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Caring for the Incarcerated Patient

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# Virtual Mentor

American Medical Association Journal of Ethics  
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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](mailto:virtualmentor@ama-assn.org).

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# Virtual Mentor

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## CLINICAL CASE

### Assessing Demand for Wheelchair Use

Owen J. Murray, DO, MBA

Mr. Franklin has been incarcerated for more than 5 years and underwent knee surgery a year ago. During his recovery he was provided with a wheelchair. After physical therapy he was able to walk on his own. When Dr. Wilson told the physical therapy technician to take the wheelchair back, Mr. Franklin blatantly refused to walk. During several follow-up attempts to get Mr. Franklin to walk on his own, he moaned and dragged himself around until he was allowed to get back into the chair.

On his next visit to Dr. Wilson, Mr. Franklin confided that having the wheelchair lowered his chance of being sexually assaulted, expressing relief that “everyone just leaves me alone.” Dr. Wilson sympathized with Mr. Franklin but knew that there were others who truly needed wheelchairs, which were in limited supply, and that spending his prison time in a wheelchair was not the best solution to Mr. Franklin’s fears.

### Commentary

Mr. Franklin is the infrequently encountered “patient” who tests the limits of prison medical and security practices and boundaries. These prisoners usually describe a long-standing but undocumented lower extremity neuromuscular condition, which required the use of a wheelchair while they were living in the free world. The etiology of the neuromuscular pathology is usually an antecedent stroke or spinal degenerative condition. Some patients, like Mr. Franklin, have been injured or have had back or lower extremity surgery while incarcerated and require temporary use of a wheelchair. At times, getting these inmates to return to the general ambulatory population can be a challenge, as we see in this case.

Upon intake into the prison system all convicted offenders give a complete medical history and receive a physical examination. Those in wheelchairs are assessed to determine what their true needs for ambulation assistance are. Wheelchairs are provided as medically necessary, but it is recognized that they pose security and safety risks. Most inmates who make this request can clearly demonstrate a need, but among a small group, the patient’s history and physical examination are less clear in determining the need.

When a prisoner comes from a county jail with a wheelchair and scant medical information, most medical personnel are reluctant to disallow the wheelchair before they take a complete history and perform a physical exam and before the patient has

been seen by a neurologist or other appropriate specialist. After the prison intake process, 30-90 days in most states, the inmate is classified and sent to his or her unit of assignment (UOA). If, during this time, the prisoner has established with both medical and security that he requires the use of a wheelchair, whether legitimately or not, he is assigned to a facility that meets ADA (Americans with Disabilities Act) requirements and is usually housed with other wheelchair-bound prisoners. Many seek out this environment because conditions are less predatory than those in the general population and because other conveniences related to meals and movement within the facility are provided.

Once at the UOA, the prisoner is evaluated for wheelchair need and sent for a physical therapy evaluation to ascertain baseline function. It is during this routine work-up and evaluation process that those feigning need usually become uncooperative with both medical and security staff. They refuse their specialist and imaging evaluations and make every effort to avoid physical therapy or participate minimally. They typically offer a multitude of reasons why they do not want anything further done and why they are content with their nonambulatory status.

With few exceptions health care treatment cannot be forced upon an offender. The exceptions are related to special clinical situations that involve acute mental illness and infectious disease (e.g., TB) treatment. Beyond that, prisoners have the right to consent to and refuse medical treatment. Consistent with most free-world practices, a signed refusal is obtained when an inmate declines care. Upon notification that someone is refusing further evaluation or is poorly participating in physical therapy, the medical staff should have the patient brought to the medical clinic to attempt to elaborate the real reasons behind the patient's uncooperativeness. Often, as in the case of Mr. Franklin, a fear for personal safety is at the heart of the behavior. Just as frequently, however, no valid reason is given, and it is clear that the patient is attempting to manipulate security and his environment. It is in these cases that the challenge of what to do really begins.

Every state prison system has policy and procedure that deal with threats against and intimidation of prisoners. Using a wheelchair to avoid harm is not the answer to threats from other prisoners. The medical director should discuss Mr. Franklin's case and concerns with the warden, and a full investigation of those complaints should be completed by security and reported to facility classification, the group responsible for assigning inmates to their units. If the classification staff believes the concerns are valid, they can move Mr. Franklin to either a different housing unit or facility to protect his safety. In parallel to security's efforts, the medical department needs to insure that allegations of physical abuse have been thoroughly investigated. Mr. Franklin should also be referred to the facility's mental health staff for evaluation. The transition from wheelchair use to being ambulatory is usually not difficult, once the personal safety concerns have been addressed. Most of those who feign need for wheelchairs have been walking in their cells at night or when not being watched and have adequate muscle strength to resume normal ambulation.

