure access to mind-affecting and mood-altering drugs. Blackmail is one means. One common practice is the gauging of the prescribing policies of each physician. Shrewd inmates soon learn which physician is most lax in prescribing desired medication, and jockey for position in his waiting line. To avoid this disruptive "pill bargaining," prescription practices must be as uniform as possible throughout the institution. Psychiatrists as well as medical practitioners should abide by uniform prescription policies. Consultants unfamiliar with institutional conditions should be authorized to recommend rather than prescribe a drug regimen; the actual prescribing should be done by a staff physician in accordance with the institution's uniform policy.

In the face of the unrelenting demand for mind-affecting drugs, it is quite easy for a health care staff to over-react—to deny prescriptions for such drugs even when their use is fully warranted. Both over-prescribing and under-prescribing can be avoided by establishing sound institution-wide policies and abiding by them.

No prescription in a correctional institution should be refillable. A limited number of doses should be prescribed, and the results should be evaluated before a new prescription is written.

A prescription should not be handed to the inmate, but should be forwarded to the pharmacy through secure channels to prevent tampering.

In correctional as in civilian medicine, there are occasional valid indications for the prescription of placebos. The pressures on physicians from inmates in a correctional setting, however, make it easy to overuse them. Prescribing a red aspirin this week and switching to a green aspirin next week if the red kind doesn't work is a self-defeating policy, for it encourages the inmate's over-valuation of medication which is the ultimate source of the problem. When an effective medication is not indicated, a polite but firm "no" is superior to a placebo under almost all circumstances.

In a correctional institution, the prescribing policies agreed upon by administration and staff are not self-enforcing. All prescriptions, or else a random sample of them, should be periodically audited by the Pharmacy and Therapeutic Committee to determine compliance with institutional policy. A physician who is prescribing one drug very frequently, or in unusually large doses, or who is prescribing placebos very frequently, or ordering numerous drugs not listed in the formulary; or who is departing from established prescribing policies in other ways, can be invited to meet with the Pharmacy and Therapeutics Committee to explain the rationale of his prescriptions. In practice, the mere existence of this review function will tend to minimize abuses; very rarely will it be necessary to call a physician to account.

A "drug profile" should be maintained for each inmate, showing all drugs prescribed for him. The pharmacist, in the course of posting this profile, can readily spot cases where the same drug is being prescribed to an inmate by two or more physicians, as well as other evidence of "pill bargaining." The pharmacist can also check the drug profile interaction with a drug already taken.

A final prescribing recommendation is perhaps the most important. Many inmates tend to confuse medication with medical care. They come to health care service for medicine, not for care. It is very easy, moreover, for the busy correctional physician to fall into precisely the same error. Prescribing a medicine is much quicker and simpler than listening to the inmate's symptoms, examining him, performing the indicated laboratory tests, diagnosing the illness, and then deciding on a treatment regimen (including but not limited to medication). Merely prescribing is quicker and simpler—but much less effective.

Dispensing and administering. The medication line or "pill line" for the dispensing and administering of drugs should be held in a different place and at a different time from sick call—both to minimize congestion and to emphasize the distinction between medical care and medication. Only a pharmacist, nurse, or other professional should dispense and administer drugs in the medication line. Only one dose should be dispensed at a time, and it should be taken under observation.

Even when these and other precautions are followed, drug hoarding and trafficking occurs in some institutions. An inmate may lodge a tablet or capsule under his tongue, then remove it and save or sell it. Dispensing drugs in liquid form discourages this procedure.

The medication line should be surrounded by adequate security precautions—a barrier, for example, between the inmates receiving the medication and the person dispensing it, with a correctional officer on duty at the dispensing site. In the event of a disturbance anywhere in the vicinity, the dispensing area should be closed until order has been restored.

A note should be made of each dose dispensed; comparing the dispensing chart with each inmate's drug profile will show whether he is in fact receiving the medications prescribed. An inmate who fails to appear for needed medication should be summoned.

While the great bulk of medication can be dispensed via the medication line, there are exceptions. If the medication line is scheduled only twice a day, for example, drugs which should be taken three or four times a day must be dispensed in other ways. Drugs may also, on occasion, have to be dispensed to inmates held in segregation. In these and similiar situations, dispensing should be in the hands of the health care staff, not the correctional staff.

Other security precautions. In many correctional institutions, drugs are the common currency of the inmate contraband market. For this reason, as well as for the health and safety of inmates, drugs should be handled and recorded with all the precautions which would be used with large amounts of cash.

Opiates and a growing list of other "controlled drugs," are subject to strict Federal and state laws and regulations, enforced by Federal and state inspectors. The system of drug security precautions required for these controlled drugs can also serve as guidelines for the handling of other prescription drugs.

The purposes of the drug security system are (a) to minimize leakage, and (b) to make it possible to pinpoint the precise place in the system where a leak occurs, so that remedial measures can be instituted.

Security begins when a drug shipment arrives at the gate of the institution. Only the pharmacist or a responsible staff member acting on his behalf should be authorized to sign the receipt for the shipment, transport it to a storage area, and open the package.

Bulk shipments containing more than a week's or month's supply of a drug should not be stored in the pharmacy but in a secure place—either in a safe or in a room outside the walls or in the administrative area—where they will not be subject to extremes of temperature or humidity.

Only minimum supplies should be available for odd-hour dispensing. Drugs for night use, for example, should be stocked in one-night quantities in a night box rather than being withdrawn after hours from the general pharmacy supply. Supplies in the infirmary should also be strictly limited.

As important as safe storage is the scrupulous logging in and logging out of each dose from the moment of receipt in the institution until it is dispensed to an inmate. The logs in the storage area, the pharmacy, and any other dispensing points (such as the infirmary) should be in a form for convenient cross-checking. The pharmacist, who has over-all responsibility for the entire system, should maintain a "perpetual inventory" system, under which: adding the number of doses received during a given week or month to the amount on hand at the beginning, then subtracting the number of doses dispensed, should equal the number on hand at the end of the period. If there is a shortage, checking the logs will determine whether it originated in the storage area, the pharmacy, or somewhere else.

Leakage from the pharmacy system, of course, is not the only or even the primary source of contraband drugs in an institution; illicit supplies are also smuggled in. Indeed, tightening up the institution's storing, prescribing, and dispensing systems may be followed by increased smuggling rather than curtailed availability. Even so, the effort is worth while: for drugs leaking from the legitimate supply bring discredit on the health care service, generate friction between the correctional and health care services, and make the health care service an accomplice to the contraband market.

2.5. The Clinical Laboratory

It is impossible to supply adequate health care unless the primary physician has access to the countless kinds of clinical tests—blood tests, urine tests, tissue examinations, and many more—needed for diagnosis and for gauging the effects of therapy. The clinical tests required can be divided into three broad categories.

First, there are the tests which the physician wants at his elbow, and which he either runs himself or has a nurse or physician's assistant run for him while the patient waits. The simple dipstick test for glucose in the urine is an example. These tests should be available even in small institutions.

Second, there are the tests which state laboratories, commercial clinical laboratories, and the laboratories in community hospitals commonly run. The blood glucose analysis is an example.

Third, there are new and highly sophisticated tests which are only run at a relatively few specialized clinical laboratories. Some of these will accept specimens by mail and report test results by mail or phone.

Deciding which tests should be immediately available, which should be run in the institution's own clinical laboratory, and which should be sent to an outside laboratory is a matter involving numerous economic, quality, and other considerations. We shall review here only a few:

- In general, no test should be run within an institution unless personnel trained to run that test properly are available.
- The precision and reliability of the tests run within the institution should be continuously or periodically evaluated. One simple way to accomplish this is to test a "reference sample" and see how closely the result confirms to the known identity and strength of that sample. Some kinds of tests should be standardized daily. Another evaluation procedure is to split a blood, urine, or other specimen; sending one portion to the institutional laboratory and the other to an outside reference laboratory—then compare the test results. There are also more sophisticated evaluation procedures.
- Regardless of whether particular tests are run inside or outside the institution, the range of

tests available should be limited only by the requirements of the institution's medical staff.

2.6. X-ray and Other Radiological Services

A full range of diagnostic radiological services should be available to the inmates of all correctional institutions.

To what extent diagnostic radiological equipment and personnel should be available within the institution depends on a wide range of considerations. The medical director of a statewide correctional system should therefore periodically review the arrangements at each institution to determine whether any diagnostic radiological services currently being rendered inside the institution can more effectively or economically be secured on the outside, and whether any services being secured on the outside can be more effectively, economically, and conveniently provided within the institution.

An inmate should not be in charge of radiological equipment. Where a radiologic technician is employed in an institution, however, the assignment of an inmate as an apprentice may prove feasible.

No complex radiological equipment should be purchased for an institution unless it is reasonably certain that personnel qualified to operate it will be available for the forseeable future.

All radiological equipment in correctional institutions should be periodically tested for compliance with the safety recommendations of the National Council on Radiation Protection and Measurements.

The services of a radiologist should be available for the interpretation of X-ray films and radiological data. In some situations it may be more effective and economical for the radiologist to visit the institution periodically; in others, the inmate may be sent to the radiologist, or X-ray films may be made within the institution and delivered to the radiologist for interpretation.

2.7. Other Supportive Services

Numerous other supportive services have been developed, and some of these are found in some large correctional systems:

Physical therapy
Occupational therapy
Respiratory care units
Orthopedic appliance laboratory
Electrocardiography laboratory

Each of these services, obviously, can contribute to the adequacy of the health care provided within the walls of the institution. One of the distressing observations, however, on our tour of correctional institutions, was the waste which results where large sums are spent for costly equipment to provide services such as these; where generous space is set aside for such services; and where the equipment thereafter lies idle and the space unused; either because no qualified personnel are available to provide the services, or because too few inmates need the service. Funds are too scarce in correctional health care to permit their waste on unused facilities. To minimize such waste, the following precautions are recommended:

- No substantial investment should be made in inaugurating a new supportive service within an institution's walls until a well-documented determination has been made of the need for the service. This determination should be made by reviewing the medical records of all inmates, or of a random sample, to see how many or what proportion will benefit.
- It may not be necessary to install a complete physical therapy unit or a complete electrocardiography laboratory or a complete additional service of any other kind. One or a few pieces of equipment or services may be enough.
- No large investment should be made in equipment unless it is certain or almost certain that qualified personnel can be secured to use it.
- Conversely, personnel for these additional supportive services should not be employed unless it is certain or almost certain that they can be provided with the equipment, space, and other facilities they need.
- The possibility of establishing one of these additional supportive services to serve two or more nearby institutions, or an entire statewide correctional system, should be explored.
- When a qualified professional is available, and his services can be secured or retained only if an expensive supportive service is established for him, it is tempting to establish the service regardless of other considerations. The result in some cases is that a large investment lies idle and wasted when the professional leaves a few years later. This likelihood should be borne in mind when weighing the pros and cons of establishing a new supportive service.

- Finally, correctional health care systems should bear in mind the axiom applicable to *all* health services: unnecessary duplication of facilities and services raises the cost of health care. What are the relative advantages, in terms of both quality and cost of service, achieved by establishing a new service within an institution's walls as compared with transporting inmates to an existing service outside? This is an issue which will be frequently considered in subsequent sections of this study.

CHAPTER 3. LEVELS OF CARE

Everyone knows that there are some conditions which you treat yourself (by taking an aspirin or a laxative, for example), others for which you visit a physician or clinic, and still others for which you put yourself to bed, or go to a nearby community hospital, or to a major medical center. In this chapter we consider the comparable levels of care for inmates in correctional institutions.

3.1. Self-care

An inmate who doesn't feel well may simply curl up on his bed and wait for the illness to go away. More likely, he may try self-medication—an aspirin, an antacid, a laxative.

Policy varies from institution to institution with respect to self-medication. Some institutions supply simple home remedies without charge; others permit their sale in the canteen or commissary; others prohibit all medication not prescribed by health care personnel. Those which make home remedies available may have a very long or a very restricted list of permitted remedies.

Policy on this matter should be set by *health care personnel*—primarily the physician in charge and the pharamacist. Where correctional personnel set policy, inconsistencies are likely to arise—as in one institution where inmates were forbidden aspirin for self-medication but were given unlimited access to Alka-Seltzer, a product composed in considerable part of aspirin.

In some institutions, inmates have access for self-medication to many of the over-the-counter remedies they would be able to obtain without a prescription on the outside. One reason for this policy is that it builds in the inmate a sense of responsibility for his own health care. It also cuts down on unnecessary sick call attendance. Correctional institutions which institute a generous policy with respect to over-the-counter remedies can restrict the list of medications available if and when abuse or over-use appears. An educational program designed to familiarize inmates with the effects of over-the-counter drugs and their proper use is recommended.

For several reasons, we urge that over-the-counter drugs be dispensed to inmates without charge or at modest charge *through the institution pharmacy* rather than the canteen or commissary. Pharmacy dispensing impresses the inmate with the fact that self-medication, like prescribed medication, is *medication* and is a part of health care. It makes possible a close daily check on quantities dispensed. A sudden run on any particular product is a signal to reevaluate policy. The pharmacist or his clerk can note whether an over-the-counter product is in general use or is being greatly over-used by one or a few inmates. For some items, the pharmacist may wish to prepare a simple instruction slip or leaflet, supplementing or replacing the inadequate or overly complicated instructions which accompany some over-the-counter medications.

A taboo exists in some correctional institutions against the dispensing of Vaseline or other lubricants or lotions, on the ground that they may be used for homosexual encounters. There is no evidence that the availability of such products affects the frequency of such encounters, and there is no good reason for denying inmates access to such products.

3.2. First Aid

In civilian life there are numerous occasions when self-care is insufficient and when care from a properly trained relative, friend, or neighbor is essential and may prove life-saving. This is *first aid.* It is of particular value for those conditions which require *immediate* aid, before qualified personnel can reach the scene, or during transportation of the patient to a health care facility.

Emergencies requiring first aid repeatedly arise in correctional institutions. Correctional personnel should therefore be trained in first-aid procedures. The American National Red Cross and its local chapters supply such training in most localities. Every correctional institution should consult with a nearby Red Cross chapter on first-aid training opportunities for correctional personnel—and perhaps for selected inmates as well.

An essential part of first-aid training is learning what *not* to do in an emergency as well as what to do. *First aid is going to be administered in an institution,* whether or not personnel are trained for it. An inmate bleeding from a wound, dragging a broken limb, or experiencing a heart attack is going to be helped. Providing first aid training is not a substitution of lay help for professional help; it is assuring that the lay help (which is going to be provided in any event) will be as helpful as possible and unlikely to exacerbate the situation.

First-aid supplies should be available at key points throughout the institution—especially in the industrial shop areas and visitors' areas—and these locations should be suitably marked and publicized.

3.3. Sick Call

This level of health care has been described above (page 11). We need only note here that even the best sick call procedures are not sufficient by themselves; rather, they should take their place in the ordered series of services described in this chapter.

3.4. Odd-hour Emergencies

Some acute illnesses cannot await the next day's sick call; heart attacks, appendicitis attacks, and trauma following interpersonal violence are familiar examples drawn from a very long list. Adequate health care includes ways in which inmates can communicate such emergency needs to the health care service, and ways in which emergency needs can be met at any hour of the day or night.

One major difficulty in planning for odd-hour emergencies is the problem of intra-institutional communication. An inmate who has a heart attack at 2 a.m. Sunday morning may with luck be able to summon the nearest correctional officer. The correctional officer may then be tempted to make a diagnosis: whether the inmate in fact needs emergency medical care, or can wait until morning, or is merely malingering. Thus, two basic principles of correctional health care may be violated—that medical decisions must be made by medical personnel, and that access to medical care is a right, not a privilege. Litigation may easily arise following such an episode. The correctional staff should accordingly be firmly indoctrinated in the one decision they can properly make when an inmate calls for odd-hour emergency care—whether to summon medical assistance or take the inmate to the medical area. Inmate abuse of the odd-hour emergency call procedure can be dealt with the following day. Abuses are not likely to be common in institutions where inmates perceive the medical service as dedicated to their welfare.

3.5. Infirmary Care

When a civilian is too sick to go to work, but not in need of hospitalization, he goes to bed and, typically, some member of his family takes care of him. In the correctional institution, *infirmary care* takes the place of family home care. An infirmary is, in its simplest form, merely a quiet place with one or more beds, and with someone on duty whenever one of the beds is occupied. Even small correctional institutions should have an infirmary.

An infirmary's equipment may vary from the simplest—a thermometer and bedpan, for example—to relatively complex devices such as resuscitation equipment. As in other portions of a health care system, everything should be available which the health care personnel know how to use, and funds should not be wasted on equipment which will not be used.

Minor surgery can be performed in an infirmary if trained staff is available and if the infirmary is adequately equipped. The infirmary can also be used to shorten hospital stays—both by providing diagnostic facilities (such as 24-hour urine collection) prior to hospitalization and by providing aftercare for patients discharged from the hospital.

Statewide health care administrators, and the physicians in charge of health care in local institutions, cannot give too much thought and attention to the question: what conditions should be handled in the infirmary and what conditions require transportation of the patient to a hospital outside the walls? Indeed, this is one of the basic issues in the whole field of correctional health care. Some very large institutions solve it by having a hospital instead of an infirmary within the walls; this alternative will be discussed in the following section. At several of the institutions we visited, however, the trend was in the opposite direction; institutional hospitals were being downgraded to the level of infirmaries—because it had become impossible to staff them as hospitals, and because, as a result, the quality of care they were rendering was lagging far behind the quality available at outside hospitals.

A considerable body of litigation arises out of this issue. Some inmates may complain that they

were treated at the institution's infirmary when they should have been transported to a fully accredited hospital or medical center. Other inmates may complain that they were transported, at risk of their lives, when the institution itself should have had staff and facilities adequate to take care of them. Either kind of complaint may be warranted—or groundless.

Whatever the decision reached concerning where to draw the line between conditions treatable in the infirmary and conditions requiring transportation, the two broad classes of conditions should be fully described in written guidelines or criteria; all health personnel should be familiar with these guidelines; and the guidelines should be reviewed at regular intervals by the state medical administrator. The addition or loss of qualified personnel, and the acquiring or retirement of equipment, will quite often make it advisable to expand or contract the list of conditions which can properly be treated in the infirmary. Departure from the guidelines should be permitted only when authorized by the state medical administrator or his deputy.

It is important in a correctional health care system to *call* an infirmary an infirmary rather than a hospital. Decades ago, the hand brake on automobiles was called an emergency brake. Litigation arose whenever the brake failed to function in an emergency and so it was renamed the parking brake. The same principle applies here. Calling a facility a hospital means that a claim is being made—a claim that it is providing the services usually provided by a hospital. Such a claim should not be made lightly or falsely.

