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HEALTH CARE IN CORRECTIONAL INSTITUTIONS

MANUAL

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Office of Development, Testing, and Dissemination
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HEALTH CARE IN CORRECTIONAL INSTITUTIONS

MANUAL

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NATIONAL INSTITUTE OF LAW ENFORCEMENT AND CRIMINAL JUSTICE

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INTRODUCTION

This manual is a reference for the workshop series on Health Care in Correctional Institutions, part of the Executive Training Program in Advanced Criminal Justice Practices (ETP). The Executive Training Program is sponsored by the National Institute of Law Enforcement and Criminal Justice (NILECJ), the research center of the Law Enforcement Assistance Administration, U. S. Department of Justice.

The manual is designed to provide information about strategies and techniques corrections officials can use in attempting to resolve the myriad issues involved in providing "adequate" health care to inmates within their custody. The manual not only focuses attention on a subject which quite often has been relegated to a position of low priority, but also raises issues--both legal and administrative--that correctional officials confront daily in improving health care to inmates. It explores means for assessing, developing, and managing a viable health care delivery system, including identifying gaps in service delivery, and reviews legal decisions and standards affecting health care in correctional institutions. Finally, the manual discusses strategies for change that can improve health care in correctional institutions.

This manual is not intended to be all-inclusive. Rather, we attempt to provide an overview of some of the more significant issues and problems of health care in correctional institutions. For example, such topics as problems unique to facilities housing women or juveniles, protecting the pre-trial detainee's right to health, among others, are not explored here.

Although this manual is for participants of the ETP Workshops on Health Care in Correctional Institutions, we hope that it will also be of interest and use to persons who have not participated, but who, nevertheless, are concerned about this important issue.

The Executive Training Program is a nationwide training effort that offers corrections personnel in states and local jurisdictions the opportunity to learn about improved criminal justice procedures and put them into operation. The National Institute of Law Enforcement and Criminal Justice, which sponsors the program, supports wide-ranging research in the many legal, sociological, psychological, and technological areas related to law enforcement and criminal justice. It also follows through with the essential steps of evaluating research and action projects and disseminating information on them to encourage early and widespread adoption. The ETP is one of the Institute's priority efforts at applying research results in police departments, courts, and correctional institutions across the country.

The workshop on Health Care in Correctional Institutions has been designed to assist medical and administrative corrections officials, public health officials, legislators, and government executives in recognizing current trends and their implications for health care delivery within correctional settings.

All of these actors must be involved if health care services in correctional institutions are to be improved. While each has a different role to play in making these improvements, all must have a common understanding of the issues and problems, as well as an appreciation of the need to interact and cooperate in their solution.

To improve health care in correctional institutions, these policymakers will need to implement new programs; try innovative approaches to staffing, funding, and service delivery; assess and, in many instances, reorganize the administration of health care delivery; monitor the quality of care provided; and identify and make other needed changes. Policymakers will also have to give health care in corrections high priority, and they will need adequate knowledge and skills to make appropriate and effective decisions.

Once these executives are provided with appropriate training, the delivery and quality of health care services in corrections should improve. As a result, the number of prisoner-initiated civil suits should be reduced; judicial intervention will be minimized; control of communicable diseases will improve; and inmate mortality rates will be reduced. Then, rehabilitation objectives of the correctional institution can be enhanced--that is, the outlook of the inmates is improved, the ability of the inmates to work is increased, and so forth.

The workshop is based upon some of the research developed by the National Institute's Health Care Prescriptive Package. It offers a variety of practical suggestions to corrections officials for improving the quality and efficiency of health care available to inmates, as well as advice from an expert panel.

The purpose of the workshops on Health Care in Correctional Institutions--and of this manual--is to increase the participants' knowledge of and skills in the use of a framework for systematically assessing the delivery of health care in correctional settings, identifying needed changes, and in the use of approaches for implementing needed change.

The Executive Training Program was designed, and is conducted and managed, by University Research Corporation (URC), a national training organization based in Washington, D.C. For the past 12 years, URC has designed, managed, and provided training to diverse local, state, and national organizations to improve the delivery of services to best meet people's needs.

About the Project Team

The development of this manual was a team effort of University Research Corporation staff members Norma B. Gluckstern, Ed.D. the HCCI Team Leader, and Margaret A. Neuse, M.A., M.P.H., trainer; and the HCCI team consultants, Jay K. Harness, M.D., Ralph W. Packard, M.S., and Cecil Patmon, M.A.

The project was coordinated and directed by Dr. Gluckstern, who is a correctional specialist and psychologist at University Research Corporation and

an adjunct faculty member in the Institute of Criminal Justice at the University of Maryland, where she teaches courses on the treatment of juvenile offenders and adults in the community. She is also a faculty member of the Psychology Department at Catholic University in Washington, D.C., and has supervised special education teachers who are working with dropout- and delinquency-prone adolescents. For the past four years, she has worked with Berkshire County (Mass.) House of Corrections as director of a project to develop management models for jails, and has recently been awarded a grant from the National Institute of Corrections to evaluate the Berkshire County project. She is co-author of four video-based training manuals in communication skills, as well as author of a number of articles in the field of corrections and psychology.

Ms. Neuse, the other URC staff member, has worked for seven years in the health services delivery field. She received her masters in public health from Tulane University's School of Public Health and Tropical Medicine with specialization in family health and population studies. As a health educator and researcher, she worked in clinic programs in El Salvador, Haiti, and Louisiana. Since joining URC in 1974, she has provided training and technical assistance to international, state, and local health care programs in self-evaluation procedures to be used in assessing and improving a variety of services, including family planning, primary medical care, dental care, and health education. In addition to her work with health care programs and their administrators, she has also worked with correctional administrators and evaluators while providing training on management-oriented evaluation procedures for corrections, a workshop series conducted under a grant with LEAA in 1975-76.

Dr. Harness is currently the director of the Office of Health Care of the Michigan Department of Corrections. He is also the founder of the Washtenaw County Jail Medical Facility in Ann Arbor, Michigan, and Prison Projects. Both programs, under the auspices of the University of Michigan Interns-Residents Association, use fully licensed and resident physicians from University Hospital to provide full-time medical care to inmates of the Washtenaw County Jail as well as some services to the State Prison of Southern Michigan at Jackson and the Detroit House of Corrections, Women's Division, in Plymouth. Dr. Harness has also served as a consultant to Michigan's Governor William Milliken's Committee on Health Care in the Michigan State Correctional Institutions. Key to Health for a Padlocked Society was published as a result of his work on that committee. He is a member of the American Medical Association's Advisory Committee to Improve Medical Care and Health Services in Correctional Institutions and a faculty member of the University of Michigan's Department of General Surgery.

Mr. Packard has worked in corrections for eighteen years. He started as a line officer and has spent the last four years developing a model for correctional change. He is currently director of the Model Education Program, developed in collaboration with the University of Massachusetts, at the Berkshire County (Mass.) House of Corrections and is responsible for training the correctional staff. He has lectured at the University of Alabama, University of Massachusetts, Berkshire Community College, Holyoke Community College, and Boston University. He has also presented papers on corrections counseling for the past two years for the American Personnel and Guidance Association and the American Psychological Association, and he is presently a principal investigator of a prerelease center in Berkshire County that is funded through LEAA.

Mr. Patmon is a medical services administrator with the Illinois Department of Corrections. He is responsible for the overall medical services administration, including budgeting, personnel policies, staffing, and training, for local institutions. He also provides consultant services in program development and implementation for facility administrators. Previously, he has worked in planning and implementing new programs in the health service areas. As a former public relations director for a hospital, he has experience in fundraising, community relations, and communications. Mr. Patmon has served as faculty advisor for the University Without Walls program at Chicago State University and has been responsible for training high school dropouts for jobs in medical service delivery systems.

Mr. Frederick Becker, Jr., provided valuable guidance to the team as the liaison with the Office of Development, Testing, and Dissemination, National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U. S. Department of Justice.

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CHAPTER 1. THE NEED FOR HEALTH CARE IN CORRECTIONAL INSTITUTIONS

During the past five decades at least, technological, organizational, and other improvements in the delivery of health care services have increased the quality, quantity, and range of medical services available to most people in America. However, health care available to inmates at most of the country's correctional institutions has failed to keep abreast of these advances. Poorer care for inmates has resulted as services have continued to deteriorate.

Increasingly, the present inability of correctional systems to provide adequate health care, the expanding numbers of law suits and court orders requiring better services, greater attention from a variety of professional and voluntary organizations about standards for health care, and the proliferation of new programs and approaches to the delivery of services are forcing correctional, State executive and legislative, and local policymakers to take steps to improve health services in their institutions.

But improved health care for inmates is part and parcel of the broader issue of correctional reform. That fact, in and of itself, makes the issue of improved health care for inmates a controversial one. Are individuals who have been convicted of so-called crimes against society to be coddled, or are they to be punished? Must society, then, bear the burden of paying for health care services to those who violate its laws? The broader issue of correctional reform changes under various societal pressures. However, the specific issue of the provision of prison health care services may be decided in the courts if it is not solved in the institutions.

Only recently has great attention been given to health care in corrections. Pressures from both inside and outside corrections have been mounting to focus on discrepancies in health care planning and delivery and to effect changes. The strongest pressure to date has come from state and Federal courts. As a result of many legal actions, the courts are ordering that the same level and quality of medical care be made available to inmates as is available in the outside community. For, although an individual may lose some of his constitutionally guaranteed rights once incarcerated, he does not surrender his right to have access to health care services. Correctional officials, thus, are obligated--by the United States Constitution and by court order--to assure access to medical care for inmates in their custody.

In a major 1976 decision, the U.S. Supreme Court ruled in Estelle v. Gamble (U.S., 97 S.Ct. 285) that "deliberate indifference of prison officials and personnel to the serious medical needs of a prisoner constitutes cruel and unusual punishment proscribed by the Eighth Amendment and gives rise to a claim under 14 USC 1983." In the same decision, the high court also established the government's obligation to provide medical care to inmates. Consequently, many corrections officials are under court order or the threat of prisoner-initiated

legal action to upgrade health care services in their systems. In addition, a variety of professional associations, voluntary groups, and inmates are also studying and evaluating correctional health services and proposing, among other changes, standards for the delivery of health care services. These groups include the American Correctional Association (which participated with the National Institute of Law Enforcement and Criminal Justice in developing the Health Care Prescriptive Package), the American Bar Association, the American Medical Association, and the American Public Health Association.

In response to these needs and pressures, many corrections systems are seeking or implementing changes in:

- Organizational structures and the role of medical care administration in them;
- Modes of service delivery;
- Patterns of staffing, funding, and delivery of services;
- Laws to allow for innovative uses of staff, allocations of funds, and budgeting; and
- Levels of funding.

However, to date, improvements in correctional health care have been scattered. While some state systems and institutions have made great advances, others have not taken the first steps. If improvements are to be made in more prisons and jails, more key executives and corrections decisionmakers need to become aware of the problem and to acquire the knowledge and skills needed to handle critical issues and take effective action.

Across the country, correctional administrators have indicated that persons working in the field are primarily concerned about health care in several respects:

- Court orders and rulings and their legal implications;
- The development and implementation of health care standards;
- Options or alternatives for health care service delivery and the acquisition of resources; and
- Managing the health care delivery system.

Our purpose is to focus on these issues and several related ones, including assessing service delivery and strategies for change. Because of the wide range of corrections systems in the country being addressed and the options available for improving health care in corrections facilities are so numerous, this book is necessarily limited to looking at some alternatives, either in quite general terms or through specific examples. But, at this early point in the development of health care models in the correctional setting, we believe that the exchange of information is essential to effecting the changes that may be imposed haphazardly if they are not deliberately attempted.

CHAPTER 2. HEALTH CARE: THE CONSTITUTIONAL ISSUES

> One of the guarantees of the "Bill of Rights" may be of little interest to Americans, unless they are accused or convicted of a criminal offense. The Eighth Amendment of the Federal Constitution guarantees, in part, that "cruel and unusual punishments (shall not be) inflicted." Although modern concepts of penology have drawn away from medieval tortures, branding, dunking, and the like, recent court decisions show that the right to freedom from cruel and unusual punishment is still a viable and necessary protection for inmates of correctional institutions--both those awaiting trial and those convicted of crimes.[1]

Traditionally, when a person violates the criminal code and is convicted of a crime, he forfeits certain rights. He forfeits the right to hold public office, the right to vote, and the right to be a juror; but today, in all but a handful of states, most of his other civil rights remain intact, including the right to bring civil actions.

Thus, most inmates can initiate medical malpractice suits when they are denied medical care or find it inadequate. These suits usually attack a single act or omission, are governed by the laws of individual states, and are similar to any other malpractice suit. (They will not be considered here.)

Prisoners who suffer injuries while incarcerated or who want to seek redress for denial of medical care can also bring an action under the Civil Rights Act. These suits generally attack the totality of medical care and conditions and are the ones that have forced prison or jail administrators to begin revamping their health care systems.

To bring a civil rights action, the injured party or parties must allege a violation of one or more of their constitutional rights. In civil rights suits that have attacked medical conditions within a correctional facility, the eighth amendment's prohibition against cruel and unusual punishment is most often cited as the right violated. Court interpretations of the prohibition have included the following important decisions:

* Punishments which are incompatible with the "evolving standards of decency that mark the progress of a maturing society" are repugnant to the eighth amendment. Trop v. Dulles, 356 U.S. 86, 101 (1958)

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[1] Isele, William Paul. Constitutional Issues of the Prisoner's Right to Health Care. American Medical Association, Chicago, Ill., 1976. (Reprinted on page 9.)

* Punishments which "involve the unnecessary and wanton infliction of pain" violate the eighth amendment. Gregg v. Georgia, 96 S.Ct. 2909, 2925 (1976) (plurality opinion)

* The cruel and unusual punishment clause of the eighth amendment embodies "broad and idealistic concepts of dignity, civilized standards, humanity and decency..." Jackson v. Bishop, 404 F.2d 571, 579 (1968)

In 1976, after reviewing principles established over the last twenty years, the Supreme Court clearly stated the inmate's right to have medical care:

> (The) principles (behind the guarantee against cruel and unusual punishment) establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. Estelle v. Gamble, U.S. 97 S.Ct. 285.

This sweeping decision still leaves to various Federal courts the work of building up a body of case law to define the nature of the medical care that should be guaranteed to inmates. Slowly, these definitions and standards are evolving. For it has only been during the last few years that health care in corrections has gained much attention. Generally, those who have looked at health care delivery systems in prisons and jails, both judges and civil rights activists, have found them to be largely inadequate--in quality, quantity, accessibility, continuity, and efficiency.

As a result, the decisions that are coming from the courts are requiring corrections officials to make numerous and sometimes radical improvements, based on the eighth amendment guarantees.

Although the courts have also placed some limitations on what they understand the eighth amendment guarantees to be in terms of medical care, they are still very much in the throes of deciding what must be made available to inmates; that is, what is reasonable or even adequate medical care. But as William Isele points out, the courts have generally taken "a negative approach, defining what is considered to be inadequate or unreasonable medical care."[2]

However, in the Gamble decision, the Supreme Court did set forth a standard for judging complaints when it concluded:

> ...deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain,"...proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. (97 S.Ct. at 291)[3]

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[2]Ibid.

[3]Ibid.

The court cited at least four major areas that apparently constitute "deliberate indifference":

- Denial of treatment,
- Failure to provide prescribed treatment,
- Delay in providing treatment, and
- Providing inadequate treatment.

In addition, judges have decided that a shortage of funds is not justification for denying an inmate his right to medical attention. (Gates v. Collier, 501 F.2d 1291, 1302, 1974).

Litigation has clearly put prison administrators under pressure and, in some cases, mandated them to provide both more and better quality medical care. Administrators of jails which house pretrial detainees--persons not convicted of any crime--have perhaps even greater responsibility to some of those incarcerated and in their charge since a person is considered innocent until proven guilty in a court of law. Again, as Isele points out, the only difference between a person detained and one who is not may be financial, and our system demands that no person be punished except by due process of law.[4] Therefore, cases involving medical services for pretrial detainees will usually center on the due process clause.

Isele has clearly discussed, in detail, the general legal principles that currently affect prisoners' rights to medical services in the paper reproduced on the following pages.[5]

Appendix I contains a detailed outline and citations of court decisions that have affected the delivery of medical care in both jails and prisons. Of course, specific types of decisions can vary from state to state and even among the Federal circuits.

This article should provide a basis for understanding the implications of recent court decisions. Such understanding, in conjunction with knowledge of various standards being written (the subject of chapter 3) should lay the foundation for directing future developments and improvements in the delivery of health care services in corrections.

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[4]Isele, William Paul, Legal Obligations to the Pre-Trial Detainee, American Medical Association, Chicago, Ill. 1977, p. 13.

[5]The AMA has also prepared studies on the rights of pretrial detainees to medical services, the legal implications of using allied health personnel, and other legal aspects of health care in correctional facilities that may be of particular interest to certain institutions.

CONSTITUTIONAL ISSUES OF THE PRISONER'S RIGHT TO HEALTH CARE

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In this paper, an attempt is made to set forth the general principles of law which govern the rights of the confined. With respect to specific issues not addressed by the United States Supreme Court, the reader will note that court decisions and statutory law do vary somewhat from state to state and that differences do exist among the various Federal Circuits. For authoritative legal advice on specific problems, competent local legal counsel should be consulted.

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INTRODUCTION

One of the guarantees of the "Bill of Rights" may be of little interest to Americans, unless they are accused or convicted of a criminal offense. The Eighth Amendment of the Federal Constitution guarantees, in part, that "cruel and unusual punishments [shall not be] inflicted." Although modern concepts of penology have drawn away from medieval tortures, branding, dunking and the like, recent court decisions show that the right to freedom from cruel and unusual punishment is still a viable and necessary protection for inmates of correctional institutions--both those awaiting trial and those convicted of crimes. The proper health care of prisoners--the medical condition of individuals as well as the health-related conditions of the prison environment--has become the subject of numerous prisoner-initiated lawsuits, and the focus of Federal Court rulings that the Eighth Amendment imposes certain duties on prison officials.

This paper will examine what the courts understand such care to be, as well as the difficulties recognized in providing for the health needs of prisoners. Specifically, attention will be paid to the duty of the State with respect to providing health care, the right of the prisoner to receive it, and the development of standards to define the extent of health care required.

For purposes of this paper, the term "jail" will be used to refer to institutions where persons are detained awaiting trial ("detainees") or, following conviction, are serving short term sentences; "penitentiary" will refer to institutions housing those already convicted of crimes and serving long term sentences; "prison" and "prisoner" will be used generically to refer to either or both.

DO PRISONERS HAVE ENFORCEABLE LEGAL RIGHTS?

One of the anomalies of discussing the Constitutional "rights" of prisoners is that, traditionally, a person forfeits certain rights when he is convicted of a violation of the criminal law, including the right to bring civil suit to enforce basic rights. As the law now stands, only eight States still retain "civil death" statutes, i.e., laws which provide that certain convicts forfeit all civil rights, including the right to bring civil suit.[1] Two additional States have Statutes which affect the status of convicts.[2] Those imprisoned awaiting trial, of course, retain all the rights of free citizens, except those necessarily suspended by the fact of their confinement.

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[1]Alaska Stat. 11.05.070 (1962); Arizona Rev. Stat. Ann. 13-1653 (1956); Idaho Code Ann. 18-311 (1948); Missouri Ann. Stat. 222.010 (1959); New York Civil Rights Law 79 (1973); Oklahoma Stat. Ann. 21-66 (1951); Rhode Island Gen. Laws 13-6-1 (1956); West Virginia Code Ann. 28-5-33 (1971).

[2]Hawaii Rev. Stat. 353-38 (1968) causes all property of a convict sentenced to life imprisonment to vest in his heirs at time of conviction. Maine Rev. Stat. Ann. 19-631 (1964) dissolves the marriage of a person imprisoned to life, without need of divorce proceedings.

Of the eight States' Statutes which still suspend a prisoner's civil rights, only six suspended those of persons sentenced for less than life terms (New York's specifically recognizes the right to sue of those sentenced to less than life terms; Rhode Island's specifically restricts only the making of wills and conveyances: the right to sue is not directly mentioned). Of these six, Missouri and Arizona provide that "injury to person" remains punishable as if the person were not convicted and sentenced; court decisions in Missouri have further limited the Statute such that it is held not to bar actions by convicts under the Federal Civil Rights Statutes.[3] Consequently, only four states (Alaska, Idaho, Oklahoma and West Virginia) might be seen as suspending, for the term of the sentence, the right of a prisoner serving less than a life term to sue under the Federal Civil Rights Statutes. Court decisions in two of these States have recognized that the right to sue is a protected right of parolees, irrespective of their original sentences.[4]

The majority of States, either by simply repealing "civil death" Statutes or by enacting specific protections, have restored to convicts the right to bring civil suit.[5] The statement made by the Judicial Council of Kansas in 1968, as a Statute was enacted restoring the rights of imprisoned persons in that State, may be considered representative:

> Under this section, the convicted person who is confined to prison loses his right to hold public office, his right to vote and his right to be a juror. Otherwise, his civil rights will remain intact, excepting of course, those rights that must be limited in order to make his imprisonment effective. No distinction is made between life termers and other prisoners, since many persons sentenced to life imprisonment are eventually released.[6]

Consequently, a prisoner currently has, under the law of all but a handful of states, two possible causes of action if he is deprived of a basic constitutional right and suffers injury while confined: he can bring an action under the Civil Rights Act (42 U.S.C. 1981-1987 (1964) or he can bring a civil action in the proper jurisdiction.)

A CONSTITUTIONAL RIGHT TO MEDICAL CARE

Basic among the rights which prisoners do not lose is the right to those things necessary to sustain life. The United States Supreme Court has recently stated that:

> (The) principles (behind the guarantee against cruel and unusual punishment) establish the government's obligation to provide medical

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[3] Wilson v. Garnett, 332 F.Supp. 888 (D.C. Mo., 1971). Beishir v. Swenson, 331 F. Supp. 1224 (D.C. Mo., 197.).

[4] Davis v. Pullium, 484 P.2d 1306 (Ok., 1971). Bush v. Reid, 516 P.2d 1215 (Alas., 1973).

[5] 21 Am. Jr. 2d. Criminal Law 626 (1965).

[6] Kansas Statutes Annotated 21-4615 (note) (Supp. 1971).

> care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. Estelle v. Gamble,-U.S.-,97 S.Ct. 285 (1976).

This ruling by the Supreme Court, while clearly establishing the prisoner's right to medical care, leaves many questions unanswered. Must every "medical" need be met, including elective or cosmetic procedures? If not, to what extent must medical care be provided? Various Federal Courts have faced these questions. Following earlier unconditioned statements that "a prisoner is entitled to reasonable medical care "[7], Mills v. Oliver, 366 F.Supp. 77 (E.D. Va., 1973), set forth this qualification:

> This does not mean that every prisoner complaint requires immediate diagnosis and care, but that, under the totality of the circumstances, adequate medical treatment be administered when and where there is reason to believe it is needed.
>
> * * *
>
> Delays in necessary medical treatment are always undesirable, and this court, alert to the precarious position of a prisoner totally dependent upon prison officials for even the most rudimentary medical care, will look closely at cases where abuse of that fundamental duty is alleged.

This Court's recognition of the fact that the prisoner is "totally dependent upon prison officials for even the most rudimentary medical care" is significant. The position of the prisoner is clearly one of dependence; but what duties are owed to the prisoner with regard to health care?

Mills defines "reasonable medical care" as that which is "adequate under the circumstances." Two questions are raised by this definition: what is meant by "adequate" and what is the "totality of circumstances" which must be considered in determining the reasonability of the care provided?

A. "Adequate" Medical Care

From the outset, it should be noted that the Courts tend to treat "reasonable" and "adequate" as equivalent terms. Attempts at further qualifying the extent of care required do not set positive standards to be followed by prison physicians and officials, but rather take a negative approach, defining what is considered to be inadequate or unreasonable medical care.

This approach is evident in the Supreme Court's discussion in the Estelle case. The Court concluded that:

> deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain,"...

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[7] Edwards v. Duncan, 355 F.2d 933 (C.A.4, 1966) and Blanks v. Cunningham, 409 F.2d 220 (C.A.4,1969).

proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. (97 S.Ct. at 291)

Nevertheless, a review of other decisions on this issue can at least establish certain parameters in an effort to define the prisoner's constitutional right to medical care more clearly.

In Church v. Hegstrom, 416 F.2d 449 (C.A.2, 1969), the Second Circuit delineated the applicable criteria for determining whether a prisoner's claim of inadequate medical treatment is sufficient to constitute a cause of action under the Civil Rights Act. The Court stated that:

> A complaint claiming failure to provide medical care...must suggest the possibility of some "conduct that shocks the conscience,"...or "barbarous act"...Mere negligence in giving or failing to supply medical treatment alone will not suffice. (416 F.2d at 451)

The Court held that where no "severe and obvious injuries" were alleged, nor any allegation that "any of the defendants knew that the treatment was required for the preservation of...life, that [the prisoner] ever requested such treatment, or even that any defendant was aware of his condition," no Constitutional deprivation was made.

The Second Circuit applied the Church criteria in Martinez v. Mancusi, 443 F.2d 921 (C.A.2, 1970) where a prisoner was not provided prescribed medication and was made to stand and walk, contrary to doctor's orders, on a leg which had just undergone surgery for correction of a polio condition. In a suit against prison officials and the prison physician, the Court stated:

> Obviously, courts cannot go around second guessing doctors. But neither can they ignore gross misconduct by a doctor, especially when it violates specific orders by specialists in charge of the case.
>
> Clearly, then, the defendants' conduct... was more than mere negligence or poor medical judgement; it is charged to have been deliberate indifference to, and defiance of, explicit medical instructions, resulting in serious and obvious injuries...We hold that the facts as alleged are sufficient to constitute a violation of [prisoner's] constitutional rights and thus to state a cause of action under the Civil Rights Act. (443 F.2d at 924-925)

The Martinez case thus defines inadequate care somewhat more closely. While it might appear at first glance that the Court has reversed itself on whether "mere negligence" can be sufficient to designate the care given as Constitutionally "inadequate," a closer look will show that the Court here is speaking of "gross negligence." The Martinez Court reaffirms that principle that, if medical care is given at all, "mere negligence" does not make such care so "inadequate" as to be a denial of prisoners' rights. However, the Court does assert that "gross negligence" as well as "deliberate indifference" are examples of "conduct that shocks the conscience," and therefore unreasonable.

Still another Court has taken additional steps in an attempt to define "reasonable" health care. In Stokes v. Hurdle, 393 F.Supp. 757 (D. Md., 1975) the Court asserted that the deprivation or inadequacy of "essential" medical care is unreasonable. The Court continued:

> In determining whether medical care was "essential" in a given case, the question is whether a physician exercising ordinary skill and care would have concluded that the symptoms evidenced a serious injury; whether the potential for harm by reason of delay or denial of medical care was substantial; and whether such harm did result. [citations ommited]. Hence, a deprivation of medical treatment that seriously endangers the prisoner's well-being would be actionable [under the Civil Rights Act]. (393 F.Supp. at 761)

Thus, inadequate or unreasonable health care can be seen to have a threefold definition, represented by these three cases: if the lack of care is such as to "shock the conscience of the Court," i.e., "deliberate indifference" to the prisoner's condition; if the treatment of the prisoner is "grossly negligent" or constitutes "barbarious acts;" or if a deprivation of care would, in the judgement of a physician exercising ordinary skill and care, seriously endanger the prisoner's well-being, the Courts will consider such treatment inadequate and therefore sufficiently unreasonable to constitute a violation of the prisoner's Constitutional rights. Nearly all of the Federal Circuits have accepted one or more of these tests.[8]

As far as they go, these negative definitions of "adequate" care are helpful. It can be determined from them that prison officials and physicians are not obligated to provide "optimal" care to prisoners, but rather "care... that is reasonably designed to meet their routine and emergency health care needs." Battle v. Anderson, 376 F.Supp. 402 (E.D. Ok., 1974)

B. Circumstances Affecting Medical Care in Confinement

For care to be considered reasonable, as is established above, it must be "adequate under the totality of circumstances." A designation of inadequate treatment does not sufficiently address the question of the competence of the physicians employed to render care; it does not address the question of what

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[8]In addition to the cases cited above, see, e.g.: Hoitt v. Vitek, 497 F.2d 598 (C.A.1, 1974); Gittelmacher v. Prasse, 428 F.2d 1 (C.A.3, 1970); and Roach v. Kligman, 412 F.Supp. 521 (E.D. Pa., 1976); Hirons v. Director, 351 F.2d 613 (C.A.4, 1965); Blanks v. Cunningham, 409 F.2d 220 (C.A.4, 1969); Newman v. Alabama, 503 F.2d 1320 (C.A.5, 1975); and Campbell v. Beto, 460 F.2d 765 (C.A.5, 1972) inter alia; Fitzke v. Shappell, 468 F.2d 1072 (C.A.6, 1972); U.S. ex rel. Knight v. Ragen, 337 F.2d 425 (C.A.7, 1964); Jones v. Lockhart, 484 F.2d 1192 (C.A.8, 1973) inter alia; Tolbert v. Eyman, 434 F.2d 625 (C.A.9, 1970); and Runnels v. Rosendalo, 499 F.2d 733 (C.A.9, 1973).

medical facilities should be provided within the prison or in what situations prisoners should be provided the opportunity of seeking outside medical care. These are some of the "circumstances" which must be considered. Although, for the most part, Courts have not set specific standards in these areas, they deserve discussion.

1. Physician Competence

Regarding the competence of physicians employed to render care in prisons, the Courts have not allowed prisoners to bring civil rights actions when there is merely a disagreement between the prisoner and the physician over what treatment is needed. When the prisoner's complaint is one of professional negligence, he is normally left to his remedies under normal principles of tort law.

When there is a disagreement between physician and prisoner over what constitutes "adequate" medical care, the Courts have clearly recognized the physician's right to exercise his professional judgement free from constitutional challenge by his prisoner-patient. In Coppinger v. Townsend, 398 F.2d 392 (C.A.10, 1968), the Court stated:

> The prisoner's right is to medical care--not to the type or scope of medical care which he personally desires. A difference of opinion between a physician and a patient does not give rise to a constitutional right or sustain a claim under 1983. (398 F.2d at 394)[9]

It is made clear in this situation that what constitutes "adequate" medical care is a medical determination, with which the Courts indicate their desire not to interfere. This has been solidly established in a series of decisions by the Eighth Federal Circuit. In Seward v. Hutto, 525 F.2d 1024 (C.A.8, 1975) the Court, quoting trial Judge Eisele, asserted:

> In light of this, the petition exhibits a mere disagreement between the inmate and the prison physician as to what is necessary and proper for his medical care. Such matters, in the absence of allegations of intentional neglect or mistreatment, should be left to the medical judgement of the prison physician. (525 F.2d at 1024) (emphasis added)[10]

It should be fairly evident that "intentional neglect" of a prisoner's medical needs could constitute the sort of cruelty prohibited by the Eighth Amendment. It may not be as clear how to differentiate "mistreatment" from what has come to be known as "malpractice." One example appeared in the case of Williams v. Vincent, 508 F.2d 541 (C.A.2, 1974). There, a prison physician made no attempt to reaffix a prisoner's severed ear, but threw away the ear and stitched the stump. The

[9] See also: Stiltner v. Rhay, 371 F.2d 420 (C.A.9, 1967); U.S. ex rel. Lawrence v. Ragen, 323 F.2d 410 (C.A.7, 1963); Jones v. Lockhart, Supra., (C.A.8, 1973); U.S. ex rel. Hyde v. McGinnis, 429 F.2d 864 (C.A.2, 1970); Walnorch v. McMonagle, 412 F.Supp. 270 (E.D. Pa., 1976).

[10] See also: Courtney v. Adams, 528 F.2d 1056 (C.A.8, 1976) and Ellingberg v. Lloyd, 491 F.2d 728 (C.A.8, 1974).

Court determined that such choice of the "easier and less efficacious treatment" may be attributable to "deliberate indifference...rather than an exercise of professional judgement." The Supreme Court is clear in upholding the lower courts in this regard, affirming that

> Medical malpractice does not become a constitutional violation merely because the victim is a prisoner, absent acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. (Estelle at 292)

Thus, where some medical care has been provided to a prisoner, such that he cannot claim total neglect of his medical needs, he must show rather grievous intentional acts to support his claim that his right to medical care has been denied. It has been clearly stated that:

> Prison officials and medical officers have wide discretion in treating prisoners, and a simple claim of malpractice does not give rise to a claim under Sections 1981 or 1983 of the Civil Rights Act , Tolbert v. Eyman, 434 F.2d 625 (C.A.9, 1970) at 626[11]

and elsewhere:

> To state the issue succinctly, the Federal Civil Rights Act was designed to protect constitutionally guaranteed rights, not to provide a Federal forum for trial of actions for alleged medical malpractice. Mayfield v. Craven, 299 F.Supp. 1111 (E.D.Cal., 1969) at 1113

Essentially, injury to the prisoner resulting from simple negligence ("malpractice") is not a violation of the Eighth Amendment guarantees. Courts have recognized that negligent injuries are an "apparently unavoidable frequent occurrence of life...not...cruel and unusual punishment." Ramsey v. Ciccone, 310 F.Supp. 600 (W.D.Mo., 1970) at 605. The prisoner has remedies available under State laws and in State Courts when he states a claim requesting damages for personal injuries. He has no constitutional right to "perfect" or "superior" medical treatment, and must pursue his claim for professional negligence in the State Courts.