The preferred treatment and resolution of Mr. Franklin's case is reasonably straightforward and would be agreed to by all correctional health care professionals. But the subset of inmates who are attempting to manipulate the system requires a significantly different management approach. In these situations, the resolution takes a consistent, coordinated effort between medical and security personnel. The first and most important step in the process is to establish that the patient does not have any condition or pathology that demands use of a wheelchair. This typically involves subspecialty consultations and imaging studies. Physical therapy assessments and consultation with a physiatrist, ideally one accustomed to seeing correctional patients, are essential.

Once it is established that the patient can walk, the medical director of the facility must discuss these findings with the patient. Invariably, the patient asserts tenaciously that he cannot walk and will not walk and that any attempt on the part of the medical department to remove the wheelchair will result in the immediate filing of a lawsuit. (Convicted offenders have the Eighth Amendment constitutional right to be free from cruel and unusual punishment, and administration's deliberate indifference to their serious medical condition is a definite violation of that right. Not providing or removing a wheelchair from a prisoner who truly requires one would be a glaring example of deliberate indifference.) The threat of litigation, uncommon in general medical practice is, however, the daily reality in correctional medicine. Prison medical staff grow comfortable over time with this prisoner defense as they realize that the threats grossly exceed actual filings.

The medical director should create a multidisciplinary plan for Mr. Franklin's transition from the wheelchair despite his objections. This plan should include input from the physical therapy, medical, nursing, and mental health staffs, and from security. Ultimately it is the security classification system's decision where to house Mr. Franklin. If there is enough ADA space, they may decide to allow him to continue using the wheelchair, but, if they do so, Mr. Franklin must acknowledge, and the medical record must reflect, that remaining in the wheelchair is not in the patient's medical best interest. In most state prison systems, ADA space is at a premium and is reserved for those with true need. Moreover, allowing an inmate to have a wheelchair when it is not clinically necessary sets a precedent that encourages others to do the same.

Given the concerted effort by all disciplines to wean prisoners from unnecessary wheelchair use and return them to ambulatory housing, most prisoners do resume walking. But there is the occasional inmate who does not walk and who, during attempts to remove the chair, lies on the floor and crawls and creates a high level of drama for security and the other offenders. Managing these individuals demands even more time and effort. Consultation with the correctional department's legal office is usually standard practice in these cases. Cameras, hidden or obvious, may be installed in the cell or dorm to monitor and document movements. Most of these inmates invariably walk when they believe they are not being watched. All necessary



physical therapy and medical treatments should continue to be offered, with all refusals of treatment being documented in the medical record.

Ultimately, a decision must be made regarding continuation of the wheelchair. If it is taken away, accommodations can be made to move the prisoner closer to the chow hall or to provide meals in his housing area. Security staff should be made aware of the unique situation and given guidance on how to respond. Given time and the commitment of all personnel, even this outlier group will eventually walk.

Correctional medicine is rapidly becoming its own medical specialty, requiring primary care expertise, creative collaborative management, and leadership skills. Mr. Franklin and patients like him are a challenge to any prison or jail system. It is the creation of a coordinated consistent multidisciplinary approach to resolving this and other unique correctional issues that eventually leads to the best outcomes for the prisoner and the system.

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# Virtual Mentor

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## CLINICAL CASE

### **Should a Prisoner Be Placed on the Organ Transplant Waiting List?**

Commentary by Andrew M. Cameron, MD, PhD, Aruna K. Subramanian, MD, Mark S. Sulkowski, MD, David L. Thomas, MD, MPH, and Kenrad E. Nelson, MD

Mr. Reading is a 45-year-old inmate serving a life sentence for double homicide. A former alcoholic and drug addict, Mr. Reading suffers from hepatitis C and symptoms of end-stage liver disease. Dr. Reardon was asked by the prison staff to evaluate Mr. Reading's eligibility for a liver transplant. Once Dr. Reardon makes arrangements to add Mr. Reading's name to the United Network for Organ Sharing (UNOS) list of those awaiting transplants, UNOS will consider only his medical need and no other factors. Before giving his "OK," Dr. Reardon wants to consider the likelihood that Mr. Reading will comply with follow-up treatment and how likely is it that he will remain drug- and alcohol-free for the rest of his life. Dr. Reardon knows that if Mr. Reading is eventually granted a transplant, his medications will be regulated by the prison staff until he dies and that all illegal drugs and alcohol are banned behind bars. In this sense, Mr. Reading seems like an excellent candidate.

In his work outside of the prison, Dr. Reardon treats several patients who will soon need to be added to the UNOS list; all of them have families and strong support networks despite low family incomes. Knowing that his assessment will have a significant impact on who receives available organs, Dr. Reardon is torn about whom to recommend for placement on the UNOS transplant list.