3.6. The Institutional Hospital

A hospital is a place staffed and equipped to handle serious illness, including major as well as minor surgery. It also provides in most cases emergency care plus a wide range of other health care services.

A hospital within the walls of an institution has at least two major advantages. It makes possible *immediate* care of serious illnesses, without the hazards and delays of transportation; and it eliminates the very high costs of transportation, of guarding hospitalized inmates, and of paying for care in a civilian hospital. There are two countervailing disadvantages: the high cost of adequately staffing, equipping, and maintaining a good hospital within institutional walls, and the ever-growing difficulties in providing in an institutional hospital the quality of care available in good civilian hospitals. As noted above, the trend seems to be away from institutional hospitals, with one exception.

The exception is the designating of one institutional hospital in a statewide system as the hospital for all of the correctional institutions in the state, or in a region of the state. *If* the institutional hospital is capable of delivering services of a quality comparable to that available on the outside, we see no objection to that solution. The *if*, however, is a big one.

Some correctional hospitals now in operation fail to meet even the minimum requirements for securing a hospital license from the state health department. All unlicensable hospitals should be reclassified as infirmaries and inmates transported to outside hospitals when hospital care is indicated.

In addition to meeting all of the requirements of state statutes and hospital licensing regulations, each correctional hospital should achieve and maintain accreditation by the Joint Commission on Accreditation of Hospitals (JCAH). If it is ineligible for accreditation because it fails to offer certain mandatory services, it should, at the very least, meet JCAH standards with respect to the services it does offer.

At this writing, only a handful of correctional hospitals outside the Federal system are accredited by the JCAH. A few others have been accredited in the past. Correctional systems and institutions which either currently maintain a hospital or plan to establish one should give full consideration to the many hurdles which must be surmounted—including high costs and staffing difficulties—if JCAH standards are to be achieved and maintained. In most situations, the best present solution and in all probability the only long-run solution, will be infirmary care within the institution plus hospital care outside.

One error which should especially be avoided is the construction of an elaborate hospital building or suite and the acquiring of costly equipment and facilities which cannot thereafter be adequately staffed. We observed several such "ghost facilities" during our tour of correctional institutions.

Even where a state correctional system maintains a correctional hospital for its institutional inmates, occasions will still arise when an inmate must be taken to a nearby community hospital for emergency care, or to a major medical center for a type of care

not available in the correctional hospital. Standing orders should govern such cases. These orders should *not* require that the inmate be transported first to a state correctional hospital and then retransported to the medical center unless a valid purpose will be served by the interim stay in the correctional hospital.

3.7. Hospitalization in Civilian Hospitals

The two great advantages of sending an inmate in need of hospitalization to a JCAH-accredited hospital outside the walls are (1) the assurance that the care he receives will be the same care available outside, and (2) the economies which result from avoiding a wasteful duplication of staffs and facilities. The two great disadvantages are (1) the cost, risk, and delay inherent in transportation, and (2) the high cost of assigning correctional officers to guard hospitalized inmates.*

On balance, it is likely that a well-organized and well-staffed infirmary inside the institution plus hospitalization outside will become the standard pattern of American correctional health care in the future. There will no doubt be exceptions; but a correctional system or institution which maintains its own hospital will come under increasing pressure to justify that policy—in terms of both quality of care and cost of care.

The decision to hospitalize on the outside is a medical decision and should be made by the institution's medical director. In emergencies, however, the senior member of the health care staff present at the moment, or a responsible member of the correctional staff, should have power to authorize immediate hospitalization.

Transportation to the hospital should be by ambulance—either the institution's own vehicle or a community ambulance meeting all state requirements. In the absence of an ambulance, of course, rapid transfer of the patient by the most suitable means available should be permitted. Standing procedures should be established to permit egress through the institution's gates and security clearance procedures with minimum delay.

Inmates who constitute a serious security risk must, of course, be kept under guard during transportation and throughout their hospital stay. Correctional officers assigned to this duty should be briefed on ways to carry out their functions with a minimum of disruptive effect on hospital routines. They should wear civilian clothing on this assignment, and weapons should be carried only when clearly essential. Use of weapons in a hospital setting should be avoided at almost any cost; occasions have been reported in which hospital bystanders have been wounded or killed during an attempted inmate escape or an altercation.

Correctional officers on hospital duty must live up to the expectation of the hospital staff that they will scrupulously perform their duties. If the hospitalized inmate offers little security risk and if he is well-known and liked by the correctional officers, they may be tempted to take their duties casually, perhaps even to leave him unattended for brief interludes. So far as the civilians in the hospital know, however, the unattended or casually attended inmate may be a mass murderer—certainly a dangerous person or a guard would not be posted.

One way to minimize these and numerous similar problems of inmate hospitalization is to maintain a secure unit within the hospital; this approach is discussed in the following section. Another way is to place the inmate on furlough for the duration of his hospitalization. Several state and local correctional systems now permit this in appropriate cases, and we recommend furlough whenever it is feasible. The decision to furlough, moreover, should be made in the light of the inmate's physical condition. Even an escape-prone inmate is unlikely to elope from an intensive-care or coronary-care unit following a heart attack. If changes must be made in laws or regulations before medical furloughs can be granted, such changes should be sought.

If the hospital lacks a secure unit, a member of the health care staff of the correctional institution should visit each hospitalized inmate daily, or at a minimum his status should be monitored by means of daily phone calls. Among other advantages, this will minimize the likelihood of unnecessarily long and unnecessarily costly hospital stays, and will make possible continuity of care following his return to the institution.

3.8. The "Secure Unit" in the Civilian Hospital

The trend toward outside hospitalization is likely to be hastened by the successful establishment of "secure units" for inmates in a number of civilian

*To guard one hospitalized inmate 168 hours a week, requires five correctional officers (including holidays and vacations) if one officer on duty at a time is sufficient. If security requires two officers at a time, ten officers are needed for round-the-clock surveillance of one inmate patient. Even at $5 per hour, this works out at $1,000 or $2,000 per week per inmate patient.

hospitals. The New York City, Los Angeles, San Francisco, and Minnesota correctional systems are examples. The most obvious advantage of the secure unit in a civilian hospital is that it permits many inmates to be hospitalized simultaneously without requiring more than one or two correctional officers on duty at a time. A less visible but at least equally important advantage is that the secure unit improves the quality of care received by inmates in the hospital.

This is accomplished in several ways. In hospitals as elsewhere, there is a prejudice against inmates. A hospitalized inmate is highly conspicuous, for the officer posted at his bedside is a constant reminder that he is a danger to the community. If inmates are handcuffed, they are even more conspicious. Hospitals are generally loath to admit inmates, and loath to establish secure units. Indeed, establishment of the San Francisco secure unit was delayed because the hospital administration feared that nurses and other personnel might refuse to serve in the unit.

The problem in San Francisco was met head-on by calling meetings of the hospital staff at which the new unit was explained; its pioneering nature and the challenge it provided were stressed. The new unit was then staffed by hospital employees who *volunteered* for the unit. Morale has been high ever since, and hospital employees are proud of their association with the secure unit.

Much the same approach can be taken with respect to correctional staff. Assignment to guarding a hospitalized inmate is often likened to be sent to Siberia. The post is considered unremittingly boring, and the correctional officer feels isolated from his fellows and his familiar scenes. Permanent assignment to a hospital secure unit changes all this. Volunteers from the correctional staff are integrated into the functioning of the unit. They handle all visitors and a variety of other ancillary duties, so that the task is no longer boring. And they soon establish new friendships in the now-familiar hospital setting They, like the hospital personnel, develop a pride in their roles within the unit.

A physician should be in charge of the unit, and he should function, in effect, as the personal physician of the hospitalized inmates. It is a part of his task to see that all of the hospital's other services are available to inmates as needed. In other respects, the hospitalized inmate is on a par with other hospital patients. If he is in for surgery, he is registered as a regular patient on the surgical service. If he is in for medical care, he is enrolled on the regular medical service. The house staff makes the rounds of the secure unit as of other units.

Correctional systems and institutions should periodically review the possibility of establishing a secure unit serving two or more correctional systems. In one county hospital we visited, the state had recently established a secure unit for inmates in several of its institutions. The county sheriff was planning to construct a similar unit on the grounds of the same hospital. We fail to see why a secure unit cannot serve the inmates of several correctional institutions, whether or not the institutions are part of a single statewide system. Ultimately a statewide plan might be built around a series of strategically located secure units serving inmates of all the state, county, and city correctional institutions within the state.

A secure unit should be geographically located as close as possible to the heart of the hospital complex rather than across the street or down the block. If it is geographically separate, it is likely to be *perceived* as separate—as a sort of hospital ghetto rather than a regular component.

Secure windows, secure doors, and other security features are needed for a hospital secure unit. They need not, however, be overly conspicuous. Secure screens, for example, may be as effective as bars in preventing escape under hospital conditions. A security officer sitting at a desk inside is quite as effective (and considerably less conspicuous) than one posted outside the unit's door. In general, security features should be designated for compatibility with the hospital milieu as well as for effectiveness.

As noted above, a secure waiting room for inmates brought to the hospital for outpatient services may also prove useful in some situations.

3.9. The Major Medical Center

While most of the hospital needs of inmates, as of civilians, can be met by even a small JCAH-accredited general or community hospital, the need occasionally arises for sophisticated health care services of a kind available only in teaching hospitals affiliated with medical schools or in other major medical centers. Open-heart surgery and organ transplantation are two well-publicized examples. We recommend that lines of communication be opened up with such a medical center *in advance of need.* The physician in charge at the institution should know at the very least who to call at the medical

center and what the conditions of admission are. Among other advantages, this may avoid, in an emergency, the transportation of an inmate to a small hospital first, the waste of time there, and his subsequent transportation to the center to which he should initially have been taken. The problem of financing very costly procedures at major medical centers is considered on page 63.

3.10 Transportation

Some correctional institutions maintain and staff their own ambulance; others depend on the regular community ambulance service. The Vienna Correctional Center in Vienna, Illinois, offers what may be a unique service; its ambulance, staffed by trained and trusted correctional inmates, is available for emergency transportation of civilians in the surrounding community as well as for inmates. In addition to providing a needed service, this arrangement has contributed much to the acceptance of the correctional center in the community.

Most states now license ambulance services and require minimum standards of both equipment and personnel training. Whether a correctional institution maintains its own ambulance or utilizes a community service, the service provided should meet all relevant state standards.

In the event of a disaster or other multiple-casualty emergency, the need may arise for the immediate transportation of substantial numbers of inmates. Wherever possible, standby arrangements should be made with other ambulance services in the event of need. (For more on diaster planning, see page 30).

In some situations, the use of a plane or helicopter for transportation may be feasible and potentially life-saving. Air transportation may be available through a state agency such as the National Guard or through a licensed commercial service. Each state correctional health system should make a feasibility study of air transportation. While it may rarely be needed, the availability of the service may contribute to inmate morale, to the morale of the health care staff, and to the reputation of the correctional health care system.

3.11. Forecare and Aftercare

The high and rising daily cost of hospitalization in a civilian hospital is well-known. Hence, measures for shortening an inmate's stay in a hospital are essential.

One determinant of length of stay is the range of services available in the infirmary of the inmate's regular institution. Upgrading the quality and range of care in the infirmary may practically pay for itself, or more than pay for itself, by shortening hospital stays. As noted above, a well-equipped and well-staffed infirmary in a correctional institution may perform various preadmission functions and thus shorten hospital stays prior to surgery or other major procedures.

Hospital stays may similarly be shortened by providing aftercare in the institutional infirmary—if the infirmary is staffed and equipped to provide it. The aftercare problem is complicated by the fact that most inmates naturally prefer the hospital to the institution; they may use considerable ingenuity to prolong their hospital stays.

Accredited hospitals maintain "utilization committees" to discourage unnecessary hospitalizations and unnecessarily prolonged stays. The records of correctional inmates, like those of other patients, should be reviewed by these utilization committees.

CHAPTER 4. HEALTH CARE SERVICES IN WOMEN'S, JUVENILE, AND OPEN (MINIMUM-SECURITY) INSTITUTIONS

Most of the policies and procedures presented throughout this Manual are applicable to correctional health care in general. In this chapter we present some additional considerations relevant to health care in women's, juvenile, and small open institutions.

4.1. Women's Institutions

The special health care procedures for women's institutions recommended below are drawn primarily from the experience of Montefiore Hospital and Medical Center in providing health care services at the women's correctional institutions on Rikers Island, under contract with New York City's Department of Health and Correction. Only those procedures are discussed which are unique to women's institutions—or which require major changes for adaptation to women's institutions.

Cancer. A Pap smear for cancer of the cervix should be taken in the course of each female inmate's initial physical examination. This is true even for adolescent females, since the incidence of abnormal findings in an adolescent female inmate population may be higher than among well-to-do suburban women a decade or two older. The specimens should be sent to a nearby hospital or cancer control program for evaluation; and all abnormal findings should be followed up in accordance with the usual policies of the hospital or control program.

A careful manual examination for breast cancer should also be part of the initial medical examination; and the female inmate should at the same time be taught the technique of breast self-examination.

As will be noted below, the employment of a woman physician in a woman's institution is an advantage for these examinations as for numerous other procedures; the presence of a female nurse or other female member of the health staff during the physical examination is imperative.

Sexually transmitted infections. Most males infected with syphilis or gonorrhea suffer relatively prompt symptoms sufficiently troubling or alarming to bring them to a physician or clinic. Most infected females, in contrast, are aware of only apparently trivial symptoms—or none at all. The importance of promptly diagnosing and treating these asymptomatic female venereal infections can hardly be overestimated—not only for the protection of the female inmates but for the protection of the outside community. This is especially true with respect to women and female adolescents held in short-term detention facilities, through which rotate large numbers of women with multiple sexual partners (many of whom are prostitutes). The release of one woman inmate with an undiagnosed untreated venereal infection may be followed by scores of subsequent infections on the outside. In the case of a prostitute, diagnosing and treating one infection inside the institution may prevent several hundred subsequent outside infections.

The initial physical examination for each woman admitted to a correctional institution should accordingly include (as for men) a serological test for syphilis. Since syphilis often has a relatively long incubation period and the test does not become positive until after the infection has become established, the serological test should be repeated three months after admission. Further, secondary syphilis (which appears weeks or months after the initial infection) can be transmitted through kissing as well as more intimate relations; hence a repeat serological test for syphilis should be run annually.

Culture specimens for gonorrhea should be secured along with Pap smears during the initial physical examination; and repeat cultures for gonorrhea should be available to all female inmates at their request, especially on return from furloughs or home visits. Both the serological specimens for syphilis and the gonorrhea cultures should be sent to the state VD laboratory or other laboratory where civilian VD tests are run, and the VD control program in the institution should be deemed a part of the civilian VD program, cooperating fully with it in contact-tracing and other control activities.

Diagnostic and treatment facilities for other sexually transmitted infections—notably yeast and trichomonal infections and genital herpes—should also be available.

Contraception is a right with which states may not interfere. It can be argued that a woman runs a minimum likelihood of becoming pregnant while an inmate, but such incidents do occur. Thus a woman who requests or demands continuing contraceptive protection during her stay has a reasonably good case. The case is even stronger for making medical contraception service available for women inmates about to leave on furlough or work release, or about to be released on parole or unconditionally.

An interesting question has been raised concerning the possibility that a woman on oral hormonal contraceptives may, if her pills are taken away from her on admission, become pregnant as a result of an act of intercourse occurring prior to her admission. No decisive evidence on this point is available, but prudence suggests that a woman on oral contraception be permitted to continue at least to the end of that monthly cycle—even in institutions where continuing protection thereafter is not provided.

These are in any event *medical* decisions. They are, moreover, decisions within the peculiar competence of the obstetrician-gynecologist. They should, accordingly, be determined by the medical staff, including the staff gynecologist or the institution's gynecological consultant.

Pregnancy. A proportion of women are pregnant on arrival in a correctional institution; a few may become pregnant after admission. A pregnancy test should accordingly be a routine part of the initial physical examination of all women of childbearing age; and repeat tests should be subsequently available at the inmate's request.

Continuing prenatal care for pregnant women is a principle of health care which has proved its worth in terms of both maternal and infant health. Comparable prenatal care, including the usual laboratory tests, diet, diet supplements, exercise, counselling, and biweekly or weekly obstetrical examinations during the last three months, should be provided for women incarcerated during their pregnancies. A higher-than-usual incidence of premature births can be expected among babies born to women inmates.

While prenatal care should be under the supervision of an obstetrician, and he should be personally involved in that care many of the routine prenatal procedures (as in civilian practice) can be perormed under his supervision by another physician, a nurse, or a nurse-midwife.

Abortion. Since January 1973, the courts have held that abortion is a right with which states may not interfere during the first three months of pregnancy; abortion during the next three months may be regulated but not prohibited. No good reason appears why a woman should lose this right by reason of being held in a correctional institution. On the other hand, some pregnant inmates reject abortion for religious or personal reasons, even under circumstances which may seem to the medical staff to dictate abortion as the only rational solution. While the availability of abortion should be brought to a pregnant inmate's attention, no direct or indirect pressure should be placed on her either to choose or to reject abortion.

To avoid charges of "undue influence," it is prudent institutional policy to transport a pregnant inmate to a nearby hospital or clinic where she can receive the same pregnancy counselling (including abortion counselling) she would receive if not incarcerated. This should be done without delay when pregnancy is diagnosed. It is similarly prudent, if an inmate requests abortion, to have it performed in a civilian hospital or clinic rather than in the institution.

Childbirth. Relatively few women reach term and deliver their babies while they are inmates in a correctional institution. The number should be reduced to an irreducible minimum by means of medical furloughs or other alternatives.

As a pregnant woman approaches term, a decision must be made whether she is to be delivered in the institution's infirmary or hospital or taken to an outside hospital where adequate obstetrical and neonatal care facilities are available. In all but the most exceptional circumstances, delivery should be in an outside hospital. Even where the institution's facilities are adequate for the actual delivery (often a debatable point), they are rarely adequate to handle the myriad of problems which may arise in the newborn infant, especially a premature infant.

Infant care. After the baby is born, complex problems of infant care and custody arise. Some institutions permit the mother to keep and care for the baby for a year or longer—perhaps even until release. In such cases, medical care for the baby is the responsibility of the instituion and may on oc-

casion require pediatric consultation. If the baby is to be sent outside, the mother's views should wherever possible govern the choice among the available alternatives: care by relatives, temporary placement, or adoption.

Menstrual problems. Amenorrhea, dysmenorrhea, and a variety of menstrual irregularities are common problems in women's correctional institutions, requiring the services of a gynecologist or gynecological consultant. Sanitary napkins and belts as well as other feminine hygiene needs should be available without delay and without embarassment. Inmates are sometimes refused access to vaginal tampons for security reasons, on the grounds that they may be used as hiding places for drugs or other contraband. We see no justification for this rule, since drugs can be secreted without tampons as easily as with them.

