

Virtual Mentor

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FROM THE EDITOR

Guaranteed Access, Not Guaranteed Quality

The impetus for this month's theme issue—Caring for the Incarcerated Patient—was the report of a yearlong investigation of Prison Health Services, the nation's largest for-profit provider of health care to prison inmates, conducted by the *New York Times* in 2005. The findings, unveiled in a series entitled "Harsh Medicine," were appalling: sporadic medication for the mentally ill and neglect of suicidal juveniles were just two examples of medical malfeasance the study revealed [1].

On a larger scale, the series highlighted the disparities in the amount of medical attention given prisoners and free citizens and introduced the notion of health care based on merit. That is, do inmates convicted of murder and rape *deserve* the same quality of care as law-abiding individuals? Physicians and health care workers are taught that the well-being of the patient is their highest priority. And, while few would claim that outright neglect of prisoners' health is a good thing, the quality of care prisoners actually get lies somewhere between the extremes of best available and manifestly poor.

In researching this topic I spoke to a number of prison doctors, many of whom insisted that treating the prison population *was* different: distrust, suspicion, and deception on the part of both parties are common. Owen Murray discusses a case in which an inmate lobbies for access to a wheelchair despite his ability to walk unassisted. Though this case could be dismissed as simple manipulation, the patient's reason for "needing" the wheelchair—protection against sexual assault—is reasonable. How does a physician in this circumstance allocate limited resources responsibly while tending to the safety of his patient?

In another clinical case commentary, Jeffrey Metzner discusses a mentally ill and potentially dangerous patient who refuses transfer to a segregation unit (i.e., solitary confinement) even though he is medically noncompliant, and prison officials think he may be a threat to others. The health law section continues this theme with Lee Black's review of judicial decisions that have restricted prisoners' individual liberty interest in refusing medical treatment for severe mental illness.

The fact that prison inmates are one of the few sectors of American society *assured* medical care doesn't necessarily mean that they are receiving anywhere near the same quality of care that the general public does. In an op-ed article Nancy Dubler describes the gap between guaranteed health care and quality of care. In a similar vein, Joseph Paris explores the legal, ethical, and social reasons why prisoners

deserve health care, and E. Bernadette McKinney relates the internal and external challenges prison physicians face in attempting to deliver that care.

In October 2007, the *Journal of Correctional Health Care* published a study that investigated levels of empathy among physicians who worked in correctional settings and noncorrectional settings. Ellena Bennett and Jamie Hirsch discuss the methodology and pitfalls of this article and what the findings may reveal about how prison-care physicians relate to their patients. Indeed, medical students are increasingly taught to be compassionate towards marginalized populations, among which the incarcerated may be considered; in a medical narrative article Julie Dombrowski relates her personal experience of interacting and teaching inmates in a women's prison.

One thing is certain: when peering into the prison population, one sees a greatly skewed microcosm of the U.S. population, especially from a disease perspective. HIV, hepatitis C, mental illness, and drug abuse are just a few of the afflictions that are all too common behind bars. The significance of this disease burden leads to larger considerations, such as the prevalence of sexual abuse, the need for organ transplants, and the cost and availability of medications behind bars—all topics we have explored in this issue. Robert Fullilove, in an illuminating policy forum article, informs us that the rate of HIV infection behind bars is three times the rate in the general population, and discusses whether distributing condoms to inmates—when sexual activity between inmates is expressly illegal—would be an effective way to try to slow down the spread of this disease. Comparative statistics for hepatitis C seem as imbalanced as HIV rates. In the clinical pearl, Howard Worman cites the prevalence of chronic hepatitis C in prisons at 12 to 35 percent, versus 1.2 percent in the general population, and offers screening, diagnosing, and treatment suggestions to help stem this growing problem. He also discusses the consequence of untreated hepatitis C and of end-stage liver disease, for which the only “cure” is a liver transplant.

In spring 2007, Democratic Senator Ralph Anderson proposed two bills in the South Carolina legislature: One would release prisoners 60 days early for donating bone marrow; the other would give good-behavior credit of up to 180 days to “any inmate who performs a particularly meritorious or humanitarian act,” which, according to Anderson, would include live kidney donation [2]. While these bills never moved forward, and ethicists and physicians barely took them seriously, the mere suggestion raised questions about organs both given to and taken from prisoners. In a clinical case commentary Andrew Cameron and his colleagues describe the roles of a physician and the United Network for Organ Sharing (UNOS), in determining, first, who is placed on the organ transplant waiting list and how priority for receiving an organ is judged, once one is on the list.

The more I researched the ethical issues in prison health care, the more intricate and entangled each became. I found myself poring through old legislation, legal documents, and even the U.S. Constitution, attempting to grasp exactly what health

care prisoners were entitled to. Indeed, a prison physician's actions are often dictated by someone with greater authority: prison officials, judges, or state and even federal governments. It was a challenge to suss out when, if ever, a physician could make an autonomous professional decision about the treatment of an inmate. The cases and essays we present here attempt to convey the complexity of caring for the incarcerated patient and to bring to light injustices and statistical imbalances seen within the prison health care system. As always, we welcome your comments and questions at virtualmentor@ama-assn.org.

References

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