### **Commentary**

The provocative story of Mr. Reading, an alcoholic and drug addict incarcerated for murder who will die without a liver transplant, asks us to consider how society should allocate its limited resources. To balance the issues raised by this case one might begin by reviewing how organs are currently allocated in our country.

In 1984 Congress passed the National Organ Transplant Act (NOTA) which assigned the task of equitable organ distribution throughout the United States to the private, nonprofit organization known as UNOS (the United Network for Organ Sharing) [1]. Over the years, via vigorous public discourse and careful analysis of outcomes, UNOS has developed an individual policy for each organ that reflects the unique medical considerations for that particular type of transplant. Since dialysis can prolong the life of those with renal failure, candidates for a kidney transplant can afford to wait; thus one's place on the wait list is predicated on the length of time one has been on the list. This system is fairness-based, in that each candidate is treated equally. For liver transplantation, the decision was made to prioritize patients based

on their medical status and, hence, urgency of their need. This justice-based system stands in contrast to the kidney allocation procedures, which are based on waiting time and a strict notion of fairness.

To identify the neediest patients for prioritization in liver transplantation, UNOS adopted the MELD (Model for End-stage Liver Disease) algorithm in 2002. The MELD formula assigns a score from 6 to 40 that represents the patient's medical status based on three laboratory values: total bilirubin, INR (international normalized ratio), and serum creatinine. Researchers at the Mayo Clinic developed this score to more accurately predict 3-month mortality rates for a heterogeneous group of liver failure patients [2]. The MELD score is objective, reproducible, and based solely on laboratory data. It reliably predicts who will die without a liver transplant and is currently the dominant measure used nationally to distribute liver grafts.

There is no specific UNOS requirement that consideration be given to a candidate's ability to participate in posttransplant care, how one came to have end-stage liver disease, or to a candidate's societal worth and contributions (or conversely societal debt and crimes). Thus Dr. Reardon should disregard the etiology of Mr. Reading's liver failure (hepatitis C is currently the most common indication for liver transplant, alcohol is second, both together rank third) and calculate his MELD score. Mr. Reading's ability to comply with medical care after transplant might be deemed a potential positive outcome predictor, and his incarceration should not be a factor. It's strictly sickest first. If Mr. Reading were predicted to die before other patients who are also waiting for a liver donation, he would be given preference over the doctor's other patients. Asking Dr. Reardon to balance the competing nonmedical interests of Mr. Reading and other patients is inappropriate; UNOS is charged with such determinations. The doctor should aggressively advocate for adding Mr. Reading to the UNOS list with the guiding mantra being "sickest first."

A case with circumstances similar to those described for Mr. Reading occurred in California in 2002. A 31-year-old prison inmate with congestive heart failure was admitted to the Stanford University Medical Center in need of a heart transplant. He had been twice convicted of armed robbery and was incarcerated at the time, serving a lengthy sentence. This man became the first prisoner to receive a heart transplant, and a storm of protest arose following the procedure [3]. The intuitive response of most was that felons have violated the rules of society and ought to be punished, not rewarded with society's most precious assets. There was a sense of outrage over the inherent injustice of awarding high-quality, costly care to a criminal at public expense when millions of law-abiding citizens remained uninsured and unable to afford similar care.

The transplant community may well wonder whether voluntary donation rates would drop if organs were routinely allocated to recipients that the public objected to so fundamentally. On the other side of the debate, however, supporters of allowing prisoners to receive transplants point out that society is morally obliged to provide those it has placed in prison with food, shelter, safety, and medical care and that

deprivation of those has been judged by the United States Supreme Court to be a violation of the constitutional protection against cruel and unusual punishment [4]. Most believe further that prison is ideally designed to rehabilitate and reintroduce wayward citizens to society and that needed medical care should be considered part of the investment in their return.

UNOS has published a position paper entitled “Regarding Convicted Criminals and Transplant Evaluation” which states that excluding those convicted of crimes from receiving medical treatment, including organ transplants, is illegitimate [5]. The paper notes that convicted criminals are sentenced by the judicial system only to a specific punishment, i.e., incarceration, fines, or probation, not to additional punishment such as inability to be considered for medical services. Their paper reasons that most criminals are not sentenced to death but are expected to return to society and be deemed worthy of being treated like others. Thus justice dictates that a person’s status as a prisoner should not preclude him from consideration for a transplant. Societies might even be judged by the degree of humanity and mercy they show their most vulnerable members.

Mr. Reading should therefore be given equal consideration by the physician for a liver transplant based on his medical need.