Douching, except when prescribed, is frowned on by some medical authorities, and douche supplies are not made routinely available in some women's institutions. Where a woman accustomed to douching requests supplies, however, we see no adequate ground for refusing her access to materials readily available on the outside—along with appropriate warnings or precautionary advice. Privacy for douching is another right which should be respected.

Anemia, especially iron-deficiency anemia, is more frequent in women than in men. Appropriate blood tests should, accordingly, be run upon admission of a woman patient and periodically thereafter as indicated.

Psychoactive medication. In women's as in men's instituions, there is a constant and vociferous demand for medication—especially for tranquilizers, pain relievers, and other psychoactive drugs (see page 22). In women's institutions, menstrual problems are often cited as a justification. Neither tranquilizers nor pain relievers, however, constitute the treatment of choice for menstrual dysfunction. This does not mean that a woman in need of temporary tranquilization or pain relief should be deprived of it; but sound policy requires that these drugs be prescribed only as indicated, and that mere medication not take the place of competent medical care.

Female staff. An all-male medical staff for a female institution is as unwise as an all-female medical staff for a male institution. A female nurse or paraprofessional should be present at all hours wherever possible, and at all physical examinations. There are advantages in the employment of a female physician.

Security classification. Most states classify their male inmates in terms of degree of security required, and send each inmate to an institution providing the appropriate level of security. Men in minimum-security institutions may be given "medical furloughs" so that they can be cared for in civilian hospitals or clinics without the need for guarding (see page 30). All women inmates in a state system, in contrast, may be held in a single maximum-security institution. In such states, the security classification of the inmate rather than of the institution should govern; medical furloughs should be available to a minimum-security risk even though she is lodged in a maximum-security institution.

4.2. Juvenile Institutions

Children and adolescents held in custody require access to almost all of the health care services necessary for adult inmates—plus a range of additional services for the unmet health care needs they bring with them to the institution.

Dr. Iris F. Litt of the Division of Adolescent Medicine at Montefiore Hospital in the Bronx, New York, has described the needs uncovered during thorough intake examinations and evaluations of 31,000 females and males aged 8 to 18 admitted to New York City detention facilities over a 5 year period. For most of these youngsters, Dr. Litt informed a subcommittee on juvenile delinquency of the United States Senate in 1973, intake evaluation at the detention center represented "the first thorough examination since infancy. Consequently, the fact that approxiately 50 percent of the healthly-appearing adolescents admitted for detention are found to have physical illness, exclusive of dental or phychiatric problems, may not be surprising.

"These health problems generally fall into three categories: First, those common to all adolescents during the period of rapid growth and body change that is the essence of adolescence. In this category are the orthopedic, gynecologic, endocrinologic and dermatologic conditions which plague teenagers of all socio-economic backgrounds. The second category is that which encompasses the medical or physical complications of the life style of some adolescent patients and includes venereal disease, unwed pregnancy, and complications of drug abuse. Four and one-half percent of the girls, with an average age of 14.5 years, were found to be pregnant at the time of admission. Most were previously unaware of their pregnancy, and none had used any form of contra-

ception. One-third of the adolescents admitted to the facility have been found to be users of drugs. On the basis of screening liver function tests on those drug users who had no symptoms of hepatitis and who had negative physical examinations, 39% or 3,700 were found to have a form of hepatitis. The third large category of illness includes those usually discovered at an earlier age but, because of the pattern of poor medical care available to the youngster's families, were not detected until the time of their examination at the center. Congential abnormalities, ranging in severity from heart disease, kidney and endocrine defects, to hernias requiring surgery make up the bulk of this category. The majority of these defects could have been corrected surgically at a younger age, at a lesser cost to the patient and to society. In some cases, the presence of these defects may have actually contributed to the youngster's school difficulty with resultant truant behavior, and may have, in fact, been a factor in their difficulty with the law."

Specialists in adolescent medicine. To manage this very heavy backlog of unmet health needs, the services of a general practitioner are not enough. Each juvenile institution should have on its full-time or part-time staff, or (for very small institutions) available as a consultant, a pediatrician or internist with a special interest and training or experience in adolescent medicine.

Juvenile health care standards. A program for meeting childhood and adolescent health care needs was developed in 1973 by the Committee on Youth of the American Academy of Pediatrics. Entitled "Health Standards for Juvenile Court Residential Facilities," it was endorsed in principle by the National Council of Juvenile Court Judges and is reprinted below as Appendix B. We recommend it to all juvenile institutions.

In broad outline, the recommendations in these standards follow the recommendations above for adult institutions: screening or inspection on admission, a health evaluation or assessment based on a thorough medical history and physical examination soon thereafter, a sound medical records system, access to all levels of care from ambulatory care in the institution to hospitalization, and so on. Emphasis is placed on a multidisciplinary health council empowered to set policy for the institution's health program—a council composed primarily of senior health staff members, advised by a technical advisory committee of outside professionals and experts. Emphasis is also placed on dental care and preventive dentistry, on mental health considerations, on environmental health, and on health education.

Consent. Although it is unnecessary to secure the consent of parents for the examination and treatment of minors suspected of having VD, it is sound correctional policy to secure the consent of the minor himself or herself, and of a parent or guardian, for all but routine procedures. The consent of the juvenile court judge is legally sufficient in many states if parent or guardian consent is not available.

Financing. The financing of health care in juvenile facilities is in some respects easier that in adult facilities. Appropriating bodies are likely to be more generous for facilities serving minors than for those serving a population which is conceived of as "hardened adult criminals." In addition, all of the community agencies concerned with childhood and adolescent health can and should be enlisted in the care of detained minors. Finally, many minors may be entitled to services under a parent's Medicaid or other health insurance coverage. While services rendered within a detention facility can rarely be charged to these plans, both outpatient and inpatient care *rendered in a civilian hospital* may be covered in some circumstances. (For further discussion, see section 9.3.)

Aftercare. Large numbers of minors are detained for only brief periods—perhaps a week or two. This is time enough to ascertain their health needs but not to meet them. Society's responsibility for juvenile health does not end, however, when a minor is released from detention. Every effort should be made to assure continuity of care for children and adolescents following release. Among the recommended measures are the following:

- A suitably worded summary of each minor's health evaluation should be prepared and forwarded to the child's parents or guardian, with recommendation for followup care. Findings which may give rise to family dissension (such as venereal infection) need not be included if there are other ways to assure adequate followup treatment.
- If a minor is released on probation, a copy of the evaluation summary should also be forwarded to the probation officer—with a request that he discuss it with the parents or guardian and that he take whatever other steps may be necessary to assure followup care.

- In some communities, a pattern of followup, in use at Montefiore Hospital for New York City juvenile detainees, may be necessary or advisable. "Community outreach workers" are employed to function as liaison between the released child, his family, and community child health resources. These outreach workers are "indigenous paraprofessionals"—residents of the neighborhoods from which detained minors come, and belonging to the same ethnic groups. They are not skilled in health care delivery but are thoroughly familiar with the health care services available in the community; and they are trained in their central function—bringing the child and his family into effective contact and communication with the needed services.

4.3. Minimum-Security and Open Institutions

In addition to conventional prisons and jails, departments of correction are increasingly making use of small community correctional facilities—farms, camps, halfway houses, and other establishments where security is a minor consideration. Residents in these "community correctional facilities" may go out to work during the day, or home on furlough during weekends, and may have other privileges permitting free circulation in the community during part or all of the week.

We regret to report that in some states small facilities of these kinds have been established in outlying areas with little or no advance planning for health care service delivery. In the absence of careful planning, serious consequences may result for the inmates, the correctional system, and the outside community.

Before any inmate is sent to a small, outlying, open institution lacking its own health service, a full physical examination should be performed, including laboratory tests as indicated; and a summary of findings and health care recommendations should be prepared both for the inmate and for the director of the institution. If facilities at the institution make it feasible, the inmate's complete medical record should accompany him. Standing orders should describe what medical conditions do and do not constitute a bar to transfer to an institution without health care facilities. A chronic condition which is under good control—for example, a seizure disorder well-controlled by Dilantin—should not constitute a bar to transfer.

Since security is not a problem in these open institutions, health care delivery is in one respect greatly simplified. Residents can patronize physicians' offices, clinics, and hospitals in the community without the need for continuous, costly surveillance by security officers. In the event of serious illness, the inmate can also be returned to a nearby correctional hospital or infirmary for treatment or can be released on medical furlough.

Health care is more difficult if the small open institution is located in an outlying area lacking civilian medical facilities; in such situations it may be necessary to provide transportation. A roster of the nearest physicians, clinics, and hospitals should in any event be prepared, and copies made available to the staff and perhaps also to inmates—together with instructions for securing care.

The department of corrections remains responsible for paying for health care services so long as an inmate remains in its custody. If the inmate in an open institution is employed in the community, however, he may be covered by health insurance in connection with his employment; or he may be expected to pay reasonable amounts for care out of his earnings. Where a small open institution is located in a community served by a prepaid group-practice plan, a medical society foundation, or a health maintenance organization (HMO), the possibility should be explored of having its inmates enrolled as a group in such a plan.

If inmates are not in a prepayment plan, their access to *elective, non-emergency* health care services at the expense of the correctional system should be subject to prior approval by the director of the correctional institution. In the absence of such a prior approval requirement, very large bills may be run up for unnecessary services. The director should be aware, however, that unwarranted denial of approval may have serious medical and legal consequences.

It should be the responsibility of the health care director in a state correctional system to explore all of these and related problems *before* a new small open institution lacking its own health care service is established, and to periodically re-examine health care policies at existing institutions of this type. Departmental policy should be set forth in clear language, and the director of the small open institution should be responsible for compliance with that policy.

CHAPTER 5. HEALTH CARE SERVICES IN LOCAL DETENTION FACILITIES (JAILS)*

The term "jail" covers a very broad spectrum of local and county institutions. Some are empty during much of the year and rarely hold more than a few inmates at any one time. Others are among the largest of all institutions, holding thousands of jailed persons on any given day—and admitting tens of thousands during the year. Some are located next door to hospitals offering a full range of health services, which may (or may not) be available to the jail inmates. Others are in remote communities, lacking adequate health care facilities even for the outside population.

Jailed persons, moreover, are an astonishingly variegated group. Most have been convicted of no crime but are being held, awaiting trial. A few are not even accused of a crime but are being held as material witnesses. Some may stay only a few hours or days until bail is posted, or they are released on their own recognizance. Others, however, stay a year or longer—either awaiting trials which are delayed, or awaiting the outcome of a prolonged series of appeals, or because they are serving consecutive one-year sentences for misdemeanors. For some, the jail is almost a permanent residence; their repeated periods of incarceration are punctuated by only brief "vacations" on the street between offenses. In many communities the jail also serves as the dumping ground for drunks and persons under the influence of drugs; these alcohol, barbiturate, and heroin admissions often constitute a large proportion of total jail admissions. A significant proportion of those admitted are mentally disordered—and mental disorder rather than criminal behavior may be the reason for the incarceration.

To expect the county sheriff or the jail warden personally to establish and maintain adequate health care services in these institutions, in addition to carrying out his countless other responsibilities, is in most cases wholly unrealistic. The warden or sheriff is not selected for his competence in the field of health care administration. In this chapter, accordingly, we shall first be concerned with ways of securing competent health care administration and services for the thousands of jails in the country, and then with the major problem which distinguishes local detention facilities from long-term institutions—the flooding of the jail health care system by vast numbers of very-short-stay admissions. We shall also call attention to potential usefulness of the jail as a crucial element in the overall case-finding activities of community health care services—and the resulting benefits to the health of the entire community.

5.1. Administrative Considerations

Wherever feasible, health care services in local and county correctional institutions should be made the responsibility of a competent civilian health care delivery organization rather than of the law-enforcement or correctional agency.

In some situations, the city or county health department, or a city or county hospital, may be the appropriate agency to administer health care services in the jail. Elsewhere, health care services may be "contracted out" to a community hospital or clinic, a prepaid group health plan, or a health maintenance organization (HMO); or a medical partnership may be employed to provide and administer services (much as some hospitals "contract out" their emergency room services to a medical partnership). Santa Clara County, California, is an excellent example of jail health care delivery provided by a county-operated community hospital. San Francisco is an example of health care delivery in the city-county jail, recently transfered under court order to the city-county health department.

There are, no doubt, a few warranted exceptions to this principle of "contracting out" jail health care services. In a few large cities and counties where the warden or sheriff has already established an adequate health care system, no purpose may be served by

*Model jail health programs are currently being developed under a grant to the American Medical Association by the Law Enforcement Assistance Administration.

transferring health care to an outside agency. The same may be true in cities or counties where no civilian organization exists which is capable of delivering adequate care. With these and perhaps a few other exceptions, however, health care in jails should be organized, administered, and delivered by an agency or organization whose primary mission is health.

5.2. Statewide Standards

Health care standards for jails in a state should be set by state law or regulation. California, Kentucky, and other states have taken or are currently taking steps in this direction.

Technical assistance in meeting these standards should be sought from local and county medical societies and other local health organizations; and in addition state departments of corrections should be given the responsibility, by law or regulation, of providing technical assistance in upgrading the health care services of local and county jails.

After a reasonable period for achieving compliance, the state departments of corrections and state health departments should monitor compliance with the health care standards, and jails unable to meet those standards should be superseded by regional jails with adequate health care facilities.

At least two states, Connecticut and Alaska, have gone much further and operate all of the jails in the state as part of the statewide correctional system.

5.3. Cooperative Health Care Plans

The independent local and county jail has deep roots in American constitutional law, history, and tradition. This does not mean, however, that the health care services in each jail must be operated as an isolated and independent enclave. Cooperation in health care delivery among jails, and between jails and state correctional institutions, is today the exception rather than the rule. Yet cooperation might do much to provide quality health care at moderate cost in both jails and state institutions.

One example is California, where state law mandates the treatment of jail inmates in the state correctional hospital under certain circumstances. Another example is Minnesota, where a recently opened secure unit in the St. Paul Ramsey County Hospital serves patients in need of hospitalization from the Ramsey County Jail as well as from state correctional institutions. In some states it may prove feasible to establish a statewide correctional health care system in which all of the state's inmates from the jails as well as the state institutions, are served by a limited number of geographically well distributed state correctional hospitals and secure units in civilian hospitals.

Traditionally, resistance to jail regionalization has come from county sheriffs who are made responsible by the state constitution for the administration of the county jails. This resistance is certainly understandable. In at least some states, however, as a result of litigation and other pressures, county sheriffs may already see health care delivery in their jails as a problem they would be delighted to delegate to a competent outside agency. As health care becomes even more complex, as the gap between health care in jails and health care outside continues to widen, and as pressures to close the gap continue to build up, more and more county sheriffs and local jail wardens are likely to see the "contracting out" of jail health care services as an opportunity rather than as a threat to their autonomy.

5.4. The Large Jail and Its Revolving-Door Problem

Even a jail which houses only a dozen inmates on any given day may admit and discharge hundreds during the course of a year. A jail with an average daily population of a thousand may admit and discharge fifty thousand per year. So long as this revolving-door policy continues, it will remain difficult to provide for all jailed persons the basic health services described throughout this manual. The shortest route to a significant upgrading of jail health services is to reduce the flow of unnecessarily incarcerated persons through the jails.

It is not just the "criminal element" whose health is threatened by current revolving-door policies; the jail without adequate health care constitutes a menace to the entire community—a health menace likely to remain so long as our jails continue to admit vast numbers of persons unnecessarily.

The principal approaches to reducing unnecessary jail admissions are (a) bail reform and (b) the diversion of alcoholics and drug users from the jail to treatment centers.

Bail reform. In New York City, the average cost per jail admission is $246; many persons are jailed at this cost for lack of $50 or $100 in bail. A nationwide jail study indicates that 40 percent of all

jail admissions are persons eligible for bail but unable to raise it.

Alcohol and drug diversion. Public drunkenness is the cause of another very large proportion of all jail admissions. This continues to be the case in some jurisdictions despite repeated court holdings that drunkenness constitutes a medical rather than a criminal justice problem.

Using the jail as a dumping ground for drunks is also a *dangerous* policy; for *delirium tremens* (a common complication of "cold turkey" alcohol withdrawal) is a life-threatening condition. Continuous nursing surveillance under medical supervision and well-controlled medication during withdrawal are necessities. The jail is inherently unsuitable as the scene for alcohol detoxification.

Barbiturate detoxification is closely parrallel to alcohol detoxification, and the same considerations apply.

Heroin detoxification is rarely as dangerous as alcohol and barbiturate detoxification, but it is also better and more economically managed in a treatment center rather than a jail.

Changes in policy affecting bail, drunks, and drug cases can readily cut jail admissions in half in almost any jurisdiction. Excessive jailing is damaging to those unnecessarily incarcerated, socially counterproductive, and grossly wasteful of community resources and tax funds—in addition to inundating the jail's health care service with burdens far beyond its capacity.

The sheriff or jail warden, of course, is not responsible for these self-defeating intake policies. Under the law, he must take custody of all persons brought in by duly constituted authorities. Yet jail crowding and substandard jail conditions are inevitably blamed on his department. In self-protection as well as in the interest of improved jail conditions, he should take the lead in urging that unnecessary jail admissions be reduced to minimum.

5.5. Admission Procedures in Jails

The admission procedures recommended in Chapter 1 — immediate screening by qualified health care personnel for trauma, infectious diseases, other mental and physical illnesses, and for alcohol or drug intoxification, plus the subsequent taking of a complete medical history, a physical examination including indicated laboratory tests, and a health evaluation—is even more important in a jail than in a long-term correctional institution; for those admitted to jails come straight in off the streets and are far more likely than those admitted to long-term institutions to suffer health or mental health problems requiring immediate identification and care. Providing these costly intake services to the vast numbers of persons admitted has benefits which extend far beyond the boundaries of the jail. A basic change in the *philosophy* governing the provision of these admission services is therefore recommended.

Each city, county, and state has a responsibility to foster the physical and mental health of its residents. This responsibility goes beyond assuring that medical care is available for those who seek it. *Case-finding programs* to identify and bring into treatment persons in need of care has for decades been a basic function of city, county, and state health services. These case-finding programs include the tracking down of contacts of persons with infectious diseases, the screening of large numbers of apparently healthy people for non-infectious diseases (hypertension, heart disease, cancer, etc.), a wide range of mental health outreach programs, and other examples. Voluntary health organization—the heart association, the lung association, the cancer society, and so on—also mount large-scale and valuable case-finding programs in many communities. The purpose is to protect the community as well as to serve the individuals screened. Experience has shown that a dollar spent in case-finding may save hundreds of dollars in subsequent community costs for the long-term care of chronic disease and disability.

