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Health Care in Correctional Facilities Barriers to Humane and Adequate Care

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 intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.

U. S. Supreme Court, Estelle v. Gamble (1976)

... no jail administrator has the right to impose a death sentence, and failure to provide for the medical needs of those in custody is equivalent to pronouncing a death sentence.

U.S. Bureau of Prisons Manual on Jails, 1972

The U.S. Supreme Court ruled in *Estelle v. Gamble* that it is the "government's obligation to provide medical care for those whom it is punishing by incarceration." The Court set a high standard for plaintiffs' attorneys to meet - "deliberate indifference to serious medical needs." In order to prove deliberate indifference, it is necessary to demonstrate that medical or custody staff knew of and disregarded an excessive risk to an individual's safety or serious medical need. A serious medical need is defined as a health problem that, without timely and appropriate medical care, will cause (1) death, (2) measurable deterioration in function, (3) unnecessary pain, or (4) a substantial risk to the public health. Thus, the finding of deliberate indifference goes beyond malpractice or even gross negligence. By requiring actual knowledge of a problem, the Court adopted the same subjective standard used to determine criminal recklessness.

Unfortunately, almost 30 years after *Estelle*, the state of health care in many correctional systems remains poor and inadequate and fails to meet the constitutional standard set by the Supreme Court. Lack of timely access to routine, specialty, and emergency care; lack of chronic care programs; incompetent and inadequate care; and deficient medical records systems are common problems. In many of the correctional institutions with a satisfactory health care delivery system, necessary changes have only come about as the result of court orders or settlement agreements. In many cases, this has involved the appointment of medical experts or special masters to oversee the health care programs and ensure compliance with court decrees.

The prison and jail population has a high prevalence of acute and chronic medical, mental health, and substance abuse problems. In addition, many prisoners come from a medically underserved population due to limited access to medical care in the community, lack of insurance, distrust of the medical establishment, competing priorities, and/or unpredictable lifestyles. Lack of adequate medical care can lead to deterioration

in their health status, development of preventable complications, unnecessary pain and suffering, and death. The National Advisory Commission on Criminal Justice Standards and Goals, in a 1973 report, stated,

One of the most fundamental responsibilities of a correctional agent is to care for offenders committed to it. Adequate medical care is basic, food and shelter are basic. Withholding medical treatment is not unlike the infliction of physical abuse. Offenders do not give up their rights to bodily integrity whether from human or natural forces because they were convicted of a crime.

Recently, U.S. District Judge Thelton Henderson decided to place California's state prison health care delivery system under receivership. As noted by James Sterngold in the San Francisco Chronicle,

The decision followed weeks of testimony from medical experts that Henderson described as horrifying in its depiction of barbaric medical conditions in some prisons, resulting in as many as 64 preventable deaths of inmates a year and injury to countless others. (San Francisco Chronicle, July 1, 2005)

Judge Henderson said he was most moved by the "uncontested statistic that a prisoner needlessly dies an average of roughly once a week" through medical neglect or cruelty, noting that anyone "would have to be shocked, as I certainly was." He added that the prison medical system offered "at times outright depravity, and I intentionally call it that." Judge Henderson concluded that "horrifying details" presented in a series of hearings over the past month had filled him with a sense of urgency and persuaded him that the California Department of Corrections was unable to manage medical care without outside help.

Judge Henderson based his conclusions on the findings of a panel of three court appointed medical experts, of which I was one. I will refer to some of our findings in the remainder of this statement. While the cases described come from our review of the California prison system, it is important to note that I have found similar problems in my reviews of cases from other systems, including prisons and jails in Utah, Nevada, Texas, Ohio, Michigan, Wisconsin, and Pennsylvania.

There are a number of factors that contribute to the lack of adequate health care in our nation's correctional facilities:

1. Healthcare is not a priority

In most correctional systems, health care is under the auspices of the Sheriff or Department of Corrections. Security is their main concern. The provision of healthcare is often not seen as a core function and is not given much attention. Health care managers often lack the authority to direct health care services because they are several

layers below the individuals who make the decisions. The officials who are responsible for the medical programs often do not have the education or training necessary to manage a healthcare system. In announcing his decision to appoint a receiver, Judge Henderson stated,

...we have seen too often in the records before me, medical, important medical decisions give way and suffer because of ill-advised security decisions so that prisoners don't even get to their medical care because of security decisions that hamper effective medical care...