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**Related in VM**

[National Organ Allocation Policy: The Final Rule](#), September 2005

[Should Alcoholics Be Deprioritized for Liver Transplantation?](#) September 2005

[The “Slip”](#), September 2005

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# Virtual Mentor

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## CLINICAL CASE

### Correctional Mental Health

Commentary by Jeffrey L. Metzner, MD

Mr. Sampson is incarcerated in a state prison and has been to see Dr. Lee several times. He has a longstanding history of psychiatric illness that includes self-injury, repeated suicide attempts, sudden violent outbursts resulting in the hospitalization of other inmates, and psychotic symptoms such as delusional beliefs. Dr. Lee has tried her best to manage his illness with a combination of antipsychotic medications, but treatment has proved difficult due to spotty compliance. Mr. Sampson has taken his medications intermittently and has recently missed clinic appointments because of his current confinement in a disciplinary housing unit.

The prison administrators are putting pressure on Dr. Lee to move Mr. Sampson to the inpatient mental health facility, which Mr. Sampson strenuously objects to, claiming that he will “really lose it in there.” He says that his compliance problems are due to his being in solitary confinement. Dr. Lee knows that this is only partially true; she believes that moving him, while directly against his wishes, would minimize potential harm to other prisoners and please the correctional officers.

### Commentary

Both case law and national guidelines on correctional health care provide clear instruction to the prison physician concerning standard of care questions. The 1976 case *Estelle v. Gamble* clearly established inmates’ constitutional right to medical care [1], deciding that “deliberate indifference” to the serious medical needs of prisoners constituted unnecessary and wanton infliction of pain, which violated the Eighth Amendment’s protection against cruel and unusual punishment. In *Bowring v. Godwin*, a federal court of appeals found “no underlying distinction from the right to medical care for physical ills and its psychological or psychiatric counterpart” [2, 3]. In other words, this constitutional right to medical treatment also includes psychiatric treatment for inmates with serious mental illness.

The National Commission on Correctional Health Care (NCCCHC) [4]—which evolved from an American Medical Association project during the late 1970s—and the American Psychiatric Association (APA) [5] have published standards and guidelines pertinent to both the structure of a correctional health care system and the nature of the treatment to be provided. The APA guidelines for psychiatric services in jails and prisons addressed quality of care concerns by stating “the fundamental policy goal for correctional mental health care is to provide the same level of mental health services to each patient in the criminal justice process that *should* [emphasis

added] be available in the community” [5]. This goal recognizes that the level of mental health care offered in the community is often inadequate due to lack of funding.

From a clinical perspective, the treatment questions in this case are easily answered. This inmate has a serious mental disorder that is associated with psychotic features. His active psychotic symptoms are probably due both to his medication nonadherence and his current stay in isolation. He needs a diagnostic assessment followed by appropriate treatment in a therapeutic environment that should include the use of antipsychotic medication, education concerning the nature of his mental illness and his treatment needs, and therapy designed to promote recovery. Based on the information in the brief case description, such an environment will most likely be the correctional institution’s inpatient mental health facility.

Like free citizens in the community, inmates can be psychiatrically hospitalized involuntarily if they meet certain criteria that generally include a mental disorder that results in danger to self or others or grave disability. The nature and extent of the due process required (e.g., judicial hearing, an administrative hearing that determines whether the criteria for involuntary hospitalization have been met) depends on the jurisdiction. The other clinical concern associated with involuntary hospitalization—the therapeutic alliance between patient and physician—is beyond the scope of this essay.

The fact that Mr. Sampson is in isolation, also known as a segregation unit (i.e., a housing unit in which inmates are generally locked in a cell 23 hours per day for either punitive or administrative reasons) indicates that he has violated prison rules in a way that has resulted in his separation from the general prison population. Based on his history of violent outbursts, it is also likely that his violence is related to his partially treated mental illness, although psychiatric assessment is needed to confirm this hypothesis.

### **Broader Questions for Physicians Who Treat Prisoners**

The more interesting discussion generated by this clinical example involves a couple of other questions. First, what if the prison mental health staff did not have access to inpatient psychiatric hospitalization? Is it ethical for a physician to practice medicine in a setting that does not have adequate health care resources? And further, do locked-down environments (i.e., segregation units) cause mental illness? Should inmates with serious mental illness be placed in such units?

It is uncommon for correctional institutions to have adequate access to inpatient psychiatric care for inmates who need it [3]. But it is nevertheless ethical for physicians to practice in such institutions for various reasons. It gives them the opportunity to provide treatment and mitigate some of the negative impact of insufficient resources. These physicians are also able to advocate for needed improvements in the correctional health care system [6].

Physicians should be aware of the tendency to become “insidiously institutionalized,” to the point that they discard common sense and practice under unreasonable conditions due to institutional and bureaucratic pressures. For example, clinicians frequently evaluate inmates in a setting that does not allow for acceptable sound privacy from other inmates or correctional staff because it is difficult (but not impossible) to obtain office space. The NCCHC and APA guidelines can be valuable tools for the clinician who is trying to obtain necessary resources and conditions because they help to establish the standard of correctional health care.