The ideal focus for almost all such public health and voluntary case-finding programs is the population which circulates through the local jails. The incidence of unmet health needs is much higher in this population than in any other. No other high-risk population is as readily accessible in a single place at convenient times. The cost of case finding per case found will almost certainly prove to be much lower in jails than elsewhere as a result of these two combined factors.

Yet, curiously enough, instead of being recognized as the population warranting the highest priority, the jail population is often overlooked in these public and voluntary case-finding programs.

One example among many is the public health VD program. Numerous studies have shown that the asymptomatic female with gonorrhea is one of the major factors in the current nationwide gonorrhea

epidemic. Accordingly, a nationwide program for screening asymptomatic females for gonorrhea is fostered by the U.S. Center for Disease Control. The program is funded jointly by Federal, state, and local public health agencies. More than five million women without symptoms were screened last year. Among the groups screened in this program have been suburban housewives attending family planning clinics, college undergraduates, and the patients of private physicians. The cost of the screening program per case found in such groups is very high, since the ratio of positive to negative findings is quite low. The screening of women admitted to city and county jails would be far less costly per case found; and since many prostitutes and other women with multiple sex partners pass through the jails, the number of subsequent infections prevented per case found would no doubt be very high. Yet in very few jails is screening for asymptomatic gonorrhea made available to all females entering the jail system.

Closely related to screening for asymptomatic gonorrhea is Pap test screening for cancer of the cervix. The number of cases of this form of cancer and the age at which it occurs are related to intercourse at an early age, to experience with multiple sexual partners, and to other factors frequently found in jail populations. Women entering jails are a high-risk group for cancer of the cervix as well as for VD. Specimens for the Pap test can be secured at the same time as the gonorrhea culture specimen, with a trivial increase in the amount of time required. Yet only in a few jails, are routine Pap tests for cancer of the cervix made available to all women admitted to the jail system.

Tuberculosis case-finding constitutes an equally dramatic example of the importance of case-finding in the jail setting. When a single case is found, many subsequent tuberculosis infections in the outside community can be readily aborted or prevented. This is done in part by rendering the patient himself or herself non-infectious as early as possible, in part by educating him or her in sanitary measures for preventing further spread, and in part by providing prophylactic medication for close associates already exposed. At few other sites in the community can fresh TB infections be diagnosed at so low a cost per case found as in the jail.

5.6. Summary

Jail health services should (with some exceptions) be delivered and administered by a community organization whose primary mission is health care. Minimizing jail admissions through bail reform and through diversion of alcohol and drug cases is an essential preliminary step toward adequate jail health care and community health protection. The jail should be viewed as a central resource in case-finding activities. In other respects, jail health care should closely parallel the patterns of health care delivery described in other portions of this study.

PART II

ORGANIZING A CORRECTIONAL HEALTH CARE SYSTEM

CHAPTER 6. THE NEED FOR STATEWIDE ORGANIZATION

6.1. Role of the Health Care Administrator

In our visits to health care units in correctional institutions, we noted many specific shortcomings: an institution with X-ray and physical therapy equipment but with no personnel capable of using them, an institution with trained personnel but inadequate equipment, and so on through a very long list. Many correctional health services (not all) were inadequately funded. Particularly distressing was the almost total lack, in many states, of administrative machinery to correct basic shortcomings.

To illustrate, let us review what happens when the physician in charge of health care in an institution of modest size prepares his health care budget for the coming year. In many cases, he must file his budget request with an assistant warden of the institution in which he works. There it is merged with requests from other units in the institution and is passed on to the warden. From the warden the request typically travels to an assistant commissioner of corrections at the state capital, where it is merged with budget requests from the state's other correctional institutions, then to the commissioner, and ultimately it becomes a part of the department's request to the Governor's budgeting agency. If it passes that hurdle and is accepted by the Governor, it is included in the budget he submits to the state legislature, where it runs the gamut of committee hearings, legislative debate, and ultimately enactment into law.

Once the budget request leaves the physician's hands, it is processed throughout all the subsequent stages by laymen unskilled in evaluating medical budgets. Wholly unwarranted expenditures may as a result be approved at each stage. Much more commonly, the budget request may be cut back at stage after stage — not because anyone really wants to curtail needed health care, but because the request has lost its medical identity before it leaves the local institution.

There are in many states at least a few legislators genuinely concerned with correctional health problems; and from time to time entire legislatures are aroused by press accounts of woefully inadequate health care. But when legislatures review the state correctional budget, they find no place to intervene in favor of better health care because there is no item in the budget labeled health care. In the extreme case (Wisconsin until a few years ago), the budget submitted to the legislature concealed medical equipment requests under the rubric "maintenance and repairs." In most states, health care requests are buried without trace in the overall budget requests of each correctional institution.

Even the state commissioner or director of corrections can accomplish little when he is separated by so many non-medical bureaucratic layers — an assistant commissioner, a warden or institutional director, an assistant warden, and perhaps others — from the personnel actually delivering health care in the institutions supposedly under his control. Any order he issues or request he makes must filter down through those non-medical layers to the health services of each separate institution.

While health care personnel at the institutional level are impotent, and know they are impotent, with respect to planning and carrying out improvements under this organizational pattern, they are free to let things slide with little or no fear of supervisory intervention. Consider, for example, the physician in a correctional institution who finds he hasn't time to examine newly entering inmates and therefore stops making physical examinations. It is unlikely that the assistant warden of the institution who supervises medical care (among many other responsibilities) will even notice a deterioration in quality of care unless a law suit or a riot follows. Neither will the warden, the assistant commissioner or the commissioner—and certainly not the Governor, his budget agency, legislative committees, or the legislature. Health care personnel in such an organizational structure are at the same time impotent to foster improvement and free to tolerate deterioration. This is a recipe for chaos. A change in this organizational structure is the most important initial step which any state can take toward improving correctional health care — more important even than increasing appropriations.

Some states in the past few years have taken a first gingerly step toward improving health care administration within their departments of correction. This first step is usually the appointment of a *health care coordinator*, a member of the state correctional staff whose task it is to maintain liaison with health care personnel in the various institutions and to advise or recommend improvements. Typically, the coordinator has no direct administrative authority and is two or three steps removed from the center of authority, the commissioner. He can *negotiate* change, but he cannot give orders or demand compliance.

This approach is not enough. Health care is a crucial and central responsibility of the state department of corrections. The department's organizational chart must reflect that central position. The health care administrator should (as in New York State) be an assistant commissioner or have comparable status in the department. He should be responsible directly to the commissioner of corrections, invested with the same administrative powers, and receive the same pay as the assistant commissioners in charge of other essential correctional functions.

Each correctional institution should similarly have an administrator responsible for health care activities in that institution. He should have direct access to the warden or director. In all professional matters, however, he should report directly to the statewide health care administrator.

With this chain of command, health care improvements can be encouraged and deterioration of care prevented at every administrative level. The health care administrator in the institution (to return to our opening example) presents his next year's budget request to the statewide correctional health care administrator. It is there merged with *health care* requests from the other correctional institutions and goes to the commissioner. The commissioner's budget request to the Governor then carries *a specific item or items for health care services*. The Governor's budgetary agency, the Governor, the state legislative committees, and the legislators can thus give correctional health care the attention it deserves. If the health care budget is cut at any level, the cut is fully visible — not disguised as a cut in "repairs and maintenance" or in some other nonmedical function. Budget reviewers and legislators concerned with correctional health care can see precisely where to intervene.

This chain of command is essential for orders filtering down as well as for requests handed up. At the recommendation of the statewide health care administrator, for example, the commissioner may order a complete physical examination for each inmate entering the correctional system. That order then goes, through *medical* channels, to the administrator in charge of health care at each of the state's correctional institutions. By means of periodic medical audits, the statewide health care administrator can (and should) determine the level of compliance at each institution; and take whatever measures are necessary to improve compliance in laggard institutions.

In some states the statewide administration of correctional health care is lodged in a physician; his title is usually medical director rather than administrator. This pattern goes back to the days when hospitals and mental hospitals also had physicians in charge, and when it was commonly believed that only someone with an M.D. after his name could administer a health care institution. As physicians became busier and as health care administration became more complex, however, lay administrators have gradually taken over administrative responsibilities from physicians. A new profession of health care administrator has arisen, and has proved its usefulness. Sometimes, too, authority is lodged in a team — a physician in charge of professional matters plus an administrator for other affairs. We recommend that state departments of correction take one of these routes and lodge overall responsibility for health care in the hands of a professional administrator or of a physician-administrator team.

Where a physician is qualified to fill the post of statewide correctional health care administrator by reason of his administrative experience and skills, we see no reason why he should not be appointed or retained as sole administrator. Indeed, his M.D. is an added qualification, and he can speak with dual authority. But it should be clear that he is being appointed to *administer*, not to practice medicine. In too many cases, the physician appointed to administer an understaffed state correctional health system has his time preempted by medical rather than administrative functions — filling in for missing physicians in the state's institutions or even (in several states) being expected to administer the statewide system during whatever time he can spare from treating patients in one of the institutions where he functions as a physician. Administering a statewide correctional health care system is (ex-

cept perhaps in a few very small states) a full-time job requiring a full-time administrator.*

Each correctional institution within the state may not require a *full-time administrator.* In a small institution — one employing only one physican and a few other health care personnel, for example—the physician, a nurse, or some other qualified health care professional may function simultaneously as administrator. As soon as health care in an institution expands enough to warrant a full-time administrator, however, there should be a *lay* administrator or a team composed of a physician and lay administrator. Physician hours are too scarce in most correctional institutions to devote them to administrative paperwork.

6.2. Duties of the Statewide Administrator

Every competent administrator is, in effect, a sort of one-man "committee to take care of things that come up." The buck stops on his desk, and he must, therefore, perform many miscellaneous functions. In addition, a statewide correctional health care administrator should have at least ten clearly delineated fields of responsibility:

(1) The development of programs for recruiting, training, and retaining of personnel.
(2) Securing the other necessary facilities — space, equipment, supplies, etc.
(3) Preparing and defending the annual health care budget.
(4) Monitoring the quality of care.
(5) Controlling the cost of care.
(6) Handling complaints and litigation.
(7) Maintaining liaison with outside agencies, professional societies, and the public.
(8) Preparing and revising a Health Care Manual for the state's correctional institutions.
(9) Planning ahead, and establishing a statistical and reporting system which will supply an adequate data base for sound planing.
(10) Concern with health care in local and county correctional institutions (jails).

*This does not mean, of course, that a physician in charge of administering a statewide system must cease functioning as a physican or lose contact with inmate patients. To the extent that he has time available, he may see patients on his tours of local institutions, in concert with the institution's medical staff.

Personnel recruitment, facilities, and budgeting are treated below in Chapters 7, 8, and 9. We shall here review the remaining seven fields of responsibility.

6.3. Monitoring the Quality of Care

In recent years the American health care delivery system has been going through a quiet (and at times not-so-quiet) revolution. Many procedures have been introduced to monitor the quality of the care patients are receiving.

The first of these procedures was called into being a generation ago, when it was suspected that much unnecessary surgery was being performed in some hospitals. Each hospital was accordingly urged to establish a "tissue committee," headed by a pathologist, to which all tissue removed during an operation was sent for examination. Even the most skilled and honest surgeon, of course, may sometimes make a mistake; but if a surgeon made too many — operated too often in cases where the tissues removed showed no need for the operation — he was called to account by the tissue committee. "Medical audit" committees were similarly set up by some hospitals to monitor the quality of medical care. The Joint Commission on Accreditaton of Hospitals (JCAH) was established: to set standards of accreditation, to inspect hospitals seeking accreditation, and to reinspect periodically. More recently, hospital "utilization committees" have been set up to curb unnecessary hospital admissions and unnecessarily prolonged stays. Blue Cross, Blue Shield, Medicare, Medicaid, and commercial insurance companies have also set up review machinery of various kinds, addressed both to quality and costs of care. Currently, a controversial Federal network of "Professional Standards Review Organizations" (PSRO's) is being established to monitor medical care. *None of these audit, review, and accreditation programs has to date included correctional health care services within its purview,* except perhaps incidentally (as when a correctional hospital applies for JCAH accreditation.) We see the establishment of an effective audit-and-review machinery as a basic function of the statewide correctional health care administrator.

The place to begin monitoring is with the quality of medical records maintained in each correctional institution (see page 13). Until each inmate's medical record truly reflects the care he has in fact received, there is no effective way to review the quality of that care. Once the medical record system is

functioning properly, a large part of the audit-and-review process can be performed through a review of medical records in each institution.

The administrator or a reveiw committee under his authority, for example, can periodically collect from all of the state's correctional institutions the medical records of patients with a particular diagnosis — diabetes, or gonorrhea, or knife wounds. Any institution which is providing less than optimum care, as measured either by the care in the better institutions or by the care rendered outside the correctional system, can thus be identified and improvements instituted. The records of patients sent to an outside hospital or clinic can also be reviewed, from the point of view of both the quality and cost of the care rendered.

Similarly, the statewide administrator should establish within each institution of moderate or large size internal machinery for improving and monitoring the quality of care. The physicians should hold periodic meetings, and there should be regularly scheduled meetings of the entire health staff at which medical records can be reviewed (with the names of doctor and patient deleted), shortcomings in treatment noted, and plans for improvement developed. Each of the institution's health services — the admission screening, the physical examinations, the laboratory, the pharmacy, and so on — can be reviewed in sequence at these meetings, as in the staff meetings of a well-organized hospital or clinic. Correctional staff should participate whenever problems of mutual concern are under discussion. Large institutions should have a Health Care Advisory Committee where the health care staff can meet periodically with health authorities from the community, whose advice can be valuable and whose help can be invaluable.

Whenever possible, a statewide administrator should in addition seek to have the services under his control audited and reviewed by the *same* machinery which audits and reviews services outside the institutions. Clinical laboratory services are a case in point. There exist, both statewide and nationwide, facilities for checking on the quality of the test procedures performed in clinical laboratories.

The tests performed by clinical laboratories in correctional institutions should be monitored and evaluated by these existing outside services. Each institution's pharmacy should be checked by the state pharmacy board. A competent statewide administrator will be alert for other ways in which he can make use of existing outside audit and review machinery to maintain quality standards within his institutions.

As the statewide administrator learns, through effective audit and review processes, what manner of care is actually being delivered in the institutions under his direction, he can more effectively face the most important of all decisions: which health care services should be performed within the system and which should be "contracted out"? (See Chapter 10).

State correctional health care systems, as noted above, are under increasing pressure from the courts to raise the quality of health care to the level available on the outside. Much of the current response to this pressure is delayed and fragmented. A state system may wait until a complaint is filed, or even until a court order is handed down, before instituting change — and the change may then be limited to the practice complained of. A continuous monitoring of the quality of care should be able to eliminate all but the most frivolous complaints *before* they arise.

6.4. Controlling the Cost of Care

One way to improve the quality of care is to secure larger appropriations. Another way is to minimize waste and thus make funds available for needed improvements out of existing appropriations.

In our field visits, we (and other observers as well) have noted many kinds of waste. There was the overstaffed and over-equipped health care unit in one correctional institution just 15 miles from another which was woefully understaffed and underequipped—and with no statewide machinery for redistributing resources. There were even two institutions a few hundred yards apart with a shocking disparity in services. There was the institution with one part-time physician which was spending $150,000 a year escorting inmates to and from a hospital for costly diagnostic and treatment services, an estimated 90% of which might better have been performed by a second part-time physician in the institution. There was the statewide system buying services at retail from the most expensive hospital in the state, with no control over utilization — so that more than half of the state's correctional health care budget went to one outside hospital while other urgent health needs went unmet throughout the system. No doubt the amount of such wastes varies from state to state; but a competent administrator

can no doubt find ways to eliminate excess costs in *any* system which has previously lacked an effective central administration.

Two common forms of waste—perhaps the most common—deserve particular emphasis:

- Performing within an institution health care services which can be more economically secured on the outside without sacrifice of quality, or even improvement in quality; and
- Sending inmates out for services which can be more economically, more promptly, and as effectively performed within the institution.

Patterns of medical care change rapidly; costs change rapidly (mostly in the upward direction). Thus, deciding what should be done inside and what should be contracted out is not a one-time decision, but an area of decision requiring continuous review.

6.5. Handling Complaints and Litigation

As the volume of inmate litigation alleging improper or inadequate medical care has grown, more and more states have begun to improve their machinery for handling complaints *before* they reach the courts. That machinery is a responsibility of the health care administrator. He, or a member of his staff, should be continuously available to review complaints.

A few correctional institutions have established policy committees composed jointly of inmate representatives and health care staff members. These committees meet periodically to review procedures and make recommendations. A well-functioning joint committee may favorably affect both the level of inmate satisfaction with the health care delivery system and the quality of the care being delivered.

Special complaint procedures established in two states impressed us favorably:

- In Minnesota, an "Ombudsman for Corrections" has been appointed by the Governor, with a staff and budget independent of the Department of Corrections, to handle medical as well as non-medical inmate complaints. The Ombudsman's staff has direct access to inmates within the state's correctional institutions, and the inmates have direct and immediate telephone access to the Ombudsman and his staff. The Ombudsman acts as representative of the inmate in pressing the complaint; he has no power to issue orders, but he does have one major power. He can simply wash his hands of the matter —in which case the Department of Corrections faces a court action brought by the inmate's attorney. Thus, the Department of Corrections is faced with a clear choice in each case: to settle through the Ombudsman or to face litigation. Correctional officials, health care staff, the Ombudsman and lawyers concerned with inmate rights all reported that the Minnesota system was working well

- Somewhat similar is the Wisconsin plan, under which an assistant state's attorney is assigned to review inmate complaints. He faces the same choice as the Minnesota Department of Corrections: either to settle the case informally or to prepare to defend it in the courts.

- We do not recommend any single system of handling complaints concerning improper or inadequate health care. We call attention, however, to another study in this LEAA "Prescriptive Package" series which reviews 16 types of grievance mechanisms established in correctional institutions, and discusses their implementation. Entitled "Toward a Greater Measure of Justice," it is available from the National Criminal Justice Reference Service, Washington, D.C. 20531.

6.6. Maintaining Liaison With Outside Agencies and With the Public

Generations ago, as noted above, the jailhouse, like the poorhouse, was a part of the community. Times have changed. Some correctional institutions today are almost wholly cut off from the communities around them; they are enclaves forgotten by the public — until trouble breaks out. The correctional health care system in particular can benefit enormously from re-establishing its ties with outside agencies.