The competence of prison physicians may be of concern in another sense, however. Many states provide that physicians who are not fully licensed may in some circumstances be employed in State institutions, such as prisons and mental hospitals. In addition, many local jails do not have "in-house" medical staff, and must rely on the services of the physicians of the surrounding communities, frequently on a voluntary "on-call" basis. Although individual limited license and voluntary physicians might be quite competent, it must be recognized that the system is not attractive to the average physician. The charge frequently made was summed up by one recent commentator as follows:

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[11] See also: U.S. ex rel. Lawrence v. Ragen, Supra.

> Traditionally prisons have been where medicine's undesirables--foreign medical graduates, doctors with drinking or drug problems, older doctors--wind up treating society's undesirables. Pay has been low; benefits poor. Working conditions remain, at best unattractive. Back-up facilities are poor or non-existent. There is also fear--fear of assault or of being held hostage.[12]

Such charges are unfair to the many foreign-trained and older doctors, and others, who are rendering competent care to the confined. But the question remains whether, overall, the quality of physicians working in prisons equals that of those outside. The economic and safety factors discussed by Coste are certainly relevant to the question. Some proposals to deal with these conditions include arrangements with medical schools (interns and residents) to provide medical services, merging prison medical facilities with existing community clinics, and "contracting out" to hospitals and other medical resource centers in the neighboring community. As one physician has stated in his concern for the standard of care in state mental hospitals:

> The direction of state-hospital staffing could be reversed through the integration of state hospitals with community health centers. It is mandatory that this be based on common professional standards and salary scales that community goals will determine as adequate to attract and reward clinically oriented [physicians]. Furthermore, an integration of services will broaden the effectiveness of both community-situated and hospital [physicians] and, permitting treatment in continuum, will be professionally more satisfying than the present medical dichotomy permits for either.[13]

Although this proposal is directed at improving the quality of care in state mental hospitals, it is equally applicable to medical facilities in state-run prisons.

Some argue that such arrangements remove the immediacy of access to physicians and the security available when medical care is provided within prison walls. Others assert that such arrangements provide for a more efficient use of financial, equipment and medical manpower resources and the access, by and large, to more highly trained physicians.

2. Facilities

A substantial diversity in the type and size of correctional facilities exists. Large state penitentiaries are more likely to have in-house infirmaries than are local jails. Yet, the rights of those confined in local jails pending

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[12] Coste, "Prison Health Care: Part of the Punishment?" 25(4) New Physician 29-35 (April, 1976).

[13] Bartlett, F.L. "Present-Day Requirements for State Hospitals Joining the Community." 276 New Eng. J. Med. 90 (1967).

trial must not be given any less attention than those convicted and confined; in fact "distinctions, if any are conceivable, should be the other way." Rozecki v. Gaughan, 459 F.2d 6 (C.A.1, 1972) at 8

Furthermore, despite statements to the contrary, circumstances surrounding the rendering of care in prison (whether by a full-time infirmarian or an on-call physician) do differ from those in the community in general. Access to specialists and hospital facilities may be more limited in prison than in the community and the very fact of incarceration alters the confined's access to medical care.

3. Specialized Treatment

The question of availability of specialists or specialized treatment is a significant one, which has not been treated in great detail by the Courts. In a recent case, Mosby v. O'Brien, 414 F.Supp. 36 (E.D. Mo., 1976), a prisoner alleged that he should have had examination at a county hospital for a kidney condition. He was denied such treatment, and the Court dismissed the suit as merely a disagreement between the prisoner and physician as to the proper course of treatment. In most instances where the need for a specialist has been raised, the Courts have deferred to the prison physician's medical judgement that treatment by a specialist was unnecessary.[14]

There have, however, been decisions which recognize a prisoner's right to "the most suitable medical treatment reasonably available" Ricketts v. Ciccone, 371 F.Supp. 1249 (W.D. Mo. 1974) at 1256. A subsequent decision interpreted this to mean that, where a private specialist can provide the more suitable treatment, procedures not available at the prison, and the prisoner is willing and able to pay the expense of such treatments, he cannot arbitrarily be denied access to them. Bartling v. Ciccone, 376 F.Supp. 200 (W.D. Mo., 1974). There may, however, be reasonable considerations (security or cost factors, for example) for denying such outside access. The Bartling case does not deal with such problems, however, because the prisoner had met all requirements for a furlough under the appropriate statute, and was willing and able to pay for the outside treatment.

Excellent standards in this regard have been advanced in the concurring opinion of Chief Judge Phillips of the Sixth Circuit Court of Appeals, in the case of Schmidt v. Wingo, 499 F.2d 70 (C.A.6, 1974):

> Once informed of the prisoner's injury or illness, it is my view that the warden has the duty...to investigate 1) the extent of the injuries, 2) the realistic possibilities of treatment, considering the availability of medical personnel and medical equipment, both inside and outside the prison, and 3) the consequences of pursuing the alternative methods of medical treatment. If one available avenue of treatment, albeit outside the walls of the prison, could save the life of an injured or ill prisoner, then that is the course which the prison warden would be required to follow.
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> Nothing in this concurring opinion is...intended to imply that a prisoner

[14] See, e.g. Santiago v. Sowers, 347 F. Supp. 1055 (M.D. La., 1972) and Sloan v. Zelker, 362 F.Supp. 83 (S.D.N.Y., 1973).

injured with a heart wound, for example, would be entitled to the services of the foremost heart surgeon in the nation. A rule of reason, applied on a case by case basis, must determine the adequacy of medical care provided. (499 F.2d at 75-76)

Such a "rule of reason" was applied in the case of Hampe v. Hogan, 388 F.Supp. 13 (M.D. Pa., 1974). In that case, the prisoner had been afforded extensive medical care both in and outside a federal prison. When he sought still one more specialized procedure, the benefit of which was seen as questionable by his physicians, the Court concluded that the prisoner had undergone "the most intensive medical treatment that could be afforded him in the federal prison system" and that he had no right of access to additional care in light of the speculative advantages of the procedure.

4. Economic Considerations

Many Courts have taken the position that cost should not be a factor in determining what is "adequate" health care for prisoners. In the colorful language of the Court in Newman v. Alabama, 503 F.2d 1320 (C.A.5, 1975):

> It is not without some trepidation that we uphold the finding of a constitutional violation. Officials in the A[labama] P[enal] S[ystem] are shackled by anachronistic equipment, inadequate staffing, and parsimonious funding, factors which render Sisyphean their task of insuring that adequate medical care is available to inmates.
>
> By the same token, however, we cannot be impervious to the precarious position of inmates who, though dependent solely on a prison for medical attention, find their pleas for attention unheeded. Deep-seated inmate frustrations can be exacerbated by a perceived callous indifference to their medical plight. The incidence of frustration thwarts the purported goal of rehabilitation...(503 F.2d at 1333)

This principle, that limited budget will not justify insufficient care. has been clearly acknowledged by numerous Courts. The position of Judge Blackmun (now a Justice of the U.S. Supreme Court) in Jackson v. Bishop, 404 F.2d 571 (C.A.8, 1968) is representative: "Humane considerations and constitutional requirements," he said, "are not, in this day, to be measured or limited by dollar considerations..." (404 F.2d at 580)[15]

Thus, when determining whether a prisoner could have access to an outside specialist, the Court in Bartling v. Ciccone, Supra. set aside the argument that allowing such treatment for a prisoner who could pay would deny equal protection to similarly situated prisoners who could not. The Court held that disparity merely in the personal resources of prisoners could not raise a violation of Equal Protection. Furthermore, the Court asserted that the government "could and should eliminate disparity by providing sufficient funds to permit [the prison] to offer adequate treatment." It would appear that, where specialized treatment is needed,

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[15] See also: Finney v. Arkansas, 505 F.2d 194 (C.A.8, 1974): Gates v. Collier, 501 F.2d 1291 (C.A.5, 1974); Costello v. Wainwright, 525 F.2d 1291 (C.A.5, 1976); Rozecki v. Gaughan, 459 F.2d 6 (C.A.1, 1972); Rouse v. Cameron, 373 F.2d 451 (C.A. D.C., 1966); James v. Wallace, Supra., Holt v. Sarver, Supra., and Holt v. Hutto, 363 F. Supp. 194 (E.D. Ark., 1973).

the Court would require that it be provided, regardless of the cost.

While the need for medical care and the improvement of prison facilities is acknowledged, it must be questioned whether such requirements are realistic. At least one Court has recognized the realities of the situation. In the trial court decision of Schmidt v. Wingo, 368 F.Supp. 727 (W.D. Ky., 1973) (appellate decision cited Supra) these significant statements were made:

> The Court is not unmindful of the contentions that the equipment and personnel for the medical care of an inmate at [this prison]...were entirely inadequate. However, it is not believed that it was the intention of the framers of the Civil Rights Act to place liability on the Warden of a penitentiary for the failure to furnish such equipment and personnel, where the budget for personnel and equipment are fixed by his superiors, the Department of Corrections and by the General Assembly of the State of Kentucky.
>
> The Court believes that the responsibility of the Warden is to render such medical care as is available at the institution, under the circumstances, and that only when he refuses to render that care should he be held liable for violation of the Civil Rights Act. It is, of course, devoutly to be hoped that provisions have been made since the tragic death in 1969 of the plaintiff's decedent for an upgrading of equipment and for a firm arrangement for the provision of such medical aid as may be needed in emergencies, recognizing, of course, that it is not the duty of the Penitentiary to have on permanent hire a thoracic surgeon, or a general anesthesiologist. (368 F.Supp. at 731)

The approach of this Court, to encourage the adoption of reasonable standards of medical care, equipment and availability of specialists, takes into account the hard fact that legislatures must provide funds. It is clear that more funds are needed to provide the sort of health care which the Courts have determined is a prisoner's right. But the question must be raised: to what extent should funds presently allocated to other programs (i.e. welfare, education, public hospitals) be drawn off to provide for this need? Public resources are limited, and legislators must make decisions regarding their use.

5. Other Factors Affecting Health Care

Because of the situation of confinement, certain specific duties are owed to inmates by prison officials. "Medical Care" is simply one ingredient in the overall health care which inmates deserve as a constitutional right. In addition to providing treatment by physicians for illness and injury, prison officials are impressed with a duty to see that hygienic conditions and a reasonably safe environment are maintained.

Holt v. Sarver, 300 F.Supp. 825 (E.D. Ark., 1969) addressed the issue of a safe environment. In this case the Court asserted that if:

> The State of Arkansas chooses to confine penitentiary inmates in barracks with other inmates, they ought at least to be able to fall asleep at night without fear of having their throats cut before morning, and...the State has failed to discharge a constitutional duty in failing to take steps to enable them to do so. (300 F.Supp. at 831)

The Court added:

> Where an unconstitutional situation is found to exist in a given prison, the prison authorities cannot escape responsibility for it by merely pointing to the existence of the same situation in other prisons, or by establishing that conditions in their prison are "better" or "no worse than" conditions prevailing elsewhere.

The importance of maintaining sanitary conditions, as well as reasonable protection from the threat of violence, was dealt with in James v. Wallace, 406 F. Supp. 318 (M.D. Ala., 1976). The Court emphasized that the Eighth Amendment "must draw its meaning from the evolving standards of decency that mark the progress of a maturing society." In this light, the Court found that living conditions in Alabama prisons constituted "cruel and unusual punishment." Primary among the Court's concerns were the lack of sanitation in living areas, infirmaries and food service areas, which presented "imminent danger" to the health of every inmate. In addition, the Court cited the lack of opportunity for exercise and recreation, and the fact that "gross inadequacies" in medical treatment has not been corrected.[16] The Court appended to its order "Minimum Constitutional Standards" which detailed, inter alia, the number of inmates to be confined in a single cell, sizes of cells, and sanitary standards. The duty to adhere to these specific standards was imposed under penalty of closing the facility as "unfit for human confinement."

Finally, with regard to officials' "affirmative duty to make available to inmates a level of medical care which is reasonably designed to meet the routine and emergency health care needs of inmates," the Court in Battle v. Anderson, 376 F.Supp. 402 (E.D. Okla., 1974) set forth the following test:

> [A]ctionable circumstances result where, as here, the level of medical care available to a confined and dependent population is inadequate to meet predictable health care needs because of obvious and sustained deficiencies in professional staff, facilities and equipment. When continued and systematic deficiencies of this nature exist and have resulted in the actual impairment of inmate health, and when such deficiencies continue to post a current and potential threat to the physical health and well-being of an entire prison population, then inmates are deprived of the basic elements of adequate medical treatment in violation of the Eighth Amendment...(376 F.Supp. at 424)

Consequently, the duty of prison authorities is to provide overall health care, including the environment which will reasonably safeguard the overall health of the prison population. The finest of medical care, if not provided in conjunction with sanitary and safe environment, will not improve the health care situation in prisons. Statements that dollar considerations must not enter into the establishment of a prison health care system may be intended to stimulate the legislature to act in this regard, but such statements alone will not alter prison conditions. If it is not sufficient, as stated in Holt v. Sarver, Supra.,

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[16] Similar concerns were expressed in Dillard v. Pitchess, 399 F.Supp. 1225 (C.D. Cal., 1975) and Jones v. Wittenberg, 323 F. Supp. 93 (N.D. Ohio, 1971).

that conditions in one prison be simply "better" or "no worse" than those in other prisons, then standards should be established which officials can use as guidelines in establishing a constitutionally satisfactory system. Two cases have resulted in judicially imposed standards: James v. Wallace, Supra. (State prisons) and Ramsey v. Ciccone, 310 F.Supp. 600 (W.D. Mo., 1970) (Federal prisons). These two sets of standards necessarily attract the attention of other prison systems and governmental agencies. An additional step towards generally applicable standards is being taken by the American Medical Association. In cooperation with the Federal Law Enforcement Assistance Administration, that Association, representing the medical profession, is currently engaged in a nationwide study of prison conditions in order to develop a comprehensive set of health-care standards.

Will the promulgation of such standards mean that the prison officials or the State are required to provide an environment frequently superior to that with which the prison inmates are familiar? Would not prisoners in such an environment be better off in terms of overall health care (sanitation, diet, medical care) than many "law-abiding" citizens dwelling in poor rural or urban ghetto areas? If so, the question must be raised, why should those who have violated society's rules be so "rewarded?" An answer to this concern is posed by the Court of Appeals in Fitzke v. Shappell, Supra.:

> An individual incarcerated, whether for a term of life for the commission of some heinous crime, or merely for the night to "dry out" in the local drunk tank, becomes both vulnerable and dependent upon the state to provide certain simple and basic human needs. Examples are food, shelter and sanitation. Facilities may be primitive, but they must be adequate. Medical care is another such need. Denial of necessary medical attention may well result in disabilities beyond that contemplated by the incarceration itself...Restrained by the authority of the State, the individual cannot himself seek medical aid or provide the other necessities for sustaining life and health. (468 F.2d at 1076) (emphasis in original)

Admittedly, many law-abiding citizens exist even without some of these "simple and basic human needs." The inequities of the situations are real and cannot be denied. The fact that prison inmates are restrained by and dependent upon the State is certainly one factor which must be considered. However, it seems necessary to point out that, while the prisoners should not be subjected to "disabilities beyond that contemplated by the incarceration itself" and a healthy, safe environment is conducive to rehabilitation, the States cannot ignore the plight of rural and ghetto dwellers who are not imprisoned. Again, the difficult question of allocation of limited human resources must be faced, and hard realities must be weighed against the ideals of our justice system.

C. Conclusion

In brief, then, a prisoner does not lose all of his civil rights during and because of his incarceration. "In particular, he continues to be protected by the due process and equal protection clauses [of the Federal Constitution] which follow him through the prison doors." Jackson v. Bishop, Supra., at 576. A prisoner clearly has a constitutional right to adequate medical treatment, under

both the Civil Rights Act and the prohibition against cruel and unusual punishment. The general view recognizes that "in the area of medical treatment prison officials have a 'broad discretion' under the civil rights statutes."[17] Consequently, it is recognized that the extent and manner of medical treatment to be given varies with the individual case, and the specifics of such care will normally be left to the medical judgement of the treating physician. Although "Courts should place their confidence in the reports of reputable prison physicians that reasonable medical care is being rendered," Cates v. Ciccone, 422 F.2d 926 (C.A.8, 1970), they will intervene where there is evidence that no care is being given, or that there is such gross, intentional mistreatment as to be effectively a denial of care. Disagreements over what is proper care, and claims of "simple malpractice" do not raise constitutional questions, but in the majority of States, prisoners have the same right as non-prisoners to sue in the State Courts for personal injury.

Physicians should not be held to any stricter standard of care for prisoners than for other patients. Their duty is the same in both cases--to render competent professional care. In some instances, as discussed above, physicians will be handicapped in this regard by facilities and conditions which are not conducive to the rendering of good medical care. In many cases, ready referral and modern equipment are a "luxury" to physicians working in prisons. While the prison officials may be held liable for failing to provide equipment and access to specialized care, can the physician, faced with these conditions, be held to the same standard of care as his colleagues in the civilian community? The Courts have not dealt with this question. It has been established that such a physician will not be held to a greater standard of care than his civilian counterparts,[18] but whether the standard of care should be lower in instances where equipment and referral are not readily available has yet to be determined. However, the general standard by which most Courts now judge the performance of such physicians may lead to a specific "prison standard of care." In Blair v. Eblen, 461 S.W.2d 370 (Ky., 1970) the Court stated:

> The defendant [physician] was under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances.
>
> Under the standard just expressed, the evidence may include the elements of locality, availability of facilities, specialization or general practice, proximity of specialists and special facilities as well as other relevant considerations. (461 S.W.2d at 373) (emphasis added)

Under this standard, the prison physicians who had limited access to specialists and modern facilities may not be held to the same standard as a

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[17] Robinson v. Jordon, 494 F.2d 793 (C.A.5, 1974)

[18] U.S. ex rel Fear v. Rundle, 506 F.2d 331 (C.A.3, 1974) and Edwards v. United States, 519 F.2d 1137 (C.A.5, 1975).

colleague with ready access to such facilities. The prison officials, of course, might be held liable for not providing adequate facilities to care for the routine health needs of inmates, but the physician's personal liability should be conditioned on his use of the facilities available to him.

CHAPTER 3. STANDARDS: THEIR IMPLICATIONS FOR HEALTH CARE IN CORRECTIONS

> ...In setting health care standards for the incarcerated population in the United States, the intent of the American Public Health Association is not to promote special treatment for this population but rather to insure that their incarceration does not compromise their health care.[1]

Only during the past decade have health care services in correctional institutions come under serious scrutiny by the courts and professional organizations involved in medical care or corrections. The American Correctional Association touched on the subject in its 1966 Manual of Correctional Standards. Last year the American Public Health Association (APHA) provided a more detailed overview of what health care should be delivered behind bars when it published its Standards for Health Care Services in Correctional Institutions.

In explaining APHA's reasons for developing health care standards, Richard Della Penna pointed out that the very "state of incarceration may create or intensify the need for health care services."[2] On the outside, both the choice (depending on income) and the responsibility for keeping healthy rest mostly with an individual. Health care for prisoners, however, "becomes a public responsibility..., to be borne jointly by the criminal justice and health care system."[3] This view largely reflects what the courts have been saying.

How to meet the demands, however, is still the problem of corrections. APHA's work, like most earlier efforts, merely sets out guidelines for health care services. The standards themselves have no built-in enforcement procedures, consequently, "no teeth." A public health rationale for each subject is the only mechanism APHA has "to reinforce the necessity for compliance requirements."[4] Indeed, as the opening quotation suggests, APHA viewed its task in defining standards as offering benchmarks for concerned institutions to use, not as a way of establishing absolute rules.

The American Medical Association's (AMA) standards for jail health care and

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[1] Della Penna, Richard, Standards for Health Services in Correctional Institutions. American Public Health Association, Inc., Washington, D.C., 1976. p. vii.

[2] Ibid.

[3] Ibid.

[4] Ibid. p. ix.

others under development, however, intend to promote some kind of enforcement mechanism. The AMA is looking for a system of voluntary accreditation currently. But enforcement is likely to become even stronger if the courts and legislatures look to these standards for guidance.

Clearly, the promulgation of health care standards for correctional institutions is going to affect how services are delivered. Administrators will need to be prepared to respond to them and justify their responses to judges and lawmakers in the future.

In the paper that follows, research consultant B. Jaye Anno compares current standard-setting efforts that will affect correctional health care. But as she points out, these efforts to set standards do not ensure change, but only point the way. Once you adapt or establish standards for your own institution (as is likely to be required if not done voluntarily), you will have criteria to evaluate your work--performance yardsticks that will help professionalize and improve your health services and help you avoid taking a spasmodic excursion into unknown territory.

STANDARDS FOR HEALTH CARE IN CORRECTIONAL INSTITUTIONS

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ABBREVIATION KEY

ACA - American Correctional Association

AMA - American Medical Association

APHA - American Public Health Association

CAC - Commission on Accreditation for Corrections

JCAH - Joint Commission on Accreditation of Hospitals

LEAA - Law Enforcement Assistance Administration

NACCJSG - National Advisory Commission on Criminal Justice Standards and Goals

NILECJ - National Institute of Law Enforcement and Criminal Justice

NSA - National Sheriffs' Association

SCUCC - Special Committee on Uniform Corrections Code*

*This is a subgroup of the National Conference of Commissioners on Uniform State Laws.

STANDARDS -- THE STATE OF THE ART

Background and History

Developing standards specifically for health care delivery in correctional settings is a relatively new phenomenon. Until three or four years ago, only two professional organizations had made any efforts of note in this direction. The 1966 edition of the American Correctional Association's (ACA) Manual of Correctional Standards included a chapter on "Health and Medical Services," as did the National Sheriffs' Association's (NSA) Manual on Jail Administration, published a few years later. In both instances, however, the sections relating to health care were relatively short and the guidelines they offered were not very specific.

In contrast to these initial efforts, more recent years have shown an increase in both the number and type of professional organizations involved in setting health care standards for corrections and in the number and specificity of the standards themselves. In 1973, the National Advisory Commission on Criminal Justice Standards and Goals (NACCJSG) released its volume, Report on Corrections, which included sections on "Healthful Surroundings" and "Medical Care" in a chapter on "Rights of Offenders." In 1974, the NSA replaced its Manual on Jail Administration with a series of seven handbooks, almost all of which contained sections relating to some aspect of health care delivery in jails. In 1976, the American Public Health Association (APHA) published the first set of standards devoted solely to health services in correctional institutions.

In addition to these published works, at least three other major standard-setting efforts are currently under way. First, the American Medical Association (AMA) has developed standards for medical care and health services in jails. These are due to be released late in the summer of 1977. Second, the Commission on Accreditation for Corrections (CAC)[1] is in the process of setting standards on all facets of corrections. Those developed for short- and long-term institutions will include sections on health care delivery.[2] Finally, the National Conference of Commissioners on Uniform State Laws has established a "Special Committee on Uniform Corrections Code" (SCUCC), which is currently drafting a medical section to be included in its proposed Uniform Corrections Act.

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[1]This group is supported and endorsed by the American Correctional Association but functions as an autonomous body. The standards developed by the CAC will be adopted by the ACA.

[2]The CAC is planning to adopt the standards developed by the AMA for health care services in short-term institutions, but will be establishing new standards for health care in long-term institutions.

All three of these recent efforts are being funded in whole or in part by the Law Enforcement Assistance Administration (LEAA) or its research arm, the National Institute of Law Enforcement and Criminal Justice. What distinguishes these latest standards from earlier ones is that all three contain some mechanisms for "enforcement" of their recommendations. Those of the AMA for jails and of the CAC for prisons are designed to serve as the base for voluntary accreditation programs, whereas the SCUCC medical section will be incorporated into a piece of model legislation for corrections.

Of these three sets of standards, however, only the AMA's are complete enough to allow for discussion of their content. Neither of the other two sets has yet been approved by their respective internal boards and neither is scheduled for release to the public until later in 1977. Hence, in the pages that follow, the discussion of health care standards for corrections will of necessity be limited to those which have already been published or are in approved and final form. Namely, this includes those of the NSA and the AMA for jails and those of the NACCJSG and the APHA for prisons.[3] Although published, the standards contained in the ACA's 1966 Manual will not be reviewed in detail since they are somewhat outdated and are expected to be largely replaced by those that the CAC is currently developing.

Definition, Purposes and Types of Standards

Having given some indication of the types of organizations involved in establishing standards, it may be helpful now to define the term "standards," to indicate their usual purposes, and to provide the reader with some examples.

To begin with, the term "standard" implies more than a simple statement of policy. It is stronger and more specific than a guideline or a recommendation. The tone is more imperative than suggestive. The use of the term "standards" also implies that there is general agreement as to their content, and that they can be used as a basis for comparison. In the words of NACCJSG,

> When clearly formulated and precisely stated in measurable terms, they (standards) can serve as the basis for objective evaluation of programs as well as development of statutes and regulations relating to correctional services.[4]

In essence then, a standard is a principle with teeth.

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[3]Strictly speaking, the standards established by the latter two groups apply equally to jails and prisons, whereas those developed by the NSA and the AMA are restricted to jails.

[4]NACCJSG, Corrections, Washington, D.C.: U.S. Government Printing Office (1973), p. 4.

The purposes to be served by health care standards for corrections--that is, the reasons professional groups establish them--include at least the following:

1. To promote awareness of a problem area previously ignored;

2. To provide models for institutional self-measurement; and

3. To facilitate corrective change (i.e., to upgrade existing health care facilities and services).

It should be noted, however, that standards in and of themselves do not ensure change. While they often provide the climate and point the direction for change, they lack the power to force it. For standards to be effective, some additional mechanism must be provided for their implementation.

The format and content of the sets of standards to be reviewed here vary widely from group to group. Those contained in the 1974 NSA Handbooks are the most general and the least imperative. In fact, they are more in the nature of recommendations than standards. With the exception of a declaration of a general principle that, "Prisoners have a right to a healthful environment, to include: ... Adequate medical and dental care rendered promptly when needed,"[5] it is difficult to find direct, unequivocal statements with respect to health care. The NSA's policy statements regarding the jailer's responsibility for providing health care--including the type and amount that should be provided and how this should be accomplished--must be extracted from general discussions of the topic. This task is complicated by the fact that there is not one section on health care but several. At least five of the seven handbooks contain paragraphs with recommendations regarding various aspects of health care. Since there is neither a comprehensive index to the seven volumes nor an individual index in the back of each handbook, persistence and diligence are required to locate all of the commentary on health care in jails and to determine the NSA's position on specific topics.

In contrast to the suggestions on health care delivery found in the NSA Handbooks, the document developed by the American Medical Association is a set of standards and not a manual for jail operation. Like the NSA's publications, the AMA document is restricted to jails. Unlike the NSA's however, the AMA's work is also restricted to health care delivery. Other aspects of the jails' operation or management are not covered.

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[5]NSA, Handbook on Inmates' Legal Rights. Washington, D.C.: 1974, p. 13.

The format of the AMA standards also differs from that of the NSA. There are 17 separate sections dealing with issues such as administrative structure, emergency care, non-emergency medical care, dental care, detoxification, intake screening, pharmaceuticals, medical records, etc. Each of these sections includes first a "performance standard," a statement of the ultimate goal to be achieved. For example, under the administrative structure section, the performance standard reads: "The jail has an adequate*[6] administrative and supervisory system for health care delivery."[7]

Each performance standard is then followed by one or more "process standards" which specify what action, process, or function must occur in order for the performance standard to be met. Thus, the process standards set down measurable objectives. For example, those under the administrative section include directives that each jail have a responsible physician or qualified medical authority who assumes responsibility for medical services, that the physician be licensed in that state, that his or her responsibilities to the jail be outlined in a written agreement, that he or she submits an annual statistical report, and that he or she reviews and reports on the health care system at least quarterly.[8]

At times, process standards are followed by a "commentary" which provides additional explanation or rationale for the process standard.

The NSA and AMA documents relate specifically to jails, the standards of both the NACCJSG and APHA are meant to cover both jails and prisons. Of these latter two, those of the NACCJSG are the less specific. In point of fact, excluding environmental issues, what this group has to say about health care occupies only two of the over 600 pages in its volume on corrections. While qualifying as standards in the sense that they are stated in measurable terms, the NACCJSG's treatment of health care issues is too cursory and too general to provide much in the way of meaningful mandates.

Again in contrast to those developed by a correctional body, the standards developed by the second health care group (the APHA) are devoted solely to health and medical issues. They are somewhat similar in format to those of the AMA but are intended to cover prisons as well as jails. In fact, the APHA standards seem most applicable to the larger, long-term facilities since many of

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[6]Asterisks are used throughout the AMA document to indicate that more specific definitions of certain words and phrases are available in the glossary.

[7]AMA, "Standards for the Accreditation of Medical Care and Health Services in Jails." Chicago, Illinois: Spring 1977 (unpublished draft), p. 1.

[8]Ibid., pp. 2-3.

the requirements are unrealistic and virtually unachievable for small, short-term institutions. In one sense, it can be said that the APHA standards represent optimal levels for jail health care systems while those of the AMA represent the minimum acceptable level.

In terms of content, the APHA standards are probably the most comprehensive. In addition to the regular sections on primary and secondary services, dental and mental health care, staffing, pharmacy services, health records, and evaluation, there are special sections on health care services for women, on environmental concerns, and on nutrition and food services. Each section, which begins with a statement of the underlying principle to be addressed, is followed by a paragraph which gives the public health rationale for the standard, and then lists the specific elements that are needed to demonstrate satisfactory compliance.

Current Problems and Future Trends

There are a number of problems with the standards that have been developed by the various professional groups to date. In the first place, they are not comparable with respect to format and depth and breadth of content. What is emphasized in one set of standards may not be mentioned in another.[9] The difficulty here is that no one set of standards has yet emerged as the definitive guide for health care delivery systems in jails or prisons or both. Until this happens, institutions will be able to pick and choose the standards they like best among the various sets.

Secondly, all of the efforts to set standards to date (including those that have not yet been released) lack process elements. They do not provide any technical assistance sections that explain how a facility can go about upgrading its health care system to meet the standards.[10]

Thirdly, the language employed in many of the sets of standards is ambiguous and subject to individual interpretation. The AMA and the APHA have been the most successful so far in stating their standards in specific terms. However, neither of these groups has been able to eliminate totally the use of such vague words as "acceptable," "adequate," "available," etc.[11]

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[9]This lack of agreement on the required elements is illustrated further in the second section of this paper where the four sets of standards are compared in terms of content.

[10]It should be noted that the AMA is planning to develop a "how-to-do-it" manual to accompany its standards, but this task has not yet been accomplished.

[11]See B. Jaye Anno, "Health Care in Jails: Realities and Remedies." June, 1976 (mimeographed), especially pp. 59-61.

Fourthly, if standards are to be meaningful mandates, they must not only be clearly stated but subject to objective verification as well. Such standards must be measurable so that compliance or noncompliance can be gauged. Again, the AMA's and the APHA's are the most satisfactory in this regard, but both of them fall short. The problem encountered by both professional groups was how to make their standards sufficiently general to encompass a wide variety of institutions yet sufficiently stringent to be effective.

It is difficult if not impossible to design one set of standards that will be equally applicable to large, long-term institutions and small, short-term jails as well. APHA tried to do this, and consequently, their standards are too stringent for small jails to meet realistically. On the other hand, while the AMA restricted itself to jails only, their standards will undoubtedly need to be tightened in the years to come to facilitate accurate evaluations of jails' health care services.

Finally, as noted earlier, standards in and of themselves are not an effective source of change. Without some additional mechanism to gauge or force compliance, there is nothing to ensure that standards will be implemented by correctional institutions. Of the four sets of standards discussed here, only those of the AMA are accompanied now by a plan for implementation--namely a voluntary accreditation program, expected to be under way later this year.

The AMA standards have already been tested in the 30 pilot sites that are part of its ongoing program to improve health care in jails. The standards have also been submitted to a number of sheriffs, jailers, and other correctional and medical personnel outside the program for their review and input. The AMA anticipates that several of the health care delivery systems in its pilot sites will be ready for accreditation by late summer, 1977. After that, the AMA will begin to accredit health care facilities in other jails across the country.

At the prison level, the standards being developed by the CAC are also designed to lead to an accreditation program. This program differs from the AMA's, however, in that it will encompass all phases of corrections (including community corrections), and is not restricted to health care. While some of the standards (e.g., those on adult parole) have already been released, it is not known when accreditation of correctional institutions will begin.

Having given some indication of the accreditation efforts which are planned or under way, it is still necessary to speculate what the future trends with respect to health care standards in corrections will be. Within the correctional community it is likely that the standards currently being developed by the CAC will emerge as the definitive guidelines for the profession. For one thing, this body is already composed of representatives of a number of recognized professional groups in corrections. For another, this effort is funded by LEAA and the standards developed will undoubtedly be the ones endorsed by LEAA, both because they are the most comprehensive and because they are tied to an accreditation program.

Like others in the corrections field, LEAA is concerned with the burgeoning sets of standards under design by groups that may even be at cross purposes with one another. Hence, the policymakers at LEAA have determined that that agency will endorse only one set of standards. While LEAA cannot force others to adopt the standards it selects, adherence can be effectively controlled by withholding federal funds from institutions and agencies that choose not to comply. Accreditation seems to be the wave of the future for corrections.