The impact of segregation units on an inmate’s mental health is a hotly debated topic, especially in the context of litigation. Claims that long-term segregation necessarily causes particular kinds of psychological harm are often described as being scientifically proven and have been published in journals, presented at educational meetings, and verbalized in testimony [7]. In my opinion, most of these claims significantly overstate what is known about the psychological impact of long-term segregated confinement, especially on inmates who have no pre-existing mental illness.

On the other hand, there is consensus among clinicians that inmates who *have* serious mental illness should not be placed in extreme isolation because many of these inmates’ psychiatric conditions will not improve or will deteriorate [8]. In other words, many inmates with serious mental illnesses are harmed when placed in such settings [9]. Thus, these inmates are usually excluded from admission to extreme isolation housing, unless the institution has a specialized mental health program in place that is similar to residential treatment programs for general population inmates. These units, also known as intermediate care, supportive living, special needs, or psychiatric services units, or protective environments, are designed for inmates who have had significant difficulty functioning in the general population within the prison due to symptoms related to their mental disorders. They offer enhanced mental health treatment for such inmates [10]. A more extensive discussion of this controversy can be found elsewhere [7].

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#### **Related in VM**

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# Virtual Mentor

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## JOURNAL DISCUSSION

### Physician Empathy in Correctional Facilities: Still in Need of Analysis

Ellena Bennett and Jamie S. Hirsch

**Dhawan N, Steinbach AB, Halpern J. Physician empathy and compassion for inmate-patients in the correctional health care setting. *Journal of Correctional Health Care*. 2007;13(4):257-267.**

Studies of physician empathy have shown that it contributes to patient satisfaction and the acquisition of a comprehensive history [1]. Dhawan, Steinbach, and Halpern were the first to analyze this quality in physicians working in a correctional environment. The study was designed to investigate the degree to which physicians may have difficulty empathizing or connecting with their inmate-patients, and the report of their findings was published in the October 2007 *Journal of Correctional Health Care* [2].

As an index of empathy, the authors began with the Interpersonal Reactivity Index (IRI), a 28- question survey developed in 1980 by Mark Davis [3]. After interviews with 6 correctional physicians and 12 inmates, the researchers “modified the IRI to be meaningful to physicians in correctional facilities and incorporated new items useful for measuring important components of empathy” [4]. In this process, the number of IRI items was reduced to 13 (for all survey recipients and with 3 more items for physicians working in correctional facilities), and they were altered drastically, a point we will comment on in our discussion section. Then the researchers employed the “cognitive and affective components of empathy” as delineated by Halpern and Weinstein—emotional resonance, intrinsic curiosity, and toleration of emotional ambivalence [5]—and added compassion as a fourth element. One or more of these 4 elements was assigned to 14 of the 16 items in the adapted questionnaire, leaving 2 items with no designated components of empathy.

The questionnaire was sent to physicians at 38 correctional facilities (including state prisons, county jails, and hospital jail wards) and to noncorrectional physicians who practiced in facilities with the same area codes as those of the correctional facilities. The questionnaire was sent to 110 correctional physicians, of whom 42 responded, and to 300 noncorrectional physicians, of whom 36 responded. The study participants were divided into three groups: physicians working exclusively in correctional facilities (onlyC); those in only noncorrectional facilities (nonC); and those working in both settings (inclC).

Demographically, the authors found two statistically significant differences. The nonC group included a larger number of primary care physicians than the inclC group, and members of the nonC group had been in practice significantly longer than those in the onlyC group [6].

Turning to the measures of empathy, statistical significance was found between the inclC and nonC groups in only three questions. The inclC scored higher (more empathic) on question 1—“My experience working with this patient population has been quite rewarding”; and the nonC group scored higher on question 7—“When I am upset at a patient, I usually try to ‘put myself in his or her shoes’ for a while”—and question 9—“I tend to think about my patients as individuals who are suffering from many problems besides medical ailments.” Comparing onlyC versus nonC, the authors found four significant differences. The onlyC scored higher (as the inclCs had) in question 1. The nonC scored higher on question 3—“I sometimes find it difficult to see things from my patient’s point of view”; question 8—“I can literally picture the lives of my patients when listening to them”; and question 11—“I am often quite touched by things that I see happen in the health care setting I work at.”

The authors assert that, because the study population was small, only large differences could be measured, so those that did show up “warrant particular analysis” [7]. The authors point out that no significant differences were found in answers to 10 questions.

Dhawan et al. concede that both groups of physicians appear empathic, overall, but vary on the components of empathy they employ. Specifically, correctional physicians appear to use emotional resonance and intrinsic curiosity less than noncorrectional physicians. This may be, as the authors suggest, due to a reluctance to “become emotionally involved with their patients” [8]. Perhaps then, Dhawan and colleagues posit, these physicians are not applying specific components of empathy in relating with their patients, a situation that should be corrected.