One place for a statewide correctional health care administrator to begin is with the state medical society. If the state society displays no interest, he can approach its committees. If that fails, liaison with one or more county medical societies should be explored, and with individual physicians outside the correctional system. The goal should be to impress physicians outside the system with the responsibilities and the opportunities available within the system. In one state, the state medical society displayed little interest until the state bar association took an interest in correctional health care problems; a joint correctional health care committee of the bar association and medical society is now functioning effectively.

The Minnesota Department of Corrections has a Health Care Advisory Committee concerned primarily with planning ahead. Members of the committee include key legislators, department of corrections representatives and representatives of the state health department, an engineering school professor concerned with environmental health and physicians and health care planners from outside agencies. Subcommittees have been established to plan ahead for improved health care—both institution by institution and problem by problem. The presence of concerned legislators on this committee is of particular importance in converting plans into action programs.

Contact with the mass media is a further example of the correctional health care administrator's many liaison duties. In most states, the correctional health care system makes news only when litigation arises or when a scandal erupts; steps taken to improve health go unnoticed. Among the many disadvantages of this situation is the increased difficulty in recruiting competent health care personnel, for no one wants to work in a health care system with an unsavory public reputation. A competent statewide health care administrator can do much to balance the unfavorable publicity a correctional system inevitably receives with information about the system's merits and achievements. Equally important, the administrator can respond to unfavorable publicity by announcing frankly and precisely just what is needed to improve health care services — thus building support for an adequate correctional health care budget.

6.7. Planning Ahead

In our visits to correctional institutions, we were repeatedly impressed by the need to plan much further ahead for health care needs than is now the common practice. We visited a bright new correctional institution, for example, with many hundreds of inmates and with a spacious 14-bed infirmary, but with no staff for the infirmary. Because governmental budget procedures are slow and complicated, two years would elapse after the institution was opened before funds became available for staffing. Worse yet, the infirmary had been planned and constructed without consultation with the health care officials who would be responsible for its operation; it therefore had numerous costly defects. A statewide health care administrator should have been involved in the planning of that new institution at least three or four years in advance, to make sure that the physical plant would match the needs and available resources of the institution.

Up to this point, the functions of a lone statewide health care administrator have been discussed. It should by now be clear, however, that the administrator must have an adequate staff. For, except in very small states, performing these manifold duties and the equally arduous duties to be described in Chapters 7, 8, and 9, exceed the capacity of any one man. A staff assistant for personnel (see Chapter 7), one for budget (see Chapter 8), and one for quality control and future planning may be adequate for a department of moderate size. Alloting 8 or 10 percent of the state's total correctional health care budget to administrative costs seems a reasonable yardstick. Another yardstick is to allot to health care administration the same proportion as is alloted for the administration of other functions.

6.8. Concern With Local and County Detention Facilities

As noted above in Chapter 5, a state's jails as well as prisons should be subject to statewide health care standards, should be inspected periodically to ensure compliance with those standards, and should receive technical assistance from state correctional health care personnel.

Cooperation between the state correctional health system and the jail health systems should be encouraged in all ways possible. Many or most of these jail-related functions can be carried out by an adequately staffed Office of the Health Care Administrator in the state department of corrections — preferably by an assistant administrator specifically concerned with jail problems.

6.9. Control of Medical Experimentation

According to an American Correctional Association survey made in the spring of 1974, medical or pharmaceutical experimentation with inmates as subjects was under way in 18 out of 38 states (with the other states not reporting). The establishment of policies concerning such experimentation and the enforcement of the policies established should be a responsibility of the Office of the Statewide Correctional Health Administrator; individual correctional institutions should not be free to set their own policies.

For states which permit experimentation, two basic sets of guidelines are called to the particular attention of administrators:

Protection of Human Subjects: Policies and Procedures. Regulations promulgated by the National Institutes of Health, U.S. Department of Health, Education, and Welfare (*Federal Register,* Vol. 38, No. 221, pp. 31738-31749, November 16, 1973).

Protocol for Medical Experimentation and Pharmaceutical Testing. 3 pages, mimeographed, plus Appendix. Available free from the American Correctional Association, 4321 Hartwick Road, College Park, Md. 20740.

CHAPTER 7. RECRUITING, TRAINING, AND RETAINING CORRECTIONAL HEALTH CARE PERSONNEL

7.1. The Challenge of Correctional Health Care

Very few physicians, nurses, or other professionals and paraprofessionals are looking for jobs in a prison or jail. Experience in New York, Chicago, and San Francisco, in the Federal correctional system, and no doubt elsewhere has repeatedly shown, however, that personnel of very high calibre can be quite readily recruited to help launch a humane and innovative program for bringing competent health care to a medically underprivileged group—the inmates of correctional institutions.

Sometimes a "bold new program to clean up the correctional health care system" arises in the wake of a major scandal or of a court decree in a class action suit. Sometimes it follows the transfer of power to a different political party, or the election of a new governor (or, in the case of a jail, a new sheriff), or the appointment of a new commissioner of corrections. There is no good reason, however why a bold new program capable of bolstering the morale of existing personnel and attracting new applicants cannot be launched without waiting for a triggering event — either by a newly appointed statewide health care administrator or by an administrator already in office By first developing and then announcing a bold new plan, an administrator may be pleased to discover that the battle for implementing it is already half won, and that his personnel recruitment problems in particular have been eased.

7.2. Adequate Pay

An, at least equally, essential factor in making a correctional health post attractive to physicians, nurses, and other health care personnel is an adequate pay scale. This scale is usually set by the state civil service agency, based on its understanding of the duties and responsibilities involved. In a state lacking a statewide health care administrator to negotiate adequate civil service levels, pay scales may lag so far behind as to attract only unlicensed personnel or personnel not employable outside the system for other reasons. A major function of the administrator, accordingly, is to draft job descriptions for personnel throughout the correctional health care system which truly reflect the very broad range of responsibilities in that system. (For a model job description, see page 18). If an administrator finds the established pay levels insufficient to attract qualified personnel in competition with other agencies, he must fight for competitive levels.

In California, and perhaps some other states, this has led to a recognition on the part of the state civil service agency that paying a physician, nurse, or other correctional health employee the same amounts paid by other state institutions is not enough. The peculiar responsibilities of service in a correctional institution are recognized by offering a differential pay incentive, over and above what the same post would pay in other branches of the state service. The differential can be pegged at a level sufficiently high to ensure the recruitment of qualified professionals and paraprofessionals.

Objections have been raised to this concept of a correctional pay differential. In some states, it is noted, the mental hospitals have already secured differentials which place them ahead of the correctional institution. The whole nursing profession is replete with pay differentials for operating-room nurses, obstetrical nurses, psychiatric nurses, pediatric nurses, intensive care nurses, and so on. In such a competition, it is argued, correctional institutions are more likely in the long run to lag behind rather than forge ahead. In place of inherent differentials, it is said, the correctional system should campaign for differentials based on merit. In view of these objections, a correctional pay differential is not here recommended—but it is called to the attention of administrators as one possibility, especially in states where other state agencies have already won differentials.

7.3. Working Conditions

Working in a correctional institution has certain unavoidable disadvantages; working in a poorly lit,

poorly ventilated, poorly equipped, run-down institution without privacy and without simple amenities constitutes an unnecessary additional handicap. In one state not long ago, negotiations between the state department of corrections and a new state medical school for the staffing of the institutions by the medical school raised high hopes on both sides until medical school representatives visited the institutions—whereupon negotiations collapsed. "Our people just won't work under such conditions," a medical school official explained.

7.4. Academic Faculty Appointments

These are invaluable aids in recruiting and holding not only exceptionally well qualified physicians but also nurses and other professionals and paraprofessionals. Other significant advantages of affiliating a correctional health care service with a teaching institution will be discussed below.

7.5. Opportunities for Continuing Education

These opportunities constitute yet another incentive in attracting health care personnel. The health care system as well as the individual employee benefits. Time off and travel allowance to attend professional meetings, opportunities to enroll in advanced training courses, with tuition paid in appropriate cases, and in-service training programs all play their role in raising the quality of a health care staff—and in attracting qualified personnel.

Both academic faculty appointments and opportunities for continuing education help solve another problem in correctional health care: the tendency of full-time staff members to "burn out," losing their interest in the job and their ability to empathize with their inmate patients. Both measures give the staff member a sense that he or she remains in the mainstream of medicine.

7.6. Opportunities for Advancement

No one wants to stay long in a dead-end job. Far too many correctional health employees are currently in such jobs. The opportunity for a clerical employee to become a medical records technician, for a nurse to become a nurse-supervisor or a nurse-practitioner, for a physician to become a medical director — as many such opportunities as possible should be built into the organizational structure of a correctional health care system, as they are into other well-administered health care services. Far more can be accomplished along these lines when the entire state correctional health service is organized as a functioning system than when each warden is responsible for personnel in his own institution.

Local conditions may suggest other recruitment inducements. One jail system, for example, advertised repeatedly for physicians with little success. Then it added a special inducement based on what was happening among recent medical school graduates in the area: "Ideal for physicians between training programs or not yet ready to finalize a long-term career objective." The responses were excellent in both quality and quantity.

7.7 Liability Protection

A major problem facing health professionals is the cost of professional liability coverage (malpractice insurance). Some physicians will not work in a correctional setting, and some have withdrawn from correctional posts, because they simply cannot afford insurance protection (which may cost many thousands of dollars a year). Administrators, too, face this problem with respect to administrative liability coverage.

A very simple solution to this problem is in use in the Federal and California correctional systems, in the Los Angeles County system, and perhaps elsewhere. The Federal government, most states, and many cities and counties already have "tort acts" under which (a) suits against officials and employees for actions taken in the course of their employment are defended by government attorneys, and (b) any awards in such cases are paid by the government. This means that physicians and other correctional health personnel need not carry individual liability (malpractice) insurance. If a correctional system's physicians and other health care personnel are not already covered by the appropriate state or local tort act, immediate steps should be taken to arrange for their inclusion. Consultants to the correctional health care system should also be covered. Tort act coverage converts what was a recruiting handicap suffered by correctional institutions into a recruiting advantage.

There have been reports that tort act coverage does not work well in some states because the state's attorney general or department of justice does not provide correctional personnel with full legal defense services, as a result of which they feel it necessary to employ private counsel despite tort act coverage. The attorney general's office, it is also

sometimes said, is more interested in protecting the state treasury than the correctional employee; hence a conflict of interest may arise. In states where tort act coverage works well, the employee's defense is in the hands of a particular attorney or unit which is specially charged with employee protection — as distinct from the lawyer or unit defending the state's interests.

7.8. Publicizing the Package

Once the state administrator has an acceptable package of advantages to offer —participation in a challenging and innovative effort to improve health care, competitive pay scales, decent working conditions, good housing, opportunities for education and advancement, malpractice protection, and so on — the task still remains to make this package known to potential employees at medical society and nursing association meetings, at educational institutions, among health care personnel retiring from the Armed Forces, and in other ways. Aggressive recruitment efforts should be the rule rather than the exception.

7.9. Physician's Assistants and Nurse Practitioners

A correctional system which, despite measures like those described above, is still unable to fill all of its M.D. vacancies should ask whether it needs to fill them all. As pointed out in Section 2.2, some of the work still being performed by physicians in some correctional health systems can be equally well performed by various physician-substitutes or physician-extenders — physician's assistants, nurse-practitioners, medical technical assistants (MTA's), etc.

Unfortunately, however, trained personnel at this level are as scarce in most parts of the country as physicians. Thus, they should not be viewed as a panacea for the short-term needs of an understaffed health care system. Rather, they should be added to staff as they become available, and plans for effective utilization of their skills should be laid well in advance.

7.10. Part-Time Physicians and Nurses

A common phenomenon in correctional health care is the physician or nurse who comes aboard with energy and enthusiasm, and performs his or her duties with dedication — then, after a longer or shorter period, slacks off, becomes unsympathetic and slovenly, fails to keep up with the changes in medical practice — or else quits altogether.

To minimize or at least delay this slacking off, the employment of two or more part-time physicians instead of one full-time physician should be considered. Their combined skills may contribute more to inmate health care than the skills of either alone. A physician is kept on his toes when he practices in a setting with a peer whose respect he values. Two part-time physicians are also an advantage when one physician falls ill, goes on vacation, or quits.

A hazard to be guarded against, however, is the employment of a half-time physician who gradually cuts his daily working hours from four to three, then to two, and eventually drops in for a few minutes from time to time. This is particularly likely to occur where physician pay scales are so low that no qualified replacement can be found willing to devote a true half of his time for the amount available.

Applicants for a part-time post are often "moonlighters" who have full-time responsibilities elsewhere. Limited use of moonlighters may be warranted — provided the total workload is not excessive. As a safeguard, all of a moonlighter's employers should know, evaluate, and approve his total time commitments.

Whether part-time nurses can be effectively used in a correctional health care setting, we cannot say. To minimize nurse "burn-outs" and to build nursing skills, however, the rotation of nurses through outside health facilities is worth considering. For example, arrangements may be made for each nurse in a correctional institution to exchange jobs with a nurse in a nearby hospital or clinic for a one-week or two-week period once or twice a year. Both nurses and both institutions may benefit from such an exchange schedule.

7.11. Employment of Women in Male Correctional Institutions

In our field visits to correctional health care facilities, we found many with all-male staffs. We found many others — including maximum-security adult male institutions — where women were employed as physicians, nurse-practitioners, nurses, technical assistants, laboratory technicians, secretarial and clerical employees, and in other roles. In general, the institutions with all-male staffs explained that it is impossible to recruit women for

work in male correctional institutions, and impossible also to assure their security. The institutions which did employ women, in contrast, reported very few recruitment, security, or other problems; a proposal to return to an all-male staff would arouse strenuous opposition in these institutions.

Equality of employment opportunity is today national policy and the policy of most states; we see no reason why correctional institutions should be an exception. In an era when securing competent health care personnel is exceedingly difficult, no correctional institution should deliberately hamper its own recruitment efforts by rejecting on priniciple one-half of the human species. Women bring to a correctional health service a humanizing influence which it urgently needs. If a correctional health care facility is in fact unsafe for female personnel, it is probably unsafe for male personnel as well, and steps should be promptly taken to make it safe for personnel of both sexes.

7.12. Relations With Medical and Nursing Schools

By establishing training relationships with medical and nursing schools, some correctional institutions have been able to secure accreditation as places where residents, nurses-in-training, and other health care personnel can work and study as a part of their professional preparation. To achieve this type of accreditation, the correctional institution staff must include personnel qualified for faculty appointments in the medical or nursing school. Relationships of the same kind with schools of pharmacy, technical institutes, community colleges, and other educational institutions where allied health care personnel are trained can also be established. The correctional institution benefits both from the training opportunities which such a program brings to its own staff members and from the services which the trainees render.

A third benefit may be the ability to secure high-quality personnel who are uninterested in an ordinary correctional health post but may be attracted to one which includes a faculty appointment and an opportunity to teach health care skills. The health care administrator in a state department of correction should be continuously alert for opportunities to introduce additional training programs of various kinds into his system.

We call particular attention to the suitability of correctional institutions for the training of physician's assistants, nurse-practitioners, and other health care providers. Many medical schools are currently launching or expanding training programs for such roles, and might welcome the inclusion of correctional institutions as training sites.

7.13. Secretarial and Clerical Assistance

As noted briefly above, it is a waste of both money and scarce human resources to leave administrators, physicians, and other health care personnel without adequate secretarial and clerical services. In one state we found a psychiatrist, employed as medical director for an entire statewide correctional health care system, including jails as well as long-term facilities, who was functioning without even a part-time secretary or clerk-typist. In many places we observed physicians laboriously writing out by hand their orders and medical-record notations, wasting time that should have been spent functioning as physicians. Registered nurses, too, were observed spending far too much of their time on essentially clerical duties. An adequate supply of secretaries, typists, medical records technicians, and clerks can significantly increase the productivity of administrators, physicians, nurses, and other costly and scarce personnel and can thus relieve the pressure for more administrators, more physicians, more nurses.

7.14. Use of Inmates in Health Care Services

Understaffed correctional institutions are inevitably tempted to use inmates to perform services for which no civilian personnel are available. "Inmate nurses" are a common example; they are not in fact nurses at all, and many have no nursing training whatever. Yet they may be found not only nursing the sick but also diagnosing illnesses, dispensing medicines, giving injections, suturing wounds, and otherwise practicing medicine in some institutions today. Untrained and inexperienced inmates may similarly be found operating X-ray equipment, performing laboratory tests, giving physical therapy treatments, and performing other duties for which they are wholly unqualified.

This use of untrained inmate personnel can no longer be tolerated. It violates state laws, invites litigation, and brings discredit to the entire correctional health care field. Two principles in particular seem to us unchallengeable:

- No inmate personnel should under any circumstances be used to handle medical records

or drugs, and none should have *access* to medical records or drugs; nor should inmate clerks control the scheduling of health care appointments or access of other inmates to health care services.

- The use of unqualified inmate personnel to perform health care services of any kind should be forthwith discontinued, and civilian personnel should be secured to take their places.

This leaves unanswered a highly controversial question: *Should qualified inmates be employed in a health care service in any capacity?*

Many competent authorities insist that inmates should be excluded altogether from correctional health facilities except in the role of patients. Others make an exception for routine maintenance chores such as floor-swabbing after hours. These authorities argue that the risks of employing inmate personnel far outweigh the benefits. Even an inmate who is personally well-qualified and trustworthy, they point out, may be subject to such pressures from *other* inmates that he is forced to violate his trust, perhaps in serious ways. From this point of view, it is unfair to an inmate himself as well as hazardous to staff and other inmates to place him in a position where the temptation is so great and the pressure perhaps irresistible.

At least two considerations point in the opposite direction. One arises out of the fact that correctional health care facilities are chronically understaffed and underbudgeted. The money saved through the use of inmate employees can be used to meet other urgent health care needs. No matter how good a health care system is, the proponents of inmate employment point out, its services can be further improved and expanded through judicious use of carefully selected and adequately trained inmate assistants functioning under close supervision.

The other and more basic argument arises out of the belief that a correctional institution should be a place where inmates can receive vocational training. Learning a skill can lead to desirable employment following release and thus lessen the likelihood of recidivism. As concrete examples of what they advocate, proponents point to the significant number of inmates trained as dental laboratory technicians who following release secure highly skilled jobs at good pay — rarely recidivate. Employment and training of selected inmates for health care services, these observers add, is especially necessary and feasible under current conditions when correctional institutions hold a variety of young people who are in no sense "hardened criminals". One San Francisco report which takes this position goes so far as to recommend that inmates fully trained in paraprofessional health roles while serving time be given *priority* in employment within the correctional system following their release.

The depth of disagreement over inmate employment in health care roles is witnessed by the fact that it is the only major issue of principle on which the authors of this "Prescriptive Package" are themselves in disagreement. A statewide health care administrator is likely to face few decisions as thorny as this one concerning inmate employment.