Since the CAC standards will cover jails as well as prisons, the question remains of what will happen to the AMA jail health care standards which are also being developed under LEAA funding and are also tied to an accreditation effort. At the moment, the most probable outcome is that the CAC will adopt the AMA standards in lieu of developing its own health care section for jails. When the CAC begins accrediting short-term institutions, those that have already received accreditation for their health care delivery systems from the AMA will be given credit for this part of the evaluation by the CAC. However, work on the CAC jail standards is just beginning. In the meantime, the AMA plans to go forward with its program to accredit the health care systems of interested jails within the next few months.

The biggest unknowns at the moment concern the third set of LEAA-funded standards and the probable actions of the courts. As noted previously, NILECJ has also funded a program designed to lead to model legislation in the nature of a uniform corrections code. Whether the SCUCC's section on medical care will be compatible with other sets of established standards is a matter of speculation.

The courts are another source of concern. Since they are generally subject to less pressure than other segments of the criminal justice system, they need not be bound by the standards endorsed by LEAA. The courts, too, are looking for guidance, however, and it seems likely that if a particular set of standards on health care is officially recognized within the profession, these standards will also be the ones mandated by most, if not all, of the courts. Until that time, though, the courts will undoubtedly continue to pick and choose among the available guidelines of a number of groups and select the ones that suit their purposes in a particular case. Or, if the standards adopted by the correctional profession are deemed unsatisfactory, many of the courts may continue to establish their own standards in particular cases as they have done in the past.

COMPARISONS OF STANDARDS ON HEALTH CARE IN CORRECTIONAL INSTITUTIONS

	Jails Only		Jails and Prisons		
System Elements	*NSA (1974)*	*AMA (1977)*	*NACCJSG (1973)*	*APHA (1976)*	*Commentary*
I. System Management[1]					
A. Monitoring and Evaluating	Topic not discussed.	The topic of internal system monitoring (i.e., quality assurance) is not treated other than in a series of standards that state that the work of all medical personnel should be performed under written or direct orders from the responsible physician (#s 1070-1073). This same physician is responsible for reviewing the health care system and the jail environment at least quarterly and issuing a written report to jail officials (#1005).	Topic not discussed.	Pages 107-108 mandate that all health care systems be audited and evaluated on a regular basis by external health care authorities and that there be "consistent, ongoing, internal evaluation . . . including both peer review and utilization review."	Only the APHA standards insist on stringent quality assurance mechanisms.
II. Service Delivery					
A. Resources[2]					
1. Personnel Required	Number and type not specified other than a recommendation that the jail have a "qualified physician on call at all times" (*Inmates' Legal Rights*, p. 14) and that where paramedical staff are employed, they should be under the supervision of (not in lieu of) a physician. The NSA notes that "Ideally, a full-time physician and part-time dentist should be available, but this objective is unrealistic except for larger institutions." (*Jail Programs*, p. 14).	Number and type not specified except that each jail must have "a physician or qualified medical authority who assumes responsibility for medical services." (#1001) In addition, all health care personnel used by the jail must be licensed or certified as the state laws require (#1069). Further, the responsible physician is expected to approve written job descriptions which govern the work of qualified medical personnel at various levels (#1070) and to provide written standing orders (#1071) for non-physician staff to follow.	Number and type not specified other than a general guideline which indicates that medical services should be "performed by persons with appropriate training under the supervision of a licensed physician." (Standard 2.6.2, p. 36.)	Number and type not specified except for a general principle which states, "Health staff should be in sufficient numbers, of sufficient diversity and of sufficient training and expertise to deliver responsibly the services outlined in these standards." Like the AMA standards, APHA also requires that all health care providers be licensed or certified and qualified to practice, and that their qualifications be on file. It is also required that the working schedule of all medical providers be available, but how and to whom is not stated (pp. 111-112).	All four of these professional groups shy away from specifying the exact number and type of health care staff required. While previous publications[3] sometimes indicated the number of staff needed based on the number of inmates in the facility on an average daily basis, more recent efforts have recognized that there is no simple formula for determining appropriate staff size. The number and type of health care personnel required by an institution is dependent not only on its average daily population, but also on the total number of inmates received during the course of a year, their varying lengths of stay, and the particular health care needs of inmates (e.g., alcoholics, addicts, etc.).
2. Materials & Equipment	Topic not discussed.	Requires a first aid kit to be on hand (#1024) and, where medical services are delivered in the jail, requires that "adequate space, equipment, supplies and materials as determined by the responsible physician" be provided (#1023). Commentary includes a short list of the basic equipment needed.	Topic not discussed.	Requires "emergency equipment and supplies" and first aid kits but does not specify type and amount needed (pp. 12-13). (See also "Facilities" section below.)	No specific standards exist.

	Jails Only		Jails and Prisons		
System Elements	*NSA (1974)*	*AMA (1977)*	*NACCJSG (1973)*	*APHA (1976)*	*Commentary*
3. Facilities	Topic not discussed.	Topic not treated other than in a general requirement that "adequate space" be provided (#1023, as noted above.)	Topic not discussed.	Contains a section on "medical care facility" (pp. 72-73) which specifies the types of medical care areas needed (i.e., "examining, patient and isolation rooms; bath and toilets; nursing and service areas; central and general storage") as well as the provisions that must be made for disinfecting and sterilizing equipment and facilities and for storing drugs and lab specimens.	
B. Activities or Procedures[4]					
1. Education					
a. Staff	Contains a general statement that "all staff should be trained to recognize the need for quick medical help," (*Jail Security Classification and Discipline*, p. 38) and that "all operational jail personnel be trained in first aid work." (*Inmates Legal Rights*, p.14.)	Requires all jailers to be trained in first aid (#1074) and at least one person per shift to be trained in first aid, cardiopulmonary resuscitation, receiving, screening and recognition of symptoms of common illnesses (# 1075).	Topic not discussed.	Topic not specifically discussed other than in a general requirement that all staff be qualified (pp. 111-112).	None of these sets of standards deals directly with the issue of in-service staff training.
b. Inmates	Topic not discussed.	States that patient education should be carried out "on a planned programmed basis" (#1031) and that certain procedures to ensure personal cleanliness among inmates should be followed (#s 1076-1080).	Topic not discussed.	Contains a section on "health education" which specifies the types of patient information that should be given to inmates for improved personal hygiene, self-care, and preventative measures. (pp. 13-14)	
2. Distribution (medications)	Requires that all medications be prescribed by a physician or other legally authorized person. Recommends that "whenever possible," medications be administered by medically trained personnel. States that "no inmate should be allowed to administer medication," (*Jail Security, Classification and Discipline*, pp. 39-39). Also includes recommendations regarding the secure storage of drugs. States that they should be inventoried regularly and all use should be recorded. Finally, the NSA recommends that medication be given in a single dose in the presence of a staff member (*Jail Programs*, p.15).	Essentially the same content as those of the NSA but has more stringent requirements regarding who can distribute drugs and under what conditions (e.g., requires a written policy approved by the responsible physician). However, the AMA standards do not specifically prohibit inmates from distributing medications, nor do they insist that they be issued one dose at a time (#s 1049-1058).	States that "the prescription, dispensing and administration of medication should be under strict medical supervision." (p. 36)	Includes specific mandates regarding the prescribing, dispensing, distributing, inventory and storage of all drugs; insists that medications be administered by "adequately trained health services personnel" and that each dose be properly documented. Non-health personnel can distribute drugs only if the facility is small, and if they have been "adequately trained" and only under specific, controlled conditions (i.e., only if the medications are "sealed single doses, packaged, delivered daily, adequately identified and labeled with directions" (pp. 99-100).	The four professional groups are mostly in accord regarding the general principles for ordering, dispensing, and distributing drugs. Those of the APHA provide the most specific, procedural guidelines.

	Jails Only		Jails and Prisons		
System Elements	*NSA (1974)*	*AMA (1977)*	*NACCJSG (1973)*	*APHA (1976)*	*Commentary*
C. Services					
1. Direct					
a. Emergency Care	Recognizes that "every inmate has a right to receive proper and timely medical treatment and care (*Inmates' Legal Rights*, p. 14), that staff should be trained to recognize emergencies, and that a physician should be available to treat emergencies (*Jail Programs*, p. 14). Also states that "Jail administrators must establish policies and procedures to cover inmate medical emergencies" and that "all actions taken with respect to medical emergencies must be documented" (*Jail Administration*, p. 45). Does not specify that the emergency policies be written nor give any indication of what the content should be.	Requires that provisions be made for "24-hour emergency medical care availability," and that these provisions be contained in a written plan that also includes procedural guidelines for jail staff to follow (#1025-1026). The major content areas of this written plan are specified in the standards. The jail is also expected to have written procedures for notifying next of kin (#1027).	Requires only that "emergency medical treatment [be available] on a 24-hour basis" (p. 36).	Comparable to the AMA's (except that there is no requirement that next of kin be notified). In addition to the written plan governing emergency procedures for individual cases, the APHA also requires an emergency plan for medical services "in the event of fire, riot or disaster" (pp. 12-13).	All four professional groups agree on principle, only the AMA and the APHA insist on having written protocols to govern the delivery of emergency care.
b. Non-Emergency Care					
1) Physical Examination	Agrees with the principle that "every new prisoner should be examined" but does not specifically list the type of screening that should be done nor the type of staff that should perform it (*Jail Programs*, p. 14).	Requires that receiving and screening be done immediately upon admission to the jail; specifies the extent of the examination; and indicates that it must be performed according to written guidelines approved by the responsible physician. The actual screening need not be performed by a physician if other staff (including jailers) have been specifically trained to perform this function (#s 1006-1009). This initial screening must be followed by a more comprehensive "health appraisal" (to include lab work, checking vital signs, and obtaining physical measurements, as well as other tests and exams) within 14 days after admission. Written protocols also govern the collection of this data (#s 1010-1014).	Specifies that "a prompt examination [be performed] by a physician upon commitment to a correctional facility" (p. 36).	States that "each individual committed to an institution of incarceration or detention, should receive a reception health assessment." These standards contain a specific list of the policies and procedures which should govern the entrance examination and include a detailed list of the items that must be checked during the initial evaluation (pp. 3-7). Essentially, the APHA requires a full-scale physical examination on admission, including testing for communicable diseases and other lab work. Additional information and testing is required for women inmates beyond that mandated for males (pp. 7-8). Further, the APHA requires an annual medical evaluation and an examination upon release (pp. 11-12).	While all four professional groups agree with the principle of an admission examination, they differ widely regarding when it should be performed, who should provide it, and how extensive it should be. Also, only the APHA requires annual and release exams in addition to admission evaluations.

	Jails Only		Jails and Prisons		
System Elements	*NSA (1974)*	*AMA (1977)*	*NCCISG (1973)*	*APHA (1976)*	*Commentary*
2) "Sick Call" (ambulatory care)	Suggests that "a daily sick call procedure be set up to assure each person the opportunity to receive prompt and adequate medical attention for illness or injury (*Inmates' Legal Rights*, p. 14), but does not mandate it. (See also *Jail Programs*, p. 15, and *Jail Security, Classification and Discipline*, p. 38.)	Requires that non-emergency medical services be governed by a written protocol and that the inmate be notified in writing, on admission, of procedures for gaining access to medical services (#1015 and #1016). Also states that medical personnel should control the access to sick call (#1017); that it be conducted by a physician and/or other qualified personnel (#1019); that complaints be collected daily (#1018); that sick call be held once a week at minimum in small jails of fewer than 20 inmates, at least three times a week in jails with 20-200 inmates and at least five times a week in larger facilities (#1020). Further, if sick call is not conducted by a physician, one must be available at least once a week to respond to inmate complaints (#1021).	States only that a physician or other qualified individual determine an inmate's need for medical services and that correctional personnel should not interfere with medical treatment (p. 36).	Essentially the same content as the AMA's except that the frequency with which such services must be offered is not specified (pp. 99-100).	There is general agreement that some type of ambulatory care service must be offered, but little agreement as to the frequency, type and duration of services.
3) Referrals	States only that the jail's "health service program should be coordinated with and utilize other resources in the community such as the local and state health departments, hospitals, clinics, medical, dental, and paramedical organizations" and that the physician should "make referrals" (*Jail Programs*, p. 14).	Requires that the jail have written guidelines to provide chronic and convalescent care and medical preventative maintenance "rendered by an appropriate health provider" (#s 1028-1030).	States that "medical problems requiring special diagnosis, services, and equipment should be met by medical furloughs or purchased services" (p. 36).	Require that health care services include "an active, viable and well-coordinated referral network." Compliance elements specify the types of arrangements that should be made and the type of consultation services that should be offered in fairly specific detail. All referrals are to be governed by written guidelines (pp. 10-11).	All groups agree on the basic need for referrals but there is little specification of the procedures or types of services that should be offered. APHA's are the most specific.
4) Hospitalization and Isolation	States only that provision should be made for hospitalizing and/or isolating inmates as needed (*Jail Programs*, p. 14).	States only that provision for hospitalization be made according to written protocols approved by the responsible physician and that the jail have arrangements for handling inmates who require close medical supervision (#s 1042-1045).	States only that inmates should have "access to an accredited hospital" (p. 36).	States only that arrangements for hospitalization be made according to written guidelines and that where the institution has its own hospital, it must meet JCAH accreditation. Infirmaries must meet the same requirements as university and college infirmaries (pp. 17-18).	All of the sets of standards are fairly general with respect to procedures governing hospitalization and isolation.

	Jails Only		Jails and Prisons		
Standards Topics	*NSA (1974)*	*AMA (1977)*	*NACCJSG (1973)*	*APHA (1976)*	*Commentary*
5) Mental Health Care	Agrees with the general principle that the mentally ill should not be housed in jail but should be referred to a hospital or clinic for more suitable detention. When this is not possible, the NSA recommends that the individual be placed under the care of a physician and be closely supervised by the jail staff. Medication should be carefully administered and, "preferably, the mentally ill should be housed in individual cells" (*Jail Security, Classification and Discipline*, p. 14. Also, *Jail Programs*, p. 20).	Requires that written guidelines be drawn outlining "procedures for implementation of the screening, referral and care of mentally ill or deficient inmates," and that specific referral sources be stated. Also, personnel are to be trained regarding symptom recognition of various mental illnesses as specified by the responsible physician (#1040). Further, the AMA believes that "admission to appropriate health facilities in lieu of jailing should be sought . . . [when] out-patient treatment is not possible" (1041).	Includes fairly specific standards regarding the treatment of the mentally ill in major correctional institutions. Among other things, the standards state treatment should be under the direction of a psychiatrist, that "program policies and procedures should be clearly defined and specified in a plan," that diagnostic tests should be conducted, that regular medical and lab work should be done, etc. (p. 374). Additional standards deal with transferring individuals to mental health facilities (p. 374) and the types of counseling services that should be provided (p. 385).	Includes a very extensive section on mental health services. Essentially, the APHA believes that such services should be made available at all institutions, that treatment should not be compelled except under extreme circumstances, that mental health personnel who participate in administrative decision-making processes that affect the inmate (e.g., parole or furloughs) should not be the ones providing therapeutic services, and that all patient information should be kept confidential. In addition, the APHA lists nine different types of direct treatment services which should be provided, including crisis intervention, short- and long-term therapy and detoxification (pp. 27-33).	Again, the groups agree that mental health care should be provided, but there is little agreement on the basic services that should be available and under what circumstances.
6) Dental Care	Indicates that "dental care should be made available to every inmate," but notes that in practice, detainees usually qualify only for emergency dental care while longer-term inmates "may get normal dental services" (*Jail Programs*, p. 15).	Requires that arrangements be made for 24-hour emergency dental care availability, governed by written guidelines that indicate where the inmate is to be taken, how he will be transported, and what the jail personnel's responsibilities are (#1033). Also requires that guidelines be written for providing all inmates with dental screening and preventive services within 14 days of admission (#s 1034-1035) and a dental exam (and treatment where needed) with three months (#s 1036-1037). Care must be supervised by a licensed dentist (# 1038) and prosthetics provided when the inmate's health requires it.	Not discussed.	Includes very specific standards relating to the responsibilities of the dentist and assistants, the set-up and operation of the dental facility, recordkeeping requirements, and the services to be offered. Services should include a dental assessment on admission plus emergency and non-emergency services (e.g., oral profile, prevention, treatment restoration, surgery, periodontics, etc.). With the exception of the admission exam, the time period for providing other services was not specified (pp. 37-42).	Again, the two health care professional groups have the most stringent standards. APHA's are the most specific in terms of the type and extent of services to be offered, but the AMA's are the most specific with respect to time.
7) Other (Special Offenders)	States that, ideally, alcohol and drug abusers undergoing withdrawal should be transferred to a hospital. When this is not possible, they should be closely watched. Does not have any special standards for women other than that they receive the same treatment as men (*Jail Programs*, pp. 20-21).	Includes standards governing detoxification procedures for alcohol and drug abusers (#s 1046-1048). Does not have a special section on the needs of women offenders.	Contains fairly extensive standards regarding the handling of drug offenders (see p. 373-374) but does not address the issue of detoxification of either drug or alcohol abusers. The standards that exist on women are not specific to health care (see pp. 378-380).	Includes standards on detoxification (p. 32) and a major section on additional health care services for women offenders. The latter calls for the provisions of services for menstrual irregularities and pregnancy and states that douching, family planning services, and abortions should be available to women who request them (pp. 21-23).	While all four of the groups have at least cursory comments to make regarding the needs of drug and alcohol abusers, only the APHA recognizes the special provisions that should be made to meet the health care needs of women offenders.

	Jails Only	Jails and Prisons			
System Elements	NSA (1974)	AMA (1977)	NACCJSG (1973)	APHA (1976)	Commentary
c. Support Services a. Medical Records	States that medical records are essential and should be maintained "in accordance with established professional standards." The NSA recommends that the inmate's condition on admission and release be recorded as well as prior medical history and any illnesses or injuries that occur or treatment or medication received during confinement. Also, inmates should be denied access to all medical records including their own (*Jail Programs*, p. 15. See also, *Jail Security, Classification and Discipline*, pp. 37-38.)	Contains specific requirements regarding the types of records that should be kept, states that the method of recording entries should be approved by the responsible physician, that records should be kept confidential, that a physician should control access to medical records, and that records should routinely accompany inmates transferred to other institutions (#s 1059-1066).	States that "complete and accurate records documenting all medical examinations, medical findings, and medical treatment should be maintained under the supervision of the physician in charge" (p. 36).	Essentially the same as the AMA's, but includes additional requirements: that each inmate should have only one record that is used by all health care providers and that the format of the record should be standardized to facilitate communication between staff members and to better enable that the records be reviewed and audited (pp. 103-104).	Again, all four groups agree that medical records should be maintained, but differ in the extent to which they specify what should be recorded and how, and who should have access to the information.
b. Nutrition and Food Services	The NSA has an excellent handbook devoted to this topic. It includes guidelines for purchasing, storing, and preparing food, and provides information on the nutritional content of foods and on standard ration allotments, etc. It also states that special diets should be provided when ordered by a physician and gives examples of five different types of medical diets. See *Handbook on Food Service in Jails.*	Other than referring readers to the NSA handbook, the only specific standards are that kitchen workers be free from disease and maintain good personal hygiene, and that special medical diets be provided when ordered by a physician (#s 1081-1083). These three elements are included in the NSA handbook also.	Topic not discussed.	The APHA requirements do not differ significantly from those in the NSA handbook, and in fact, are not as extensive. They cover nutritional content, dietary consultation and management, food preparation and service, sanitation and safety, and the types of preparation, storage, and dining areas that are needed (pp. 91-95).	While more of a manual than a set of standards, the NSA *Handbook on Food Service in Jails* is recommended as the most comprehensive set of guidelines on this topic.

FOOTNOTES

[1] Other aspects of system management (i.e., organizing, planning, coordinating, providing feedback and problem solving) are not dealt with by these sets of standards.

[2] While one would not expect professional groups to develop standards on the amount and source of money used by a system or the type of inmates that feed into it, the lack of specific standards on materials and equipment and on appropriate methods seems somewhat surprising.

[3] For example, see the ACA *Manual of Correctional Standards* (1966) and the NSA *Manual on Jail Administration* (1970). However, the former will be supplemented by the standards currently under development by the Commission on Accreditation for Corrections and the latter was replaced by the 1974 *Handbook*.

[4] Procedural standards for medical treatment, examination, and diagnosis are all but non-existent. Correctional bodies undoubtedly do not feel qualified to set such standards and the medical profession has been reluctant to do so.

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CHAPTER 4. THE HEALTH CARE DELIVERY SYSTEM

Pressures for Change

The courts as well as the professional organizations drafting standards for delivering health care in prisons and jails are essentially demanding that correctional administrators close the gap between the level of care available on the outside and that available to the incarcerated population.

In response to these escalating outside pressures, many states have appointed health care coordinators or administrators who are, in turn, putting pressure on the system from within. These administrators are seeking changes in many problem areas--recruiting and training personnel, improving facilities and humanizing them, monitoring the quality of health care, as well as controlling its costs, to name a few.

Whether the changes are being recommended or mandated from inside or outside prison walls, they usually involve both the nature of services available and the management of them. Effecting necessary changes in service delivery and management will require administrators to keep the correctional setting secure while learning to use more community resources.

Putting the Problem in Perspective

To date, many prison systems have been unable to surmount the major constraints placed upon them (principally budgetary and security constraints) and create a viable health care delivery system. Services are too often stopgap efforts, especially when provided primarily through a sick-call system. There is seldom good communication about problem solving, much less coordination of resources among the various health care providers themselves or between the health care and security staff. Lacking coordinated management, piecemeal services, rather than comprehensive and continuous health care, are more often the rule than the exception.

Clearly, the delivery of "adequate" health care services will be a complex and expensive system to administer in a setting that also demands security. But correctional administrators cannot lose sight of the fact that the courts have consistently said that health care must take precedence over security and the right of inmates to health care cannot be subjugated to security requirements.[1]

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[1]Weisbuch, Jonathan B., "Public Health Professionals and Prison Health Care Needs" American Journal of Public Health, August 1977, p. 721.

Fear and arguments that security may diminish if prisoners have access to more and better services are probably spurious. Security is more likely to be enhanced by a sophisticated health care program, as North Dakota's State Health Officer, Jonathan B. Weisbuch, recently pointed out:

> An adequately organized health care system, with appropriate communication and record system linkages, modern treatment facilities, and qualified health care providers, would have fewer breaches of "security" than the disorganized system now in force. In a well organized system, the movement of patients is dictated by professional judgment of medical need; the hazards involved are communicated by providers in both the sending and receiving facility; knowledge of the disease process allows for a tailoring of the security coverage.[2]

Since correctional health care has been largely the responsibility of wardens or sheriffs, untrained in the complex work of health care administration, the patchwork approach to service delivery easily arose. As long as most budgets allocate money for specific health care personnel and services and not overall management, the patchwork is likely to be perpetuated until the courts or others step in.

What Makes A Health Care System?

There is no reason why prison health care systems should differ from other health systems--the components are essentially the same. Preventive services should be a major concern; all inmates should have access to such primary care as a physical examination; secondary care, such as referrals to specialists, and tertiary care, such as hospitalization for acute illness, must be available to those who require it; and support services, especially a medical records system to provide linkages for conducting followup care or for monitoring care, must be integrated into the system.

Since many administrators are not readily familiar with the variety of components that can comprise a health care system, an outline of many of the services required at various levels appears on the following pages. Services that fall under the purview of the professional groups establishing standards are starred to allow readers to refer to the standards outlined in the preceding chapter in considering the nature of services in their own institutions.

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[2] Ibid.

[3] More detailed descriptions of various components of health care systems are available in the Prescriptive Package for Health Care in Correctional Institutions, Key to Health for a Packlocked Society, and other works listed in the bibliography in appendix IV.

I. DIRECT SERVICES

A. Ambulatory Care
   1. Primary health care services
      a. Entrance screening**
      b. Entrance examinations**
         - Vital signs
         - Medical history
         - Physical exam
         - Laboratory work-up
         - Vision screening
         - Mental health exam**
         - Treatment plan
         - Referrals**
      c. Sick call--daily**
         - Diagnostic services: physical, lab as needed
         - Treatment plan
         - Prescription of drugs
      d. Over-the-counter (OTC) medication
      e. Segregation block visits
         - Diagnostic services
         - Treatment
         - Referrals
   2. Secondary care services
      a. Speciality clinics
      b. Follow-up acute and chronic care
      c. Physical therapy
      d. Referrals
   3. Emergency care**
      a. First aid on-site
      b. Ambulance
      c. On-call coverage, 24-hour
      d. Referrals**

B. Inpatient Care
   1. Infirmary care**
      a. Diagnostic services (e.g. lab, physical, X-ray)
      b. Minor acute care
      c. Convalescence
      d. Chronic care
      e. Isolation**
   2. Hospital care**
      a. Major diagnostic
      b. Major acute care
      c. Major surgery
      e. Major psychiatric care

II. PREVENTIVE SERVICES

A. Infection and Disease Control

B. Sanitation Inspection

C. Dietary Services

D. Intake Physicals and Routine Screening**

E. Health Education

F. Periodic Health Examination (see entrance examination)

III. SUPPORT SERVICES (for primary and secondary care)

A. Medical Record**

B. Pharmacy
   1. Formulary
   2. Medication distribution procedures**

C. X-ray and Fluoroscopy

D. Physical Therapy

E. Occupational Therapy

F. Orthopedic Appliance Laboratory

**Affected by professional groups' standards. See B. Jaye Anno's paper in chapter 3.

Assessing the System

Correctional officials have mostly had to react to demands for more and better health care services by adding a nurse here or an X-ray machine there. This patchwork of services that has often evolved has resulted in patchwork health care that is proving to be unacceptable. Many of the changes needed to improve services will require access to additional resources--more money, personnel, better facilities. Legislatures and agencies or institutions outside corrections will be involved in many cases.

To design and justify new programs, corrections administrators should have a systematic way of assessing current care (in comparison to other institutions or outside services) and of defining their needs as specifically as possible. Standards can be used as the basis for defining what components make up an "adequate" system and also for justifying the costs.

Viewing the delivery of health care in the framework of a system with measurable outcomes and based on the standards of health care professionals can also promote better working relationships with the outside professional community (whose resources are essential), and inside the institution's walls, with the security staff, whose cooperation is also essential. This framework will help

point up some of these complex interrelationships that will have to be understood before change can be introduced.

A simple framework is illustrated in Figure 1. It is an attempt to isolate conceptually the critical points of interaction in a health care system. For instance, all components of health care delivery and management will be affected by the demands and nature of the correctional setting--for example, institutional culture, attitudes, and policies--and vice-versa. In addition, external influences, such as state and local laws, court orders, or professional organizations, affect how corrections must manage and deliver health care.

The arrows on the chart imply that the health care components are interactive--a change in one will produce changes in the others. For instance if the number and range of services are increased, corresponding changes will have to be made in the activities and resources needed to produce the services. One outcome in this case should be better health care that reaches more people. Management, in turn, will have to broaden to meet the increased demands of more services. Ideally, external pressures, such as court orders arising from inmates' class action suits, will subside.

By this systems framework, health care delivery can be seen as a "means-end" change in which various resources--personnel, facilities, supplies, and so forth--can be combined to produce a variety of services to meet specific needs and result in tangible outcomes. The framework will help in assessing service delivery by providing the administrator with a way to observe whether a standard is being met appropriately. By using it to compare a present program to what is demanded, gaps or deficiencies can be identified more easily and realistic alternatives developed for meeting both short- and long-term needs.

To identify what is needed, measurable outcomes or goals should first be set for a health care system. Then the administrator can select appropriate services, activities to produce them, and finally, he or she can identify the overall resources that will be needed. Figure 2 indicates how to start assessing health care programs.

The problem of tuberculosis provides a specific example of health care assessment. The prison environment increases the risk of spreading such a communicable disease and prisoners in turn can spread it to communities they contact or return to. The desirable outcome of an institutional TB screening program, then, would be prevention and containment--the same standard that exists in the community. The services needed for such a program would include coordinated evaluation of tests administered to the prison population and treatment where necessary. Activities would involve the testing procedures (the Mantoux test and chest X-rays) and the taking of family medical histories. Among the resources that might have to be available are a public health nurse, an X-ray technician, other medical as well as correctional staff, supplies and equipment to administer the tests, and a place to do it. (If inmates must go outside the institution, there will be other considerations--security, transportation, etc.).

A major benefit of arriving at needs by using such a systematic evaluation process should be clear. Some elements of a TB screening program, such as the taking of a family medical history and the personnel needed, can be elements of other programs as well. This analysis can point out ways in which programs and resources overlap and so can help in deploying resources, including personnel and

Figure 1--Critical Points of Interaction in a Corrections Health Care System

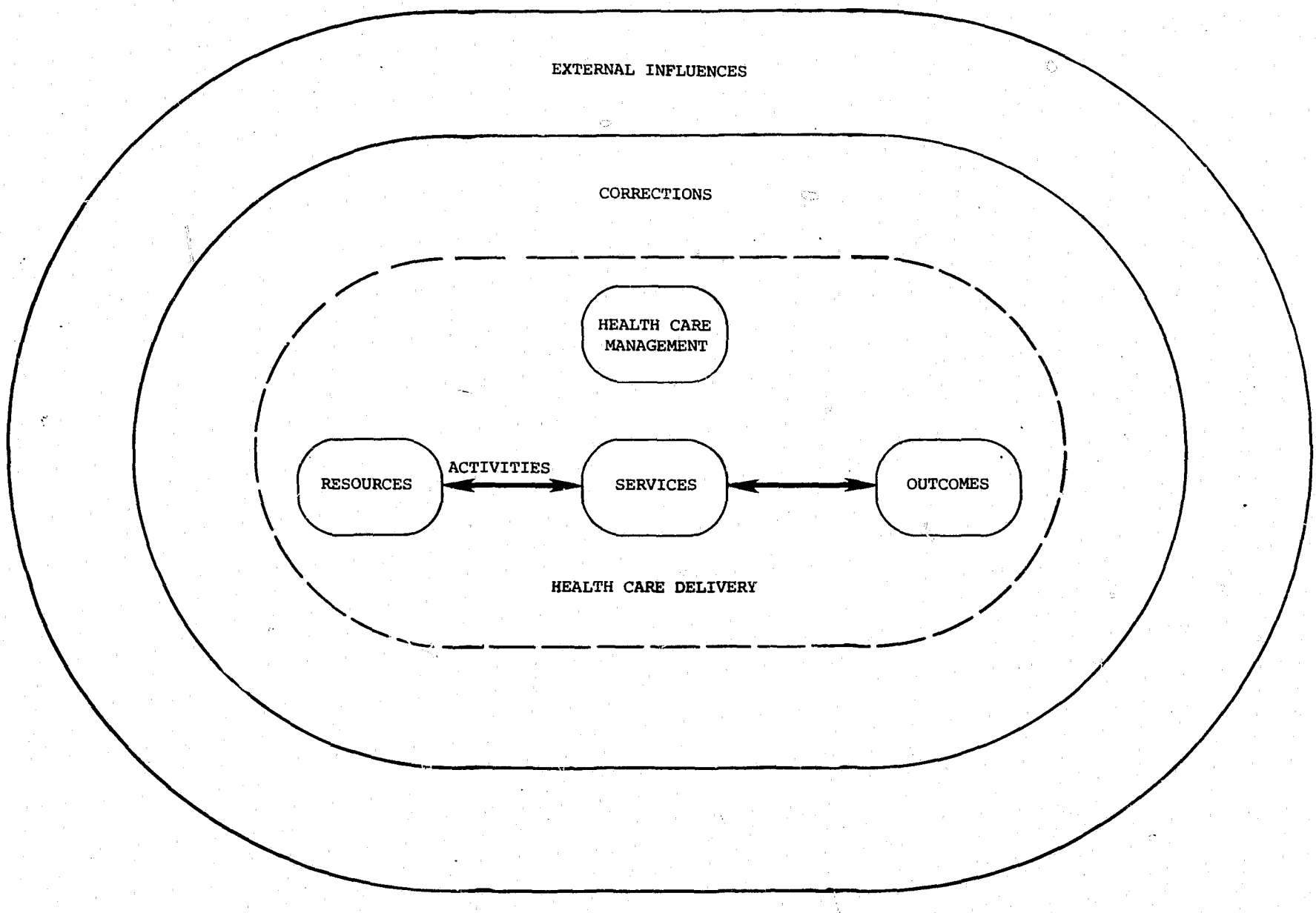
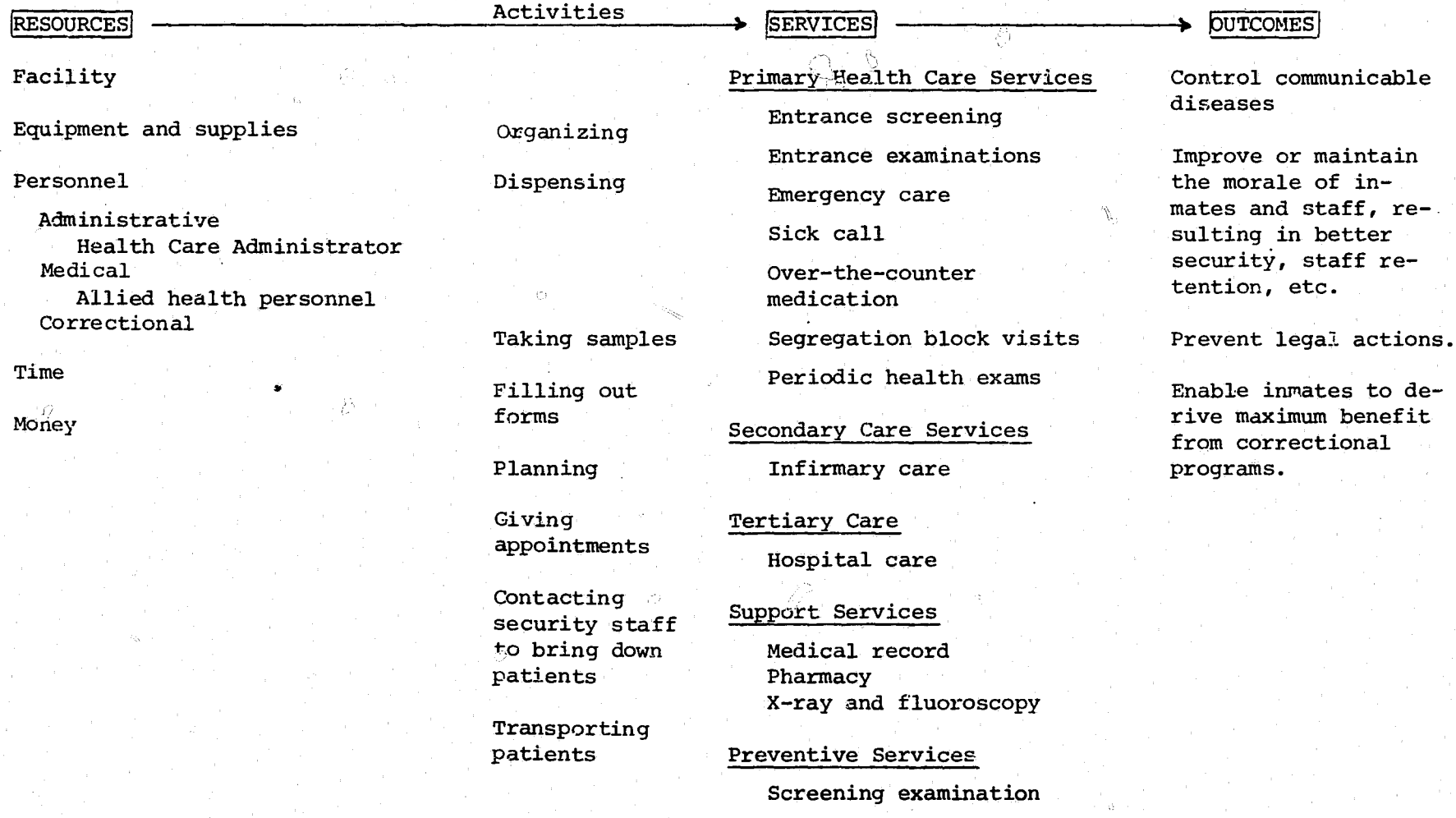


Figure 2--Correctional Health Care: Systems Framework



their time, more efficiently.