### **Errors and Ambiguities**

Prior to a discussion of the merits of this paper, we think it necessary to identify several problems with the study design and execution.

1. The authors initially noted that the questionnaire for noncorrectional physicians was distributed to primary care, internal medicine, family medicine, and emergency medicine physicians. Later, in discussing the sample of nonC and correctional care physicians to whom the questionnaire was sent, they state that the questionnaires went to “a broad sampling of physicians who work in family medicine, internal medicine, psychiatry, and primary care” [6]. This discrepancy is not clarified in the demographics table (table 3), which describes practice types only as primary care, psychiatric, and other [9].
2. The authors sent questionnaires to noncorrectional physicians who worked in the same area codes as the correctional institutions. Perhaps, as is often done, the authors intended to match for variables such as socioeconomic factors

among the physicians. Yet, matching by area codes—which typically cover large geographic areas and diverse populations—rather than zip codes is puzzling.

3. Based on demographic information, the authors assert “ample randomization” between groups, but the differences among the specialties of the physicians may have had an effect on empathic concerns, an issue that the authors ignore. Moreover, although the article text states that there is statistical difference between the length of time in medical practice in the onlyC versus nonC groups, the data presented in the table contradicts this. The statistically significant difference lies between inclC and nonC and in the “years physician has been practicing medicine at current site” [10]. NonC physicians had spent considerably more time at their current site than inclC physicians had, a factor which could confound empathy data, especially since the authors themselves note that correctional physicians have a “developmental course” and that empathy emerges and grows over time. In the discussion section of their paper, Dhawan et al. comment that physicians develop a greater ability to empathize with their inmate-patients after many years, so, if trying to compare the empathy of correctional physicians to that of noncorrectional physicians, it would have been far more helpful for them to have compared groups with equal or similar time spent at their sites of practice.
4. Though not described in the introduction, the authors say that a point of interest in their study was physician satisfaction with work and note that correctional physicians scored higher on the question, “My experience working with this patient population has been quite rewarding” [11]. But, as they go on to state, this question may reflect satisfaction at taking on medical challenges rather than empathy (and indeed, none of the aforementioned characteristics of empathy was ascribed to this question).
5. In several instances the text of the article and the data tables contradict each other, and this error, whether authorial or editorial, leaves readers wondering which recorded result is correct. For example, the authors state that question 8, “I can literally picture the lives of my patients when listening to them,” tests all four of Halpern’s components of empathy, yet table 1 of the questionnaire items lists only one component—intrinsic curiosity/interest.

Secondly, the authors write that the inclC scored slightly higher than nonC physicians on question 9, “I tend to think about my patients as individuals who are suffering from many problems besides medical ailments.” Table 4, however, breaks the respondents for this item (question 9) into “Correctional Physicians” and “Noncorrectional Physicians,” so it is impossible to confirm the finding stated in the text. Does “Correctional” in table 4 refer to both inclC and onlyC or just the former? In another example, the answers to question 1 “My experience working with this patient population has been quite rewarding”—differed significantly in both the inclC/ nonC comparison and in the onlyC/nonC comparison. Therefore these data appeared in two places, table 4 and table 6. Not only did the titles and column heads of these

tables disagree (table 4 comparing “Correctional” to “Noncorrectional” physicians and table 6 comparing “Exclusively Correctional” to “Noncorrectional” physicians), but the mean and standard deviations for nonCs’ score to this question were different in table 4 than in table 6 [12].

### **Discussion**

Although conceptually intriguing, the validity of the study’s instrument, design, and implementation are questionable. The low response rate—only 38 percent of correctional physicians and 12 percent of other physicians completed and returned the questionnaire—forces us to wonder about the representativeness of the sample, the selection bias, and the power of the study results. The authors dismiss and rationalize both concerns.

The authors justify using the Interpersonal Reactivity Index “because it contains items suitable for participants in our study and has demonstrated reliability and validity in assessing empathy” [1]. Why did they choose a questionnaire with no specific application to physicians and health care settings to evaluate precisely that? The authors could instead have used a psychometrically proven tool, like the Jefferson Scale for Physician Empathy [13], which has been shown to be empirically successful in assessing this research team’s primary inquiry.

Although the IRI has shown “reliability and validity” in measuring cognitive and emotional aspects of empathy in the general population [14], its efficacy is irrelevant in this specific study because Dhawan et al. drastically altered its original form. They trimmed the questionnaire from 28 questions to 13 (16 for correctional physicians) and modified the wording of many of the questions. Comparing the IRI with the questions in the Dhawan and colleagues’ survey reveals that at least half of the questions in the latter were so altered that their connection to the original IRI is unrecognizable [3].