CHAPTER 8. ASSEMBLING THE OTHER RESOURCES

8.1. Space

Among the most distressing situations we oberved on our site visits were institutions in which personnel were working in quarters so crowded that sound health care was impossible. Physicians and nurses were performing their duties with inmates, sick and well, crowding around them and looking over their shoulders. Inmates were forced to discuss their most intimate problems with other inmates listening in. Corridors were jammed during sick call for lack of a waiting room. Both drugs and medical records require secure handling, which is impossible without secure and separate areas for their storage.

Physicians, nurses, and other health care personnel are demoralized by such conditions. Securing adequate space—properly heated, ventilated or cooled, lighted, and partitioned for privacy in each of the states' institutions should be high on the priority list of the state administrator.

One county jail health service we visited had recently expanded into a bright new addition to the jail.

"How did you get the money?" we asked the physician.

"I brought the county commissioners out to see for themselves", he replied.

State legislators, too, can be invited to see for themselves why adequate amounts of suitable space are needed for health care services.

8.2. Equipment and Supplies

Expenditures for equipment and supplies take only a small proportion of the total budget in a correctional health care system. Yet the failure to spend that small portion effectively — to have equipment and supplies available when and where they are needed — can seriously deteriorate the quality of care.

In some institutions the need may not be for more money, but for better judgment and better scheduling of present expenditures. It is not unusual in a correctional health service to see some kinds of supplies piled up far beyond current need while others are out of stock. Methods of requisitioning, of inventory control, and of meeting without delay emergency needs for items unexpectedly in short supply should be a continuing concern of one individual in the Office of the Statewide Health Care Administrator.

The procurement and control of prescription drugs is separately treated in Chapter 2.

8.3. Library

Some institutions lack a medical library — even the standard reference works which are basic tools of the medical and nursing professions. Also often absent are subscriptions to medical periodicals needed to keep the staff up to date. Providing a satisfactory library is essential both for improving medical care and for improving staff morale.

One state, Minnesota, has a correctional health care newsletter which is of considerable value in bringing news of current developments to interested persons in and out of the system. This *Minnesota Prison Health Newsletter* is published, interestingly enough, by a state legislator — the chairman of a legislative subcommittee particularly concerned with health care in correctional institutions. A national correctional health care newsletter is, we believe, an urgent need in the field. Such a publication is currently being planned by the newly formed American Correctional Health Services Association (see footnote to page 3).

CHAPTER 9. FINANCING CORRECTIONAL HEALTH CARE

9.1. Costs Per Inmate Per Year

How much money should a state spend on the health of its correctional institution imates?

No answer in terms of dollars is possible. Under applicable court decisions, as much must be spent as is necessary to supply adequate health services — which in most respects means services comparable to those available on the outside.

In general, the costs per imate per year are likely to be higher in small correctional institutions than in large ones; hence, the statewide cost will be dependent upon the nature of a state's institutions as well as on local salary levels and other cost levels.

Some states are currently spending more than $1,000 per inmate per year for correctional health care; yet the care in these states is admittedly less than adequate. Other states make do with less. There is no way to prescribe or even to suggest a proper figure.

It is possible, however, to set standards with respect to *adequacy of service*. In general, a state or local government should spend, and is legally bound to spend, whatever sums are necessary to provide the range and quality of services described in this study.

9.2. How Much Is Now Being Spent?

Each correctional health care administrator should make a thorough study of costs within his own system. Such a study should include as much detail as possible — with separate entries, for example, for dentistry, pharmaceuticals, and so on. As such cost figures become generally available, it will be possible for administrators to make comparisons between their own state's correctional health care expenditures and those of neighboring states. Such comparisons are common (and useful) in education, welfare, and highway maintenance; they are *needed* for correctional health care services.

9.3. Where the Money Comes From

So far as we have been able to determine, only insignificant sums for health care have flowed into the correctional system from the U.S. Department of Health, Education, and Welfare, from other Federal and state non-correctional agencies, or from private foundations. That none of the tens of billions of Federal dollars spent on hospital construction under the Hill-Burton Act went for correctional hospital construction is one dramatic example among many of this underfunding. We believe that far more outside financial support could be secured if a concerted effort were made. The newly formed American Correctional Health Services Association is the logical group to make such an effort. Securing a Federal or foundation grant to finance the organization itself may be a good place to begin.

So far as we have been able to determine, similarly, benefits are rarely or never paid for the health care of correctional inmates by Medicare, Medicaid, Blue Cross, Blue Shield, or private insurance companies.* Inmates may be excluded from benefits by law, by custom, or by the terms of a health care contract. The impact of these exclusions can be seen from the table below. Of the nearly $500 per year per person paid for health care in 1972, more than 70 percent came from health insurance (including Medicare, Medicaid, and the Blue plans) and from government agencies:

$145	per person per year paid out of pocket by the health care recipient
$170	per person per year for insurance coverage
$185	per person per year spent by Federal, state, and local governments
$500	

No one correctional health care administrator, of course, can "buck the system" and secure reimbursements not provided by law, regulation, or contract. AHCSA, however, might have some success in securing changes in the laws, regulations, and contract provisions which currently exclude services to inmates.

*Medicaid in New York State does pay for inpatient and outpatient care in civilian hospitals, of children of Medicaid families held in juvenile detention centers.

At this writing, in mid-1975, both the Congress and the Ford Administration have under consideration a variety of National Health Insurance plans. The desirability of having correctional inmates covered under any such plan is obvious. The American Correctional Association at its 1974 meeting passed a resolution urging that the fullest possible inmate coverage be included in any plan which may be enacted. This proposal should also have the support of correctional administrators, legislators, and others concerned with correctional health care. Providing the same health insurance benefits for inmates as for others would mark a major turning point in the history of inmate health care.*

9.4. Securing Appropriations

These alternative sources of financial support, however, are at the moment "pie in the sky." The hard fact is that correctional institutions are today and for the immediately forseeable future dependent almost entirely on state, county, and local appropriations out of tax funds. If improvements are to be made in correctional health care, they must be funded by legislative bodies under enormous pressure to curtail rather than increase appropriations. To secure funds in the face of this trend requires both a sound case and skill in presenting it.

The sad fact is, however, that under present circumstances in many states, counties, and cities, correctional health care has neither a case nor an opportunity to be heard. As noted above, budget requests may lose their distinctive health care character as soon as they reach the assistant warden of a correctional institution. Correctional health care needs may have no effective spokesman within the department of corrections, or before the budgeting agencies, or before legislative committees, city councils, or county boards of commissioners. In at least some states, *the case for adequate correctional health care funding is being lost by default.*

The solution has been outlined in Chapter 6: a separate category for health care expenditures within the correctional budget, plus a health care administrator capable of defending his requests all the way through the budgeting and appropriating processes.

The first time a health care administrator accompanies the commissioner of corrections to a budget hearing and explains his budget requests may prove a golden opportunity. In the brief time available, he must make as many points as he can, such as the following:

- The various ways in which he is eliminating wastes in the system and thus securing more for each dollar currently available.
- The clear legal duty, enforceable in the courts, to provide correctional inmates with access to the same quality of care available on the outside, and the likelihood of litigation if this standard is not met.
- The ways in which this standard is not currently being met, as documented by the reports of objective outside groups.
- The steps proposed to improve care — with emphasis on those steps which give promise of producing major improvement at relatively small cost.

But preparing and defending budgets is not merely an annual or biennial matter; it should be a continuing process throughout the year. Depending on the state's fiscal pattern, an administrator in 1975 may have to be planning his health care budget needs for 1977 or even 1978; and he should be continuously building support for his budget requests.

The ways of building that support are numerous and vary widely from state to state. Learning how the appropriations machinery works in a particular state and then making use of that knowledge is the best over-all recipe we can offer. In addition, knowledgeable administrators with whom we consulted made two quite practical suggestions:

- There is a natural tendency of almost all administrators to put their best foot forward, to point with pride to their services, and to resent and rebut criticisms. In the field of correctional health care, this can be a self-defeating stance. If all is going well, how can improvements be justified? The correctional health care administrator who makes constructive use of outside criticism to stress his department's needs, and who stresses those needs himself even in the absence of outside criticism, may accomplish more.
- Seeing is believing. Budgeting officials and key members of the legislative appropriations committees can be invited (or, if necessary, urged) to inspect for themselves the health care facilities in a correctional institution — not at budget time when they are busiest but during the

*The Province of Quebec currently provides inmate coverage under its Health Insurance Act.

course of the year. Legislators representing the districts where correctional institutions are located can similarly be invited in. Reporters for the mass media who publish sensational allegations may, at least in some cases, become interested in the reasons why correctional health care falls short of reasonable standards, and in proposals for improvement. In some situations this study, *Health Care in Correctional Institutions,* may prove helpful in fostering an understanding of the problem and in enlisting budget support.

9.5. Funds for Extramural Care

Mention should be made of a special problem in preparing an annual or biennial correctional health care budget. One element in that budget is the payment for extramural services for inmates whose illnesses cannot be treated within the system. These costs may vary from year to year, and in some years the sum set aside may be inadequate — yet surely an inmate should not be deprived of needed extramural care merely because his illness happens to occur late in the fiscal year, after the designated fund has been exhausted. We have three suggestions in this connection:

(1) Expenditures for extramural care fluctuate much more widely for a particular institution than for the statewide system as a whole. One small institution may have its entire annual allotment exhausted by a single costly illness or by an outbreak of violence requiring very costly care for traumatic injuries; another small institution nearby may have no need for extramural care during the same year. To take advantage of this "averaging out," funds for extramural care should be alloted on a statewide basis and paid for out of a statewide fund rather than institution by institution.

(2) In other situations where costs cannot be adequately estimated in advance — for example, welfare costs — a legislature may set standards and then appropriate a "sum sufficient" to meet those standards. One Wisconsin study has suggested a "sum sufficient" appropriation for extramural correctional health care in that state. This solution is particularly recommended for the unpredictable extramural care costs of county and local jails which cannot make use of "averaging out." If this path is followed, of course, adequate controls should first be established to curb over-utilization.

(3) Two states, Illinois and Pennsylvania, have under consideration the purchase of Blue Cross coverage for extramural health care of inmates. In addition to making possible exact budgeting of next year's extramural health costs, this approach would use the auditing, utilization control, and accounting services of Blue Cross to minimize the likelihood of overcharges or other abuses.

We have not the slightest doubt that during the years ahead, funds will eventually be found to finance adequate health care for correctional inmates. Increases may come as a result of court mandates. They may come through the inclusion of inmates in a National Health Insurance plan, or in other ways not now foreseeable. Meanwhile, the existing budgeting and appropriating machinery must be intensively made use of by responsible health care administrators. This cannot be done until health care costs are extricated from other correctional costs and skillfully presented to budgeting agencies and legislative bodies.

CHAPTER 10. "CONTRACTING OUT"

The overwhelming bulk of health care in the United States is delivered by physicians and by *medical* organizations such as hospitals and health departments. The U.S. Indian Bureau once delivered health care on reservations, but that function has now been transferred to the Public Health Service. Some colleges and universities deliver health care — but usually through their medical schools or through independently organized student health services. Among the very few places where health care is still delivered by non-medical organizations are correctional institutions. Serious consideration should be given to the delivery of correctional health care by medical rather than correctional organizations — that is, to the "contracting out" of the health care function, in whole or in part.

An extreme example is a contract drafted a few years ago between the Department of Correction and the Department of Public Health in Massachusetts — both of them units in that state's Department of Human Services. That contract, which never became effective, would have transferred from the corrections to the health department substantially all health care personnel, resources — and responsibilities. At the local and county levels, too, there have been recent transfers of responsibility from corrections to health departments. In San Francisco City and County, such a transfer has been ordered by a state court in a class action suit, and is currently under way.

Whether such a wholesale transfer of responsibilities will work out well in practice depends on a variety of considerations: whether the department of health is staffed and equipped to carry out the correctional health care function; whether it is willing to give this new function the priority it requires; whether the department of corrections is willing to cooperate with the new plan; and so on. Such a changeover is, accordingly, not recommended, but it should be given consideration.

New York City's experience involves "contracting out" at two levels. In 1968, the City of New York contracted out the medical and dental care of children held in the city's juvenile detention facilities to Montefiore Hospital and Medical Center. This affiliation contract worked well from the points of view of Montefiore, the city, and the juvenile detainees; and it remains in operation.

In 1971, following a series of inmate disturbances, New York City went much further and transferred all of its correctional health care responsibilities from its Department of Corrections to its Health Services Administration. This transfer did not solve all problems, and an effort to duplicate the success of the 1968 Montefiore contract followed. The Health Services Administration entered into a much larger contract of affiliation under which Montefiore agreed to provide intramural health services for inmates in the group of very large correctional institutions on Rikers Island. Relevant portions of this contract are reprinted in Appendix C.

Another example of large-scale contracting out is the supplying of health care at Cook County Jail, and the staffing and operation of the jail's Cermak Memorial Hospital, by Cook County Hospital. Somewhat similar is the recent transfer of both intramural and extramural health care in the Santa Clara County (California) jail system to the Santa Clara Valley Hospital.

At a more restricted level, the U.S. Bureau of Prisons has entered into a contract with a physician under which he and his associates provide round-the-clock *medical* coverage for the large new Federal Correctional Facility in San Diego. A somewhat similar contract for medical services at the Joliet Correctional Center in Illinois will be found in Appendix D.

Rather more common are arrangements under which the Department of Corrections continues to provide intramural health care, but contracts out to a health department or hospital the care of inmates whose medical and surgical needs cannot be met within institutional walls.

A rapidly growing feature of the American health care scene is the prepaid group health plan or health maintenance organization. The Kaiser Health Plan

on the West Coast, Group Health Association in Washington, D.C., and the Health Insurance Plan of Greater New York are the largest and best-known examples; but there are scores of others. The parallel between such plans and correctional health care systems is remarkably close. A prepaid health plan, like a correctional system, has responsibility for delivering full medical care to a known number of individuals for a fee per person per year which is fixed in advance; it must therefore be concerned with the costs as well as the quality of the care delivered. We found no example of a correctional system "contracting out" to a prepaid group health plan or HMO for both intramural and extramural care of correctional inmates at a fixed annual fee per inmate; but we believe this possibility may be worth exploring.

On a still smaller scale, there are numerous possibilities of "contracting out" particular functions within a correctional health care institution. Many hospitals, for example, contract out their radiological departments to a radiologist or radiological partnership. Suggestions have been made that the procuring, stocking, and dispensing of drugs in a correctional institution be contracted out to a nearby community pharmacy. Most states maintain clinical laboratories which can easily perform a substantial proportion of the clinical tests needed in correctional health care delivery, and this is in fact common practice. Exploring these and other "contracting out" possibilities should be a continuing function of the Office of the Correctional Health Care Administrator.

In each case, of course, two determinations must be made before a function is contracted out. Will the quality of care be improved or adversely affected? Will costs go up or down? Administrators should be particularly on the alert for opportunities to contract out which will simultaneously improve quality and lower costs. Such opportunities may prove to be more common than was anticipated.

Along with exploring new contracting-out opportunities, the administrator should, of course, closely monitor existing contracts, from the point of view of both quality of care and reasonableness of cost — and should terminate contracts which lack a favorable cost-benefit ratio.

PART III

OTHER CONSIDERATIONS

CHAPTER 11. INTERPERSONAL RELATIONSHIPS IN A CORRECTIONAL HEALTH SYSTEM

11.1. Health Care Staff, Correctional Staff, and Inmates

To be successful, a correctional health care service must be alert to the social characteristics of the correctional institution — and exquisitely sensitive to the interpersonal relationships among the people living and working within the institution.

In any health care system, there are the staff and the patients. A correctional health care system has a far more complicated tripartite structure: health care staff, correctional staff, and inmates.

In any health care system, the staff is in complete command — but its policies are moderated by the fact that dissatisfied patients can turn to other providers of health care service. Inmates cannot turn elsewhere — and the health care staff must therefore moderate its own policies.

Relationships within the correctional institution are greatly intensified by the wall or fence which surrounds it. The health care staff and correctional staff, though they can leave at the end of their tour of duty, are aware of that barrier throughout their working hours. The inmates are aware of it throughout their waking hours. Uniforms, lock-ins, head counts and body searches remind the forgetful. For the inmate, petty annoyances and frictions become magnified beyond all reason. Untold effort may be devoted to manipulations designed to achieve the most trivial advantages. Escape from boredom becomes almost as difficult as escape from the institution. These features of the inmate's life have repercussions on both the correctional and the health care staffs — and on the relations between corrections and the health care service.

The different missions in life of the three groups walled in together exacerbate the tensions. The prime mission of the correctional staff is to maintain security and good order — two sides of the same coin. The mission of the health care staff is to maintain and improve the health of the inmates. The prime goal of most inmates is to get out at the earliest possible date — and, in the meantime, to secure whatever advantages are available under the conditions which prevail. The possibilities of open conflict among these disparate goals is unlimited.

At its worst, the correctional institution is a place where correctional staff, health care staff, and inmates eye each other with mutual distrust and undisguised or ill-disguised hostility. A staff member or inmate who seeks to break through this distrust and hostility is viewed by peers with suspicion and his loyalty to his peer group falls under serious question.

But it doesn't have to be that way. Many correctional institutions have found ways of achieving a tolerable *modus vivendi* — a way of life acceptable if not welcome to all three groups in the institution. A few have gone further, establishing a reasonable degree of mutual trust based on open communication and fair dealing. In this chapter, a few of the ways in which the health care staff can contribute to better interpersonal relations within a correctional institution will be reviewed.

11.2. The Warden and the Medical Director

The warden or superintendent is the person specifically charged by law with the *custody* and *care* of persons committed to his institution by the courts. He is almost always in direct personal charge of the entire institution, sets its policies and priorities, makes major program decisions, and in many institutions decides detailed personal issues as well. He may take the view that, just as he controls his institution's food, housing, and industrial and recreational services, so he must make all decisions with respect to health care services.

The medical director, in contrast, sees health care decisions as peculiarly within his own province. If these two views conflict, the repercussions will be felt throughout the institution.

A medical director should avoid such a conflict at almost any cost — by making it as easy as pos-

sible for the warden or superintendent to accept with good will the presence in his institution of a relatively independent enclave to which discretionary powers have been delegated, and which is exercising those powers in a responsible manner. The medical director can achieve this kind of relationship with the warden through methods such as the following:

Communication. When any change in the health care system is contemplated which may have even an indirect impact on the correctional function, the warden or his deputy should be informed *in advance.* It is one thing for a warden to learn in advance that a change is being made and either approve it or let it happen without comment. It is quite another for him to discover late in the day that a change has already been made in *his* institution without even his knowledge, much less his consent.