Kevin Carruth, who at the time was the second ranking corrections official in California, stated at an evidentiary hearing that medical care is "not the business of the CDC [California Department of Corrections] and it never will.... [M]edical care is not one of CDC's core competencies."

2. Lack of medical autonomy

Custody staff often has managerial responsibility over medical decision making, a role, as noted above, for which they do not have the necessary medical education and training. In addition, medical staff is dependent on custody staff for the transportation of patients for both on and off site medical appointments. The lack of sufficient staff to transport patients results in delay or denial of necessary care.

The provision of health care services in a correctional facility requires cooperation between medical and custody staff. In all cases, however, matters of medical judgment must remain under the control of the health care staff. Custody staff must not be allowed to override medical decisions. If there are security concerns (i.e., should a certain prisoner be allowed to have crutches, or can another prisoner be taken off site for a specialty consultation), they should be jointly discussed, and any decisions must have the approval of the medical staff.

3. Lack of appropriate funding and resources

In most systems, the health care budget is part of the overall corrections budget and is controlled by the Sheriff, warden, or other officials within the custody bureaucracy. Here again, custody concerns take precedence over medical needs, and health care services are often underfunded. Salaries often are lower than those for comparable positions in the community, making it difficult to hire and retain qualified health care staff, and it is often difficult for programs to obtain necessary materials and supplies.

4. Lack of qualified staff

It is difficult to attract qualified physicians and nurses to work in correctional facilities. This is due to a number of factors, including the poor reputation of health care staff who work in corrections, the stigma of working in a correctional facility, inadequate facilities,

and poor working conditions. In addition, many prisons tend to be located in remote, isolated areas.

Many facilities are saddled with a legacy of poor quality and inadequately trained staff. In addition, many systems do not have appropriate criteria for selecting and hiring medical staff. It is not uncommon to find retired radiologists, pathologists, and other non-primary care physicians providing primary care to patients with complex medical problems. A review of facilities in the California Department of Corrections revealed a pattern of inadequate and seriously deficient physician quality [Second Report of the Medical Experts, July 2004]. Many of the physicians had either a prior criminal record, a loss of privileges at a community hospital, or had questions of mental health or substance abuse problems. In testimony at a recent court hearing, Dr. Renee Kanan, the Acting Deputy Director of the CDC's Health Care Services Division, noted that approximately 20 percent of CDC physicians had a record of an adverse report on the national practitioner data bank, had a malpractice settlement, had a license that had been restricted, or had been put on probation by the Medical Board of California.

Review of medical records by the medical experts revealed care that was often incompetent, callous, indifferent, and, at times, cruel. As noted above, review of death files revealed that many of the deaths were preventable. In addition, many patients are at risk of significant injury, harm or medical complications due to poor care. In one case, a physician saw a 48-year-old man on an emergency basis. The patient's vital signs were very abnormal, indicating that he may have been in shock and required immediate acute-care hospitalization. The physician did not perform an adequate evaluation, diagnosed and treated him for bronchitis and influenza, and sent him back to his housing unit. On his way back, the patient collapsed and was brought back to the medical area for further evaluation. The physician failed once again to perform an adequate examination. He ordered intravenous fluids, but staff was unable to start an IV and, despite this, the physician cleared him to return to his housing unit. Another physician saw the patient the next day, at which time the patient was in shock. The physician sent the patient to a local emergency room for further evaluation and treatment, where he subsequently died. At the time of this incident, the first physician was under investigation for two prior cases in which patients had died under questionable circumstances.

In another case, a physician diagnosed a patient with endocarditis (an infection of the heart requiring immediate treatment with intravenous antibiotics). The physician saw the patient multiple times over a period of six weeks without providing appropriate therapy. The patient was ultimately seen by the physician in the facility's emergency room, at which time the patient was in shock. Despite pleas from the nurse that the patient was suffering from endocarditis and required further care, the physician refused to send the patient to the local emergency room and sent him back to his housing unit. The patient died 2 ½ hours later.

