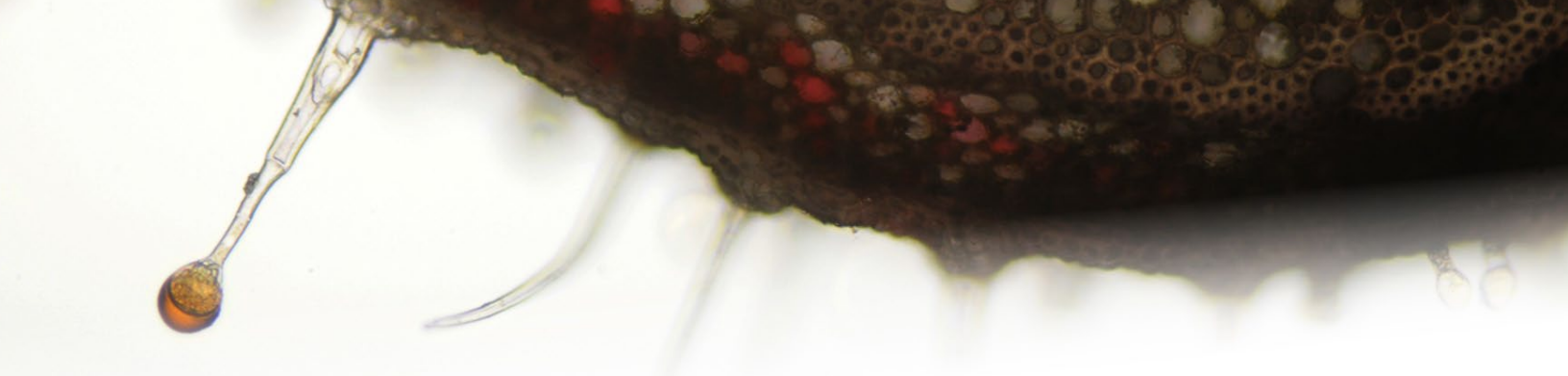

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HISTORY OF MEDICINE

How Foundations of Carceral Health Care Came From a Right to Sue

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Abstract

The focus of the American Medical Association (AMA) on health care for persons who are incarcerated was in response to the US Supreme Court's 1964 *Cooper v Pate* holding. This article summarizes key points from AMA work during the 1970s that led to further development of carceral care standards by the National Commission on Correctional Health Care.

Carceral Facilities as Sites of Physicians' Obligations

When the American Medical Association (AMA) was founded in 1847, its goals included promoting public health, in part by defining the nature and scope of physicians' professional roles. It is unsurprising that one of its first tasks was to enumerate physicians' duties to the public, including to persons who are incarcerated. Article I, Chapter III of the first *Code of Medical Ethics* explicitly acknowledges ties between AMA work and carceral settings as they pertain to public health.

> As good citizens, it is the duty of physicians to be ever vigilant for the welfare of the community, and to bear their part in sustaining its institutions and burdens: they should also be ever ready to give counsel to the public in relation to matters especially appertaining to their profession, as on subjects of medical police, public hygiene, and legal medicine. It is their province to enlighten the public in regard to quarantine regulations, - the location, arrangement and dietaries of hospitals, asylums, schools, prisons, and similar institutions,- in relation to the medical police of towns, as drainage, ventilation, &c.,- and in regard to measures for the prevention of epidemic and contagious diseases; and when pestilence prevails, it is their duty to face the danger, and to continue their labours for the alleviation of the suffering, even at the jeopardy of their own lives.[1]

It is notable that "prisons" are named explicitly. Victorian-era America was awash in ideas about prison reform, with some of the most notable and notorious systems designed during that time, including the Auburn System and the Pennsylvania System.[2]