Much the same goes for *incidents* which occur within the institution — for example, a confrontation between a correctional officer and a health care staff member, or between a health care staff member and an inmate. The warden or deputy warden who first learns of such an incident through the institutional grapevine is very likely to get a distorted view of what actually happened. If he thereupon intervenes on the basis of incomplete information, he may take a stance from which it will be difficult for him to retreat. To obviate such sources of friction, brief "incident reports" should be routinely prepared *immediately* after any confrontation, and a copy immediately supplied to the warden or the appropriate deputy warden.

Except for very small institutions, a correctional institution is commonly a place with an established protocol and formalized channels of communication. The medical director and other responsible members of the health care staff should familiarize themselves with these formal channels and make use of them. In addition, of course, the medical director should, to the fullest extent possible, develop a relationship with the correctional administration so that informal communication occurs naturally.

It is a mistake, however, to limit communications to times when changes are contemplated or when incidents occur. It is also essential for meetings between warden or deputy wardens and the medical director to occur *when all is going smoothly.* A brief weekly, or biweekly meeting, or at worst monthly meetings should be scheduled, even when there are no pressing problems, in order to maintain rapport between corrections and health care services under favorable circumstances.

Role definition. The sense of territory is almost instinctive in man. The warden properly resents intrusion of the health care staff into correctional matters which do not concern them, and the medical director similarly resents intrusion into medical affairs. The medical director who is punctilious in avoiding intrusions on the correctional function is less likely to be intruded upon. The roles, rights, and domains of the correctional and health care staffs must be determined and mutually understood if territorial conflicts are to be minimized.

Conflict resolution. Despite open communications, role definition, and good will on both sides; conflicts of principle will arise between corrections and health care services. To what extent should the warden and his correctional staff have access to privileged medical information? To what extent should the medical director have power to move a sick inmate from his cell or from isolation unit to infirmary or hospital? Issues such as these — and many more could be cited — are best *not* resolved in the heat of a particular case. Indeed, such points of disagreement transcend the boundaries of a particular institution. Ideally, given the mode of organization of a statewide health care system described in Chapter 6, they should be decided in principle after discussions between the statewide health care administrator and the commissioner of corrections. Once statewide guidelines have been laid down, it should be relatively less stressful to apply those guidelines to particular cases which arise within a particular institution.

11.3. Correctional Line Officers and Health Care Personnel

The correctional line officers have the responsibility of maintaining security and safe environment for all persons living and working in the institution — including themselves and the health care staff. They commonly exercise this responsibility in accordance with a manual of regulations which prescribes in detail what they may, must, and must not do.

The health staff must understand and appreciate this. Physicians, nurses, and other professionals are *not* exempt from the security regulations of the institution. New members of the health staff must be made aware of these regulations and told they

should anticipate and accept some limits on their flexibility of movement. They should be reminded that their own safety is dependent on the consistent performance of duties by the correctional staff, and on their own cooperation.

Conflicts will inevitably arise. When a correctional officer is expected to bring an inmate for a health appointment at 3 p.m. and the two fail to appear, for example, or when the physician is informed that no correctional officers are available to escort an inmate to the hospital for emergency care, there is a tendency for bristles to arise. As in the case of conflicts between warden and medical director, these issues at the line level can better be solved in terms of basic principles, at times when bristles are not raised. The recommended procedure is *not* to "chew out" the correctional officer responsible or file a complaint against him, but to have appropriate priorities established for health care needs within the institution's standing regulations.

When interpersonal relations within an institution are sound, the correctional officer can be of great help to the health care service. He spends the most time with inmates and often knows them best. If he observes an ill inmate, or a health problem within the institution, he can and should bring it to the attention of the health care staff.

As in the case of relations between warden and health care director, relations between correctional line officers and health care staff can be notably improved by regularly scheduled meetings — not just meetings called to meet a crisis or resolve a conflict. At such a meeting, correctional officers should be free to call attention to ways in which health care staff are jeopardizing security (by careless handling of needles, syringes, adhesive tape, or drugs, for example); and health care staff can similarly call attention to ways in which correctional officers are impeding, or could contribute to, the effective delivery of health care services. At such meetings, the mutual definition of roles can be further refined, mutual respect fostered, and friction minimized. The meeting can be a safety valve for relieving rising tensions; better yet, it can be a regulating device for preventing tensions from rising.

Correctional institutions are by their nature conservative. The way things were done yesterday is the way things will be done today and tomorrow. Changes are commonly resisted on the ground that they will impair security. Health care staff should be aware of this conservative tendency and be prepared to exert the patient, continuing effort needed to achieve change. Meetings between correctional and health care staff can be an effective instrument for change. Once correctional personnel understand the *reasons* for a proposed change, they may become less resistant — and may show astonishing ingenuity in working out ways in which the change can be accomplished without compromise of security requirements.

11.4. Health Care Staff and Inmates

Even in the most enlightened institution, there is a necessary (perhaps healthy) tension between the staff and inmates. Why should an inmate adopt an attitude toward health care personnel which is different from his attitude toward correctional personnel, toward the whole institution which is holding him against his will, and toward a society from which he is, to a greater or lesser degree, alienated?

There are sound answers to those questions. A health care service which is in fact dedicated to maintaining and improving the health of the inmate population will be perceived in that role by most inmates most of the time. The result will be to make the institution a more tolerable place to live and work for both health care staff and inmates.

This does *not* mean that the health care staff must be "softies," doing special favors for selected inmates. On the contrary, the "special favor" approach is the short path to disaster. The physician, physician's assistant, or nurse who ignores the rules is an open target for subsequent blackmail. The slightest favoritism toward or discrimination against one inmate is perceived and exaggerated by others; hence, even-handed fairness to all inmates is the only viable policy.

Excessive use and misuse of an overburdened health care system is a natural and proper source of resentment on the part of overworked health care personnel. It is hard to maintain professional courtesy and respect toward an inmate you know has come to the medical unit, not because he is sick but because he wants to get away from the blare of the radios and TV sets, or expects to meet and "take care of business" with an inmate from another unit. Anger and resentment, however, accomplish nothing in such a situation. Readers are referred back to Section 1.8, on practical ways of minimizing the misuse and over-use of sick call and other health care services.

Inmate health care committees. Just as open communications between medical director and warden, and between health care personnel and correctional line officers, make the institution a better place to live and work, so we strongly recommend open communications between health care staff and inmates. The inmates, after all, are the consumers of the institution's health care services; to the extent that the health care staff can see themselves as they are perceived by the inmates, they can do a more effective job. One way to open lines of communication is to encourage inmates to form a medical committee to meet periodically with the health care staff and to discuss problems of mutual concern.

Meetings between health care staff and an inmate committee offer opportunities to explain and interpret health care policy to the inmate community as a whole; for the grapevine promptly spreads the news. Equally important, such meetings make it possible to *improve* health care policy. For health care staff and inmates share a common goal—the health of the inmate population. Inmates may have little medical expertise, but they are the ultimate experts on the way in which the institution functions. On that subject, even the most knowledgeable staff members are rank outsiders. A health care staff which listens to inmate suggestions, either during informal contacts or at scheduled committee meetings, may be surprised at how much this inmate input can contribute to the smooth and effective functioning of the health care service.

CHAPTER 12. DENTAL CARE

Dental care is an essential component of correctional health care. Correctional institutions have a responsibility to meet the dental needs of inmates along with their other health needs. The quality of dental care should be comparable to that available on the outside.

There is a need for a study of Dental Care in Correctional Institutions comparable to the present study—a need which might be met by the newly formed American Correctional Health Services Association.

Pending the publication of such a study, a few basic considerations are presented here.

- There should be a statewide dental health administrator in each state department of corrections. He should in most cases be a dentist.
- The administrator should be guided and assisted by a Dental Advisory Council composed of dentists and representatives of the allied dental professions.
- There should be a separate and identifiable item or items for dental services in the budget of each correctional institution and of the state department of corrections (see Chapter 9).
- The duties of the dental health administrator should closely parallel those of the health care administrator (see Chapters 6 through 9):

The recruiting, training, and retaining of personnel.

The planning and launching of new dental facilities and the rehabilitation, upgrading, and expansion of existing dental facilities.

Monitoring the quality of dental care.

Controlling the cost of dental care.

Developing priorities and criteria for care.

Handling complaints.

Maintaining liaison with dental societies, schools of dentistry, and other outside agencies.

- The dentist himself is the most costly component in dental care. His productivity can be significantly increased by supplying him (a) with the staff he needs—chairside dental assistants and dental hygienists; and (b) with the equipment and supplies he needs. Inferior equipment or supplies can seriously impair dental productivity.
- No dentist should be expected to perform work outside his field of competence. He should accordingly be able to refer inmates to specialists in oral surgery, periodontia, prosthetics, and endodontics, as indicated.
- Dental records, like medical records, are an essential part of health care. There should be a uniform set of record forms and coding methods throughout the statewide system, and dental records should accompany an inmate on transfer between institutions.
- If an institution or statewide system maintains a dental laboratory, it should be staffed by certified dental technicians.
- Correctional institutions are proper settings for the training of non-inmate personnel—dental students and persons training to become dental hygienists, dental technicians or dental assistants. For this reason affiliation with a dental school and with a college or junior college awarding A.A. degrees in dental technology is recommended. Vocational training programs for dental assistants may also be a possibility worth exploring. Some correctional institutions have reported success in the training of inmates as dental technicians and assistants.
- Dental personnel should, like other health personnel, be covered by the state tort act for malpractice protection.
- A dental program in a correctional institution should include teaching inmates how to take care of their own teeth—dental hygiene.

The statewide dental health administrator and Dental Advisory Council can readily extend this list of requirements and recommendations.

CHAPTER 13. ENVIRONMENTAL HEALTH CONSIDERATIONS

The five most important factors contributing to good health or impaired health in a correctional population are all too often considered beyond the purview of the medical staff: a proper diet, plenty of exercise, personal hygiene, a good night's sleep, and a clean, safe environment.

In many institutions, moreover, a considerable list of other health factors are for the most part ignored by the medical staff: the milk and water supply, kitchen and food storage sanitation, the health inspection of food handlers, plumbing, sewage disposal, garbage and trash disposal, air quality, heat in winter and ventilation in summer, lighting levels, noise levels, and accident hazards.

All of these factors should be concerns of the statewide correctional health care administrator. His position as assistant commissioner at the heart of the correctional system should include his advising the commissioner of corrections on such matters and establishing survey teams to review and improve conditions.

13.1. Food Services

Whether or not a dietician is employed within a correctional system or institution, menus should be drawn up in advance, in sufficient detail (including size of portions) to make evaluation possible, and these menus should be periodically reviewed by a qualified dietician (who may be either an outside consultant or a health department employee).

Special provision should be made for low-salt diets, diabetic diets, or other diets prescribed by a physician.

Hot foods should be served hot and cold foods cold, as periodically ascertained with thermometers. This is important for preventing growth of bacteria as well as for palatability.

All food handlers should receive periodic health examinations, as in civilian restaurants.

13.2. Kitchen and Food Storage Sanitation

These facilities should meet the standards set for outside restaurants, and institutional kitchens should be periodically inspected for compliance with standards by the same health department inspectors who inspect civilian restaurants.

13.3. Water Supply

If the institution is not served by a public water supply monitored by the health department, water samples should be drawn at least monthly and sent to the health department for testing. The water supply should be inspected at least annually by state water officials, as arranged by the state health care administrator.

13.4. Sewerage

If the institution is not served by a public sewer system, the sewage disposal installation should be inspected at least annually, perhaps by the local health department, and cleaned on a regular schedule in accordance with health department recommendations. The entire plumbing system should be surveyed for cross-connections, and all plumbing changes should be checked for possible cross-connections after completion. The use of chamber pots for either urine or feces, even temporarily, is a health hazard to staff as well as inmates and must not be tolerated.

13.5. Prison Industries

Compliance with the standards of the U.S. Occupational Safety and Health Agency (OSHA) should be required and should be under continuous supervision of state occupational health officials from the point of view of accident prevention, excessive noise levels, inhalation hazards, contact with noxious chemicals, and other potential health hazards. Protective shoes, hats, gloves, masks, and other equipment should be issued as indicated. The statewide health care administrator should assure himself that all recommended as well as mandatory occupational health safeguards are being followed.

13.6. Fire Prevention

This function is properly a correctional staff responsibility. The health care service, however, should

have plans for handling of casualties following a major fire, disaster, or riot, and there should be periodic fire inspections and fire and disaster drills in each institution—including the mobilization of additional physicians and nurses from the community. Security considerations should not impede these measures; rather, the correctional staff should devise ways to maintain security during drills and actual emergencies.

13.7. Adequate Lighting and Ventilation, Noise Control, and Accident Prevention

These environmental properties are in considerable part architectural matters. In addition to its concern with these factors in existing buildings, the Office of the Health Care Administrator should review all new building plans or make sure that they are reviewed by competent environmental health authorities. The environmental and occupational health faculties of the state university and its medical school can be a useful resource in all such matters.

CHAPTER 14. INMATE HEALTH EDUCATION

A repeated comment about inmates is that they have long neglected their health before admission and continue to neglect it within the institution. This is certainly not true of all inmates, but it is true of enough of them to warrant an intensive health education program within each institution. Such a program can be a part of the institution's regular education activities or can be a function of the health care service.

As noted earlier, there should be a first aid course and a dental hygiene education program. Sex education is commonly a part of health education and can properly be included in the program of a correctional institution. Outside volunteers can in some situations be effectively utilized as health educators; or teachers may be procured from an adult education program, a school system, community college, or medical school.

Many inmates are deeply concerned with their own bodily functions and anxious about their health. The only outlet for these concerns and anxieties in some institutions is attendance (often needless) at sick call. A health education program tailored carefully to the needs and interests of inmates is likely to prove popular, to take some of the stress off the sick call system—and to stand inmates in good stead throughout the rest of their lives.

APPENDIXES

APPENDIX A. State Correctional Health Directors, Administrators, and Coordinators Participating in This Study

On July 10 and 11, 1975, the following state directors, administrators, and coordinators of health care in correctional institutions met in Alexandria, Virginia, to review the contents of this study. They also formed at this meeting the American Correctional Health Service Association. For further information about the ACHSA, consult Cecil Patmon, acting secretary, at the address below.

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APPENDIX B. Health Standards for Juvenile Court Residential Facilities

APPENDIX B

AMERICAN ACADEMY OF PEDIATRICS
COMMITTEE ON YOUTH

HEALTH STANDARDS FOR JUVENILE COURT RESIDENTIAL FACILITIES*†

Young people who find themselves in juvenile court facilities constitute a group who traditionally have displayed a high incidence of health problems. Many have had inadequate care in the past, and enter with preexisting medical and dental conditions. Whether or not they are in good physical health, they often are handicapped in the area of mental health. The conditions which necessitate removing them from their homes and placing them in institutions may aggravate, or even cause, physical and mental health problems.

When society undertakes to remove children and youth from their homes and place them in institutions away from the care of their parents, it assumes certain obligations. Among these obligations is care of their physical and mental health.

Health programs in juvenile court facilities must be broad and comprehensive and must go beyond the mere provision of medical care. The extent of the health care which should be offered to an individual will depend on the length of time he is in the institution. But, every institution which confines juveniles should have a health program designed to protect and promote the physical and mental well-being of residents, to discover those in need of short-term or long-term medical and dental treatment, and to contribute to their rehabilitation by appropriate diagnosis and treatment and provision of continuity of care following release.

The standards given here are designed to attain these goals.

ADMINISTRATIVE STRUCTURE OF THE HEALTH PROGRAM

Health Council

1. Each institution should have a multidisciplinary health council to set the policies of the health program.

2. The council may be organized within the institution or by the authority which operates the institution.

3. The following persons should be members of the council of every institution: (a) the superintendent of the institution, (b) a physician who cares for the residents of the institution, and (c) one or more mental health workers (a psychiatrist, psychiatric social worker, or child psychologist) with experience with children and adolescents in a residential psychiatric treatment facility.

4. The following persons, if available, may be members of the council: (a) a nurse working within the institution, (b) a dentist who treats residents of the institution, (c) an educator who teaches residents of the institution, (d) a dietitian working within the institution, and (e) a vocational counselor.

5. Other persons may also be members of the council, depending on circumstances. For example, if feasible, one or two young people who are residents of the institution should be members.

6. The council should meet regularly to consider all matters concerning the physical and mental health of children in the institution. It should establish policies and operating procedures, direct the activities of health programs in the institution, oversee the maintenance of high standards of health care, and recommend necessary changes to appropriate authorities.

Technical Advice

When appropriate, the health council should seek advice either from technical

* This statement has been approved and endorsed by the Academy's Council on Child Health and has been endorsed in principle by the National Council of Juvenile Court Judges.

† Detention centers, training schools, and similar residential facilities.

advisory committees consisting of suitable professionals and other experts in the community, or from a list of experts (e.g., in communicable disease or drug abuse) who could be called on to consult with the health council as needed.

Operation of the Health Program

1. One full-time or part-time person should direct the health program and carry out policies set by the health council. This person should have administrative responsibility for medical, dental, nursing, and mental health personnel. The health program administrator and his staff should not be required to implement the custodial or security functions of the institution.

2. The director of the health program should designate a physician to: (a) approve all standing instructions for medical care and instructions stating when a physician or nurse should be consulted, and (b) approve all supplies of medications kept within the institution and regulations for their use.

Responsibilities Toward Patients

1. In most instances the court will have legal authority to approve medical care for residents. In addition, the principles of rendering medical care with due regard for the dignity of the patient require appropri ate permission to be obtained for the performance of medical and dental procedures. Preferably, an attempt should be made to obtain this permission from the child's parents. However, permission for dental procedures and permission for rectal and pelvic examinations, when indicated, should also be sought from the child.

2. Medical and dental records should be kept for each child remaining overnight or longer in the institution. A written record should be kept of the administrative inspection of the condition of each child at entry (see discussion of Admission Inspection).

3. Access to medical and dental records should be restricted to persons caring for the health needs of the patient.

4. Medical and dental records should be reviewed prior to each child's discharge. Procedures should be established for ensuring the continuation and completion of treatment begun in the institution and for correcting health problems discovered in the institution, whether the child returns home or is transferred to another institution.

5. Health conditions which might affect behavior, such as epilepsy or diabetes, should be reported to appropriate authorities in a manner compatible with medical ethics and the rights of the patient.

6. All medical and dental care should be rendered with consideration of the patient's dignity and feelings. Medical procedures should be performed in privacy—with a chaperone present when indicated—and in a manner designed to encourage the patient's subsequent utilization of appropriate medical, dental, and other health services.