More perplexing is the use of Halpern’s components of empathy. Davis’s IRI “consists of four seven-item subscales, each of which taps a separate aspect of the global concept ‘empathy’” [3]. Why then change the questions, assign new, unvalidated characteristics of empathy to them, and add an undefined characteristic of empathy called “compassion”? Due to the many ambiguities and severe alteration of the IRI study instrument, it is difficult to determine whether this research team could use it to measure physician empathy effectively.

Although the authors found statistically significant differences between the groups in the answers to some survey questions, the actual discrepancy remains murky. While the mean values may be different, the standard deviations are remarkably wide. With such a small study population, the true nature of the statistical significance cannot be assessed.

The authors say that their purpose was to “examine the specific aspects of empathy that correctional physicians are more or less likely to use in medical practice” [1],

and *not* to conduct a comparative study between correctional and noncorrectional physicians, but every aspect of their study appears to focus solely on the latter task. The data presented are comparisons of the two groups; no data are recorded on intragroup variation in response, which might have better elucidated the components of empathy that correctional physicians use. Rather, we are merely provided with “statistically significant” but practically dubious information on responses that revealed intergroup differences during data analysis.

Although it is important to investigate physicians’ perspectives on empathy in correctional health care settings, physician self-assessment questionnaires simply do not suffice. If the goal is to determine what components of empathy correctional physicians lack, then the empirical research should begin by surveying the inmate-patient population. There are psychometrically validated instruments for evaluating both physician empathy and patients’ perceptions of physician empathy, specifically the Jefferson Scale of Physician Empathy and the Jefferson Scale of Patient Perceptions of Physician Empathy [15] that might help achieve more valuable and informative results.

The importance of this research is not merely investigating empathy generally, but determining if, as Halpern implies, by failing to demonstrate intrinsic curiosity, correctional physicians dehumanize their inmate-patients [5]. By distinguishing and analyzing the correctional physician intersubjectivity through a more developed measurement of Halpern’s “intrinsic curiosity,” a different aspect of correctional physicians’ empathic understanding might be illuminated, leading to a truly humanistic approach to patient care.

The subject of physician empathy in correctional settings is an important area for empirical research and, although we found the design and implementation of this specific study to be less than rigorous, the concept deserves further examination.

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# Virtual Mentor

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## CLINICAL PEARL

### Diagnosis and Treatment of Chronic Hepatitis C in Incarcerated Patients

Howard J. Worman, MD

The prevalence of chronic hepatitis C infection among prison inmates in the United States is between 12 and 35 percent, compared to about 1.3 percent in the nonincarcerated population [1]. The prevalence of end-stage liver disease, likely reflecting the elevated rates of hepatitis C virus infection, is estimated to be three times higher in prison than in the general population [2]. These high rates of disease raise complex questions about the diagnosis and treatment of hepatitis C in incarcerated patients. In a 2003 meeting funded by the Centers for Disease Control (CDC) and National Institutes of Health (NIH), hepatitis C experts failed to reach consensus on optimal approaches to prevention, identification, and treatment of the disease among prisoners [3]. Nevertheless, recognizing several facts about hepatitis C provides a foundation for treatment of incarcerated patients (see table 1).

Table 1. Hepatitis C facts and figures

<ul style="list-style-type: none"><li>• Screening identifies patients who need further medical evaluation.</li><li>• Evaluation requires advanced tests, including liver biopsy in most cases.</li><li>• Treatment is virtually never urgent; most individuals can put off treatment for several years without detrimental consequences.</li><li>• It usually takes decades for cirrhosis to develop in an individual with chronic hepatitis C.</li></ul>	<ul style="list-style-type: none"><li>• Mortality from complications of liver disease is low in individuals with hepatitis C, and most will never develop cirrhosis or end-stage liver disease.</li><li>• Current treatment is effective only about 50 percent of the time.</li><li>• Treatment is expensive, associated with myriad adverse events, and requires regular injections and monitoring.</li></ul>
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### Screening

Screening for serum antibodies against hepatitis C virus using ELISA (Enzyme-Linked ImmunoSorbent Assay) is straightforward and relatively inexpensive. These are the same assays used to screen the blood supply, and they have high sensitivity and specificity rates. Given the prevalence of hepatitis C in incarcerated individuals, the CDC recommends that all inmates be screened at the time of incarceration, but, if that is not possible, it recommends that those with high risk factors, such as intravenous drug use, be tested [1]. Most prison systems, however, do not offer routine screening [3]. Moreover, when offered screening after receiving health



education on hepatitis C, only 8.5 percent of prisoners in one study accepted testing for the infection [4].