5. Lack of adequate space

In many facilities, patients are seen and examined in spaces that are completely inadequate for the provision of medical care. In some of the prisons visited by the medical experts, medical staff evaluated patients in rooms or closets with inadequate lighting and lacking any medical equipment, such as examination tables, to conduct basic examinations. Some of the clinical areas did not meet minimal sanitation standards, and in others there were no hand washing facilities.

In one facility that the medical experts visited, sick call for prisoners housed in administrative segregation was conducted with the patients standing upright in a metal cage that is approximately 3 feet wide by 3 feet deep and a little over 6 feet in height. The physician or nurse examined the patient by placing their hands through the food port (an approximately 4 by 12 inch rectangular opening in the front of the cage).

6. Attitude of medical staff

In my experience, a surprisingly large number of medical staff working in correctional facilities do not like their patients and do not think they deserve good medical care. It is not uncommon for staff to ask why those in jail should have access to timely and quality medical care when their own families or others in the community do not have such access. Many staff view prisoner requests for medical care as attempts at manipulation.

One particularly disturbing case reviewed by the medical experts involved a patient with multiple chronic medical problems, including congestive heart failure. From January 5 to February 15, 2005, he complained on 11 occasions (through health care requests or unscheduled clinic visits) that he had abdominal pain, yet his symptoms were never fully evaluated by nurses or physicians. He expressed concern for his health by requesting a transfer to another facility to prevent “death or permanent disability,” and then by demanding to see a physician. A physician saw him on January 12, January 31, and February 14, but did not appropriately evaluate his complaints. Her histories were either inadequate or non-existent, and she did not examine him on any of these occasions. Her attitude, as evidenced by documentation in the medical record, was unprofessional and mean-spirited. The patient died in his cell on February 15. The coroner noted the cause of death to be cardiac arrest /arrhythmia, caused by acute congestive heart failure. If he had been appropriately evaluated and treated, it is likely that his death could have been prevented. The same physician had 62 grievances filed against her in a year’s time, and had advised one of the court experts that most of the prisoners she examined had no medical problems and were simply trying to take advantage of the physicians. In a case at a different facility, a prisoner was brought to the medical clinic for evaluation following a fight. His neck had been injured, and he stated that he could not move his legs. Instead of following accepted medical practice and immobilizing the patient’s neck, the physician stated that the patient was faking and moved his neck from side to side, thereby causing or exacerbating the patient’s paralysis.

7. Overcrowding

Many jails and prisons are overcrowded, often vastly exceeding their rated capacities. In addition, the prisoner population is older and sicker than it was in the past. As a result, many health care programs, which are already underfunded and understaffed, are overwhelmed by the health care needs they are responsible for addressing.

Conclusion

The lack of adequate medical care in correctional facilities leads to unsafe conditions and, as noted above, can rise to the level of abuse. Individuals are taken away from their families and community and sent to prison as punishment. The pain and suffering resulting from poor medical care is not supposed to be part of that punishment. Provision of inadequate health care creates needless pain and suffering for the many prisoners who require such services. In its most appalling form, inadequate care transforms a prison sentence into a death sentence.

Recommendations

1. Medically trained staff must have programmatic control over medical programs in correctional facilities. In addition, matters of medical judgment must be the sole province of the responsible medical authority.
2. Federal rules that deny Medicaid and Medicare funding to prisoners need to be changed in order to alleviate the financial burden faced by states and counties in providing medical care to prisoners.
3. State and local health departments need to take responsibility for overseeing and supervising the healthcare provided in correctional facilities within their jurisdictions. This should include an assessment of the appropriateness of clinical decision-making and the overall quality of care.
4. All correctional medical programs should have procedures to credential and privilege staff to ensure that they are providing care that is appropriate to their level of licensure, education, training, and experience. (Credentialing is the verification of a clinician's education, training, and licensure, including any formal disciplinary actions or restrictions imposed by a licensing agency. Privileging is a listing of specific clinical services that a clinician is permitted to perform in a facility).
5. The overcrowding of our nation's jails and prisons needs to be addressed. Correctional facilities are filled with individuals who are incarcerated because of mental illness or substance abuse problems. Alternatives to incarceration need to be developed for these individuals. In addition, the rules and regulations related to parole and probation revocation should be reviewed in an effort to reduce the overcrowding of our correctional facilities.