Review Procedures

1. All complaints against the institution, from any source, should be routinely screened by the health council or a designated member of the council to determine if they imply a deficiency in the physical or mental health program of the institution.

2. The health council should investigate and take appropriate action for all claims of deficiencies in the physical or mental health program of the institution, and should inspect and review all aspects of the program as required to maintain quality standards.

3. Written policies should require a formal case review by qualified professionals of any death within the institution and other events and conditions which may be specified by the health council.

HEALTH SERVICES

Admission Inspection

1. An initial inspection by the admitting staff officer should be part of the admitting procedure. It should include: (a) state of consciousness (drowsiness, disorientation, and so forth); (b) state of gross motor function (severe depression, severe hyper-

activity, difficulty in coordination, and so forth); (c) fever or other signs of illness; and (d) apparent injuries.

2. Written standing orders should define conditions appearing at the initial inspection which require prompt medical or nursing attention.

Health Assessment

All children should undergo a health assessment at the first possible opportunity after initial admission to the institution. Exceptions should only be made for children admitted with a written record of an adequate assessment done elsewhere if this assessment was recent enough that no substantial change would be expected.

Content of Health Assessment

Medical History

1. Sufficient time should be allowed to obtain an adequate history of the child's past illnesses and treatment, and of any health problems that are known or suspected. The history should include appropriate behavioral, family, and social information, including such items as source and type of routine medical and dental care, school performance, exposure to venereal disease, and need for contraceptive information.

2. If possible, the medical history should be obtained from a parent or other adult with whom the juvenile customarily lives, in addition to a history from the juvenile himself.

3. Information about the child should be requested from his source of routine medical care, if one exists.

4. The medical history may be obtained by a physician, a nurse, a physician's assistant, or a suitably trained health aide who has no duties in the implementation of custodial or security functions of the institution.

Physical Examination

1. A physical examination should be performed as part of the health assessment of all residents within 24 hours of initial admission to the institution.

2. The examination should include a search for signs of communicable disease, including venereal disease in all exposed juveniles; for any correctable health defects; and for any signs of medical conditions (such as neurological disease or drug abuse) which might influence behavior. A dental inspection to identify children in need of emergency dental care should be included.

3. The physical examination should be performed by a physician or a physician's assistant.

Screening Procedures

1. All children should be screened at admission for vision and hearing defects, immunization status, tuberculosis, and such other conditions as the health council or its advisory committee may recommend.

2. All sexually active juveniles should be screened for venereal disease.

Dental Assessment

1. In addition to the dental inspection performed as part of the physical examination, assessments should be performed by a dentist on all resident children, and a plan should be made for correction of dental defects.

2. The dental assessment should include examination of each tooth, bite-wing x-rays on all children, and periapical x-rays where indicated. If available, a panographic x-ray may be substituted for the bite-wing and periapical films.

3. The dental assessment should classify children according to the priority of their treatment needs. The following priorities are suggested: (a) Individuals requiring emergency dental treatment for such conditions as injuries, acute oral infections (e.g., periodontal and periapical abscesses, Vincent's infection, acute gingivitis, acute stomatitis, and painful conditions. (b) Individuals requiring early treatment including extensive or advanced caries, extensive or advanced periodontal disease, chronic pulpal or apical periodontal disease, heavy calculus, chronic oral infection, surgical procedures required for removal of one or more teeth, and other surgical procedures

not included in priority a, insufficient number of teeth for mastication, restorations for cosmetic reasons as part of rehabilitative treatment. (c) Individuals requiring treatment, but not of an urgent nature, for such conditions as moderate calculus, prosthetic cases not included in priority b, caries (not extensive or advanced), periodontal diseases (not extensive or advanced), other oral conditions requiring corrective or preventive measures. (d) Individuals apparently requiring no dental treatment related to the type of examination or inspection performed.

Correction of Health Defects

1. All institutions should undertake correction of health problems identified at entry to the institution.

2. Health defects should be corrected wherever possible without cost to the child or his family, either within the institution or at suitable facilities in the community.

3. Arrangements should be made in the community for ready access to all types of health care not available within the institution, including outpatient and inpatient care, diagnostic facilities, specialist consultation, and pharmacy.

4. Referral should be made to health care facilities in other institutions or to a source of regular health care whenever a child is discharged from the institution in the course of treatment for any health problem. Following release, appropriate health records, including x-rays, should be transferred as confidential documents to the new source of health care.

Care of Illness and Emergencies

1. All institutions should provide for routine care of illnesses. They should make provision within or outside of the institution for care of emergencies, including dental emergencies, arising within the institution at any hour of the day or night. Written procedures should specify these emergency provisions.

2. Illness and emergency care may be provided within or outside the institution; but, if outside, the source must be readily accessible.

3. Care of illnesses and emergencies must include all applicable types of health care either at the point of primary care or by referral. These should include outpatient and inpatient care, diagnostic facilities, specialist consultation, and pharmacy.

4. Care of illness should be provided daily, at a time and place known and accessible to all the residents of the institution.

5. Routine provisions should be made for serious or common problems, including drug toxicity and withdrawal, pregnancy, venereal disease, suicide threats and other emotional problems, and learning disabilities.

Dental Care

1. All institutions should make provision for care of dental emergencies arising at any time of the day or night.

2. Preventive dentistry should include at least plaque control, fluoride treatment, and counseling.

3. All institutions should undertake dental treatment and restoration using the priorities given in point 3 of Dental Assessment. When children do not remain in the institution long enough for proper treatment to be accomplished, the institution should make appropriate referrals for the treatment to be done elsewhere and arrange for transfer of appropriate records, including x-rays.

4. The extent of restorative dentistry provided by an institution should be determined by the health council; however, it should include, as a minimum, the restoration of adequate masticatory function. When feasible, quadrant dentistry is the optimal method.

HEALTH PROTECTION

The health council and the director of the health program should make themselves responsible to ensure the following minimal standards of a healthy institutional environment.

Health Service Facilities

1. Facilities for health services within the institution should meet standards for equivalent types of care given in the community. If direct care of illness is provided within the institution, the following standards should be met: (a) A primary physician should be present at each session. (b) A registered nurse should be present at each session. Licensed vocational nurses may be used for general nursing duties under the supervision of a registered nurse. (c) The following laboratory studies must be obtainable on the premises or by immediate referral: hemoglobin and/or hematocrit; WBC or differential; urinalysis, chemical and microscopic; serology drawing; microscopic studies of exudates and scrapings (e.g., gonococcus and trichomonas); culture (by transfer media where necessary) of gonococcus and other common pathogens; urinalysis for narcotics. (d) The following procedures, although desirable on the premises, may be obtained by referral: x-ray, blood chemistry, hematology.

2. Preventive medical services such as immunization and contraceptive service should be available on the premises or by referral.

3. All health service facilities should have the following: (a) sufficient light, heating, cooling, water, and toilet facilities; (b) privacy for patient interviews with nurse, physician, or other personnel; (c) privacy of examination should be ensured; (d) if there is one physician, there should be at least two examining rooms, with hand-washing facilities; if there are two physicians, there should be at least three examining rooms.

Dental Facilities

1. A dentist should be available for emergencies.

2. A hygienist is optional for dental hygiene and dental health education.

3. If dental care is provided on the premises, facilities must include operatory with equipment designed for four-handed, sit-down dentistry.

Physical Environment of Institution

1. Adequate space should be provided for each resident.[1, 2]

2. Adequate ventilation should be provided for the number of people within a building.[1, 2]

3. Residents should be separated appropriately by sex, age, and the type of problem they present.

4. There should be sufficient facilities to maintain cleanliness of residents, their clothing, and their bedding.

5. Precautions should be taken to protect children against sexual assault, against violence by other residents or by themselves, and against physical or emotional injury.

6. Food should be nutritious and attractively served.

7. A dietitian should be on the staff of each institution, or available and used for regular consultation. An outside consultation should include the dietitian's presence during at least one complete meal cycle.

Mental Health Aspects of Environment

1. Recreation: (a) An adequate recreation program should be available for each child. (b) The program should include both gross motor and sedentary activities of various kinds each day.

2. Education: (a) There should be an educational program in each institution making appropriate use of community facilities. It should include the following, where appropriate: general education, compensatory and remedial education, vocational education, and vocational referral and placement services. (b) Children in institutions should receive the same education as those who live in the community. For those unable to profit from standard educational programs—whose mental and emotional problems necessitate modification of the educational program—education programs should operate a minimum of two hours a day, three times a week.

3. All institutions should have consultants in mental health (psychiatrists, psychiatric social workers, or psychologists) with experience with children and adoles-

cents in a residential psychiatric treatment facility. In addition to serving on the health council, the consultants should be used for (a) emergency consultation, and (b) in-service training.

4. All institutions should have on the premises, or by referral, facilities for diagnosis and individual and group treatment of children with mental health problems in accordance with recent court rulings recognizing the right of children to appropriate treatment.

5. Behavior control measures used within the institution should be reviewed at regular intervals by mental health consultants.

Health Education

All institutions with education programs should provide health education. The subjects to be covered should include nutrition, alcohol and drug abuse, communicable disease (including venereal disease), dental health, and sex education (including contraception).

Employees

1. All personnel employed within institutions should meet health standards similar to those required for school personnel.[3]

2. All food handlers should meet appropriate state and local requirements.

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(See also the commentary on page 434, this issue.)

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APPENDIX C. The Montefiore - New York City Contract

In June 1973, the New York City Department of Corrections entered into a three-year contract with Montefiore Hospital under which Montefiore undertook to supply substantially all medical services (except psychiatric care, dental care, and certain services not available in ordinary hospitals) to some 7,000 correctional inmates housed at Rikers Island, New York—plus specialty clinic services to other New York City inmates, for a fee of $2.5 million the first year and $4.5 million per year thereafter. The complete contract is a long document and covers a wide range of topics; a few extracts describing the services to be rendered are reprinted below.

> AGREEMENT dated between the CITY OF NEW YORK, a municipal corporation (the "City"), acting by and through the Administrator of the Health Services Administration (the "Administrator") and the Commissioner of the Department of Correction, and MONTEFIORE HOSPITAL AND MEDICAL CENTER, a New York not-for-profit corporation (the "Hospital").

"The [Montefiore] Hospital shall provide during the Term of this Agreement at each of the Institutions (subject to the provisions of paragraph (b) of this Section,) medical services" that will provide every inmate of the Institutions with high quality medical care (other than hospitalization requiring the services of a medical center, psychiatric care and dental care) and will provide only infirmary and specialty clinic services to inmates not housed in the Institutions, as provided in paragraph (c) of this Section. The Hospital Program will include the services set forth in Annexes A, A-1, A-2, A-3, and A-4."

"In addition to medical services to inmates housed in the Institutions, the Hospital Program shall include specialty clinic services to inmates referred for such care from any correctional facility operated by the New York City Department of Correction. The Hospital's obligation to provide these services to inmates not housed in the Institutions shall be subject to the adequacy of the facilities and to the adequacy of the amounts budgeted in Annex B for specialty services."

"The [Montefiore] Hospital shall name a Physician as Director for the Hospital Program. The appointment of the Director for the Hospital Program shall be subject to the approval of the Administrator and of the Commissioner of Correction, which approvals shall not be unreasonably withheld. The Director shall have authority and responsibility for supervising the operation of the . . . Program on a day-to-day basis, and shall designate for each Institution a physician to be the Physician-in-Charge of the medical program at that Institution."

"The [Montefiore] Hospital shall operate the . . . Program in compliance with all applicable Federal, State, and City laws and regulations."

ANNEX A

The Hospital shall provide the following medical services at the Institutions:

1) Each inmate of an Institution shall be given a physical examination after he is admitted to one of the institutions. The examination ("admission physical") shall be a high-quality work-up, shall include such items as are specified in Annex A-1 and as the parties may subsequently agree to.

2) All inmates requesting medical attention after the admission physical set out in (1) above shall be given medical attention, as set forth in Annex A-2.

3) The Hospital shall provide sufficient physician coverage on Rikers Island 24 hours a day at all times during the Term of this agreement in order to render emergency care.

4) The Hospital shall provide in-house specialized clinic services as are indicated in Annex-3 and such other specialty clinic services as are necessary to meet the needs of inmates in the New York City correctional system, whether or not housed in that institution, subject to provisions in Section 3 and Annex A-3.

5) The Hospital shall administer a program of opiate detoxification for heroin addicts.

6) The Hospital shall provide full staffing for the Infirmary and shall provide the medical services set forth in Annex A-4.

7) Treatment of all illnesses detected or brought to the attention of the Hospital Program staff will take place, as appropriate, through referral to sick call, specialty clinic services and infirmary care, or hospitalization. Medical follow-up care for inmates treated or referred to treatment will be provided by the Hospital Program staff.

ANNEX A-1

The admission physical for all inmates shall include the following, unless medically counterindicated:

hematocrit
urinalysis
serologic test for syphilis
chest X-ray

In addition, the following tests will be given to certain inmates as deemed appropriate:

sickle cell anemia screening test
pregnancy screening test
gonorrhea screening test.

ANNEX A-2

In all institutions except the Rikers Island Infirmary, a "sick call" (i.e., screening clinic for inmates desiring or needing medical attention after they have been given their admission physical) shall be held each day.

1. All inmates requesting care must be seen by a member of the medical staff and if found to require treatment by a physician, such inmates are to be seen by a physician on the same day.

2. Inmates referred for treatment as a result of the admission physical examination must be seen the following day unless the physician initially examining the inmate orders him to sick call on another day.

3. Inmates treated at sick call and whose condition warrants a further sick call visit shall be seen on the day specified by the initial sick call physician.

4. Patients discharged from the Rikers Island Infirmary shall be seen at sick call for a follow-up visit as specified by the Infirmary staff or by the physician examining the inmates on their return to their Institution from the Infirmary.

ANNEX A-3

The Hospital shall provide in-house specilized clinic services up to the amount of 80 hours per week, with the types of specialty services and the number of each type being agreed upon by the parties on the basis of experience. An estimate of such needs is set forth as an example in item 1.

Item 1.

Specialized Clinic	*Sessions/Week*
Surgery	3
Orthopedics	2
Dermatology	2
Ophthalmology	2
Radiology	3
Neurology	2
ENT	2
Gynecology	2
Urology	1

All clinic sessions shall be of at least four (4) hours duration.

Item 2. The minimum adequacy of funds service loads discussed in Section 3(d) for each specialized clinic is as follows:

	Patients/Sessions
Surgery	20
Orthopedics	20
Dermatology	26
Ophthalmology	16
Neurology	16
ENT	16
Gynecology	16
Urology	16

ANNEX A-4

The Hospital shall provide the following medical services at the Rikers Island Infirmary (also known as the "Rikers Island Hospital").

1. Care for tuberculosis patients;
2. Convalescent care;
3. Subacute medical care.

ANNEX D

The Hospital shall send the following reports to the City relating to its activities under this Agreement:

1. A monthly report for each institution, excluding the Infirmary and Health Center, setting forth the number of admissions, admission physical examinations, admission X-rays, admission VDRLs and other admission tests.

2. A monthly report on infections and communicable diseases diagnosed and treated.

3. A monthly report on the number of patients treated in specialty clinics, indicating the institution of origin for these patients.

4. A monthly report on the number of patients referred to hospitals for treatment on an outpatient basis, indicating the name of the hospital to which the patient was sent and the reason for referral.

5. A monthly report on the admissions, discharges, average length of stay and census of the Infirmary by services.

APPENDIX D. The Lockport-Joliet Contract

The following is the full text of a contract under which Lockport Associate Clinic in Lockport Illinois, agreed to furnish specified medical services to approximately 600 inmates of the Joliet Correctional Center for one year beginning July 1, 1975.

CONTRACT AGREEMENT - MEDICAL SERVICES

The signature affixed by the contractor designates an agreement with the party herewith that the medical services listed below will be extended to the Department of Corrections, Joliet Correctional Center, Joliet, Illinois 60432 for the fiscal year 1976 (July 1, 1975, thru June 30, 1976.)

Charges will be paid at the rate of $3,500.00 per month. This contract may be terminated by either party giving the other party ninety (90) days prior notice in writing.

Listing of Services:

1. To assure "on call" medical care consistent with the needs of the institution.
2. To furnish General Dermatalogical services to residents as needed.
3. To furnish General Cardiac care services to residents as needed.
4. To furnish General Orthopedic care services to residents as needed.
5. To furnish Ear, Nose & Throat care services to residents as needed.
6. To furnish General Internal Medical care services to residents as needed.
7. To interpret X-rays within the institution.
8. To furnish Emergency Surgery as needed. (Surgical assistants billed separately on contractual services.)
9. To furnish sick call coverage 5 days per week, beginning at 8:30 a.m. until completion. Also—(includes sick call Monday - Wednesday - Friday)
10. To recommend and assist in procedures to update Medical Services when requested.

PRESCRIPTIVE PACKAGE: "Health Care in Correctional Institutions"

To help LEAA better evaluate the usefulness of Prescriptive Packages, the reader is requested to answer and return the following questions.

1. What is your general reaction to this Prescriptive Package?

☐ Excellent ☐ Above Average ☐ Average

☐ Poor ☐ Useless

2. Does this package represent best available knowledge and experience?

☐ No better single document available
☐ Excellent, but some changes required (please comment)
☐ Satisfactory, but changes required (please comment)
☐ Does not represent best knowledge or experience (please comment)

3. To what extent do you see the package as being useful in terms of: (check one box on each line)

	Highly Useful	Of Some Use	Not Useful
Modifying existing projects	☐	☐	☐
Training personnel	☐	☐	☐
Administering on-going projects	☐	☐	☐
Providing new or important information	☐	☐	☐
Developing or implementing new projects	☐	☐	☐

4. To what specific use, if any, have you put or do you plan to put this particular package?

☐ Modifying existing projects
☐ Administering on-going projects
☐ Others:
☐ Training personnel
☐ Developing or implementing new projects

5. In what ways, if any, could the package be improved: (please specify), e.g. structure/organization; content/coverage; objectivity; writing style; other)

6. Do you feel that further training or technical assistance is needed and desired on this topic? If so, please specify needs.

7. In what other specific areas of the criminal justice system do you think a Prescriptive Package is most needed?

8. How did this package come to your attention? (check one or more)

☐ LEAA mailing of package
☐ Contact with LEAA staff
☐ LEAA Newsletter
☐ Other (please specify)
☐ Your organization's library
☐ National Criminal Justice Reference Service

(CUT ALONG THIS LINE)

9. Check ONE item below which best describes your affiliation with law enforcement or criminal justice. If the item checked has an asterisk (*), please also check the related level, i.e.

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☐ Commercial/Industrial Firm		☐ Professional Association *	
☐ Citizen Group		☐ Crime Prevention Group *	

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