Applying Standards to Institutional Health Care

Focusing on defining measurable outcomes will put administrators in the position of possibly using standards as a tool to acquire what they need to deliver services. An example is the American Public Health Association's health education standard, some parts of which just about every institution would like to meet.

STANDARDS FOR HEALTH EDUCATION[4]

Principle: The recognition of the normal and abnormal functionings of one's body often means the prevention of serious disease. Education, in this sense, can thus avoid serious outbreaks of disease which can easily occur in the confines of the correctional institution.

Public Health Rationale: Special attention should be given to providing personal health information to inmates since the inmate of a correctional institution is at greater risk of not having had proper medical care throughout his/her life prior to entry into the correctional system.* Staff should be prepared and willing to answer any inmates' questions regarding health or health-related problems.

Satisfactory Compliance: Information of a preventive nature is especially relevant in the following areas and shall therefore be given at the most appropriate encounter with the inmate:

1. Information regarding dental hygiene;
2. Information regarding personal hygiene and nutrition;
3. Training in breast self-examination in women inmates;
4. Information regarding maintenance of health;
5. VD and TB information;
6. Family planning information relating to services and referrals;
7. Education shall be directed to particular epidemiological problems;
8. Upon discharge (whether on furlough, work release, parole, or unconditional discharge) as well as during incarceration inmates shall be made aware of their particular health needs so that they can help themselves stay healthy;
9. Specific advice shall be given to women inmates using contraceptive devices regarding possible negative effects.

*Note: Maintaining a "problem list" always at hand would be an excellent way to begin caring for oneself, and can be made part of the health education program of the institution.

[4] Standards for Health Services in Correctional Institutions, American Public Health Association, Washington, D.C. 1976 pp. 13-14.

This standard is concerned principally with prevention--a high priority need in correctional institutions. Some of the outcomes of a good prevention program are easily identified--increased knowledge and skills of inmates in recognizing disease may help control the spread of communicable ones, prevent outbreaks, cut down on more costly treatments, and so forth.

This particular standard is typically vague about exactly what should be done (that is, service delivery) and even more so about how to do it (resources and acitvities). Since we can state specific outcomes related to applying the general standard, we can fit this standard into the systems framework and come up with the missing information. For example, the health education standard is outlined below and the information needed to fill it in is underlined.

RESOURCES	Activities	SERVICES	OUTCOMES
5-15 minutes at each encounter Trained health professional and/or Pamphlets on appropriate topics at inmate reading level and/or Films on appropriate topics Time to show film and discuss Discussant	Discuss health problems/needs at each medical encounter and/or Describe pamphlets with appropriate information and/or Show films Conduct discussions of films	Information provided regarding: • dental hygiene • personal hygiene and nutrition • maintenance of health • VD and TB • family planning • particular epidemiological • particular health needs when leaving institution	Increase in: • Understanding of normal and abnormal functioning (of body) and • Skill in recognizing problems. Prevent unnecessary outbreak of disease.

Many of the health care standards will be similarly limited in scope and difficult to apply to a specific situation unless some system is used to clarify what the standard covers and what it does not. Many standards, such as the health education one, indicate the types or range of services that should be available, but few will spell out exactly what ratio of services to inmates must be available or the timing of providing them (a screening examination, for example, must be accomplished within 48 hours). Informed managers and administrators can consult with their staffs, other institutions, outside professionals, and the inmates to fill in the missing pieces. They are then in the position of having straightforward backing for their needs based on accepted standards. They can shift the burden of accountability back where it belongs--to state officials, legislators, the public, and the medical community.

To use standards effectively, administrators should follow four general steps in determining how to apply them and whether they will actually help provide the elusive quantity known as adequate health care.

1. Administrators should consider the relevance of the particular standard in achieving particular outcomes of health care delivery in his or her institution. (Any difference in perception among various types of administrators about what the outcomes should be will have to be negotiated.)

2. The administrator should identify the services covered by the standard; list the range and number of services needed; and specify the time periods in which they are needed, taking into account at the least: court and legal requirements, professional opinions, past experience, projections of inmate population, and experience at similar institutions.

3. The options available for delivering services should be identified and all the resources that might be used, again considering such factors as legal requirements, inmate population, etc., and any particular restrictions imposed by the standard.

4. The administrator should select the most appropriate option and calculate what resources are needed. He or she should examine the option in three respects:

    - Ability of the option to provide the number, type, and timing of the services needed.
    - Availability of resources for the option and the feasibility of procuring them.
    - Cost of the option.

The process used to think through the implications of standards on the overall health care delivery system can also be applied to segments of it, such as personnel, equipment, and so forth. The same process can be applied even when standards are not available. In one sense, a standard is simply a basis of comparison--something to show you where you fall short and by how much compared to another institution, the public standard, or some other measurable outcome.

However, to use this process or any other to organize a health care delivery system or bring one up to par requires that the information and data are made available so administrators can make informed choices. Administrators must also carefully identify the people who should be involved in the decisionmaking processes.

Many professionals believe that until health care providers are hired by correctional superintendents to administer the delivery of services and not just provide care, deficiences will continue to plague the programs. As public health officer Dr. Weisbuch put it:

> In the past, prison health programs have been inefficiently managed. When placed under the management of trained professionals, cost may be expected to drop and benefits grow, at least until an efficient steady rate is achieved. In some systems where extremely low budgets for health services have been the rule, reorganization under a health director will necessitate increased expenditures in order to bring the quality of service to an acceptable level; but the increase in services coupled with good management should outweigh the increase in cost.[5]

Hiring medical professionals to administer corrections health care programs may not be practical in all systems. But clearly, there must be health care professionals involved who have some management responsibility and real authority to ensure that health care standards are being implemented as "adequately" as possible.

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[5] Weisbuch, Jonathan B., "Public Health Professionals and Prison Health Care Needs," American Journal of Public Health, August 1977, pp. 721-22.

CHAPTER 5. MANAGEMENT OF HEALTH CARE

> If you ask a manager what he does, he will most likely tell you that he plans, organizes, coordinates, and controls. Then watch what he does. Don't be surprised if you can't relate what you see to these four words.
>
> Henry Mintzberg

Theories and descriptions of management proliferate. For the most part they have addressed or looked at the characteristics of the work that managers do and the content of that work. They do not provide particularly useful descriptions or insight into how effective managers arrive at the myriad decisions they must make constantly to keep an organization or institution running smoothly.

In chapter 4, one approach to examining and then identifying ways to improve health care delivery in correctional institutions was presented. It offers managers a way to extract some of the important information they will need to respond to the health care standards that are being proposed to set viable objectives and outcomes for their own facilities.

Initiating new programs or upgrading old ones to an "adequate" level of health care will demand that many important decisions be made: about what standards should be implemented; whether new standards need to be developed, and, if so, how specific they should be; and finally, how the standards will be implemented.

Some of these decisions can probably be made using only information derived from systematic analyses of operating programs. But most decisions are likely to demand the involvement of persons, both inside and outside corrections, who will be affected by the imposition of standards--that is, health care providers, legislators, other agency personnel, the security force, inmates, and so forth. The way in which the significant decisions are made and the various actors involved in them are likely to affect how successfully programs are developed and instituted and how successfully standards are met. It is some of these decisionmaking aspects of management that we find it critical to focus on in this chapter.

Management Professor Henry Mintzberg, whose paper is included in this chapter, has developed a useful description of various roles and activities managers use to arrive at appropriate decisions. In his research, he discovered that the greatest input comes from verbal communications of numerous sorts rather than from management information systems or other modern management tools. This discovery may not actually be new information to managers, but it may slip from their attention. Accordingly, "the first step in providing the manager with some help is to find out what his job really is," as Mintzberg says.

Mintzberg has analyzed management in terms of what he has actually seen managers do and he describes their activities under three major headings; interpersonal roles, informational roles, and decisional roles.

The interpersonal roles arise from a manager's formal authority. There are ceremonial activities related to these roles that take up time and possibly augment status, but they do not directly affect decisions. Inside his organization or institution, the manager undertakes interpersonal activities in the role of a leader who may hire, fire, train, and work to motivate his staff. He also serves as a liaison to the outside, communicating with others in his field, and in the case of correctional administrators, with legislators, state or local officials, health officials, and so on. He is likely to perform his liaison function in formal ways, such as at meetings, or in a variety of informal ways--over the telephone, at lunch. (Such constant contact with outside people and agencies is especially important to corrections administrators if they are to make decisions that will accurately respond to external pressures.)

The second class of roles, informational ones, are closely related to the interpersonal ones. It is the interpersonal style and skill of the manager that lays the foundation for the quality and quantity of information he will be able to assemble and monitor from his information network, including his staff, outside people, and unsolicited sources. The better he can then act to disseminate significant information to his subordinates, through meetings, debriefing sessions, etc., the better his organization will function. A manager can also use his informational role to act as a spokesman and satisfy those organizations to which he may be responsible, such as commissions or legislatures.

This information is not an end in itself, but rather the basic ingredient of decisionmaking, whether those decisions involve improving the institution (upgrading health care), responding to crisis situations, allocating available resources, or negotiating between competing interests.

Clearly, these roles are interdependent or "inseparable," as Mintzberg says. Since managers in corrections and many other fields are under constant pressures and have limited time to make many decisions, they may tend to act superficially and too abruptly without reflecting on the nature of their job, as Mintzberg suggests.

The type of interpersonal and informational activities in which a prison or jail manager engages and the people he relies upon to inform him, in this case, about health care delivery, not only affect the quality of his decisions but also the nature of the health care delivery system that he plans.

This decisionmaking process can be analyzed in much the same way that health care services were in chapter 4. In a sense, making decisions can be viewed as a "service" of managers, who use various resources (mostly people, according to Mintzberg) and interpersonal and informational activities to arrive at decisions.

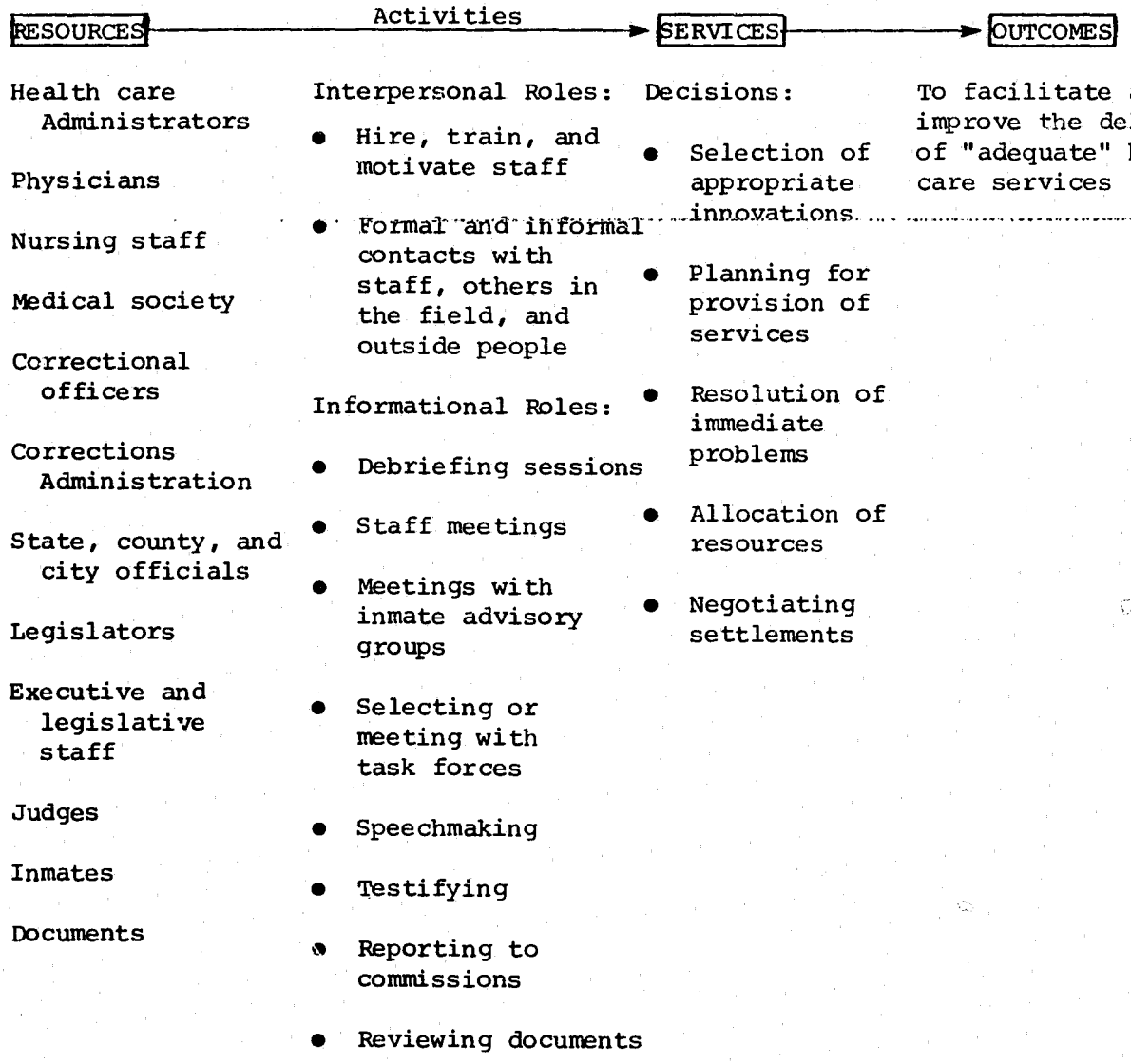
In working through such an analysis, the manager will have to consider what decisions will have to be made about health care delivery, that is, what are the general or particular deficiences in services that he is expected to alter; then, who are the most effective people who are also available to him and what activities

can he engage them in to enhance the quality of his decisions. It is possible to chart some of this information in the same framework used to chart the components of the health care delivery system. In this case, the outcome is the delivery of effective services that meet acceptable public or professional standards. To obtain this outcome requires an active interplay among services (managerial decisions), resources (people and, in some cases, documents), and activities (the informational and interpersonal ways the manager chooses tc obtain input). Figure 3 is an attempt to represent this interaction.

When the outcome is more specific, then it is possible to narrow the other components in the framework as well. For example, the outcome might be to institute a health education program following the American Public Health Association's guidelines that were used in chapter 4. In this case, the APHA standard offers the starting point for identifying the particular deficiencies in an institution's program; a manger might be able to see readily that he can rely on the input of a few health professionals, the staff members who would be involved in operating the program, and so on, to design a program. The activities he might select to activate the program could include soliciting input from inmates, even hearsay about their health education needs from health care providers or other staff; instead of convening a task force, holding a series of meetings might be the most appropriate activity.

This analogy is only an attempt to illustrate how Mintzberg's analysis of the decisionmaking process can assist correctional administrators. For the health care professionals, the legislators, the judges, the inmates, and all those the administrator involves in making decisions, will, in effect, be helping him define and establish the standard of health care service delivery that is being demanded.

Figure 3


RESOURCES
Activities
SERVICES
OUTCOMES
Health care Administrators
Physicians
Nursing staff
Medical society
Correctional officers
Corrections Administration
State, county, and city officials
Legislators
Executive and legislative staff
Judges
Inmates
Documents
Interpersonal Roles:
Hire, train, and motivate staff
Formal and informal contacts with staff, others in the field, and outside people
Informational Roles:
Debriefing sessions
Staff meetings
Meetings with inmate advisory groups
Selecting or meeting with task forces
Speechmaking
Testifying
Reporting to commissions
Reviewing documents
Decisions:
Selection of appropriate innovations
Planning for provision of services
Resolution of immediate problems
Allocation of resources
Negotiating settlements
To facilitate and improve the delivery of "adequate" health care services

THE MANAGER'S JOB: FOLKLORE AND FACT

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Some Folklore and Facts About Managerial Work

There are four myths about the manager's job that do not bear up under careful scrutiny of the facts.

1. Folklore: The manager is a reflective, systematic planner. The evidence on this issue is overwhelming, but not a shred of it supports this statement.

   Fact: Study after study has shown that managers work at an unrelenting pace, that their activities are characterized by brevity, variety, and discontinuity, and that they are strongly oriented to action and dislike reflective activities. Consider this evidence:

   - Half the activities engaged in by the five chief executives of my study lasted less than nine minutes, and only 10% exceeded one hour.[1] A study of 56 U.S. foremen found that they averaged 583 activities per eight-hour shift, an average of 1 every 48 seconds.[2] The work pace for both chief executives and foremen was unrelenting. The chief executives met a steady stream of callers and mail from the moment they arrived in the morning until they left in the evening. Coffee breaks and lunches were inevitably work related, and ever-present subordinates seemed to usurp any free moment.

   - A diary study of 160 British middle and top managers found that they worked for a half hour or more without interruption only about once every two days.[3]

   - Of the verbal contacts of the chief executives in my study, 93% were arranged on an ad hoc basis. Only $1 of the executives' time was spent in open-ended observational tours. Only 1 out of 368 verbal contacts was unrelated to a specific issue and could be called general planning. Another researcher finds that "in not one single case did a manager report the obtaining of important external information from a general conversation or other undirected personal communication."[4]

   - No study has found important patterns in the way managers schedule their time. They seem to jump from issue to issue, continually responding to the needs of the moment.

Is this the planner that the classical view describes? Hardly. How, then, can we explain this behavior? The manager is simply responding to the pressures of his job. I found that my chief executives terminated many of their own activities, often leaving meetings before the end, and interrupted their desk work to call in subordinates. One president not only placed his desk so that he could look down a long hallway but also left his door open when he was alone--an invitation for subordinates to come in and interrupt him.

Clearly, these managers wanted to encourage the flow of current information. But more significantly, they seemed to be conditioned by their own work loads. They appreciated the opportunity cost of their own time, and they were continually aware of their ever-present obligations--mail to be answered, callers to attend to, and so on. It seems that no matter what he is doing, the manager is plagued by the possibilities of what he might do and what he must do.

When the manager must plan, he seems to do so implicitly in the context of daily actions, not in some abstract process reserved for two weeks in the organization's mountain retreat. The plans of the chief executives I studied seemed to exist only in their heads--as flexible, but often specific, intentions. The traditional literature notwithstanding, the job of managing does not breed reflective planners; the manager does not breed reflective planners; the manager is a real-time responder to stimuli, an individual who is conditioned by his job to prefer live to delayed action.

2. Folklore: The effective manager has no regular duties to perform. Managers are constantly being told to spend more time planning and delegating, and less time seeing customers and engaging in negotiations. These are not, after all, the true tasks of the manager. To use the popular analogy, the good manager, like the good conductor, carefully orchestrates everything in advance, then sits back to enjoy the fruits of his labor, responding occasionally to an unforeseeable exception.

But here again the pleasant abstraction just does not seem to hold up. We had better take a closer look at those activities managers feel compelled to engage in before we arbitrarily define them away.

Fact: In addition to handling exceptions, managerial work involves performing a number of regular duties, including ritual and ceremony, negotiations, and processing of soft information that links the organization with its environment. Consider some evidence from the research studies:

- A study of the work of the presidents of small companies found that they engaged in routine activities because their companies could not afford staff specialists and were so thin on operating personnel that a single absence often required the president to substitute.[5]

- One study of field sales managers and another of chief executives suggest that it is a natural part of both jobs to see important customers, assuming the managers wish to keep those customers.[6]

- Someone, only half in jest, once described the manager as that person who sees visitors so that everyone else can get his work done. In my study, I found that certain ceremonial duties--meeting visiting dignitaries, giving out gold watches, presiding at Christmas dinners--were an intrinsic part of the chief executive's job.

- Studies of managers' information flow suggest that managers play a key role in securing "soft" external information (much of it available only to them because of their status) and in passing it along to their subordinates.

3. Folklore: The senior manager needs aggregated information, which a formal management information system best provides. Not too long ago, the words total information system were everywhere in the management literature. In keeping with the classical view of the manager as that individual perched on the apex of a regulated, hierarchical system, the literature's manager was to receive all his important information from a giant, comprehensive MIS.

But lately, as it has become increasingly evident that these giant MIS systems are not working--that managers are simply not using them--the enthusiasm has waned. A look at how managers actually process information makes the reason quite clear. Managers have five media at their command--documents, telephone calls, scheduled and unscheduled meetings, and observational tours.

Fact: Managers strongly favor the verbal media--namely, telephone calls and meetings. The evidence comes from every single study of managerial work. Consider the following:

- In two British studies, managers spent an average of 66% and 80% of their time in verbal (oral) communication.[7] In my study of five American chief executives, the figure was 78%.

- These five chief executives treated mail processing as a burden to be dispensed with. One came in Saturday morning to process 142 peices of mail in just over three hours, to "get rid of all the stuff." This same manager looked at the first piece of "hard" mail he had received all week, a standard cost report, and put it aside with the comment, "I never look at this."

- These same five chief executives responded immediately to 2 of the 40 routine reports they received during the five weeks of my study and to four items in the 104 periodicals. They skimmed most of these periodicals in seconds, almost ritualistically. In all, these chief executives of good-sized organizations initiated on their own--that is, not in response to something else--a grand total of 25 pieces of mail during the 25 days I observed them.

An analysis of the mail the executives received reveals an interesting picture--only 13% was of specific and immediate use. So now we have another piece in the puzzle: not much of the mail provides live, current information--the action of a competitor, the mood of a government legislator, or the rating of last night's television show. Yet this is the information that drove the managers, interrupting their meetings and rescheduling their workdays.

Consider another interesting finding. Managers seem to cherish "soft" information, expecially gossip, hearsay, and speculation. Why? The reason is its timeliness; today's gossip may be tomorrow's fact. The manager who is not accessible for the telephone call informing him that his biggest customer was seen golfing with his main competitor may read about a dramatic drop in sales in the next quarterly report. But then it's too late.

To assess the value of historical, aggregated, "hard" MIS information, consider two of the manager's prime uses for his information--to identify problems and opportunities[8] and to build his own mental models of the things around him (e.g., how his organization's budget system works, how his customers buy his product, how changes in the economy affect his organization, and so on). Every bit of evidence suggests that the manager identifies decision situations and builds models not with the aggregated abstractions an MIS provides, but with specific tidbits of data.

Consider the words of Richard Neustadt, who studied the information-collecting

habits of Presidents Roosevelt, Truman, and Eisenhower:

> "It is not information of a general sort that helps a President see personal stakes; not summaries, not surveys, not the bland amalgams. Rather...it is the odds and ends of tangible detail that pieced together in his mind illuminate the underside of issues put before him. To help himself he must reach out as widely as he can for every scrap of fact, opinion, gossip, bearing on his interests and relationships as President. He must become his own director of his own central intelligence."[9]

The manager's emphasis on the verbal media raises two important points:

First, verbal information is stored in the brains of people. Only when people write this information down can it be stored in the files of the organization--whether in metal cabinets or on magnetic tape--and managers apparently do not write down much of what they hear. Thus the strategic data bank of the organization is not in the memory of its computers but in the minds of its managers.

Second, the manager's extensive use of verbal media helps to explain why he is reluctant to delegate tasks. When we note that most of the manager's important information comes in verbal form and is stored in his head, we can well appreciate his reluctance. It is not as if he can hand a dossier over to someone; he must take the time to "dump memory"-- to tell that someone all he knows about the subject. But this could take so long that the manager may find it easier to do the task himself. Thus the manager is damned by his own information system to a "dilemma of delegation"-- to do too much himself or to delegate his subordinates with inadequate briefing.

4. Folklore: Management is, or at least is quickly becoming, a science and a profession. By almost any definitions of science and profession, this statement is false. Brief observation of any manager will quickly lay to rest the notion that managers practice a science. A science involves the enaction of systematic, analytically determined procedures or programs. If we do not even know what procedures managers use, how can we prescribe them by scientific analysis? And how can we call management a profession if we cannot specify what managers are to learn? For after all, a profession involves "knowledge of some department of learning or science" (Random House Dictionary).[10]

   Fact: The managers' programs--to schedule time, process information, make decisions, and so on--remain locked deep inside their brains. Thus, to describe these programs, we rely on words like judgement and intuition, seldom stopping to realize that they are merely labels for our ignorance.

I was struck during my study by the fact that the executives I was observing--all very competent by any standard--are fundamentally indistinguishable from their counterparts of a hundred years ago (or a thousand years ago, for that matter). The information they need differs, but they seek it in the same way--by word of mouth. Their decisions concern modern technology, but the procedures they use to make them are the same as the procedures of the nineteenth-century manager. Even the computer, so important for the specialized work of the organization, has apparently had no influence on the work procedures of general managers. In fact, the manager is in a kind of loop, with increasingly heavy work pressures

but no aid forthcoming from management science.

Considering the facts about managerial work, we can see that the manager's job is enormously complicated and difficult. The manager is overburdened with obligations; yet he cannot easily delegate his tasks. As a result, he is driven to overwork and is forced to do many tasks superficially. Brevity, fragmentation, and verbal communication characterize his work. Yet these are the very characteristics of managerial work that have impeded scientific attempts to improve it. As a result, the management scientist has concentrated his efforts on the specialized functions of the organization, where he could more easily analyze the procedures and quantify the relevant information.[11]

But the pressures of the manager's job are becoming worse. Where before he needed only to respond to owners and directors, now he finds that subordinates with democratic norms continually reduce his freedom to issue unexplained orders, and a growing number of outside influences (consumer groups, government agencies, and so on) expect his attention. And the manager has had nowhere to turn for help. The first step in providing the manager with some help is to find out what his job really is.

Back To a Basic Description of Managerial Work

Now let us try to put some of the pieces of this puzzle together. Earlier, I defined the manager as that person in charge of an organization or one of its subunits. Besides chief executive officers, this definition would include vice presidents, bishops, foremen, hockey coaches, and prime ministers. Can all of these people have anything in common? Indeed they can. For an important starting point, all are vested with formal authority over an organizational unit. From formal authority comes status, which leads to various interpersonal relations, and from these comes access to information. Information, in turn, enables the manager to make decisions and strategies for his unit.

The manager's job can be described in terms of various "roles", or organized sets of behaviors identified with a position. My description, shown in Exhibit I, comprises ten roles. As we shall see, formal authority gives rise to the three interpersonal roles, which in turn give rise to the three informational roles; these two sets of roles enable the manager to play the four decisional roles.

Interpersonal Roles

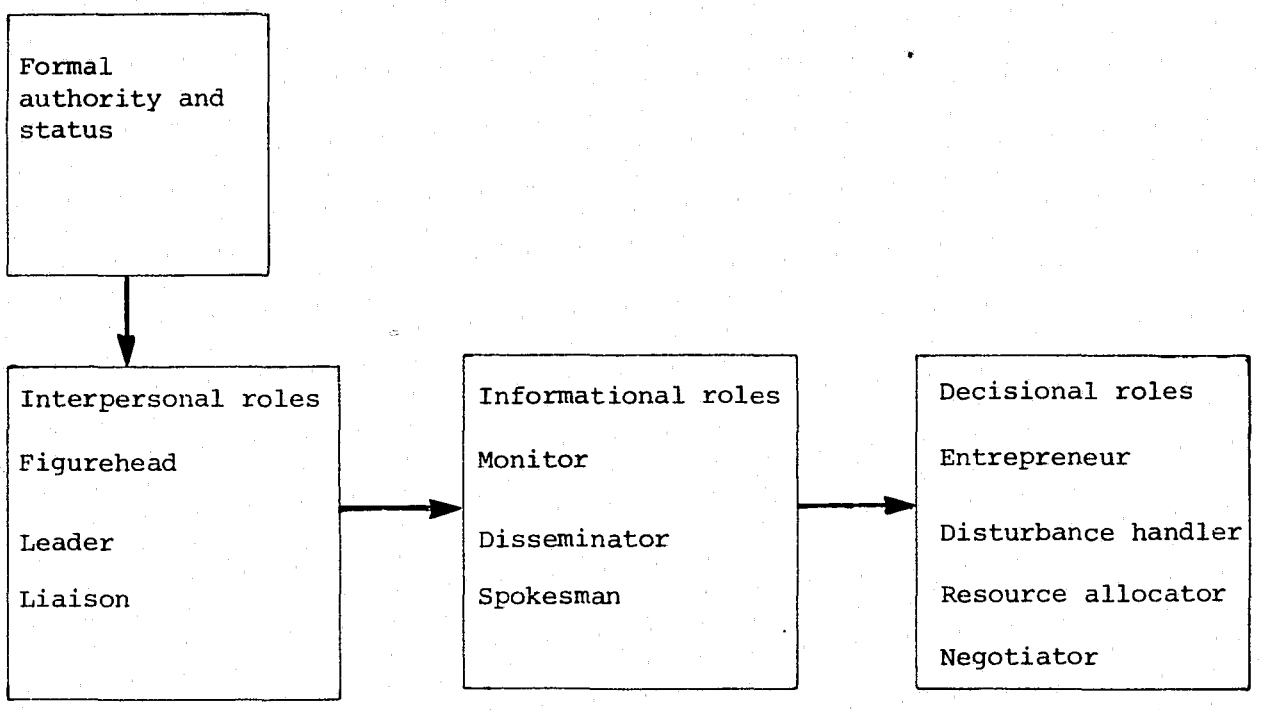
Three of the manager's roles arise directly from his formal authority and involve basic interpersonal relationships.

1. First is the figurehead role. By virtue of his position as head of an organizational unit, every manager must perform some duties of a ceremonial nature. The president greets the touring dignitaries, the foreman attends the wedding of a lathe operator, and the sales manager takes an important customer to lunch.

The chief executives of my study spent 12% of their contact time on ceremonial duties; 17% of their incoming mail dealt with acknowledgments and requests related to their status. For example, a letter to a company president requested

EXHIBIT I

The Manager's Roles



free merchandise for a crippled schoolchild; diplomas were on the desk of the school superintendent for his signature.

Duties that involve interpersonal roles may sometimes be routine, involving little serious communication and no important decisionmaking. Nevertheless, they are important to the smooth functioning of an organization and cannot be ignored by the manager.

2. Because he is in charge of an organizational unit, the manager is responsible for the work of the people of that unit. His actions in this regard constitute the leader role. Some of these actions involve leadership directly--for example, in most organizations the manager is normally responsible for hiring and training his own staff.

   In addition, there is the indirect exercise of the leader role. Every manager must motivate and encourage his employees, somehow reconciling their individual needs with the goals of the organization. In virtually every contact the manager has with his employees, subordinates seeking leadership clues probe his actions: "Does he approve?" "How would he like the report to turn out?" "Is he more interested in market share than high profits?"

The influence of the manager is most clearly seen in the leader role. Formal authority vests him with great potential power; leadership determines in large part how much of it he will realize.

3. The literature of management has always recognized the leader role, particularly those aspects of it related to motivation. In comparison, until recently it has hardly mentioned the liaison role, in which the manager makes contacts outside his vertical chain of command. This is remarkable in light of the finding of virtually every study of managerial work that managers spend as much time with peers and other people outside their units as they do with their own subordinates--and, surprisingly, very little time with their own superiors.