Carceral Health Deficiencies

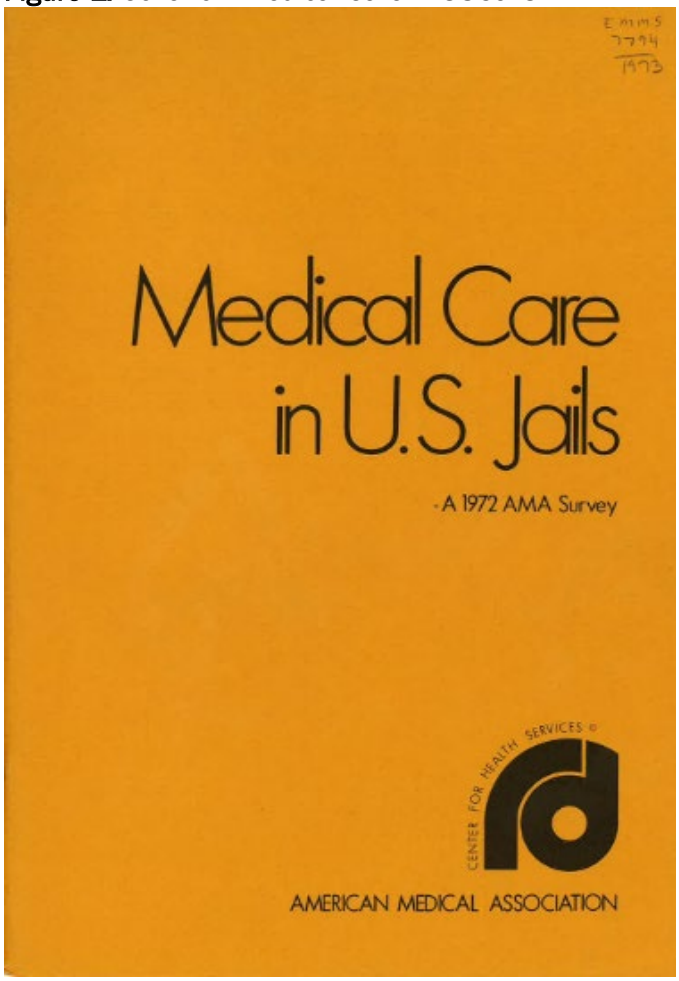
The AMA did not take a leading role in carceral health care until the 1970s, after *Cooper v Pate*,[3] a 1964 US Supreme Court case, ruled that state prison inmates have standing to sue in federal court to address grievances. The formation of the Law Enforcement Assistance Administration (LEAA) in 1968[4] also created an environment in which prison conditions could be scrutinized. An early task of the LEAA was a national jail survey, which was completed in 1970. A goal of the survey was to provide answers to "such fundamental questions as the number of jails, the number and type of inmates ... the

operating costs, and the presence or absence of selected facilities."[5] The results revealed that health services delivered in infirmaries, for example, were dismal: only about half of jails either at the county level or located in municipalities of 25 000 or greater population had "facilities" for their inmate populations.[6]

These results worried members of the Commission on Correctional Facilities of the American Bar Association, so they contacted their frequent collaborators on medical-legal issues, the AMA. According to Dr Herbert C. Modlin of the AMA:

> In 1971 representatives of the Commission on Correctional Facilities of the American Bar Association expressed their concern to the AMA about the poor quality of medical services in correctional institutions, particularly in jails. Discussions with members of the National Sheriff's Association and the American Correctional Association clearly showed that the problem was serious. To acquire more accurate data than any available, staff members composed and submitted to 2,900 sheriffs a four-page questionnaire on medical services.[7]

Figure 1. Cover of "Medical Care in US Jails"



Courtesy of the American Medical Association Archives.[8]

The questionnaire, sent to sheriffs across the country (though only 39.6% of jails responded[6]), excluded administrators of federal and state prisons or other correctional institutions; institutions exclusively for juveniles; jails located in Connecticut, Delaware, Rhode Island, New Hampshire, Vermont, Hawaii, and Alaska that were not operated on a county level; and overnight lockups. Questions posed included the following: "What is

the average number of inmates receiving medical care per month?" and "What type(s) of medical facilities are available in the institution?"[8] The survey's results were published[5] and sent to various stakeholders, including the AMA's Board of Trustees, which promptly allocated $50 000 for further study and planning of a program to improve medical care in the nation's jails.[7]

Bleak results quickly emerged: a picture of outdated facilities, inadequate staffing, limited funds, and disinterested clinicians. Fewer than 40% of facilities had physicians regularly available and 66% had only first-aid facilities.[5] Moved by the findings, the LEAA joined with the AMA in 1974 to begin a 3-year pilot project that began on April 1, 1976.[7] Notably, 1976 was also when the Supreme Court ruled in *Estelle v Gamble* that jails and prisons have an "obligation to provide medical care for those whom it is punishing by incarceration."[9,10]