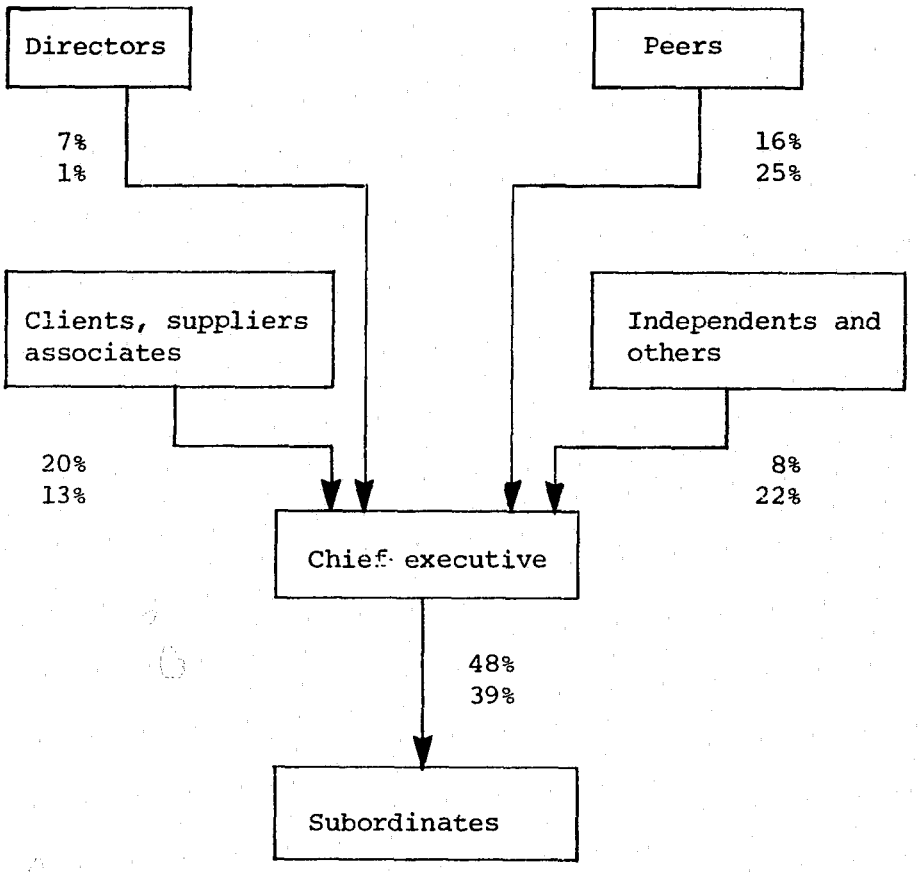
   In Rosemary Stewart's diary study, the 160 British middle and top managers spent 47% of their time with peers, 41% of their time with people outside their unit, and only 12% of their time with their superiors. For Robert H. Guest's study of U.S. foremen, the figures were 44%, 46%, and 10%. The chief executives of my study averaged 44% of their contact time with people outside their organizations, 48% with subordinates, and 7% with directors and trustees.

   The contacts the five CEOs made were with an incredibly wide range of people: subordinates; clients, business associates, and suppliers; and peers--managers of similar organizations, government and trade organization officials, fellow directors on outside boards, and independents with no relevant organizational affiliations. The chief executives' time with and mail from these groups is shown in Exhibit II on page 68. Guest's study of foremen shows, likewise, that their contacts were numerous and wide ranging, seldom involving fewer than 25 individuals, and often more than 50.

As we shall see shortly, the manager cultivates such contacts largely to find information. In effect, the liaison role is devoted to building up the manager's own external information system--informal, private, verbal, but, nevertheless, effective.

EXHIBIT II

The Chief Executives' Contacts



Note: The top figure indicates the proportion of total contact time spent with each group and the bottom figure, the proportion of mail from each group.

Informational Roles

By virtue of his interpersonal contacts, both with his subordinates and with his network of contacts, the manager emerges as the nerve center of his organizational unit. He may not know everything, but he typically knows more than any member of his staff.

Studies have shown this relationship to hold for all managers, from street gang leaders to U.S. presidents. In The Human Group, George C. Homans explains how, because they were at the center of the information flow in their own gangs and were also in close touch with other gang leaders, street gang leaders were better informed than any of their followers.[12] And Richard Neustadt describes the following account from his study of Franklin D. Roosevelt:

> "The essence of Roosevelt's technique for information-gathering was competition. 'He would call you in', one of his aides once told me, 'and he'd ask you to get the story on some complicated business, and you'd come back after a couple of days of hard labor and present the juicy morsel you'd uncovered under a stone somewhere, and then you'd find out he knew all about it, along with something else you didn't know. Where he got this information from he wouldn't mention, usually, but after he had done this to you once or twice you got damn careful about your information.'"[13]

We can see where Roosevelt "got this information" when we consider the relationship between the interpersonal and informational roles. As leader, the manager has formal and easy access to every member of his staff. Hence, as noted earlier, he tends to know more about his own unit than anyone else does. In addition, his liaison contacts expose the manager to external information to which his subordinates often lack access. Many of these contacts are with other managers of equal status, who are themselves nerve centers in their own organization. In this way, the manager develops a powerful data base of information.

The processing of information is a key part of the manager's job. In my study, the chief executives spent 40% of their contact time on activities devoted exclusively to the transmission of information; 70% of their incoming mail was purely informational (as opposed to requests for action). The manager does not leave meetings or hang up the telephone in order to get back to work. In large part, communication is his work. Three roles describe these informational aspects of managerial work.

1. As monitor, the manager perpetually scans his environment for information, interrogates his liaison contacts and his subordinates, and receives unsolicited information, much of it as a result of the network of personal contacts he has developed. Remember that a good part of the information the manager collects in his monitor role arrives in verbal form, often as gossip, hearsay, and speculation. By virtue of his contacts, the manager has a natural advantage in collecting this soft information for his organization.

2. He must share and distribute much of this information. Information he gleans from outside personal contacts may be needed within his organization. In his disseminator role, the manager passes some of his privleged information directly to his subordinates, who would otherwise have no access to it. When

his subordinates lack easy contact with one another, the manager will sometimes pass information from one to another.

3. In his spokesman role, the manager sends some of his information to people outside his unit--a president makes a speech to lobby for an organization cause, or a foreman suggests a product modification to a supplier. In addition, as part of his role as spokesman, every manager must inform and satisfy the influential people who control his organizational unit. For the foreman, this may simply involve keeping the plant manager informed about the flow of work through the shop.

   The president of a large corporation, however, may spend a great amount of his time dealing with a host of influences. Directors and shareholders must be advised about financial performance; consumer groups must be assured that the organization is fulfilling its social responsibilities; and government officials must be satisfied that the organization is abiding by the law.

Decisional Roles

Information is not, of course, an end in itself; it is the basic input to decision making. One thing is clear in the study of managerial work: the manager plays the major role in his unit's decision-making system. As its formal authority, only he can commit the unit to important new courses of action; and as its nerve center, only he has full and current information to make the set of decisions that determines the unit's strategy. Four roles describe the manager as decision-maker.

1. As entrepreneur, the manager seeks to improve his unit, to adapt it to changing conditions in the environment. In his monitor role, the president is constantly on the lookout for new ideas. When a good one appears, he initiates a development project that he may supervise himself or delegate to an employee (perhaps with the stipulation that he must approve the final proposal).

There are two interesting features about these development projects at the chief executive level.

First, these projects do not involve single decisions or even unified clusters of decisions. Rather, they emerge as a series of small decisions and actions sequenced over time. Apparently, the chief executive prolongs each project so that he can fit it bit by bit into his busy, disjointed schedule and so that he can gradually come to comprehend the issue, if it is a complex one.

Second, the chief executives I studied supervised as many as 50 of these projects at the same time. Some projects entailed new products or processes; others involved public relations campaigns, improvement of the cash position, reorganization of a weak department, resolution of a morale problem in a foreign division, integration of computer operations, various acquisitions at different stages of development, and so on.

The chief executive appears to maintain a kind of inventory of the development projects that he himself supervises--projects that are at various stages of development, some active and some in limbo. Like a juggler, he keeps a number of

projects in the air; periodically, one comes down, is given a new burst of energy, and is sent back into orbit. At various intervals, he puts new projects on-stream and discards old ones.

2. While the entrepreneur role describes the manager as the voluntary initiator of change, the disturbance handler role depicts the manager involuntarily responding to pressures. Here change is beyond the manager's control. He must act because the pressures of the situation are too severe to be ignored: strike looms, a major customer has gone bankrupt, or a supplier reneges on his contract.

   It has been fashionable, I noted earlier, to compare the manager to an orchestra conductor, just as Peter F. Drucker wrote in The Practice of Management:

   "The manager has the task of creating a true whole that is larger than the sum of its parts, a productive entity that turns out more than the sum of the resources put into it. One analogy is the conductor of a symphony orchestra, through whose effort, vision and leadership individual instrumental parts that are so much noise by themselves become the living whole of music. But the conductor has the composer's score; he is only interpreter. The manager is both composer and conductor."[14]

Now consider the words of Leonard R. Sayles, who has carried out systematic research on the manager's job:

> "(The manager) is like a symphony orchestra conductor, endeavouring to maintain a melodious performance in which the contributions of the various instruments are coordinated and sequenced, patterned and paced, while the orchestra members are having various personal difficulties, stage hands are moving music stands, alternating excessive heat and cold are creating audience and instrument problems, and the sponsor of the concert is insisting on irrational changes in the program."[15]

In effect, every manager must spend a good part of his time responding to high-pressure disturbances. No organization can be so well run, so standardized, that it has considered every contingency in the uncertain environment in advance. Disturbances arise not only because poor managers ignore situations until they reach crisis proportions, but also because good managers cannot possibly anticipate all the consequences of the actions they take.

3. The third decisional role is that of resource allocator. To the manager falls the responsibility of deciding who will get what in his organizational unit. Perhaps the most important resource the manager allocates is his own time. Access to the manager constitutes exposure to the unit's nerve center and decision-maker. The manager is also charged with designing his unit's structure, that pattern of formal relationships that determines how work is to be divided and coordinated.

   Also, in his role as resource allocator, the manager authorizes the important decisions of his unit before they are implemented. By retaining this power, the manager can ensure that decisions are interrelated; all must pass through a single brain. To fragment this power is to encourage discontinuous

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1 OF 2

decision making and a disjointed strategy.

There are a number of interesting features about the manager's authorizing others' decisions. First, despite the widespread use of capital budgeting procedures--a means of authorizing various capital expenditures at one time--executives in my study made a great many authorization decisions on an ad hoc basis. Apparently, many projects cannot wait or simply do not have the quantifiable costs and benefits that capital budgeting requires.

Second, I found that the chief executives faced incredibly complex choices. They had to consider the impact of each decision on other decisions and on the organization's strategy. They had to ensure that the decision would be acceptable to those who influence the organization, as well as ensure that resources would not be overextended. They had to understand the various costs and benefits as well as the feasibility of the proposal. They also had to consider questions of timing. All this was necessary for the simple approval of someone else's proposal. At the same time, however, delay could lose time, while quick approval could be ill considered and quick rejection might discourage the subordinate who had spent months developing a pet project.

One common solution to approving projects is to pick the man instead of the proposal. That is, the manager authorizes those projects presented to him by people whose judgement he trusts. But he cannot always use this simple dodge.

4. The final decisional role is that of negotiator. Studies of managerial work at all levels indicate that managers spent considerable time in negotiations: the president of the football team is called in to work out a contract with the holdout superstar; the corporation president leads his company's contingent to negotiate a new strike issue; the foreman argues a grievance problem to its conclusion with the shop steward. As Leonard Sayles puts it, negotiations are a "way of life" for the sophisticated manager.

   These negotiations are duties of the manager's job; perhaps routine, they are not to be shirked. They are an integral part of his job, for only he has the authority to commit organizational resources in "real time," and only he has the nerve center information that important negotiations require.

The Integrated Job

It should be clear by now that the ten roles I have been describing are not easily separable. In the terminology of the psychologist, they form a gestalt, an integrated whole. No role can be pulled out of the framework and the job be left intact. For example, a manager without liaison contacts lacks external information. As a result, he can neither disseminate the information his employees need nor make decisions that adequately reflect external conditions. (In fact, this is a problem for the new person in a managerial position, since he cannot make effective decisions until he has built up his network of contacts.)

Here lies the clue to the problems of team management.[16] Two or three people cannot share a single managerial position unless they can act as one entity.

This means that they cannot divide up the ten roles unless they can very carefully reintegrate them. The real difficulty lies with the informational roles. Unless there can be full sharing of managerial information--and, as I pointed out earlier, it is primarily verbal--team management breaks down. A single managerial job cannot be arbitrarily split, for example, into internal and external roles, for information from both sources must be brought to bear on the same decisions.

To say that the ten roles form a gestalt is not to say that all managers give equal attention to each role. In fact, I found in my review of the various research studies that

> ...sales managers seem to spend relatively more of their time in the interpersonal roles, presumably a reflection of the extrovert nature of the marketing activity;
>
> ...production managers give relatively more attention to the decisional roles, presumably a reflection of their concern with efficient work flow;
>
> ...staff managers spend the most time in the informational roles, since they are experts who manage departments that advise other parts of the organization.

Nevertheless, in all cases the interpersonal, informational, and decisional roles remain inseparable.

Toward More Effective Management

What are the messages for management in this description? I believe, first and foremost, that this description of managerial work should prove more important to managers than any prescription they might derive from it. That is to say, the manager's effectiveness is significantly influenced by his insight into his own work. His performance depends on how well he understands and responds to the pressures and dilemmas of the job. Thus managers who can be introspective about their work are likely to be effective at their jobs. The paragraphs on page 76 offer 14 groups of self-study questions for managers. Some may sound rhetorical; none is meant to be. Even though the questions cannot be answered simply, the manager should address them.

Let us take a look at three specific areas of concern. For the most part, the managerial logjams--the dilemma of delegation, the data base centralized in one brain, the problems of working with the management scientist--revolve around the verbal nature of the manager's information. There are great dangers in centralizing the organization's data bank in the minds of its managers. When they leave, they take their memory with them. And when subordinates are out of convenient verbal reach of the manager, they are at an informational disadvantage.

1. The manager is challenged to find systematic ways to share his privileged information. A regular debriefing session with key subordinates, a weekly memory dump on the dictating machine, the maintaining of a diary of important information for limited circulation, or other similar methods may ease the logjam of work considerably. Time spent disseminating this information will be more than regained when decisions must be made. Of course, some will raise

the question of confidentiality. But managers would do well to weigh the risks of exposing priviledged information against having subordinates who can make effective decisions.

If there is a single theme that runs through this article, it is that the pressures of his job drive the manager to be superficial in his actions--to overload himself with work, encourage interruption, respond quickly to every stimulus, seek the tangible and avoid the abstract, make decisions in small increments, and do everything abruptly.

2. Here again, the manager is challenged to deal consciously with the pressures of superficiality by giving serious attention to the issues that require it, by stepping back from his tangible bits of information in order to see a broad picture, and by making use of analytical inputs. Although effective managers have to be adept at responding quickly to numerous and varying problems, the danger in managerial work is that they will respond to every issue equally (and that means abruptly) and that they will never work the tangible bits and pieces of informational input into a comprehensive picture of their world.

As I noted earlier, the manager uses these bits of information to build models of his world. But the manager can also avail himself of the models of the specialists. Economists describe the functioning of markets, operations researchers simulate financial flow processes, and behavioral scientists explain the needs and goals of people. The best of these models can be searched out and learned.

In dealing with complex issues, the senior manager has much to gain from a close relationship with the management scientists of his own organization. They have something important that he lacks--time to probe complex issues. An effective working relationship hinges on the resolution of what a colleague and I have called "the planning dilemma."[17] Managers have the information and the authority; analysts have the time and the technology. A successful working relationship between the two will be effected when the manager learns to share his information and the analyst learns to adapt to the manager's needs. For the analyst, adaptation means worrying less about the elegance of the method and more about its speed and flexibility.

It seems to me that analysts can help the top manager especially to schedule his time, feed in analytical information, monitor projects under his supervision, develop models to aid in making choices, design contingency plans for disturbances that can be anticipated, and conduct "quick-and-dirty" analysis for those that cannot. But there can be no cooperation if the analysts are out of the mainstream of the manager's information flow.

3. The manager is challenged to gain control of his own time by turning obligations to his advantage and by turning those things he wishes to do into obligations. The chief executives of my study initiated only 32% of their own contacts (and another 5% by mutual agreement). And yet to a considerable extent they seemed to control their time. There were two key factors that enabled them to do so.

First, the manager has to spend so much time discharging obligations that if he were to view them as just that, he would leave no mark on his organization. The unsuccessful manager blames failure on the obligations; the effective manager turns

his obligations to his own advantage. A speech is a chance to lobby for a cause; a meeting is a chance to reorganize a weak department; a visit to an important customer is a chance to extract trade information.

Second, the manager frees some of his time to do those things that he--perhaps no one else--thinks important by turning them into obligations. Free time is made, not found, in the manager's job; it is forced into the schedule. Hoping to leave some time open for contemplation or general planning is tantamount to hoping that the pressures of the job will go away. The manager who wants to innovate initiates a project and obligates others to report back to him; the manager who needs certain environmental information establishes channels that will automatically keep him informed; the manager who has to tour facilities commits himself publicly.

The Educator's Job

Finally, a word about the training of managers. Our management schools have done an admirable job of training the organization's specialists--management scientists, marketing researchers, accountants, and organizational development specialists. But for the most part they have not trained managers.[18]

Management schools will begin the serious training of managers when skill training takes a serious place next to cognitive learning. Cognitive learning is detached and informational, like reading a book or listening to a lecture. No doubt much important cognitive material must be assimilated by the manager-to-be. But cognitive learning no more makes a manager than it does a swimmer. The latter will drown the first time he jumps into the water if his coach never takes him out of the lecture hall, gets him wet, and gives him feedback on his performance.

In other words, we are taught a skill through practice plus feedback, whether in a real or a simulated situation. Our management schools need to identify the skills managers use, select students who show potential in these skills, put the students into situations where these skills can be practiced, and then give them systematic feedback on their performance.

My description of managerial work suggests a number of important managerial skills--developing peer relationships, carrying out negotiations, motivating subordinates, resolving conflicts, establishing information networks and subsequently disseminating information, making decisions in conditions of extreme ambiguity, and allocating resources. Above all, the manager needs to be introspective about his work so that he may continue to learn on the job.

Many of the manager's skills can, in fact, be practiced, using techniques that range from role playing to videotaping real meetings. And our management schools can enhance the entrepreneurial skills by designing programs that encourage sensible risk taking and innovation.

No job is more vital to our society than that of the manager. It is the manager who determines whether our social institutions serve us well or whether they squander our talents and resources. It is time to strip away the folklore about managerial work, and time to study it realistically so that we can begin the difficult task of making significant improvements in its performance.

Self-Study Questions for Managers

1. Where do I get my information, and how? Can I make greater use of my contacts to get information? Can other people do some of my scanning for me? In what areas is my knowledge weakest, and how can I get others to provide me with the information I need? Do I have powerful enough mental models of those things I must understand within the organization and in its environment?

2. What information do I disseminate in my organization? How important is it that my subordinates get my information? Do I keep too much information to myself because dissemination of it is time-consuming or inconvenient? How can I get more information to others so they can make better decisions?

3. Do I balance information collecting with action taking? Do I tend to act before information is in? Or do I wait so long for all the information that opportunities pass me by and I become a bottleneck in my organization?

4. What pace of change am I asking my organization to tolerate? Is this change balanced so that our operations are neither excessively static nor overly disrupted? Have we sufficiently analyzed the impact of this change on the future of our organization?

5. Am I sufficiently well informed to pass judgement on the proposals that my subordinates make? Is it possible to leave final authorization for more of the proposals with subordinates? Do we have problems of coordination because subordinates in fact now make too many of these decisions independently?

6. What is my vision of direction for this organization? Are these plans primarily in my own mind in loose form? Should I make them explicit in order to guide the decisions of others in the organization better? Or do I need flexibility to change them at will?

7. How do my subordinates react to my managerial style? Am I sufficiently sensitive to the powerful influence my actions have on them? Do I fully understand their reactions to my actions? Do I find an appropriate balance between encouragement and pressure? Do I stifle their initiative?

8. What kind of external relationships do I maintain, and how? Do I spend too much of my time maintaining these relationships? Are there certain types of people whom I should get to know better?

9. Is there any system to my time scheduling, or am I just reacting to the pressures of the moment? Do I find the appropriate mix of activities, or do I tend to concentrate on one particular function or one type of problem just because I find it interesting? Am I more efficient with particular kinds of work at special times of the day or week? Does my schedule reflect this? Can someone else (in addition to my secretary) take responsibility for much of my scheduling and do it more systematically?

10. Do I overwork? What effect does my work load have on my efficiency? Should I force myself to take breaks or to reduce the pace of my activity?

Self-Study (con.)

11. Am I too superficial in what I do? Can I really shift moods as quickly and frequently as my work patterns require? Should I attempt to decrease the amount of fragmentation and interruption in my work?

12. Do I orient myself too much toward current, tangible activities? Am I a slave to the action and excitement of my work, so that I am no longer able to concentrate on issues? Do key problems receive the attention they deserve? Should I spend more time reading and probing deeply into certain issues? Could I be more reflective? Should I be?

13. Do I use the different media appropriately? Do I know how to make the most of written communication? Do I rely excessively on face-to-face communication, thereby putting all but a few of my subordinates at an informational disadvantage? Do I schedule enough of my meetings on a regular basis? Do I spend enough time touring my organization to observe activity at first hand? Am I too detached from the heart of my organization's activities, seeing things only in an abstract way?

14. How do I blend my personal rights and duties? Do my obligations consume all my time? How can I free myself sufficiently from obligations to ensure that I am taking this organization where I want it to go? How can I turn my obligations to my advantage?

FOOTNOTES

[1]All the data from my study can be found in Henry Mintzberg, The Nature of Managerial Work (New York: Harper & Row, 1973).

[2]Robert H. Guest, "Of Time and the Foreman," Personnel, May 1956, p. 478.

[3]Rosemary Stewart, Managers and Their Jobs (London: Macmillan, 1967), see also Sune Carlson, Executive Behaviour (Stockholm: Strombergs, 1951), the first of the diary studies.

[4]Francis J. Aguilar, Scanning the Business Environment (New York: Macmillan, 1967), p. 102.

[5]Unpublished study by Irving Choran, reported in Mintzberg, The Nature of Managerial Work.

[6]Robert T. Davis, Performance and Development of Field Sales Managers (Boston: Division of Research, Harvard Business School, 1957); George H. Copeman, The Role of the Managing Direct (London: Business Publications, 1963).

[7]Stewart, Managers and Their Jobs; Tom Burns, "The Directions of Activity and Communication in a Departmental Executive Group," Human Relations 7, no. 1 (1954): 73.

[8]H. Edward Wrapp, "Good Managers Don't Make Policy Decisions," HBR September-October 1967, p. 91; Wrapp refers to this as spotting opportunities and relationships in the stream of operating problems and decisions; in his article Wrapp raises a number of excellent points related to this analysis.

[9]Richard E. Neustadt, Presidential Power, (New York: John Wiley, 1960), pp. 153-154; italics added.

[10]For a more thorough, though rather different, discussion of this issue, see Kenneth R. Andrews, "Toward Professionalism in Business Management," HBR March-April 1969, p. 49.

[11]C. Jackson Grayson, Jr., in "Management Science and Business Practice," HBR July-August 1973, p. 41, explains in similar terms why, as chairman of the Price Commission, he did not use those very techniques that he himself promoted in his earlier career as a management scientist.

[12]George C. Homans, The Human Group (New York: Harcourt, Brace & World, 1950), based on the study by William F. Whyte entitled Street Corner Society, rev. ed. (Chicago: University of Chicago Press, 1955).

[13]Neustadt, Presidential Power, p. 157.

[14]Peter F. Drucker, The Practice of Management (New York: Harper & Row, 1954), pp. 341-342.

[15]Leonard R. Sayles, Managerial Behavior (New York: McGraw-Hill, 1964), p. 162.

[16]See Richard C. Hodgson, Daniel J. Levinson, and Abraham Zaleznik, The Executive Role Constellation (Boston: Division of Research, Harvard Business School, 1965) for a discussion of the sharing of roles.

[17]James S. Hekimian and Henry Mintzberg, "The Planning Dilemma," The Management Review, May 1968, p. 4.

[18]See J. Sterling Livingston, "Myth of the Well-Educated Manager," HBR January-February 1971, p. 79.

CHAPTER 6. OPTIONS IN HEALTH CARE DELIVERY

Prisons and jails come in so many forms and sizes, with individual needs and demands, that it is not possible to draw models of how health care should or even can be delivered, but only to look at options for the future.

Throughout the country, many administrators in corrections have been working to find ways to improve their health care systems and facilities and to make them more responsive to human needs.

Several members of the Executive Training Program's team in Health Care in Correctional Institutions traveled to a variety of institutions to see and hear firsthand how some of these innovative programs are working.

This chapter examines the unique features of health in eight institutions, ranging from a small county facility to major city and state operations. The programs are described here largely in the words of the men and women who are directly involved in them. Often, these people have had to fight an uphill battle to improve the health care in their facilities and must continue to do so. We hope their experiences will support others who are trying to initiate change in prison health care, as well as expand their views of the resources, needs, and alternatives available in both the delivery and management of health care services in corrections.

Eight Alternatives--An Overview

1. We will begin by looking at how the state of North Carolina administers and delivers health care in its 77 prison facilities. This system is under the direction of a health administrator, uses centralized hospitals and a pharmacy, and has developed a comprehensive intake examination and a sophisticated record-keeping system.

2. Perhaps at the other end of the corrections spectrum is the Marion County Jail in central Ohio. This facility houses an average of 50 people and has developed, over the past three years, what the sheriff and jail physician believe is an accountable and cost efficient medical program for their population.

Administrators in the next three systems have all chosen to upgrade various aspects of medical care by developing arrangements with medical schools and teaching hospitals.

3. In New York City, Montefiore Hospital is under contract to provide all major services to about 5,000 men and women incarcerated in the short-term facilities on Rikers Island. Administrators of Rikers Island Health Services use a "health team" approach to provide care and have designed innovative

recruiting and inservice training programs for the staff.

4. In Virginia, the Richmond City Jail has a contract with the medical school at Virginia Commonwealth University to provide primary health care to inmates. Administrators there also described the screening examination they have devised to safeguard the population's health and the "medical request box" which inmates who desire attention can use.

5. In St. Paul, Minnesota, a community hospital, St. Paul-Ramsey Medical Center, provides health services to the county jail and workhouse. According to the program's administrators, the hospital has successfully combined the provision of these services with a residency training program in family practice.

6. In San Francisco, we looked at one now well-established facet of the jail's medical program--the hospital security ward. The ward houses all major medical, surgical, and psychiatric patients from the jail. We discussed both medical and security concerns on the ward with representatives of the sheriff's department and the hospital.

Finally, we looked at two systems that have developed innovative training programs for inmates that affect the institutions and, in one case, the community's medical services.

7. The Vienna Correctional Institution, a minimum security prison in southern Illinois, has a program to train inmates as emergency medical technicians. They serve in that capacity on ambulances used for emergency transportation for both the prison and the surrounding counties.

8. In Michigan, the Department of Correction currently operates two training programs in the dental field. One is a degree program to train dental technicians and the other involves on-the-job training in the production of prosthetic dental devices. Current plans call for phasing out the on-the-job program, however, in favor of expanding the degree program to include medium and minimum security inmates.

Most of the information contained in this chapter was originally presented in a film produced by the training team, entitled "Options in Health Care Delivery."

A list of the people who participated in the film and whose programs, work, and words inform this chapter is included here so that they may be contacted for additional information.

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A Health Administrator

Dr. Richard Kiel is chief of health services for the North Carolina Division of Prisons. He explains his job this way: "I'm a health administrator and my responsibility is to take health professionals, medical supplies, medical equipment, and health care facilities and merge them together so that we can deliver optimum health care to the inmates of North Carolina at the lowest possible cost."

The system he administers is rather large--77 facilities, 66 of which are small field units scattered around the state. The largest facility, Central Prison, and a large Correctional Center for Women are located in Raleigh. According to Kiel, there are approximately 14,500 inmates in the system, with about 14,000 coming in each year.

Intake Examination and Record Procedures

Each inmate receives an extensive examination upon entering the system which Kiel said consists of essentially four stages: a complete medical history; physiological measurements such as weight, height, blood pressure, and so forth; then, blood analysis, urinalysis, a tetanus immunization and a PPD screening test for TB; and an examination in which a physician completes at least 21 separate clinical observations. The results of this examination are recorded on a form which is compatible to computer input and entered into the computer through a keypunch system. Quarterly, a report is issued indicating what percent of the intake population has some abnormal condition. According to Kiel, this information not only provides an excellent profile of the health of the inmates, but it also provides a quality control device whereby certain findings from one reception diagnostic center can be compared against findings at another to determine whether or not things are going smoothly. In addition, these forms become a part of the inmate's health records. "It's very important to have a complete and accurate health record for two reasons," Kiel said. "Since there are a large number of health professionals involved in delivering care, the record ensures continuity. The second reason, particularly important in a prison system, is that it gives us a legal document to prove that the care that we have rendered has in fact been delivered."

The Hospitals and Clinics

Kiel administers his state's system from Raleigh where many of the major health care facilities for the state's prison population are located, including a hospital, two mental health units, and a pharmacy. Central Prison is the hub of the health delivery system, with a 100-bed acute care medical-surgical hospital and two 72-bed mental health inpatient treatment facilities. These facilities provide the care for the Central Prison population as well as for those inmates in the other state prisons who require hospitalization or specialty care.

The two 72-bed inpatient mental health units provide psychiatric care for all males 18 years and older. Mental health intervention is provided by a full-time psychiatrist, a clinical psychologist, a recreational specialist, and other members of the treatment team. There is only limited inpatient capability for

women and juveniles. But there are also 12 satellite mental health clinics located at the diagnostic centers at the larger institutions. These clinics are staffed by psychiatrists and clinical psychologists under contract and full-time nursing personnel.

The Pharmacy

A central pharmacy service distributes medical supplies, over-the-counter items, and prescription medications to all units within the state system. The use of a central pharmacy service for a system as large as North Carolina's is cost effective, Kiel said, because by buying large quantities under state contract they are able to purchase supplies at a cost which is really below wholesale.

MARION COUNTY JAIL

Marion County is located in central Ohio and has a population of about 70,000. On the average, the county jail will have a population of about 50 inmates, according to Sheriff Ron Scheiderer.

Three years ago, the jail had no real health care policy and all the problems of a small facility: "We were underfinanced, certainly understaffed, and we had absolutely no medical services at all," explained Scheiderer. In less than three years, the jail has developed a program that meets not only legal obligations, but moral ones as well, the sheriff believes.

The Health Care Program

Dr. Robert Gray helped the sheriff set up the medical program. He is still the jail's physician and is responsible for health care administration. According to Gray, the health care program was initiated at the request of the sheriff in about March 1975. At that time, the medical budget for the year had already been used up on unnecessary hospitalizations and emergency room calls. At first Gray covered the whole jail. Then, a registered nurse came for one hour a day, made sick calls, and passed out medicines. Costs started down.

By August 1976, having shown the county taxpayers that these methods were cutting overall cost to them, the sheriff was able to hire a full-time registered nurse under the Comprehensive Employment Training Act program. She worked a 40-hour week, but was also on call for emergencies. Gray expects the nurse to be a regular county employee in the near future.

The doctor is also proud of the problem-oriented records that are now part of the system for legal protection as well as for good medical practice. "This is one of the things I emphasized to Sheriff Scheiderer when I agreed to accept the job as jail physician, that if something was going to be done, it was going to be done right and within the strict guidelines of good medical practice and medical ethics. They could not, and cannot, afford to be a halfway operation--to me that would be the strongest basis for a suit of all."

Intake Procedures

The jail has developed a simple intake procedure and record system that helps the staff keep on top of potential problems. Any medical, emotional, or mental problems are noted by the arresting officer. At the time of book-in, the warden also questions the inmate mostly to find out if he has any injuries, current medical problem, or if he is on medication. If an inmate has a medical problem, the book-in card itself is heavily red-lined on top. In that way, when a new shift comes on duty, they know they have a potential problem. Immediate first aid can be given, if necessary, especially since all of the officers at the jail are equipped, and many are specially trained, to deliver emergency first aid.

Jail Nursing

Marilyn Lawrence is the CETA-employed nurse at the jail. In the year that she has been there, Lawrence says she has had to feel her way along in defining her role. "Jail medicine is totally new in the area of nursing--there are no standards to go by, not only because nurses are in a totally new area but every jail setting is completely different. It's a case of improvisation most of the time."

Lawrence finds her job challenging and she believes other jails can successfully recruit competent nurses if word gets out that it can be an exciting position: "For nurses who shudder at the thought of coming to work at a dirty jail where nothing ever happens as I did about a year ago, I'd like to tell them that this is the place where the action is. Nurse practitioners are the newest approach in nursing but I'll bet a jail nurse does more than any nurse practitioner ever dreamed of. Eventually you cover every conceivable acute emergency," she explained.

The Results

The Marion County Jail staff reported that the medical program has produced much cooperation and better relationships within the jail. As nurse Lawrence explained it: "We're forced to live with the inmates on a 24-hour basis. We can either have inmates who are rioting and tearing up the jail or we can have inmates who are cooperating with us. And part of that is our own cooperation. When they have a need that we meet, they're inclined to meet our needs. Now where medicine is concerned, they know I'm coming. If I don't show, they're reasonable about it because they know I've got a reason. If the deputies ignore a request they know that eventually the next shift will not be so busy and they'll get the request answered."

RIKERS ISLAND HEALTH SERVICES

Montefiore Hospital

For more than four years, Montefiore Hospital and Medical Center has supplied the bulk of medical services to the approximately 5,000 men, women, and youths housed on Rikers Island. The Island has four clinics to serve four correctional facilities--the Correctional Institution for Men, the Correctional Institution for Women, the Adolescent Detention Center, and the House of Detention for Men. These jails, which hold prisoners from all five boroughs of

the city, have short-term inmates--those in detention have an average stay of 30 days and those under sentence have an average stay of 90 days with a year being the maximum.

Montefiore is under contract to the City of New York (under both the corrections and health departments) to administer the Rikers Island Health Services. According to Ken Pearson, assistant administrator of the health services, there are several advantages to being under contract to deliver health services in a correctional setting. "We are able to define the medical program within the institutions; the contract has allowed us to attract an excellent staff; and that staff has shown a high degree of professionalism. The quality of work has meant that rapport has been built up between the help staff and the correctional staff. Although we have the option of taking problems or difficulties to the Commissioners of Corrections or Health, we have found that the rapport we have built has allowed us to make changes and to resolve institutional problems by working with the wardens and the other superior officers right in the institutions."

The Health Team

According to the medical director of Rikers Island Services, Dr. Barbara Starrett, "we like to think that we operate with a health team in each of our institutions." The prison is the primary responsibility of the chief physician in the institution, but that individual works hand-in-hand with the unit administrator and the clinical nursing supervisor. Under them are staff physicians, staff physician's assistants, nurses, physicians, pharmacists, pharmacy technicians, and clerk typists. Dr. Starrett reports: "In all we have 13 full-time physicians, 15 full-time physician's assistants, 70 nurses, 10 pharmacists, 15 pharmacy technicians, and about 12 to 14 medical records clerk typists, plus the 4 unit administrators, chief physicians and clinical nursing supervisors. In addition to this full-time staff, we have moonlighting physicians who provide care on some evenings, nights and weekends."

Recruiting

As Dr. Starrett pointed out, this is a large staff to maintain. But during her two years plus of running the health services, she says she has seen a tremendous increase in the quality of the physicians who have come to Rikers Island as well as a growing commitment to patient care by the entire staff teams. She believes the program's recruiting tone and flexibility are responsible for attracting some of the good people. As she explained it: "When we advertise, we say, 'come and join our health team.' So we are telling you right away that you are going to be working with other people. Then we say, 'do something different!' That's because we're looking for somebody who has got a little of that medical school spirit--that I came to medical school to help people--left. We want somebody who is comfortable using a problem-oriented record. And we tell them, 'you don't have to sign your name in blood and stay forever. You can come between training programs, while deciding whether to go into private or group practice, or while just trying to make up your mind.' So we have been able to attract well-trained physicians who are using problem-oriented records, who want a salaried, regular job, and who want to come for a year or two." Physicians have come to Rikers for as short a time as six months and as long as two years, but the average stay is a little over a year. Using a team approach to health care makes it possible for Dr. Starrett to hire the kind of physicians she does:

"Having substitute players coming in and out works all right as long as the team maintains good lines of communication."

Inservice Training and Education

The Montefiore program has also built in programs and activities, according to Dr. Starrett, that address one of the major problems health care professionals have faced when they go behind bars--isolation. The large size of the staff, the use of outside consultants, and Rikers' own various specialty clinics help in this area. In addition, the chief physician and clinical nursing supervisor hold monthly seminars on selected topics for their staffs. There is an accredited inservice training program for nurses and as part of their contract, doctors can have one afternoon a week off to devote to an approved training or education program or even for doing reading and research. Montefiore Hospital radiologists regularly give conferences on radiology at Rikers and the hospital plans to send consultants to Rikers to help them improve the functioning of their health care teams.

RICHMOND CITY JAIL

The Richmond City Jail was built to hold 600 persons, but like many cities' short-term and detention facilities, it has often housed well over a hundred more individuals than expected in the past several years. The jail has men, women, and some adolescents, but no one under 15 years of age. As a short-term institution, it houses detained individuals who are awaiting trial or involved in litigation and also individuals sentenced for up to 12 months. The average length of stay is seven to nine months.

For some time, the jail's administrators have been interested in getting proper medical attention to inmates and not only out of fear of legal action. As City Sergeant Andrew Winston explained: "I sometimes look at it rather selfishly. It makes the administrator's job a more comfortable one when proper medical attention is administered within the institution."

Medical College Contract

Winston likes going outside the system for medical services to get the community involved in the institution and to avoid excessive isolation. The Richmond jail decided on a contractual arrangement with Virginia Commonwealth University's Medical College to supply primary health care to inmates. Under the contract, a pool of residents from the university's hospital center operates an "extension clinic" at the jail three times a week.

Screening Examination

The jail's medical program includes an immediate preliminary examination for every person committed to its charge. Licensed practical nurses perform the examinations. They take a brief medical history of the individual to determine whether he has diabetes, heart trouble, or other medical problems that need attention. If necessary, an inmate can be sent immediately from the jail to the hospital. Otherwise, he will be referred to one of the resident physicians for a checkup.

Medical Request Box

Finally, the jail has set up a medical request box near the cafeteria. Inmates are given an opportunity to drop notes into the box three times a day. All requests are answered within 24 hours. For those people confined to their cells, a nurse makes rounds three times a day to dispense medication and conduct sick call.

ST. PAUL-RAMSEY MEDICAL CENTER

Background of the Family Practice Program

Dr. Vincent Hunt is an associate professor in the Department of Family Practice and Community Health at the University of Minnesota. He is also director of the Family Practice Department at St. Paul-Ramsey Medical Center--a department that has the responsibility for clinics in a medically disadvantaged area on the West Side of the city that includes the County Workhouse and City-County Jail.

Dr. Hunt got his hospital's program started under unique circumstances: "I became involved in the idea of prison health in a rather roundabout manner. There was an incident in our hospital in about 1971--a resident was taken hostage by a prisoner and a guard was actually killed. This problem was resolved. However, it caused all of us to consider what might be the best way to care for the prison population in as humane a manner as possible while also making certain that safety was ensured.

"Those of us at St. Paul-Ramsey who became involved in providing health care to prisoners found that it was necessary to become immersed. We had to go right down into the institution and work with all the problems, wrestle with them, try to figure out how best to take care of these people, and how to stimulate others to really want to take care of these people while also making it intellectually stimulating and rewarding.

"There are many times when I was worried that some prisoner might actually stab me or take me hostage or maybe even threaten members of my family. (In fact, that happened.) This was a real concern to have to get over and work with."

Medical Services

Dr. Robert A. Derro, a full-time staff physician in the hospital's Department of Family Practice, also has responsibility for the provision of health care services at the City-County Workhouse, a 150-inmate facility. He described the program of health care that has evolved using hospital residents.

"We provide services at the workhouse twice weekly for one to two hours per session and we see anywhere from 10 to 15 inmates at a given session. There is a full-time nurse at the workhouse who also provides appropriate services and assists us. In most cases, we also supervise the care of inmates if they require hospitalization at the support hospital.

"A unique feature of our program of health care services at the workhouse is its integration with a family practice residency training program. Family practice residents can elect the option of participating in health care at the

City-County Workhouse with a full-time staff physician. We combine service and teaching since the resident works alongside the staff physician and acquires competence in dealing with unique medical and emotional problems that one encounters in a correctional facility."

Health Care Goals

"We have established several defined goals for health care services at the St. Paul-Ramsey County Workhouse," Derro said. "Some of these objectives were determined prior to the institution of services and others became apparent after we began providing services.

"Firstly, we wanted to provide accessibility to health care in the event of crisis or medical emergency situations. We achieved this by having a full-time nurse and by providing onsite services with consultation services available from members of the staff of the support hospital. Secondly, we wanted to provide services for elective medical conditions at a level which would at least be equal to that on the outside. Thirdly, we have instituted a series of high-yield, cost-effective admission screening techniques based on a survey of health care needs at our institution.

"Finally, by combining our program of health care services with a family practice residency training program we have exposed physicians in training to a medical model of care that is very different from the models they have encountered in medical school and which in many ways will be different from the model they will encounter in practice. Hopefully, this exposure will stimulate them to pursue this interest in their practices by providing care to local or county correctional facilities.

"This relationship that we've established between the correctional facility, the City-County Workhouse, and City-County General Hospital may be applicable to a wide variety of correctional settings. The increase in concern for health care in correctional institutions makes it likely that a particular department within a support hospital or a particular individual will share a commitment to the provision of health care in the correctional facility. By establishing contact with that individual or that department, a strong working relationship between the two institutions can be established."

SAN FRANCISCO GENERAL HOSPITAL SECURITY WARD

The Hospital's Security Ward

In San Francisco, a major lawsuit, charging among other things that medical services in the county jail were wholly inadequate, forced a major overhaul of the system. Financial considerations dictated that a security ward would have to be established at a community hospital for major medical care of prisoners.

At first, according to the current medical director on the ward, security was at a minimum. There were several escapes; the health care staff was afraid; and there was constant tension between the doctors and nurses and the security staff.

The original, makeshift ward is gone, and a tight security ward, with specially selected guards from the sheriff's department, closed-circuit

television, and other equipment, supply round-the-clock surveillance. The ward has about 22 beds with one or two beds in a room. It serves both medical and surgical patients and some psychiatric patients. In 1978, however, a second ward will open at the hospital to serve psychiatric patients exclusively.[1]

The Sheriff

San Francisco Sheriff Richard Hongisto recounted the history of the security ward. "When I took office five years ago," began Sheriff Hongisto, "I found that our jail lacked 24-hour nurse coverage, adequate supplies and equipment for a medical program, adequate transportation crews to take people to the hospital, and an adequate security ward at the hospital. We virtually had no ability to treat people who were in need of intensive medical care while in detention, and without a security ward, our staff was severely depleted just trying to maintain custody over people in the hospital--we had to guard them one-on-one, and we didn't have enough staff to do that.

"To meet these needs, we had to go repeatedly to our county supervisors and to the public. We explained to them over and over the need for adequate medical care in the jail. We told them that if the dollars weren't spent, if the program wasn't initiated, people would die in jail. Severe medical neglect could lead to the injury of many prisoners, most of whom hadn't even been found guilty of anything. But it wasn't until the city was faced with a very large civil suit in which they had to pay a large judgment that the officials and the public finally began to get the idea.

"Now we have a new security unit built into our general hospital. It is well staffed, 24 hours a day, and we have the ability to take an inmate to clinics inside the hospital for every kind of treatment. It's been a vital component in our medical care delivery and I know that it has resulted in the savings of enormous human misery if not the saving of life."

Security on the Jail Ward

Sergeant Edgar Flowers of the San Francisco Sheriff's Department is commander of the security patient care unit, also known as the jail ward, at the San Francisco General Hospital. He told us that his job is to supervise the deputies, ensure security, and see that the patients get the best care available while they remain in custody.

One of his major concerns has been to choose the appropriate staff: "Not everyone in the sheriff's department is capable of functioning well in a unit such as we have. We recognize that some people are ill-suited for this type of duty. Therefore, a key thing is to pick the proper people to serve in our unit--a man who is security conscious and security conscious in terms of working outside of a jail situation; someone who can function well in dealing with people who are ill as well as someone who can deal with doctors, nurses, hospital administrators, and the families of sick patients.

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[1]See appendix II for a detailed discussion of mental health care provided in the ward, written by the director of San Francisco's Criminal Justice Mental Health Unit, G. Thomas Peters.

"Physical security is particularly important since some inmates in the county jails, especially ones who are facing long prison sentences, will probably view a hospital ward as an easier place to escape from than a jail. It's not unheard of that people will make themselves sick or successfully convince the doctors that they have an undefined illness to get into the hospital. What we have done is use physical security methods that make escape virtually impossible by providing secure windows, electronic surveillance, secure doors, a lock control room, and other security measures.

"None of this works, however, unless everyone involved on a ward of this type is security conscious. We were very fortunate in that the hospital administration supports this view and they encourage it. The nurses, the doctors, the janitors, the technicians--everyone cooperates.

"We maintain this cooperation by having good working relationships, and by holding a weekly ward meeting where a representative from every unit attends. If there are any problems to be solved, this is the place where it's done. If the security staff reports that anyone is breeching security, I bring this up at the meeting. If we find that someone is deliberately refusing to follow good security measures, he's transferred.

"Personally, I think that the major thing that I have done is to establish open lines of communications and a rapport with the hospital administration, with the nurses, and with the doctors. The thing that the sheriff's department has done that's most important (and I'm not talking about just money and buildings) is to give me the authority to accomplish things. I have not been weighed down in bureaucratic red tape. I can solve problems right away because I know that I have the authority and the backup. I'm only a sergeant but I don't have to deal with a lieutenant or captain. I'm an administrative assistant to the sheriff, responsible only to the sheriff, and he's given me the authority and he expects that I will do a good job."

The Security Ward: The Medical Perspective

Dr. Richard Fine is the medical director of the security ward at San Francisco General Hospital. He is also chief of the outpatient department at San Francisco General Hospital. The security ward, he said, provides basically all hospital services for county jail prisoners--both detainees or sentenced persons--who require hospitalization. The ward also takes patients from other correctional facilities, such as the state prisons or the federal prison, who are best handled in a community hospital situation.

Fine agrees with the sheriff that the ward was established to save money, but it has also proved eminently successful: "The security ward was mandated by economics. It was very, very expensive for the city to provide individual guards around-the-clock for each patient. Clearly, for a city the size of San Francisco, the economic argument mandated that the city say to the hospital, 'You put in a security ward because that will save us money.'"

But according to Fine, the hospital "hemmed and hawed" for years about building a security ward. "Everyone was afraid for numerous reasons--that the quality of care would decline, that nobody would work on it, that the majority of prisoners would fake illness and get in and waste our time. In point of fact, none of that has happened. We were able to attract a very confident and dedicated

staff just by advertising throughout the hospital.

"One of the things that makes our security ward work has been the use of volunteer staff--volunteer in the sense that health care workers from other areas of the hospital were recruited. A vast number of people who worked in other wards wanted to transfer and work on the security ward as a specialty type unit. That counteracted our fears that we wouldn't be able to attract qualified doctors, nurses, orderlies, and technicians. Now, there is even a waiting list of nurses and technicians who want to transfer from their wards to the security ward."

The relationship between the custody staff and the health care staff has been refined during the past five years. Initially, the sheriff's department did not control the security operation and every eight hours a new police officer, who did not know the regulations of the ward, would be in charge, according to Fine. "The result was utter chaos." That began to change when a sergeant from the sheriff's department was assigned to the ward to coordinate and supervise the deputies--tasks the medical director once had to perform as well as watch over health care.

Fine explained how the health care and security staffs interact now. "Whenever there is a question as to whether something is a health care issue or a custody issue, we can sit down and talk about it. If there is a problem, we can appeal to either the executive committee of the hospital or to the sheriff. That's almost never necessary because when we set the ward up, we agreed upon a list of ground rules about how the ward would be run--what constituted security issues and what constituted health care issues. These can get very, very tricky. Something as simple as a telephone call becomes a very complicated issue in a jail, as well as in a hospital.

"For us, it's important that prisoners have some contact with the outside world and with their family, especially when they're sick and especially when they're having psychiatric problems. But, you can't just apply jail rules to the hospital setting. We worked out a negotiable kind of agreement. If a conflict or a problem arises, we discuss it and change the rules if necessary. I think this has helped more than anything to keep the staff relationships close and open."

The existence of the tight security ward has minimized the kinds of conflicts that can arise between the security and health care staff in a community hospital, and it has allowed medical decisions to take precedence over custody decisions, as Fine believes they must. The two staffs have also been able to maintain a good working relationship, according to Dr. Fine, by exchanging helpful information. For example, the deputies have requested training in such areas as cardio-pulmonary resuscitation, how to handle someone with a broken leg, or how to handle a disturbed person. It has helped both groups, especially since deputies may be the first to encounter some of the problems, Fine added.

The Medical Social Worker

Finally, Fine told us about what he considers to be one of the most important additions to the security ward's health care team--a medical social worker.

"One of the crucial people in our health care team on the security ward is the medical social worker. Basically, he or she--in our case she--has knowledge of all the community resources that can be incredibly helpful to people when they

leave jail and have a major health care problem. The social worker gets involved in every single discharge planning. In fact, we have now made it a rule that no patient can be discharged from the ward until the social worker says it's okay.

"This social worker is, I'm sure, a cost-efficient staff member because she saves us so much in terms of aggravation and time and energy that are critical. Also, the social worker is the main contact between the day-to-day problems that a prisoner has on the ward and the medical staff or the custody staff. The prisoners will gripe to the social worker who can act as an advocate for them, and talk to the deputies. We try to work those things out on a case-by-case basis and it runs pretty smoothly. It tends to make things much smoother, in fact, when the prisoners get good health care."

VIENNA CORRECTIONAL INSTITUTION

Since 1972, inmates at the minimum security Vienna Correctional Institution in southern Illinois have had a unique opportunity to become part of emergency medical teams that serve both the prison and the surrounding community. The institution runs 6-week courses for the inmates and civilians to train them as emergency medical technicians who can be assigned to one of the three ambulances housed at the prison. Inmates rotate on ambulance duty so as many as possible can get some real and advanced on-the-job training.

The Emergency Ambulance Service

According to Warden Vernon Housewright, "The ambulance service came about when area funeral directors decided to get out of the ambulance business. We recognized that we, as well as the people of the area, needed emergency medical services. We developed a grant proposal and, in 1972, when we got the ambulances and the funds to operate them under the Highway Safety Act, we began our operation.

"It services the inmate population and the staff at this institution, and also serves the people in the free community. Inmates who are trained as emergency medical technicians ride on the ambulances, but civilian staff, who are also emergency medical technicians, drive the ambulances. In the years that the ambulances have been in operation, the service has been invaluable to us in saving lives, especially of heart attack patients. In addition, the service that is provided to the public in two county areas has been a big boost not only in terms of public relations but also in the health care services that are available to free community citizens."

The two rural counties that participate in the program are sparsely populated and hospitals are often distant. If the prison did not operate ambulances, this emergency service would probably not be available to the approximately 12,000 people in its range, according to Housewright.

The warden said the service "works very well" and has had few problems. This may be due in part to the fact that the inmates participating are well trained. "They must be certified on a national level as a result of written tests and practical tests given by doctors, nurses or instructors," Housewright explained.

As pressure has increased on correctional institutions to provide better health care to inmates, Vienna has been able to meet some of the demands for its

550 to 600 residents because of its emergency ambulance service, according to the warden. "Court decisions in the past few years, as well as standards being developed in corrections around medical services, has resulted in many jurisdictions going to free community hospitals to get needed services for inmates. What we find with the ambulance service based here at the institution is that in cases of serious illness, heart attacks, and things of that nature, we have trained emergency medical technicians who can respond quickly, know how to move patients, and can get them fast to our own medical facility or the community hospital if necessary."

Housewright told us that he believes a similar ambulance service could be set up inside larger institutions and even in maximum security prisons: "It could be a real advantage to administrators of large institutions in terms of either moving a man to the institution's hospital or moving him to a free community hospital. It would also be extremely valuable in the event of disturbances in which numbers of people are injured."

Housewright is aware that the issue of using inmates to perform some tasks is a controversial one. But his experience to date prompts him to give wholehearted support to Vienna's program. "There is a great deal of concern about inmates being used in medical services within the hospitals of institutions," he said. "But one way that they can be used legitimately, I think, is to train them as emergency medical technicians for ambulance services, require them to meet national standards so they can be certified, and then put them under staff supervision. That is what we have done and it has proven itself over the past several years to be a service that we depend on greatly."

CAMP WATERLOO, MICHIGAN

Camp Waterloo is the headquarters of Michigan's minimum security camp program and also the home of the prosthetic laboratory of the dental department. All the prosthetic dental devices for the Michigan Department of Corrections and for some mental health institutions throughout the state are manufactured at Camp Waterloo. The camp also administers the training programs for residents studying to be technicians in dental technology.

Dr. William Byland supervises the dentistry operations and the training programs. There are currently two training programs within the institution that Byland described. "In the prosthetic laboratory we have on-the-job training. We take resident applicants, check their grade level, their past history in the system as far as work performance, dependability, and so forth, and if they appear acceptable, then we give them an aptitude test. If they pass, we put them to work in the laboratory, training them in the various techniques. It's only a matter of 18 to 20 months until they have covered all phases of the dental laboratory operation and they are pretty much a finished product.

"This past year, 1976, we initiated a new program that will eventually replace the on-the-job training program. In cooperation with Jackson Community College we are offering a two-year associate degree program in dental technology. The program will take approximately 18 to 20 months, and the students will have sixty hours of college credits accumulated in this field when they finish. We have hired one dental technician who serves as the instructor in this program. (He has a college degree, is a certified dental technician, and he has three to five years of teaching experience. So he fits the qualifications for a junior college instructor.) We supplement his instructing with assistance from some of

our own technicians and then I also teach some of the classes."

According to Byland, the program has recently been expanded to allow inmates in a medium security prison to participate. This was a necessary step because of the time required to complete the degree program. For, out of the first class of some 20, only half finished the program. The rest, inmates of the minimum security camp, won early releases.

The second class began in September 1977 at a medium security facility. Twnety-eight inmates are enrolled and there is a good chance that all will complete their degrees, Byland said.

These programs are an extension of Michigan's and Dr. Byland's efforts to offer the state's incarcerated population essential dental care. Over the past couple of years, Dr. Byland has overseen the modernization of the dental clinics. More positions for dentists were created and well-qualified ones were recruited.[2]

Now, the University of Michigan's Dental School, which discontinued its association with the Department of Corrections in the mid-1960s, citing sub-standard conditions, is again expressing interest in having one residency training program at a prison clinic, according to Byland. If one is successful, he expects that others will follow, offering inmates more and better services.

"We have certainly gone a long way in restoring the confidence of residents in dental care," he noted. That is gratifying to Byland because, as he explained, "We are very conscious in the State of Michigan of dental appearance because we feel this is vital to the success of our residents as they return to society. There is nothing like a winning smile to help encourage an interview for a job position!"

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[2]Michigan has developed an extensive Dental Policy Manual that sets out guidelines for correctional dental care in the state. See appendix II for a more detailed discussion of the dental program.

CHAPTER 7. OPTIONS IN FUNDING

When one considers the resources and vast sums of money swallowed up by health care in the free community, then the enormity of the problems facing correctional institutions take on a little perspective. Indeed, it is no wonder that correctional institutions are one of the few places in the country where health care may still be delivered by nonmedical personnel.

People who have looked at funding sources generally have discovered, perhaps not unexpectedly, that only insignificant amounts of money have filtered into the correctional systems from the U.S. Department of Health, Education, and Welfare, from other Federal and state agencies, or from private organizations. In addition, few inmates are covered by health insurance plans.

Where is the money going to come from to fund better health care in prisons and jails, especially in the face of growing legislative pressures to cut spending? Clearly, correctional administrators are going to have to apply all their imaginative and creative powers to locate funds, as well as use innovative approaches such as some described in chapter 6.

The American Correctional Association is reportedly leaning toward national health insurance as one answer to the problem of funding health care in prisons and jails. That avenue is explored in the paper that follows, as well as other potential routes of national funding that may not be as familiar.

Experts on institutions point out, however, that the first step in acquiring adequate funding is to separate the health care budget from other expenditures, which is an unwieldy task in corrections systems that lack an administrator responsible for health care.

Without such administrators, who can apply a systematic approach to creating realistic and defensible budgets and manage them effectively, correctional health care may continue merely to limp toward supplying basic human needs. To tap the "potential" funds and to make essential short- and long-term improvements in correctional health care will demand that administrators and managers convince those in charge of the money of the real need for change in their institutions.

P O T E N T I A L F E D E R A L

R E S O U R C E S

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INTRODUCTION

The plight of health care services in the correctional facilities is this country has reached crisis proportions. The problem originates in the initial screening process (or lack thereof) which admits prisoners without a proper medical review--exposing the entire institution to a potpourri of virus and disease, largely due to the type of population with which they deal. Once inside the doors, the inmates are forced to live in close quarters with both the well and the ill, spreading disease and compounding the health problem. To receive medical attention, prisoners must wait long hours in a sick-call line to receive a cursory glance from the overburdened medical practitioner on duty, and possibly a couple aspirin or sugar pills (placebos) for the pain. Seldom are serious illnesses recognized during a routine sick call, and diseases which require more sophisticated detection almost invariably are ignored.

For such reasons, over 50 percent of the nation's penal institutions are under court order for inadequate health care provision. Too much of the problem is caused by neglect, disinterest, or ignorance. But even in the cases in which an administrator recognizes the problem and seeks viable solutions, he is too often stopped short because of the lack of adequate funds.

This guide is the result of the initial attempt to locate funding sources for health care in prisons. Several, but by no means all, avenues were explored for their hidden possibilities and buried resources. In section I, the effects of the various proposals for national health insurance on the provision of health services in prisons and jails were investigated. Section II details several grant programs sponsored and funded by the Federal government that could feasibly be applicable for use in the criminal justice system. The third section reviews two specific public laws, 93-641 and 94-484, which amend the Public Health Services Act and, consequently, contain provisions that can be generalized to include the prison population. Finally, in section IV, the National Institute of Corrections, an obvious source of assistance, is discussed briefly, with a view to recent developments and innovation within the Institute.

The research that produced this document was involved; the process of finding satisfactory answers, and more importantly, formulating the right questions, is cumbersome and tedious. I wish to thank the Honorable Edwin B. Forsythe, most able Representative from the Sixth Congressional District in New Jersey, under whose name much of the investigation was done and without which the web of governmental complexity would still be hopelessly tangled.

NATIONAL HEALTH INSURANCE

National health insurance is a phrase that has been floating elusively in the minds of many people since the beginning of the 20th century, and since at least the 91st Congress in terms of significant and meaningful legislation. (Though even as far back as 1943, the "Wagner-Murray-Dingell" bill was introduced, proposing universal and compulsory insurance through payroll taxes.) Ironically, the concept's longevity bears no direct correlation to its maturity: national health insurance is still far from becoming a reality.

At present, approximately a dozen bills relating to such insurance are pending before the House and Senate, with a small number of these highlighting the major differences of approach to the health insurance issue:

The Kennedy-Corman bill (S.3/H.R. 21), supported by the Committee on National Health Insurance, the United Auto Workers, and the AFL/CIO

The Ullman bill (H.R. 1 in the 94th Congress), supported by the American Hospital Association

The Long-Ribicoff bill (S.2513/H.R. 14079 in the 94th Congress)

The Hansen-Carter bill (S.218/H.R. 1818), supported by the American Medical Association

Most of these bills have been revised and reintroduced from past Congresses. Yet, at the time of this writing, none has been discussed or even scheduled for discussion in subcommittee or committee hearings.

Proponents of national health insurance have reason for optimism with the election of a new administration. President Carter has spoken out clearly in favor of a comprehensive health insurance program. However, he has also promised jobs legislation and welfare reform, in addition to proposing tax cuts; hence, national health insurance has been forced to take a back seat behind the more immediate concerns of the administration. This in turn has minimized the need for related action in Congress. Representative Dan Rostenkowski (D-Ill.), chairman of the House Ways and Means subcommittee, the body that must initiate congressional action on the tax portion of any health insurance program, has stated that he plans to wait until the administration offers its own bill before taking any steps toward legislating national health insurance.

Still, it must not be construed that national health insurance is suffering a slow death; on the contrary, its supporters are well aware of the rewards of patience and tolerance for effecting gradual but steady change. The administration's first apparent steps were taken on February 2, 1977, when the President supported Congress in its effort to deal with the widespread fraud, waste, and abuse of our system in his fireside chat, and in a more substantive and recent move when he proposed a strict Federal limit on hospital cost increases.

To many, limiting hospital cost increases is seen as a testing ground for, or possibly a stepping stone to, subsequent health care cost reform. In the style of Congress, even action on this legislation, the "Hospital Cost

Containment Act" (H.R. 6575/S. 3191) is slow to materialize. Subcommittee hearings in the House were completed May 13; Senate hearings, June 17. However, alternate bills (e.g., H.R. 8121) and numerous amendments are now pending markup sessions in both Houses to add further uncertainty to the timetable of cost containment. Allowing minimal time for floor action, conference committee work, and final congressional passage, enactment of this legislation has been optimistically set for October 1, 1977.

Passage of this legislation is only one small battle in the struggle toward approval of national health insurance.

Because the outlook for the enactment of major health insurance legislation in the immediate future is bleak, the opportunity for input is excellent. In terms of specific concerns (in this case, the inclusion of prisoners in such a program), this time lag is vital to have adequate opportunity to lobby, petition, suggest, and plead with the various "powers that be" to gain even acknowledgement of the existence of these special interests.

In numerous discussions with a variety of experts in various capacities relating to national health insurance legislation, I found no prior recognition or acknowledgement of the need to address the issue of the incarcerated population of the United States. Also, the suggestion of their inclusion was, in all cases, accepted graciously for consideration, even after their obvious exclusion in the regulations of Medicare and Medicaid had been pointed out.

The Legislation

The Kennedy-Corman bill appears to be the most liberal and inclusive of all bills offered thus far and is supported by the Committee for National Health Insurance. The verbiage of basic eligibility (section 11) is as follows: "Every resident of the United States and every nonresident citizen thereof is eligible, while within the United States, to receive health services under this Act...", leaving the impression that there is no one who is not covered under this proposal. According to the opinions of several experts (Edward Klebe, Congressional Research Service, Library of Congress; Paula Kalivoda, House Republican Conference Legislative Digest; Debbie Wood, Committee for National Health Insurance), prisoners are included under this bill because they are not specifically excluded. This is further substantiated later, in Section 55. There it is stated that no institution of the Department of Defense, the Veterans' Administration, the Department of Health, Education, and Welfare engaged in the provision of services to merchant seaman or to Indians or Alaskan Natives, and no employee of any of the foregoing acting as employee, is a participating provider; hence, by merit of its exclusion of reimbursement to the named Federal agencies for the provision of care, this bill recognizes that some persons might have "dual entitlement" to medical care--under national health insurance and some other Federal program. Whether or not this contention can be expanded to encompass the prison population is, at the least, a promising avenue to pursue.

The Ullman bill, which has not been introduced as yet in the 95th Congress, carries a more explicit definition of the affected population, but nonetheless covers basically the same population described in the Kennedy-Corman bill.

According to the staff expert on the bill, Mary Nell Lenhardt, the idea of inclusion of prisoners has not even been considered, though she could see no reason why they were not necessarily included because they had not been excluded. The exact wording of the bill seems to support Ms. Lenhardt's impression:

> "Every resident of the United States who is a medically indigent person...and who is not otherwise entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act or enrolled in the supplementary medical insurance program established by part B of such title, shall...be provided by the Secretary...with benefits under this Act..." (Section 116)

A slightly different interpretation was offered by John Campbell, one of the national health insurance staffers at the American Hospital Association. Mr. Campbell suggested that penal institutions could pay the health care corporations for access to facilities for prisoners; to extrapolate, the prison population would be dealt with apart from the general population where the government would be directly responsible for the health care of low-income and medically indigent people.

The Long-Ribicoff bill deals with national health insurance in three segments: catastrophic illness insurance for the entire population of the United States; a medical assistance plan for the low-income bracket of our population; and provision for those not eligible for the low-income plan to purchase a private insurance policy at a reasonable price. The Long-Ribicoff bill is silent on the issue of the incarcerated.

"All Americans" are allegedly covered under the catastrophic illness plan; however, in generalizing to include prisoners, attention must be paid to the proposal that the Social Security Administration administer the program "parallel to the administration of Medicare." Because inmates of penal institutions are presently excluded from Medicare coverage, this simple association may lead to exclusion from catastrophic illness insurance.

The other relevant section, the medical assistance plan, carries a similar reference; the plan proposes to expand Medicaid to include "twelve million working poor not now covered by Medicaid" (Congressional Record, October 3, 1975, Senator Abraham Ribicoff). But even this increase in the eligible population defined under Medicaid does not offer coverage to the incarcerated, a population excluded under the present Medicaid program.

Finally, the Hansen-Carter bill, supported by the American Medical Association, lists an exclusion in section 32 which appears to apply to our specific question: "No payment may be made under this title for any of the expenses incurred for health care services...(3) which are paid for directly or indirectly by a governmental entity other than under this Act." If the funding source for health care in prisons and jails can be termed governmental, it must be assumed that the inmate population is excluded from coverage. (Incidentally, this is the same type of exclusion that has been written into the governing laws of Medicare and Medicaid, and which, therefore, has prevented prisoners' coverage under these titles.)