Creating Standards

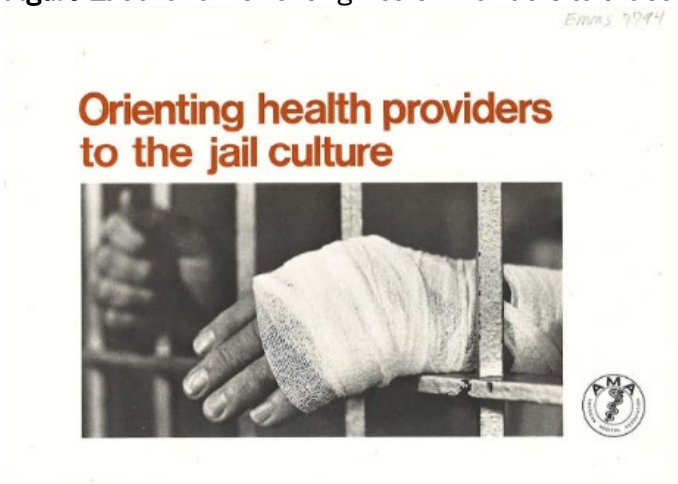
The AMA and LEAA sought to develop "model health care delivery systems for jails," construct minimal standards and implement a national certification program for jails, and create "a national clearing-house of information on jail health services."[7] Six pilot states were chosen, and, by mid-1977, a much-revised draft of the medical standards for jails was nearing its final form.[7] It included 83 guidelines for minimum standards for medical, dental, and mental health and for alcohol and drug addiction services offered to inmates. It also set procedures for keeping medical records and prescribing medications and called for physical examinations for inmates.[11]

With approval from the AMA's Board of Trustees and House of Delegates, the standards were distributed to jails in the 6 pilot states, along with invitations to apply for certification.[7] As Modlin explains: "A survey team evaluated each applicant jail. The National Advisory Committee then granted or denied certificates on the basis of results and recommendations from its accreditation subcommittee."[7] Once approved by all relevant parties, this set of standards was sent to participating states in order to prepare them for accreditation. That same year, the AMA also hosted the first-ever National Conference on Improved Medical Care and Health Services in Jails.[12] By 1979, 20 more states had joined the program and sought accreditation.[7]

AMA Materials on Carceral Health

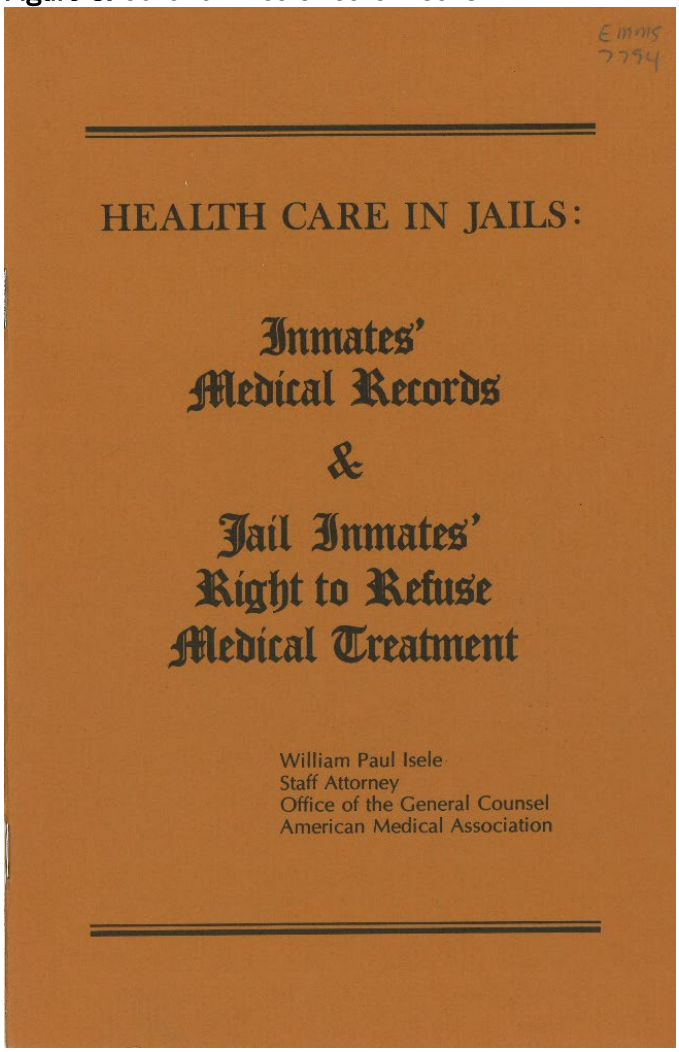
The pamphlets whose covers are displayed in Figures 2 to 5 represent just a fraction of the materials created by the AMA to advise carceral institutions on specific issues related to health care for inmates. They are largely undated but were all created in the late 20th century.[13]