All of these bills are yet to be scrutinized in committee--no formal hearings have been held, and many of the bills have undergone major and frequent revision since their initial introduction in previous Congresses. The apparent procrastination by Congress to take substantive action on any of this legislation appears to be in deference to the Executive Advisory Committee, called for by the President and designated by Health, Education, and Welfare Secretary Joseph A. Califano. Unfortunately, the committee has only started to meet, and significant activity is not expected until fall. As on Capitol Hill, the issue of prisoner inclusion has not even been considered, though the committee staff was very receptive to the suggestion of its importance. The committee is not only open to suggestion of topics of discussion, but will also welcome subjective opinion regarding any specific area of interest. In addition to letters from lobbying interest groups, it was indicated that senatorial and congressional input would be regarded highly and weighed heavily. Support or reactions or both can be directed to:

Karen Davis
Deputy Assistant Secretary of Planning
and Evaluation/Health
405 F, South Portal Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Lobbies

Though Califano's committee is expected to provide primary direction for an acceptable national health insurance policy, several lobbies will carry considerable weight in directing the final outcome of national health insurance.

Once such group, the National Governors' Association, is among the most respected lobbying organizations on the Hill. They have established a consortium to deal specifically with national health insurance and related issues. Though the consortium is only in its organizational stages, it already is planning to sponsor a series of meetings across the country to ascertain feelings on the national health insurance and other health matters. The director of the consortium, Jerry Conner, indicated that he was very receptive to the idea of input from various interest groups, and felt that the national meetings scheduled would provide an adequate arena for the airing of such concerns. He offered to send notification on a regular basis of the meetings to be held, and extended an open invitation to anyone who wishes to attend. His address is:

Mr. Jerry Conner
Health Policy Consortium
444 North Capitol Street
Washington, D.C. 20001

Another heavyweight with regard to its influence on national health legislation is the National Conference of State Legislatures (NCSL). The NCSL is presently working to establish the "New Coalition" under the leadership of Dick Merritt. It will attempt to serve the interests of the National

Governors' Association, the National Association of Counties, the U.S. Conference of Mayors, and the NCSL itself. One of the coalition's first duties will be to investigate the national health insurance issue, a process to which the NCSL has already devoted considerable energy. The NCSL started work on the health issue two years ago by ascertaining the concerns of various municipalities and state governments, soliciting input on predetermined issues. This year, they intend to pursue this topic with a followup series of discussion groups designed to pinpoint and clarify the initial issues. The first of these local hearings was tentatively scheduled for early August, with subsequent hearings scheduled to resume in late August, after their National Conference. The New Coalition carries only advisory power with the organizations it was established to represent, but with their approval, the New Coalition will also coordinate its efforts and its timetable with that of the President's committee under HEW, offering supportive data and additional information. Regarding the inclusion of the prison population, this group joined the ranks of its lobbying colleagues in having overlooked the topic entirely. Merritt stated that it would welcome the input of any interested party, if directed to him at the following address:

Mr. Dick Merritt
Staff Director for Human Resources
National Conference of State Legislatures
444 North Capitol Street, Suite 203
Washington, D.C. 20001

Though the method of input would obviously be more indirect, Merritt agreed that lobbying at a local and state level with those who will be participating in the cross-country seminars might also serve as a means of voicing concerns over health care in prisons.

The complete picture of national health insurance exposes many gaps and provokes many unanswerable questions. If national health insurance is desirable for the nation's incarcerated population, there are more considerations necessary than the wording of a particular bill. By nature, most insurance policies exclude payment for any service covered under another policy or guaranteed by another provider--an exclusion which would have a direct effect on payment or reimbursement or both for the health care of prisoners. Another more subtle complication is presented by the freedom, at least implicit, in most national health insurance bills, to choose one's own "health care provider." Though acceptable in theory, this concept is practically unworkable when dealing with an imprisoned population. A complication of this sort could endanger the inclusion of prisoners, if not on the legislative level, then on the executive level at which the regulations will be promulgated. Further, the process which dictates the promulgation of regulations by a Federal administration, commission, or agency demands specific wording in the legislation concerning the inclusion of prisoners if their exclusion is to be prevented. Otherwise, very little can be offered in the way of input, save for oversight hearings by either legislators or lobbying organizations, once national health insurance has reached this level and the fate of the prison population is out of their hands.

The political climate presents a formidable obstacle to including prisoners under national health insurance: it is no more politically acceptable to include prisoners under national health insurance than it is politically desirable to

exclude them. The prevailing attitude toward crime and prisoners is that committing crimes is analogous to drinking alcohol--both are seen as illnesses that need to be cured, not behaviors that need to be punished. In that light, there is much reluctance to exclude prisoners outright. However, being forced to answer to and represent diverse and often unsympathetic constituencies, Congressmen are too often unwilling to lay their reputations on the line by lending attention to such a questionable population.

Finally, a subtle question remains unanswered at an even more basic level. Is national health insurance wanted in the penal institutions in our country? Will the benefits to the inmates outweigh the ramifications of governmental intervention in prison and jail policy because of its involvement in health care provision? Only one piece of legislation, the Hansen-Carter bill, addressed this possibility, and that in favor of autonomy of prisons and jails:

> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the practice of dentistry or the manner in which dental services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person. (Section 41)

This prohibition is not only desirable, but also necessary for the unanimous acceptance by executives in criminal justice of any national health insurance legislation that would include, implicitly or explicitly, the incarcerated population of the United States.

FEDERAL GRANTS

An obvious, substantial source of funds for providing health care in prisons and penal institutions is the Federal government. To this end, the Catalog of Federal Domestic Assistance was combed for programs which pertain to health care in prisons. The catalog itself is a governmentwide compendium of Federal programs and activities which provide assistance or benefits to state and local governments, public and private, profit and nonprofit organizations and institutions, and specialized groups and individuals. Under the broad subjects of health, mental health, alcoholism, and drug abuse, several programs were selected as possible sources of funding for health care in prisons and penal institutions. With the assistance of the Department of Health, Education, and Welfare, the possibilities were narrowed to those programs which most directly relate to the needs of prison health systems. The following are designated by program numbers as they appear in the May, 1977, edition of the Catalog of Federal Domestic Assistance.

Training

Three categorical training programs are administered by the various entities that comprise ADAMHA--the Alcohol, Drug Abuse, and Mental Health Administration.

13.244 "Mental Health Clinical or Service Related Training Grants"

Objective: To provide training grant support for clinical or services related training and manpower development projects which provide mental health training for primary care providers and/or train mental health specialists for effective roles as trainers of and consultants to primary health care providers; research and development in mental health manpower training as reflected in diversified, experimental, special, and pilot development; manpower development projects designed to develop and strengthen the capability of service authorities and training institutions for joint manpower planning and development at state and sub-state levels; basic training projects for the development of core mental health specialist manpower; and projects in the specialized areas of crime and delinquency, metropolitan problems, and minority groups.

Contact: Dr. William Denham
Director of the Division of
Manpower and Training
Room 8101, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

The ADAMHA division that would most directly deal with prison health care proposals is the Division of Special Mental Health Programs, directed by Dr. Saleen Shah, with minor supportive assistance from the Division of Experimental and Special Projects, directed by Dr. Ralph Simon. An example of the kind of project they support is one jointly sponsored and produced by the Division of Special Mental Health Programs' Center for Studies on Crime and Delinquency and

the National Institute of Corrections. A "working conference" is being planned emphasizing acute psychiatric problems to create a pool of individuals whose expertise will then be made available to others in the field. The guest list will consist of 50 to 60 experts in the area of prison mental health, including directors of state mental health agencies, key jail administrators, and selected individuals from mental health services. Together, this group will formulate approaches and solutions to the various problems that arise in penal institutions attending to the mental health of the inmates. Not clear is what direction this group will take in counseling fundraising operations. Funding is acknowledged as one of the primary obstacles, and it will be profitable to keep abreast of the work of this group as they attempt to surmount that hurdle. For further information, Dr. Chris Dunn can be reached at:

Center for Studies of Crime and Delinquency
Room 18004, Parklawn Building
Rockville, Maryland 20857

13.280 "Drug Abuse Clinical or Service Related Training Programs"

Objectives: To support training programs for treatment personnel to work with the drug addict or abuser via multidisciplinary, short-term and specialized grant and contract programs. Programs may be for professionals, paraprofessionals, and ex-addicts to work in drug treatment. Also, programs are supported for evaluation of teaching methods for development of new training methods.

Range of Financial Assistance: $28,393 to $640,073
Average Financial Assistance: $102,180

Contact: National Institute of Grant Management
Room 854, 11400 Rockville Pike
Rockville, Maryland 20852

These training programs can pertain either to an institution or to an individual.

13.274 "Alcohol Clinical or Service Related Training Programs"

Objectives: To provide specialized training of personnel who will staff community projects by grants primarily concerned with development and assessment of training models for a wide range of new types of professionals and paraprofessionals in both academic and non-academic settings.

Range of Financial Assistance: $6,541 to $529,526
Average Financial Assistance: $84,390

Contact: Dave Orchard
Chief of Grants Management Branch
Room 16-86, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Under this program, several prison pilot programs have already been funded and have been or are presently operating. In fact, because of the receipt of a number of applications for alcoholism projects directed toward the criminal justice population, the Division of Special Treatment and Rehabilitation of the NIAAA felt it necessary to develop interim principles and criteria for assessing the merits of such applications.

National Research Service Awards Act

In relation to the ADAMHA training programs, these awards can best be described as fellowship grants (grant codes: F31, F32, and T32). Two types of awards are made:

1) Individual awards--These awards provide a stipend, tuition, and fees directly related to obtaining an education. In addition, the sponsoring institution receives an allowance for maintaining the fellows at their facility. These fellowships are for pre- and postdoctorate work, mainly for training individuals for work in research.

2) Institution grants--These grants are made directly to an institution or university in order that they may select and provide for their own fellows.

Each of the administrations under ADAMHA offers awards under the guidelines of the National Research Service Awards Act. In addition to the offices listed above as contacts, applications and information regarding fellowships are available at most universities and educational institutions.

Demonstration

The purpose of demonstration programs is to "demonstrate something new." Practically, this translates into controlled research with a small treatment program for exhibition and testing.

13.252 "Alcohol Demonstration Programs"

Objectives: To prevent and control alcoholism through the development of projects relating to the provision of prevention and treatment approaches for population groups; to conduct surveys and field trials to evaluate the adequacy of programs and demonstrations of new and effective methods of delivery services.

Range of Financial Assistance: $25,000 to $569,952
Average Financial Assistance: $122,100

These programs differ from the training programs in that they are not available for use by Federal institutions.

The key factor in judging relevance of a proposal to this program is whether the intention is to treat abuse of alcohol. In writing a proposal, the state alcohol authorities provide technical assistance and advice, and also are the primary vehicles through which applications are made. (These alcohol

authorities are under the authority of the state government and designated by the governor.)

13.254 "Drug Abuse Demonstration Programs"

Objectives: To cover the operational costs of programs for: (1) surveys and field trials to evaluate the adequacy of programs for the treatment of narcotic addiction and drug abuse for the purpose of determining ways and means of improving, extending, and expanding such programs; and (2) treatment and rehabilitation of narcotic addicts and drug abusers determined to be of special significance because they demonstrate new or relatively effective or efficient methods of delivery of services to such narcotic addicts and drug abusers.

Range of Financial Assistance: $50,354 to $1,024,025
Average Financial Assistance: $177,279

Contact: Helen Crown
Grants Management Officer
Rockwell Building, 11400 Rockville Pike
Rockville, Maryland 20852

Education

13.275 "Drug Abuse Education Programs"

Objectives: To collect, prepare, and disseminate drug abuse information dealing with the use and abuse of drugs and the prevention of drug abuse.

Range of Financial Assistance: $15,000 to $183,000
Average Financial Assistance: $111,000

Contact: Helen Crown (address as above)

This program is not designed to support the treatment of drug abusers; rather, the target population is drug "non-users" and first time or minimal users. The program emphasizes drug abuse prevention. Further, awarding of these grants is limited to state and local institutions and is, therefore, unavailable for projects in Federal prisons.

All grants programs found in the Catalog of Federal Domestic Assistance are subjected to constant review and revision by both Congress and the executive branch. Hence, it is important to consult the latest edition of the Catalog often to keep abreast of changes and deletion of old programs, and to check for the addition of new programs in order to use most effectively the Federal funds that are available.

PUBLIC LAWS

In recent times, two laws have been enacted which have the potential to affect health care in penal institutions through revision of the Public Health Services Act. Neither of the laws, Public Law 93-641 and Public Law 94-484, was written to deal directly with the incarcerated population, but the policies and programs therein established may be generalized to include that population. In this section, very few sources of funding will be specified; rather, broad avenues for action and possible arenas for lobbying will be discussed.

A portion of Public Law 93-641, the National Health Planning and Resources Development Act of 1974, is concerned with the designation of health service area boundaries to establish corresponding health systems agencies (HSA). In general, the purpose of an HSA is to provide effective health planning for its health service area and promote the development of services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and can implement the health plans of the agency.

More specifically, each HSA is responsible for approving or disapproving the proposed use within its area of Federal funds (under the Public Health Service Act, the Mental Health Centers Act and the Alcoholism Act) for development, expansion, or support of health resources. In other words, it is very difficult, though not impossible, to receive approval of the area HSA. Further, these HSAs are responsible for recommending and giving priorities to projects for the modernization, construction, and conversion of medical facilities. To this end, grants are allocated to each HSA for the establishment of an "Area Health Services Development Fund" from which their recommended projects are funded. Needless to say, a strong working relationship with the HSA can only prove beneficial to any prison or jail. (See appendix II.)

In terms of actual monies for projects pertaining to health care in prisons, Public Law 93-641 provides for Federal assistance in the form of allotments, loans, and loan guarantees (with interest subsidies) for the modernization of medical facilities and the conversion of existing medical facilities for the provision of new health services. Moreover, not less than 25 percent of such allotments shall be used for outpatient facilities serving "medically underserved populations."

The rules governing the approval of projects for Federal funding regarding prison health care are:

> Receipt of Federal project assistance is contingent upon submission of an application to the Secretary of HEW through the State agency. Applications for special project grants must be submitted directly to the Secretary by a State or political subdivision of the State. Each application must be reviewed by the health systems agency in accordance with the requirements for review of proposed use of Federal funds.

The application must include a finding of need by the State Health Planning Development Agency, description of the project, reasonable assurance that adequate financial support will be available for project completion and subsequent operation, certification of Federal share of the project, and assurances regarding compliance with labor standards.

The law includes special provisions in the case of an application for a modernization project for an outpatient facility which will provide general purpose health services, which is not part of a hospital, which will serve a medically underserved population, and for which not more than $20,000 is sought for allotments or loans.

The Secretary is required to approve (emphasis added) a project application for allotments or loans or loan guarantees if the application is in conformance with the state medical facilities plan, has been recommended and approved by the State Agency, is entitled to priority over other projects in the State, and contains the necessary assurances. In addition, applications for allotments may not be approved unless there are sufficient funds in the allotment to pay the Federal share. (Section 1604, P.L. 93-621)

This allotment is calculated by the formula of one dollar per capita for the health service area. Funds may be used by the HSA to make grants or contracts for health service development projects which advance the goals enumerated in the agency's health systems plan and annual implementation plan, but may not be used for actual delivery of services.

An important designation required by the language of the funding sections of Public Law 93-641 is that of "medically underserved areas." Accordingly, the Bureau of Community Health Services of the Health Services Administration was assigned the task of establishing guidelines for the pronouncement of such areas across the country. Subsequently, an "index of medical service" was calculated according to the following criteria:

1) infant mortality,
2) percentage of the population 65 years and older,
3) number of physicians providing primary care relative to the size of the population,
4) the percentage of poverty in the overall population.

The index was then computed for all counties, based on both geographic considerations and population size, and ranked. All counties falling below the median (index of 62) were designated "medically underserved" and therefore, eligible to receive funding.

The proper channel for appealing for designation as a medically underserved area is through the regional HSA. If an area feels that it meets the criteria established according to the four guidelines (i.e., an index of 62 or below, or slightly more if there are accompanying extenuating circumstances), the HSA can be approached. If there is a problem with response, the Bureau of Community Health Services can be asked to intercede.

The primary emphasis of Public Law 94-484, the Health Professions Educational Assistance Act of 1976, is on the provision of health manpower and training. The relationship between such a title and the existing needs in penal institutions is blatant--adequate numbers of qualified health personnel are conspicuously absent from most prisons and jails.

Concepts of the act can easily be generalized to apply to the provision of health manpower in a prison setting, especially since much of the proposed action described by the law is contingent on the designation of "manpower shortage areas." The Bureau of Health Manpower, under the Public Resources Administration of the Department of Health, Education, and Welfare is currently attempting to establish the "Criteria for Shortage Areas" required by the law. These guidelines, at last report, were at the office of the general counsel awaiting approval, with a tentative publication date set for sometime in August, 1977.

Among the guidelines pending approval is a clause specifically related to prisons. To qualify as a "manpower shortage area," a penal institution must have a minimum of 250 inmates, and a ratio of one, full-time physician for every thousand inmates. (This ratio is greater than that of the general populace--one doctor for every 3500 people--the rationale apparently being that the prison population has demonstrated the need for more frequent medical attention.) In the actual designation of shortage areas, in a prison setting, a few gray areas still exist. For example, can it be assumed that the physician must be a licensed M.D. or Doctor of Osteopathy (D.O.)? Is the substitution of paraprofessionals and nurse practitioners in the equation valid and, if so, how many of each does it take to equal one practitioner? The spirit of the criteria and the standard on which the Bureau will attempt to operate is that only licensed M.D.'s and D.O.'s will be used to ascertain shortage designation, making the optimistic assumption that paraprofessionals and nurse practitioners will be used only to augment the doctors in areas of special demand (i.e., an area in which the population is spread over a large distance).

In addition to establishing guidelines for "manpower shortage areas," the Bureau of Health Manpower is also responsible for designating such areas. Subject to the approval of the regional Health Systems Agencies (another reason to stay in the good graces of the HSAs), the areas of manpower shortage will be published in the Federal Register no later than November 1, 1977. These designations are open to challenge and review at any time, with the appropriate channel of appeal being the HSA for the area. Similarly, any areas that feel they meet the criteria, but have not been acknowledged as doing so, have the same avenue for appeal.

One of the primary purposes for designating these areas is facilitating placement of members of the National Health Service Corps, the membership of which will increase due to revision under this act of the National Health Service Corps (NHSC) scholarship program. Until recently, Federal prisons were medically staffed in part through the Civil Service Register under the direction and placement of the Bureau of Prisons Medical Program. In 1970, with the establishment of the NHSC, a new source of manpower was realized, though placement in prisons was not an initial action. At present (figures as of June 30, 1977), there are 58 members of the NHSC, 16 of whom are commissioned officers and 42 of whom serve under Civil Service. Of this number, 18 have been placed in Federal penal institutions.

Although the figures seem bleak now, the revisions established by Public Law 94-484 provide for a significant change in the system. Because of new guidelines governing the NHSC scholarship program, the Corps' rosters are expected to carry 600 members within the next few years. The ramifications are numerous and optimistic with regard to health manpower in penal facilities. Initially, the increase in the pool from which Federal prisons are staffed will most likely enable the Bureau of Prisons to give much needed assistance to areas that have been suffering due to the inadequate resources of the NHSC system. Further, there is substantial optimism concerning the possibility of receiving NHSC assistance at both the state and local levels of the penal system. However, a policy decision of this sort will require a concentrated lobbying effort to the NHSC administrators. The Bureau of Prisons Medical Program is likely to spearhead this effort, under the direction of Doctors Harry Weller and Robert Brutsche. They can be contacted at:

320 First Street, N.W.
Washington, D.C. 20534
Telephone: 202-724-3055

These gentlemen are responsible for placing the allocation of corpsmen in penal institutions, and they can serve as a starting point at least for an institution in desperate need of qualified health manpower.

NATIONAL INSTITUTE OF CORRECTIONS

No guidebook on funding for health care in prisons is complete without mention of the National Institute of Corrections. It is unwise to assume that everyone in the criminal justice field is cognizant of the resources NIC has available.

Operating with a budget of $9.6 million for fiscal year 1977, the NIC will be providing grants in four major areas: staff development, field services, jails, and screening for risk. Of these, two carry special interest for the penal population:

1) Staff Development--Under this heading, NIC will provide funding for further development and upgrading of existent services provided in prisons and jails, especially in specialty areas. This has the possibility of affecting the health staff.

2) Jails--This year, the main thrust in this area will be "medical attention in jails." NIC will look for "model" programs for possible use in similar jail situations. For FY '77, for example, a grant of $50,000 has been awarded to Joe Rowan through the American Medical Association for the training of "booking officers." This program will teach the staff that handles incoming inmates the most effective and valuable methods of health screening.

The administration of much of NIC's grant awards has been centralized in Boulder, Colorado, at the Jail Center. The center serves as a clearinghouse for information as well as a training ground for a broad spectrum of criminal justice personnel. In addition, the Jail Center has available at all times a team of experts who are ready to provide immediate assistance for major problems faced by those in the field of corrections. The center will also offer one of its experts to serve on location in a temporary capacity to provide guidance in ascertaining needs, developing programs, and working with the local power structure in an effort to obtain assistance and support.

With regard to actual funding, the staff of the Jail Center will provide guidance to an institution attempting to fund a program. With applications for NIC grants, an effort is made to supply a decision within 72 hours. In the event that all other avenues explored have failed, the Jail Center itself is sometimes willing to take a particular project into consideration for funding from its own resources.

CONCLUSION

The task of locating sources of funding for health care in penal institutions in this country has proved to be far more complex and massive than originally anticipated. It is obvious now that to complete such a task satisfactorily--to talk to each one of the scores of experts tangentially involved in health care provision, to untangle the maze of Federal grants and appropriations, and to wade through the sea of bureaucratic red tape to trace the process of legislative change--would take a team, not an individual, working for months, not weeks.

The information provided here by no means pretends to be a complete analysis of available funding sources for health care in prisons. The foundation for successful research into obtaining monetary assistance has been laid; the final results depend on the industry and perseverance of the executives in the criminal justice system.

CHAPTER 8. IMPLEMENTING CHANGE IN THE CORRECTIONAL INSTITUTION

> ...Partly because measures of progress are hard to devise..., partly because public accounting systems tend to be designed to control expense and not to support management and planning, partly because the civil service protects personnel from the immediate desires of political leaders, and partly because it is virtually impossible to change any organization's behavior quickly--for all these reasons, public managers seldom find it possible to make changes they would like.[1]

Correctional and health care administrators around the country have indicated that they often know what changes are needed in health care delivery. Their efforts to introduce them, however, can be blocked by resistance inside their own institutions as well as by outside forces. They are not alone--change is undoubtedly the most difficult hurdle confronting just about any manager, but particularly a manager in the public sector.

Harvard University Professor Joseph Bower has described the major differences between public and private management that must affect how changes are designed.

> However management in the public sector is defined and delineated, it differs from corporate management in several important ways. Public sector managers frequently must:
>
> - Accept goals that are set by organizations other than their own.
> - Operate structures designed by groups other than their own.
> - Work with people whose careers are in many respects outside management's control.
> - Accomplish their goals in less time than is allowed corporate managers.[2]

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[1] Bower, Joseph L., "Effective Public Management," Harvard Business Review, March-April 1977, p. 137.

[2] Ibid., p. 134.

Whether the delivery of correctional health care services follows the route of bringing in a health care administrator, contracting for services, or uses other options, such as some of those described in chapter 6 and illustrated in the literature, the four problems facing public sector managers are important to keep in mind. Public administrators generally have less freedom of choice than their private sector counterparts in instituting changes.

Nevertheless, many public institutions and agencies have been able to direct large reorganizations despite the constraints of public financing, limited time, and so forth. Bower suggests that one public administrator who was particularly successful was able to bring about changes because he was able "to devise a politically acceptable way of phrasing the goals of his organization."[3] One of the ways managers can facilitate changes that will improve health care delivery in prisons and jails, then, is to weigh and select carefully the manner in which they describe the outcomes of their programs and objectives to the public and all those affected.

Facilitating politically acceptable changes is an extremely difficult task, requiring a wide range of skills, and must often by conducted in unchartered territory. Such difficulty is, therefore, the reason why good public managers are rather rare, Bower concluded. "Progress comes not from revolutionary turn-around or purging of established agencies but from adjustments in the perspective, manning procedures, and measures of the existing framework."[4]

Developing a Strategy for Internal Change

Progress requires "adjustments in perspective," Bower suggests, which clearly applies to effecting internal, as well as external, change.

Looking first inside an institution, research has shown that changes which affect someone in a personal way are the ones most likely to arouse resistance. Therefore, when changes in internal operations are in the making, the staff who may be personally affected, by a change in a role or responsibility, should have a voice in the process, if resistance is to be minimized.

A recent article in The New Yorker pointed up the type of problems that can arise when dramatic changes echo through a system without adequate preparation or compensation to some of the staff, in this case, the security staff. In discussing the New York State system, the author said:

> All these men (the inmates), the guards note, had enjoyed the after Attica changes to more liberal prison conditions and theoretically more rehabilitative rehabilitation programs. The guards believe it is a mistake to treat convicts as if they were law-abiding citizens--that such courtesies and privileges only make them cocky and cause trouble...The

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[3] Ibid., p. 139.

[4] Ibid., p. 140.

> after Attica changes meant a lot more work for the guards, without a compensatory increase in the guard force.[5]

Such a situation sets the stage for all kinds of internal resistance.

In some instances, there may be little administrators can do to ease transitions. But there are some general steps to follow in bringing about changes, whether they are imposed from the outside or initiated from inside. First of all, it is essential to define precisely the nature of the changes and who and what they will touch. Then it is possible to identify the points of potential resistance and develop a plan to ease them, if and when they develop.

Several tactics developed from numerous theories and studies may be useful in planning a change strategy for dealing with internal resistance:

- Present the case in simple language that the staff can readily understand.
- Get top managers committed to the change program.
- Make everyone aware of the problems and document the need for change in terms the staff can relate to.
- Use groups to help make decisions about implementation.
- Make change tentative; suggesting that a program is being implemented on a trial basis often helps unfreeze attitudes, but evaluation that demonstrates progress must be forthcoming.
- Offer inservice training to staff, if appropriate.

These suggestions are based on certain important assumptions about the nature and function of organizations: that groups, not individuals, are the building blocks; that more collaboration and less inappropriate competition can result in better operations; that people lend support to what they help to develop and also need a sense of ownership in planning and implementing when they are affected by it.

It should be kept in mind, however, that mere participation in a decision does not guarantee acceptance. Managers must also have a way of communicating and even demonstrating to those involved in the change process that their suggestions or contributions are indeed being considered. For there may be no greater resister to change than a contributor scorned.

Although the more open policies suggested here have not been a common practice in corrections, it is likely that as chief administrators find themselves more accountable to legislatures, the courts, professional organizations,

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[5] Sheehan, Susan, "Annals of Crime (Prison Life--Part II)," The New Yorker, October 31, 1977, p. 80.

other agencies, and the public, they will need to develop appropriate skills in effective group decisionmaking.

The Internal-External Change Agent Team[6]

One approach administrators might consider to open up the decisionmaking process and facilitate necessary changes in prison health care delivery would be to involve the health care establishment directly through a health care administrator.

The idea that a warden and a doctor could form a change team for a "closed" institution should not seem farfetched, especially since, in effect, officials in many institutions have and are forming such alliances. It would not be unusual for them to be unaware of the roles, however, since researchers suggest that such an alliance must be worked out: "Two people with different backgrounds, values and goals learn to share skills, information, and mutual support."

The characteristics of a "closed" institution, such as a prison or a jail, in which absolute authority is usually vested in a chief administrator, decision-making is undemocratic or centralized, normal rights are constricted, and access by outsiders is tightly controlled, are powerful forces operating against change. They present unique problems which solutions may demand or at least benefit from a team approach. A person who attempts to work only from the outside "is limited in his efforts to gain legitimacy, understand the institution..., and have access to the decisonmaking process." On the other hand, an insider "is limited by strong institutional constraints that threaten to penalize the innovator and that also keep him from seeing the situation in a wider context."

Developing new programs in health care or other areas, devising ways to carry them out, and finally institutionalizing them in a tightly controlled system calls for the extensive knowledge of how that system operates that an inside manager has. But some distance and perspective from the daily life of the system may also be needed to assess it critically with an eye to uncovering ways of changing it. Inevitably, change in a "closed" system is going to involve constant intervention and disruption and probably many compromises. Joint efforts of health care providers and correctional personnel who respect each other and have similar goals are one way to initiate and integrate changes.

Affecting External Change Decisions

"Adjustments in perspective" of those people outside corrections may be the key to realizing goals for improving health care delivery in prisons and jails. Correctional administrators are well aware that more money, more personnel, and better facilities are critical requirements of most of their health care systems.

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[6] All material in this section is adapted or quoted directly from an article by Norma B. Gluckstern and Ralph W. Packard, "The Internal-External Change Agent Team: Bringing Change to a 'Closed Institution,'" The Journal of Applied Behavioral Science, Vol 13. No. 1, 1977, pp. 41-52. (The article reflects their experience in starting a model education program in the Berkshire County House of Corrections in Massachusetts.)

Often, their hands will be tied in bringing about change until legal action or actions by other public or private agencies are taken. But if administrators can gain access to the external groups and agencies that control their purse strings, they can try to influence the decisions made so that they are more responsive to identified needs. In the case of corrections, the major public participants that must be swayed include legislators; State, county or city executives; and representatives of the courts, the community, and the media.

Volumes have been written on changing attitudes, but one strategy that seems particularly applicable to the position of correctional administrators is one described by Philip Zimbardo and Ebbe Ebbensen.[7] They outline three major steps in developing an effective plan for influencing attitudes and altering outside behavior:

Decide carefully who is to present the case for improving health care in the corrections facility, how it will be presented, and what audience should be the target.

The authors suggest that in choosing who should present the case, the presenter's credibility and ability to articulate and expected audience response should be the deciding factors. How to present the case is really dependent on the audience--the information legislators want may be very different from what the press wants and the two groups will probably be swayed by different approaches. Still, the most important thing for the spokesperson to have is documentation--facts and details. Finally, the spokesperson should know the audience well.

Implications of Litigation and Standards

Some administrators in corrections have suggested that litigation might well be viewed as an effective vehicle for bringing about the social changes required to make better health care available to the incarcerated population. Lawyers are also aware of this potential. For instance, in summing up some of the after-effects of the implementation of judicial decrees in four significant correctional law cases (not related specifically to health care), an American Bar Association report said:

> ...The litigation sensitized public officials and public servants to correctional deficiences and increased responsiveness to correctional needs. Legislative, regulatory, and supervisory bodies adopted rules, provided funds, and took other actions that facilitated correctional improvements. Changes were initiated that had not been ordered by the courts.

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[7] Zimbardo, Philip and Ebbesen, Ebbe, "Influencing Attitudes and Changing Behavior" in Organizational Behavior and the Practice of Management, Scott, Foresman and Company, Glenview, Ill. 1973. pp. 162-4.

> In each jurisdiction, progressive administrators were able to take advantage of the general climate of change that accompanied the litigator. In a sense, the court was used as a "scapegoat" and court orders as a tool for improving correctional programs.[8]

In San Francisco, it was a court action that shook up the city administrators enough so that they demanded changes in health care and other services in the county jails.

Also, the courts have indicated that more and more they may look for guidance regarding prison health care in the standards developed by various professional organizations. These standards may also be a tool for corrections administrators to use. Applying Mintzberg's idea that managers can play a large public information role as spokesman (see Chapter 5), they may be able to use the discrepancies between what services the health care standards demand and what their own institutions provide to sensitize staffs, the public, and legislators to their needs and, in that way, turn the general tide of inertia more in their favor.

Conclusion

The role that administrators in corrections are being asked to assume is a difficult one. They are expected to be advocates for a constituency that has a limited voice and little public sympathy. Change will be a slow process. Dr. Richard Kiel, the North Carolina Department of Corrections' health administrator, summed it up for a visitor quite well:

> As you see, it takes a significant amount of resources to deliver health care services. We have a long way to go; we have a lot of unmet needs. One of the biggest problems we still face is recurring resistance to change. It is difficult to implement new programs, new policies, and new procedures. It takes a cooperative effort of the correction community and the health care professionals in order to bring about improved standards of health delivery. And the standard we always shoot for is one that is equal in quality and quantity to that available on the free street.

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[8] Harris, M. Kay and Spiller, Dudley P. Jr., "After Decision: Implementation of Judicial Decrees in Correctional Settings," report of the American Bar Association's Commission on Correctional Facilities and Services, Resource Center on Correctional Law and Legal Services, Washington, D.C. November 1976.

APPENDIX I

THE LEGAL BASIS FOR MEDICAL CARE IN CORRECTIONAL SETTINGS

Prepared by
Richard Crane, Esq.

I. The Eighth Amendment

To bring a civil rights action under section 1983 of the United States Code, it is necessary for the injured party or parties to allege a violation of their constitutional rights. In suits attacking medical conditions within a correctional facility, the eighth amendment's prohibition against cruel and unusual punishment is most often cited as the right violated.

A. Court Interpretation of the Eighth Amendment

1. The cruel and unusual punishment clause of the eighth amendment embodies "broad and idealistic concepts of dignity, civilized standards, humanity and decency..." Jackson v. Bishop, 404 F.2d 571, 579 (1968)

2. Punishments which are incompatible with the "evolving standards of decency that mark the progress of a maturing society" are repugnant to the eighth amendment. Trop v. Dulles, 356 U.S. 86, 101 (1958)

3. Punishments which "involve the unnecessary and wanton infliction of pain" violate the eighth amendment. Gregg v. Georgia, 96 S.Ct. 2909, 2925 (1976) (plurality opinion)

B. Application to Prison Medical Classes

After reviewing the principles established in the cases noted above, the Supreme Court in 1976 stated: "These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration." Estelle v. Gamble, 97 U.S. 285, 290 (1976)

1. An inmate must rely on prison authorities to treat his medical needs since by deprivation of his liberty, he is unable to do so. Estelle v. Gamble, 97 S.Ct. 285 (1976)

2. "When government imprisons people, it deprives them of freedom to look after their own health and safety...Since the prisoner is very much at the mercy of his jailers, no one should be surprised that the common law recognizes the duty on the part of the jailer to give confined persons reasonable protection against..."
Wayne County Jail Inmates v. Board of Commissioners of Wayne County (Wayne County, Mich. Cir. Ct. May 17, 1971, at p.32)

II. Medical Care Systemwide

A. General

1. "...the adequacy of conditions of confinement of prisons--such as medical treatment, hygienic materials, and physical facilities--is clearly subject to eighth amendment scrutiny."
Gates v. Collier, 501 F.2d 1291, 1302 (1974)

2. The institution has an affirmative duty to establish a medical care system that will meet the medical care needs of the inmates. Failure to establish such a system is a violation of the eighth amendment.
Costello v. Wainwright, 397 F.Supp. 20 (M.D. Fla. 1973)

B. Elements of Constitutional Medical Care Systems

In examining those cases which address the medical care system as a whole, it is fairly easy to pinpoint those elements which the courts will examine to determine whether or not the care being provided is constitutionally deficient. In general, the courts have looked at the totality of the medical care system and the lack of one of these elements standing alone may not constitute a civil rights violation.

1. Sufficient Medical Personnel

a. The paramount concern regarding the quality of medical care in the Alabama prison system is insufficient staffing.
Newman v. State of Alabama, 503 F.2d 1320 (1974 or 1975)

b. Medical staff for a 1,700-man prison in Mississippi must consist of at least three full-time doctors, two full-time dentists, two full-time trained physician's assistants, six registered nurses or licensed practical nurses, one medical records librarian, and two medical clerical personnel.
Gates v. Collier, 349 F.Supp. 881 (1972); affirmed 501 F.2d 1291 (1974)

c. State officials in Louisiana must provide the following medical staff for a prison of approximately 2,600 inmates: 4 full-time doctors, 1 psychiatrist, 2 dentists, 1 psychologist, 11 physician assistants, 1 dental assistant,

3 registered nurses, 1 x-ray technician, 1 pharmacist, 1 laboratory technician, and 2 medical records technicians.
Williams v. McKeithen, Docket No. 71-98 (U.S.D.C., M.D., La. 1975) (Unreported)

d. One full-time dentist is not adequate for a 900-man facility.
Battle v. Anderson, 376 F.Supp. 402

2. Around-the-Clock Staffing

a. Twenty-four hour medical care for inmates of Escambia County Jail (Fla.) is required.
Mitchell v. Untrener, ___ F.Supp. ___, 20 Crim. L. Rptr.

b. Nursing care 24 hours a day, seven days a week is required for a 900-man jail.
Battle v. Anderson, 276 F.Supp. 402 (1974)

c. Twenty-four hour emergency care and regular visits by physicians are required.
Barnes v. Virgin Islands, 415 F.Supp. 1218 (1976)

d. Jackson County, Missouri, officials entered into a consent order requiring one registered nurse to be on duty from 8:00 a.m. to 4:00 p.m. Monday through Friday and sufficient physician assistants to provide 24-hour medical coverage.
Goldsby v. Carnes, 365 F.Supp. 395 (1973)

e. In a 400-man jail, a physician or licensed physician's assistant must be on call 24 hours a day.
Miller v. Carson, 401 F.Supp. 835 (1975)

But see:

a. Medical care is adequate without a full-time nurse or infirmary, but coverage at the institution must be sufficient to meet all problems of the inmates, not just those inmates who can be fitted into a particular period of time.
Coxson v. Godwin, 405 F.Supp. 1099 (1975)

3. Medical Procedures Performed by Professional Medical Staff

a. The use of inmates and other nonprofessional personnel to perform medical procedures must be discontinued.
Gates v. Collier, supra; Williams v. McKeithen, supra

b. "Medical technical assistants" must meet, at a minimum, the standards required of licensed practical nurses.
Newman v. State of Alabama, 349 F.Supp. 278

c. The use of unlicensed persons to diagnose ailments and prescribe medicine is unconstitutional. Campbell v. Beto, 460 F.2d 765 (1972)

d. Leaving the ultimate decision of who is to receive medical attention in the hands of a nonmedical correctional officer is totally inadequate. Miller v. Carson, supra

e. Prescription of medication by jail nurse is prohibited. Jones v. Wittenberg, 330 F.Supp. 707 (1971)

But see:

a. Prison policy of sending a medical assistant to visit punitive isolation to determine which inmates would be able to see the doctor is constitutional. McCray v. Sullivan, 509 F.2d 1332 (1975)

b. Where two medical technicians visited protective custody three times a day to receive complaints and provide medication, prison met constitutional standards for medical care. Sweet v. South Carolina Department of Corrections, 529 F.2d 854 (1975)

4. Adequacy of Quality and Quantity of Medical Equipment and Supplies.

a. Serious shortages of medication and use of anachronistic and precarious medical techniques will not be tolerated. Newman v. State of Alabama, supra

b. Antiquated equipment is inadequate. Miller v. Carson, supra

c. Purchase of three fully equipped ambulances was ordered. Williams v. McKeithen, supra

d. The unavailability of eyeglasses and prosthetic devices is cited. Newman v. State of Alabama, supra; Williams v. McKeithen, supra

e. The lack of basic x-ray and emergency services is cited. Finney v. Arkansas Board of Correction, 505 F.2d 194 (1974)

f. Hospital and equipment were ordered brought up to standards for state licensing of hospital. Gates v. Collier, supra

5. Sanitary Facilities/Segregation of Contagious Diseases

a. Unsanitary conditions, particularly in the TB ward, and

allowing some inmates with serious contagious diseases to mingle with the general prison population were cited as reasons for a finding of constitutionally inadequate facilities. Gates v. Collier, supra

b. Glaring unhygienic conditions, including the potential for contagion caused by nonsegregated sanitary facilities for the general ward population and hepatitis and tuberculosis ward populations, were condemned.
Newman v. State of Alabama, supra

But see:

a. Removal of TB patients from general population as discovered and testing all other inmates in the unit for the disease was sufficient to satisfy the courts that prison conditions did not constitute cruel and unusual punishment.
Chapman v. Plaseman, 417 F.Supp. 906 (1976)

6. Record Keeping and Organization

a. Disorganized lines of therapeutic responsibility resulting in treatment prescribed by doctors not being administered by medical subordinates, the ill-conceived system for referrals to the prison hospital, and "the maladroitly operated 'emergency' referral system also present grave constitutional problems."
Newman v. Alabama, 530 F.2d 1320, 1331

b. "Medical records shall be established and maintained for every inmate showing at least the date of each examination or treatment, the medical findings and the medication or treatment administered."
Rodriquez v. Jimenez, 409 F.Supp. 582, 597 (1976)

7. Preventive Medical Procedures

a. Incoming inmates must be screened for communicable diseases.
Alberti v. Sheriff of Harris County, 406 F.Supp. 649 (1975)

b. Every individual confined to jail should be given a physical examination within 24 hours of admission.
Rodriquez v. Jimenez, supra

c. Physical exams are required once every two years.
Newman v. Alabama, supra

But see:

a. Although expert medical witnesses indicated that intake physicals are advisable, court could not say that the lack of same amounted to cruel and unusual punishment.
Collins v. Schoonfield, 344 F.Supp. 257 (1972)

b. Black inmates are not entitled to routine examinations and genetic counseling for the detection and control of sickle cell anemia.
Ross v. Bounds, 373 F.Supp. 450 (1974)

III. Medical Care--Individual

A. Measuring the Adequacy of Medical Treatment

In a section 1983 action, not every complaint regarding medical care will be sufficient to state a constitutional claim. In determining whether a constitutional violation is present, "courts will not attempt to second-guess licensed physicians as to the propriety of a particular course of treatment for a given prisoner-patient" (Thomas v. Pate, 493 F.2d 151, 158). But on the other hand, the complaint need not allege that prison officials consciously sought to inflict pain on a prisoner by withholding treatment (Runnels v. Rosendale, 499 F.2d 773).

In 1976, the Supreme Court set forth a standard by which cases of this nature are to be judged.

1. "...deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain...' proscribed by the Eighth Amendment." Estelle v. Gamble, 97 S. Ct. 285, 291 (1976)

2. "This is true whether the 'deliberate indifference' is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." Estelle v. Gamble, supra at 291

B. Examples of "Deliberate Indifference"

Many of these cases were decided before the Supreme Court's enunciation of the standard to be applied. However, many of these decisions were cited in Gamble as examples of deliberate indifference and the others would seem to meet the standard as well.

1. Denial of Treatment

a. Denial of a request for a special diet and medication for treatment of a bleeding ulcer.
Westlake v. Lucas, 537 F.2d 857 (1976)

b. Denial of medical treatment for hepatitis to inmate confined in isolation cell.
Collins v. Schoolfield, 344 F.Supp. 257

c. Refusal by prison administrators to treat prisoner

for histoplasmoses.
Riley v. Rhay, 407 F.2d 496 (1969)

2. Failure to Provide the Treatment Prescribed

   a. Prison physician's refusal to administer prescribed pain killer and subsequent unsuccessful leg surgery by requiring prisoner to stand despite contrary instructions given by surgeon.
   Martinez v. Mancusi, 443 F.2d 921 (1970)

   b. Refusal by prison officials to provide a special diet prescribed by the senior medical officer for prisoner with heart condition.
   Edwards v. Duncan, 355 F.2d 993 (1966)

   c. Overruling by warden of doctor's order that prisoner's medication be given to him whole and not crushed.
   Sawyer v. Sigler, 320 F.Supp. 690 (1970)

   d. Refusal to perform nonemergency tonsillectomy and submucus resection of nasal septum for a life prisoner, when such surgery had been recommended by prison physician.
   Derrickson v. Keve, 390 F.Supp. 905 (1975)

   e. Refusal to return prisoner for hand operation ordered by doctor at state hospital.
   Wilbron v. Hutto, 509 F.2d 621 (1975)

   f. Assigning a prisoner who has been given light duty status by prison doctor because of heart trouble to heavy manual labor in the field.
   Campbell v. Beto, 469 F.2d 765 (1972)

3. Delay in Providing Treatment

   a. Refusal to permit inmate to see a doctor until the 13th day of confinement in segregation.
   Campbell v. Beto, supra

   b. Inmate was forced to wait 20 days before a maggot-infested wound was cleaned and the dressings changed.
   Newman v. Alabama, supra

   c. Denial of medical care for three days to a 15-year-old juvenile complaining of asthma, headaches, dizziness, and a heat rash.
   Thompson v. Montemuro, 383 F.Supp. 1200 (1974)

   d. Intentional delay in removing sutures while inmate was confined in isolation for 15 days with the result that ear became infected.
   Thomas v. Pate, supra

e. Refusal by sheriff to call for medical assistance for 13 hours to attend to injuries later diagnosed as two dislocated and one fractured cervical vertebrae.
Hughes v. Nobel, 295 F.2d 495 (1961)

4. Inadequate Treatment

The Supreme Court has stated in Gamble that the inadvertent failure to provide medical care, such as negligence on the part of the physician in diagnosing or treating a medical condition, is not a constitutional violation. However, as illustrated below, some courts have found the treatment so inadequate as to amount to no treatment at all. In such cases a constitutional claim will exist.

a. Administering penicillin despite inmate's known allergy.
Thomas v. Pate, supra

b. Doctor's choosing of the "easier and less efficacious treatment" of throwing away the prisoner's ear and stitching the stump may be attributable to "deliberate indifference...rather than an exercise of professional judgment."
Williams v. Vincent, 508 F.2d 541 (1974)

C. Claims Not Amounting to "Deliberate Indifference"

1. "An accident, although it may produce added anguish, is not on that basis alone to be characterized as a wanton infliction of unnecessary pain."
Estelle v. Gamble, supra at 291.

2. Fact that inmate was seen 17 times for back problem, even though the doctor never ordered an X-ray or like measure, does not amount to cruel and unusual punishment.
Estelle v. Gamble, supra

3. Failure to provide prescribed corrective shoes to inmate suffering from hammertoe condition is not a civil rights violation.
Henderson v. Secretary of Corrections, 518 F.2d 694 (1975)

4. Failure to consult specialist, while desirable, was not required for a prisoner suffering from emphysema.
Sawyer v. Sigler, supra

5. Physician's reduction and later elimination of medication for neural dermatitis does not state a civil rights claim.
Coppinger v. Townsend, 398 F.2d 392 (1968)

6. Refusal to move a prisoner to a private hospital for examination by a private proctologist does not amount to deliberate indifference when inmate is being given adequate care within the prison.
Hampe v. Hogan, 388 F.Supp. 12 (1974)

7. Request to be operated on at state rather than prison hospital because of previous poor treatment is not of constitutional import.
Haggerty v. Wainwright, 427 F.2d 1137 (1970)

8. A 1 1/2-week day delay in receiving medication for an ear infection did not state a claim where no damages resulted therefrom.
Feazell v. Augusta County Jail, 401 F.Supp. 405 (1975)

9. Two-day delay in seeing doctor, when no injury results therefrom is not deliberate indifference.
Cotton v. Hutto, 540 F.2d 412 (1976)

10. Where an inmate's dental problems were not serious and the potential harm caused by a 3-week delay was, at most, the extraction of a tooth, the denial of dental care for three weeks was not a violation of the Eighth Amendment.
Stokes v. Hurdle, 393 F.Supp. 757 (1975)

11. Refusal, after taking prisoner's temperature and determining that it was normal, to permit prisoner to be absent from work due to alleged headaches and dizziness and subsequent punishing of inmate for refusing to work did not constitute so grievous a denial of medical attention as to be unconstitutional.
Turner v. Plageman, 418 F.Supp. 132 (1976)

IV. State Court Actions

Even though a particular claim may not evidence the "deliberate indifference" necessary to support a civil rights action, the Supreme Court, in Gamble, and many lower courts have clearly stated that the inmate may still have a remedy for medical malpractice in state court.

A. Prison doctor's failure to comply with prevailing county medical practice in treatment of inmate's broken wrist was negligence, and the doctor was liable for damages. Doctor's defense that he followed prison administrative rule which required contacting orthopedic specialist only when there were 15 inmates in need of one was not valid since the prevailing medical standard required contacting specialist immediately in a case of this nature.
U.S. ex rel Fear v. Rundle, 506 F.2d 331 (1974) (applying Penn. law)

B. State department of corrections held liable for $16,000 in damages as a result of improper treatment of an inmate's broken ankle.
Dancer v. Department of Corrections, 282 F.2d 730 (1973)

V. Miscellaneous Problems

A. Expense of Providing Proper Medical Care

1. "...if the State chooses to run a prison it must do so without depriving inmates of the rights guaranteed to them by the federal constitution...Shortage of funds is not a justification for continuing to deny citizens their constitutional rights."
Gates v. Collier, supra

2. Refusal to follow prison doctor's recommendation that prisoner receive $2.00 cortisone treatments daily because of the expense was a failure to meet required state standard of care.
Pisacano v. State of New York, 8 A.D.2d 335 (1959)

B. Right to Rehabilitative Treatment

1. Dangerously violent or suicidal prisoners must be examined immediately and removed to a mental hospital if physician deems it advisable.
Jones v. Wittenberg, 330 F.Supp. 707 (1971)

2. Alcoholics and drug addicts should not be permitted to go through withdrawal in county jail without proper medical attention and care. Thereafter, they should be diverted to incarceration at county rehabilitation centers or other locations with properly trained personnel.
Alberti v. Sheriff of Harris County, supra

3. Psychological or psychiatric treatment is required if prisoner's symptoms evidence serious disease, disease is curable, or may be substantially alleviated and delay in providing treatment would cause substantial harm.
Browning v. Godwin, ___F.2d___, 21 CrL 2040 (1977)

But see:

1. Failure of superintendent to furnish medical treatment for narcotics addiction is not a constitutional violation without showing that superintendent could have provided such treatment.
Smith v. Schneckcloth, 414 F.2d 680 (1968)

C. Unwanted Treatment

1. Inmate who refused to take orally the tranquilizer prescribed by prison physician and who was forcibly given injection by prison officer who was neither a doctor nor a medical technician was not subject to cruel and unusual punishment.
Peek v. Ciccone, 288 F.Supp. 329 (1978)

APPENDIX II

MENTAL HEALTH CARE IN CORRECTIONS

The paper that follows discusses the considerations and approach applied in delivering mental health care to San Francisco County jail inmates. As is the case with all aspects of providing health care in the correctional setting, it is not possible to offer all-encompassing models of service delivery because of the diversity of institutions. However, many of the problems that the staff of the San Francisco County jails face illustrate those with which smaller jails and large prison systems must also contend. The resources available to an institution within its own system and accessibility to outside resources will predetermine and limit many aspects of any mental health care program, as will such other variables as the size of the facility, the type of inmate population, sources of possible funding, local political priorities, and even the location of the prison or jail.

In the broadest sense, mental health problems in jails may be more acute than in some prison systems for a number of reasons. Jails are often holding centers with limited space, facilities, and diversions to mitigate the potential for mental crises; and the short-term nature of the jail population often does not allow for as effective a screening and diversion process of severely disturbed inmates as do some prison reception centers.

For the most part, the needs of jails will center only on emergency and short-term treatment, such as crisis intervention. Prisons may additionally have to consider other long-term programs of optional therapy for inmates along the lines of those outlined by the American Public Health Association. At this time, however, some corrections professionals believe that the courts will not mandate care beyond the emergency level, especially since so many institutions are still far from providing reasonable care in other critical health areas.

Nonetheless, incarceration can undoubtedly exacerbate mental problems, and it is to the benefit of the institutions as well as the inmates to have a mental health program.

The issues that must be addressed in delivering mental health care, whether to a prison or jail population, are generally the same ones that J. Thomas Peters describes--treatment, hospitalization, a referral network, access to the inmates, assessing needs, and staffing.

MENTAL HEALTH CARE IN JAILS

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Treatment

Because of the incidence of significant and often severe psychiatric problems within jails, and because staff and other resources are usually relatively limited, some hard decisions have to be made with regard to the requests for mental health services to inmates. Often these decisions mean that referrals that would be acted upon in other mental health systems cannot be responded to adequately in the jails.

In most jails, the first priority is to get certain inmates immediately out of the jail and into a hospital. Generally such inmates are actively suicidal or are grossly agitated and psychotic. Beyond these classifications, though, the potential for diversion into the mental health system depends on a number of factors, among them: the availability of locked (and sometimes guarded) mental health facilities; the legal and custody status of the inmate; and, the judge's or sheriff's willingness to consider at least temporary diversion.

The decision on what can be done for the vast majority of inmates who have notable psychiatric problems but who are not being considered for diversion is a most difficult one. Many of the mental health referrals will be for inmates presenting behavioral and personality disorders. The mental health field in general has evidenced little success in dealing with this category of patient, and no miraculous exception can be expected within the jails. One positive step that can be taken is to have a mental health staff person act as mediator between the inmates and custody staff, trying at least to diffuse some of the potential for explosive behavior on both sides.

Often the presenting problem is clearly one of schizophrenia or affective disorder, and here, depending on the skills and experience of the staff, more can be done for the individual exhibiting such symptoms than for the inmate with a behavioral or personality disorder. If used judiciously and with proper observation and followup, the major psychoactive medications can be of considerable value. The best system is one where the medication is used in conjunction with individual therapy sessions, where close monitoring of medication effects and side effects is undertaken, and where the time and opportunity for verbal therapy also exist.

Many of the inmates' problems are not of psychotic proportion, but are still serious and in need of professional attention. In many who come into the jail experience, quite notable depressive and/or anxiety reactions are seen. Here again, the therapeutic skills of the clinical staff are crucial. For the primary goal often is not long-range rehabilitation, but helping inmates deal with an acute and immediate reaction to an often nearly overwhelming change in circumstance and environment. Regularly scheduled supportive counseling sessions and the availability of immediate crisis intervention can be of considerable value.

Hospitalizations

In many instances, one of the key elements of jail mental health treatment is the removal of an inmate from the jail environment. While in many counties a fully psychotic prisoner is something of a rarity, in counties such as San Francisco and Los Angeles, such inmates are quite regularly found in the jail

population. Some are floridly psychotic when they are brought to jail, others decompensate shortly after arrival. For these people, for those who are severely depressed and suicidal, and for some others, an essential to effective treatment is their removal, at least temporarily, from jail.

In San Francisco two hospital options are available for county prisoners; San Francisco General Hospital and the State hospital at Napa. At San Francisco General, the psychiatric service shares a maximum security ward with the medical service. The ward has a 22 beds with one or two beds per room. Specially selected guards from the sheriff's department, cameras, and other hardware provide 24-hour security. The ward has several particularly good features: (1) its proximity to the courts allows a patient, when appropriate, to be brought directly to court and returned to the ward on the day of his scheduled appearance; (2) it is richly staffed, allowing for close development and monitoring of treatment; and, (3) it allows greater access by family, friends, and in some instances, clinicians whom the patient had seen before.

In January 1978, a second ward will be opened at San Francisco General which will be exclusively for jail psychiatric patients. This ward will not only increase bed availability, but it will also help alleviate one of the major drawbacks of the present ward. Since the current ward also serves medical/surgical patients, highly agitated and potentially explosive psychiatric patients must be sent to the State hospital or some other facility for treatment. (Interestingly, for some psychiatric patients in other diagnostic categories, the presence of medical/surgical patients on the local ward has often been felt to be of some benefit.)

The minimum security State hospital at Napa has a much greater bed capacity (we average 30-35 admissions per month) and is better designed to deal with long-term patients. There are two main disadvantages, though, which have us working to reduce significantly our use of the hospital. Its distance from San Francisco (approximately 40 miles) means much greater transportation problems and costs. Its relative isolation means patients are denied the numerous clinical advantages of local community-based treatment.

Referrals

One of the key elements in running a jail psychiatric program is devising a referral system that is appropriate both to the needs of the jail population and to the staffing pattern of the mental health team. It does little good, and in fact a great disservice to all involved, to set up a referral system that cannot be acted upon realistically.

It can be tempting, particularly when first establishing a mental health team within the local criminal justice system, to make a general offer of psychological services throughout the system. But if the inmates come to expect to be seen whenever they request it, and the courts expect psychological evaluations on a number of defendants before the bench, and the probation department expects assistance in drafting presentencing reports, and the sheriff's parole board expects consultation on its applicants, then soon the realities of limited budget and staff will force a constriction of services.

Focusing for the moment on the system for referrals within the jail itself, what is needed is a processs wide enough in scope to ensure that all inmates needing assistance from the mental health team will be seen, but also, a process that allows efficient triage decisions to be made.

In San Francisco we have a procedure whereby in each of the jails our team will take referrals from a variety of sources. From the medical staff we get referrals on inmates whom staff members feel have psychiatric as well as medical problems, or on inmates whose medical complaints seem more appropriately dealt with by mental health staff. Another valuable referral source is from on-line custody staff, especially those on swing and graveyard shifts. Also, certain inmates, notably the trustees who have greater mobility in parts of the jail, can give valuable referrals. They are often in a particularly good position to notice consistent eating and sleeping difficulties which, when of certain severity, can indicate significant psychological distress. We also take referrals directly from the inmates themselves, who can sign up on the psychiatric list kept in the medical dispensary or who can speak to one of the mental health staff.

The critical next step is to screen these referrals and make appropriate triage decisions. In the large San Francisco jail that holds sentenced male inmates, we have one staff person who screens and makes initial triage decisions. At this point his decision is basically whether the person's presenting problem is severe enough to warrant immediate further attention, whether the person can wait and be seen in two to five days in an individual session, or whether the person must be told that there is nothing at this time that the psychiatric team can do for him. (This last response comes most often to the requests for sleeping medication or mild tranquilizers.)

In the other jails, the screening and triage decisions are left to each mental health staff person. Each can decide whether further sessions are appropriate, whether other staff people should be brought in for additional opinions, as well as make an initial assessment on the need for medication.

Access

A practical issue of considerable import concerns the availability of private interviewing and counseling rooms. Private and reasonably quiet space is at a true premium in any jail, and privacy becomes a matter of primary concern in offering psychological services to inmates. Since very few jails are designed to have private rooms available for much more than the minimum amount of attorney-client contact, the competition for space among agency representatives who come into the jail can be keen indeed. Of course, this problem is often even more greatly exacerbated by the fact that most professionals want to work during standard business hours. In any event, privacy is an issue that must be resolved by the sheriff, based on his assessment of needs and priorities.

In San Francisco, a wide variety of agencies, from probation, to Social Security, to the community college district, send workers into the jails. Aside from the medical service, which has its own examination room and dispensary in each of the jails, these workers, along with the attorneys, must wait on a first-come first-serve basis for access to one of the two to eight interview rooms available in each of the San Francisco jails. The one exception is the

psychiatric service, which the sheriff has indicated has top priority. In each of the jails, the mental health team has space reserved during part of every day, maximizing not only the efficient use of the staff's time, but also the privacy and regularity of their interactions with the inmates.

Assessment

Whom in the jail population the mental health staff should deal with varies with the characteristics of the inmates, the treatment capabilities of the staff, and the availability and feasibility of using outside facilities.

One of the main factors that influences how precisely a county wants to determine the mental health characteristics and needs of its inmate population is the local political determination of how much staff and facility resources will be committed to jail treatment. Thus, if the political forces have judged that the county's only responsibility to the inmates regarding mental health treatment is to deal with acute psychiatric emergencies, they will be disinclined to conduct a general sampling to set the incidence of mental health problems within their jails.

Such a general incidence study was, however, recently mandated by the California State Legislature and conducted by Arthur Bolton Associates under the auspices of the State Department of Health.[1] In a sample of California counties taken last year, it was found that around six percent of the total jail population had psychotic disorders, and that an additional nine percent had significant non-psychotic mental disorders. They found, in addition, approximately 20 percent who were categorized as personality or character disorders. While many questions are raised by this study, and though the authors themselves caution against generalizing these results, it is clear from their findings, and from several years of jail experience, that a mental health problem of notable proportion exists within the county jails.

Staff

The clinical skills and personal sensitivity of the mental health staff will clearly determine the success or failure of the effort to bring psychiatric care to the county jail. Since very few mental health professionals have had the experience of working a jail, the early time on the job must of necessity include a good amount of desensitization to the sights, sounds, smells, and other realities of the jail environment.

Not only for the acclimation, but for other reasons as well, it is critical that the mental health staff work full time within the jail and not come only occasionally as consultants. The staff must become intimately aware of the myriad legal, custodial, and interpersonal vectors that come together within the jails. It is a vastly complex system with its own rules, standards, and mores.

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[1] A Study of the Need for and Availability of Mental Health Services for Mentally Disordered Jail Inmates and Juveniles in Detention Facilities, Arthur Bolton Associates, October 1976.

The staff must also have the ability and inclination to confront some of their own biases and stereotypes. Most mental health professionals come into the jail with little direct knowledge of this system and the people who run it. The backgrounds and training of the mental health and custody staffs are obviously most often quite disparate. But one of the most positive effects of having the two staffs work together is the breaking down of stereotypes--the sadistic guard versus the bleeding heart counselor.

The relationship that these two staffs develop is one of the most critical elements in determining how effectively the mental health services are delivered. It is not enough simply to have court and top-level sheriff's department approv to work within the jail. It can be of inestimable value if the mental health staff can gain the respect of the on-line jail staff, for their cooperation and input can be of tremendous assistance.

The benefits of developing a mutual respect between the two staffs can be many. The mental health staff can pick up a number of insights from the custody staff on behavior, language, and routine of the jail. The custody staff, in turn, can learn new ways of viewing and dealing with some of the more troubled, and often troublesome, inmates in their jail.

APPENDIX III

MICHIGAN'S DENTAL CARE SYSTEM IN PRISONS

The State of Michigan has established a comprehensive system of dental clinics and care available to all inmates in the charge of the Department of Corrections. The facilities range from an infirmary clinic at Jackson State Prison (population 3,500) that is staffed by four dentists (to be six soon), three dental aides, a clerk, and one hygienist, to small clinics staffed by a contractual dentist for up to 16 hours every two weeks to serve facilities that house between 250 and 300 inmates. All of the clinics are being remodeled and new equipment is being installed and staff added as funds become available, according to William J. Byland, D.D.S., who is the department's assistant director in the office of health care. The remodeling, expected to be completed by the end of 1978, as well as the addition of several more clinics over the next two years, will permit even more efficient operation of dental services plus more efficient use of auxiliary personnel such as hygienists and civilian dental aides, Byland said.

Michigan's program of, and approach to, dental care have been elaborated in a Dental Policy Manual that covers everything from overall objectives of the service to guidelines for specific treatment. Those parts of the policy that may be of general interest to correctional and health care administrators have been selected for discussion or quotation here.

General Dental Policy

As a general policy, the dental department in the Michigan Department of Corrections tries to provide "the highest quality comprehensive dental care possible for residents, with their consent and within the limits of available resources." The department gives priority to "correcting oral conditions detrimental to the health of the individual which constitute a hardship in the rehabilitation of the resident." The availability of funds and personnel define the parameters of services to be offered.

Levels of Care

Basic care is available to all inmates upon entrance into the system. No service is provided, however, that could not be provided to all residents with the same needs. Currently, the dental department defines basic care as: "the relief of pain; extractions when necessary; restoration by filling all teeth that can be restored; and replacing missing teeth by prosthetic devices either cast or wrought wire, acrylic partials, or complete dentures." Optional care,

including endodontal or periodontal work, is also available. But cases requiring the services of an oral surgeon are usually referred to board certified oral surgeons serving in the particular prison area.

The department does not do crown (gold or ceramic) or fixed bridgework nor are orthodontic services available at the prisons. According to Dr. Byland, residents can get these services in some instances, but they have to pay their own treatment expenses and, in addition, pay for the cost of a security escort to visit an outside specialist.

Administration: Chain of Command

The dental department has a straightforward chain of command. First of all, all health care personnel at all institutions and at all levels, including the dental director, are responsible to the director of the Department of Corrections, Office of Health Care. Then, the dental director himself is responsible for the staffing, planning, and all aspects of dental care in all the institutions. This responsibility includes the planning for the equipping and remodeling of the existing clinics that is now under way. In addition, the dental director administers the dental technician education programs for residents that were described in chapter 6. Finally, each clinic has a chief dentist who is responsible for the day-to-day operation of his clinic and for supervising the staff. The chief dentist at each clinic is responsible both to the infirmary medical director and to the dental director.

Initial Dental Examination

All residents of Michigan's prison system have an initial dental examination at the time of incarceration. For men, the examination is conducted at what is called the Reception and Guidance Center. Women are examined at a women's prison in Ypsilanti. During the examination, which takes about 30 minutes, a complete dental history is taken along with X-rays (bite-wings and periapical, as needed). Dental needs are charted and treatment priorities are assigned. These are explained to new residents during a briefing session. Dental services that are available and procedures for making appointments are also explained. The plan of dental treatment recommended at the initial examination begins after the resident is transferred to his assigned institution. Only emergency treatment is available at the intake clinic.

Appointment and Treatment

Residents are scheduled for dental treatment in the chronological order of their arrival at their institution. The institution initiates treatment on the basis of the initial examination and arranges the treatment schedule according to assigned treatment priorities. Appointments are scheduled until the case is completed, but, where conditions permit, residents are recalled yearly for examination.

Residents not on any treatment plan of appointments can place themselves on dental sick call where that is available, or they can send out a written request to see a dentist. Emergencies are seen at any time upon the request of the housing unit officer or work supervisor.

As much as possible, the department has made appropriate arrangements with dental specialists, such as oral surgeons located in the immediate areas surrounding various institutions. In cases where specialists are not available in the area, residents are transferred to Jackson Prison where the services of such specialists can be made available on the outside. However, according to Byland, his department has arranged for consultants to come to the prison infirmary in the future, rather than have residents go outside. This procedure will begin at Jackson and at the women's prison in Ypsilanti as soon as the remodeling and upgrading of the clinics and infirmaries at both sites are complete.

Refusal of Treatment

If a resident refuses the treatment recommended by the examining dentist, he is asked to sign a special form. It is attached to his file and placed in a central medical file. If the resident refuses to sign the form, the dentist initials it instead.

Once a resident has refused treatment, he has relinquished his right to any further dental care until he is willing to accept the recommended treatment. If there is a history of refusal of treatment, the resident is asked to sign a consent form before any work is done. Emergency care will still be provided.

Records

At the time of the initial dental examination, an admission dental card opens the patient's dental file and an outpatient dental record, which becomes part of the master medical record, is prepared. The latter contains the findings of the initial examination and records the presence of caries, missing teeth, pathology, bridge, and so forth; it also includes the dental history.

According to Byland, his department is now in the process of setting up a complete new dental patient record system. Eventually a computer reporting system will be established to keep track of the patients, the work being done at each clinic, and the work being done by individual dentists.

Priorities

The priorities for improving dental care that had been established by administrators in the state have apparently been or are in the process of being met. As Byland explained, the budget has been greatly expanded since 1974; the staff has been substantially expanded since 1975 although several positions still need to be filled; and all facilities will have new equipment by the end of 1978 or it will at least be on order. In the future, facilities that open will be equipped with new dental units.

As a result, Byland concluded, all the recommendations set forth in Key to Health for a Padlocked Society, by Michigan's Jay K. Harness, have been instituted or are in the process of being instituted.

APPENDIX IV

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