Figure 2. Cover of "Orienting Health Providers to the Jail Culture"



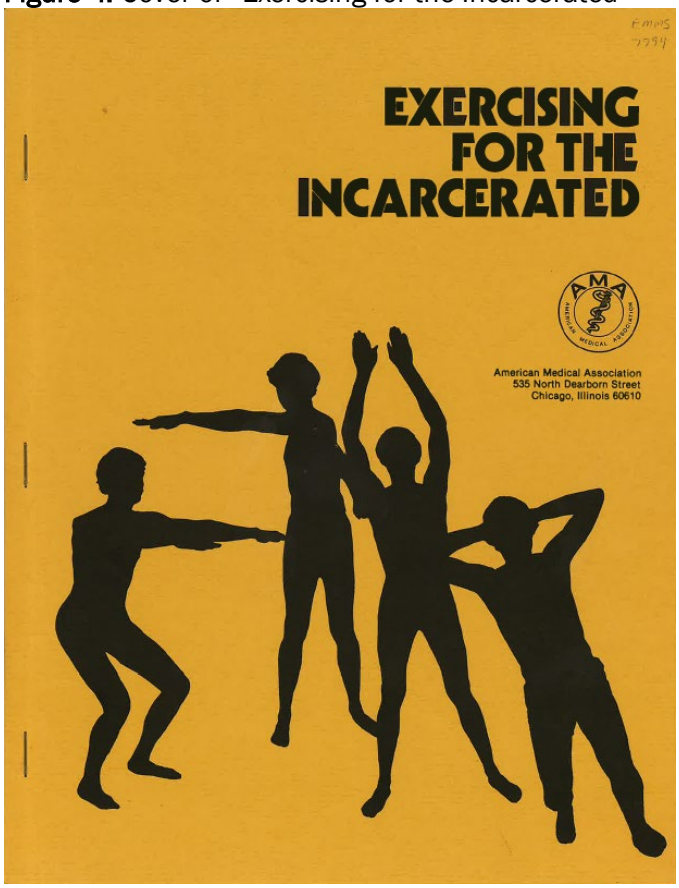
Courtesy of the American Medical Association Archives.[12]

Figure 3. Cover of "Health Care in Jails"



Courtesy of the American Medical Association Archives.[12]

Figure 4. Cover of "Exercising for the Incarcerated"



Courtesy of the American Medical Association Archives.[12]

Figure 5. Cover of "Guide for the Care and Treatment of Chemically Dependent Inmates"

Courtesy of the American Medical Association Archives.[12]

Before 1980, this work had begun to bear fruit. The American Correctional Association and National Sheriffs' Association incorporated the medical standards proposed by the AMA into "their general standards for correctional institutions," and, in overseeing a lawsuit against the Los Angeles County jail for insufficient medical care by inmates, the presiding judge asked the AMA's survey team to investigate using its newly created standards as criteria.[7]

Expansion

"Reasonably satisfied" with the standards it had created in jails, the AMA in 1978 turned its focus on prisons and juvenile institutions, where the standards were field-tested and modified as necessary. Additional specifications for mental health were studied and incorporated as well.[7] In 1982, with funding from the Robert Wood Johnson Foundation, the program was subsumed under a larger advisory body, with the AMA as one participant among many.[12] It evolved into the National Commission on Correctional Health Care, which is still active to this day.[12]

After it relinquished control of the program, the AMA occasionally waded into the discussion of health services for people who are incarcerated. Since 2016, the House of Delegates has been refining and modifying its policy on "Health Care While Incarcerated." Some of the measures advocated for include programs and training to address distinct health service needs of women and girls who are incarcerated and state Medicaid agencies' acceptance and processing of Medicaid applications from adults and children who are incarcerated.[14] Most recently, in 2023, the House of Delegates voted to collaborate with relevant parties to advocate for quality care and oversight of care for people who are incarcerated by ensuring that staff and administrators meet the same standards as those in community-based health care with similar roles.[15]

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