### **Further Diagnostic Evaluation**

Further evaluation is necessary in those with serum antibodies against the hepatitis C virus present in their blood. A reverse-transcription-polymerase chain reaction assay to detect viral nucleic acid in serum is generally performed and increases the specificity of diagnosis to essentially 100 percent. Concurrent testing for viral genotype is usually carried out during this period. While the need for liver biopsy in all patients with chronic hepatitis C is debatable, it is generally recommended to assess the grade of inflammation and stage of fibrosis [5, 6]. Molecular diagnostic tests and liver biopsy would place a significant financial burden on prison systems if provided to all incarcerated patients with chronic hepatitis C. These types of evaluations also require the services of medical subspecialists, such as hepatologists and pathologists experienced in liver biopsy interpretation, who are not likely to be part of a system's routine medical staff.

### **Treatment**

Treatment of chronic hepatitis C is virtually never urgent (one rare exception is the presence of cryoglobulinemia with renal insufficiency). Progression of fibrosis is slow, and it generally takes decades for cirrhosis to develop [7, 8]. Restriction of heavy alcohol use in prisons and jails may slow overall progression rates [7]. Mortality from complications of liver disease is low in individuals with chronic hepatitis C, and most will never develop cirrhosis [9]. Hence, the vast majority of infected individuals can wait a few years to start treatment without detrimental consequences.

The current standard therapy for chronic hepatitis C is peginterferon plus ribavirin, which yields a sustained virological response rate defined as undetectable viral nucleic acid in serum 6 months and longer after stopping treatment in approximately 50 percent of treated patients [10]. Treatment responses are lower for patients infected with genotype 1 isolates—the majority in the United States—but better for those with genotype 2 or 3. Treatment is also longer (48 weeks) for genotype 1 than genotypes 2 and 3 (24 weeks). Peginterferon is administered by injection once a week and ribavirin is taken orally twice a day. Peginterferon is expensive and, along with ribavirin, is associated with many adverse events that require relatively frequent blood tests and monitoring by a physician or nurse. Patients with psychiatric disorders, which are not uncommon in the incarcerated population, have increased neuropsychiatric side effects. Further, many incarcerated patients with chronic hepatitis C are co-infected with HIV or the hepatitis B virus, making treatment more complicated. Several new antiviral agents currently in clinical trials will probably be indicated for use along with peginterferon with or without ribavirin [10].

When a patient with chronic hepatitis C develops cirrhosis, treatment is aimed at ameliorating the complications. Ultimately, the only treatment for individuals with end-stage liver disease is transplantation. Costs associated with organ

transplantation, lifelong immunosuppressive therapy, and medical follow-up would decimate the health care budgets of most prison systems [2]. There are also ethical reservations about providing incarcerated individuals with scarce cadaveric organs. Why offer a transplant to a convicted murderer but not an active alcohol abuser? Why transplant a liver into a criminal instead of giving that organ to a child with an inherited liver disease? These complex ethical questions must be resolved by government and society.

### **Concluding Considerations**

Routine screening of incarcerated individuals for hepatitis C virus infection will produce many newly diagnosed patients. Most state prisoners serve an average of 30 months [3], and, given the natural history of chronic hepatitis C, the majority of inmates can probably wait until release from state correctional systems for further evaluation and possible treatment without deleterious consequences. One potential drawback to this plan is that many of these individuals do not have health insurance or ready access to medical care after their release from prison. Another concern is that the small minority of patients with advanced fibrosis and severe inflammation (“early” cirrhosis) may progress to cirrhosis with clinical complications if treatment is delayed a few years.

The moral and ethical questions are much more challenging in the case of long-term or lifelong prison patients with chronic hepatitis C. Society must realize that appropriate evaluation and treatment, including the participation of subspecialty physicians, will be tremendously expensive. No data on cost effectiveness, including figures for decreasing the need for liver transplantation if early medical treatment is initiated in prisons, are available.

Finally, prisons and jails provide a setting to educate high-risk individuals about hepatitis C and other infectious diseases, such as hepatitis B and AIDS, that are prevalent in incarcerated patients. Interventions aimed at curbing drug addiction are also critical in a significant percentage of the incarcerated population.

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### Relevant Web Sites

CDC Infectious Diseases: Hepatitis.

[http://www.cdc.gov/correctionalhealth/ID\\_Hepatitis.htm#C](http://www.cdc.gov/correctionalhealth/ID_Hepatitis.htm#C). Accessed January 9, 2008.

The National Hepatitis C Prison Coalition (Includes Federal Bureau of Prisons and State-by-State Practice Guidelines). <http://www.hcvinprison.org/>. Accessed December 18, 2007.

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## HEALTH LAW

### Forced Medication of Prison Inmates

Lee Black, JD, LLM

It is well established in the law that prison rules and regulations—designed to enforce the goals of the penal system (punishment, retribution, rehabilitation) and to ensure the safety of inmates—will not be scrutinized as closely as those of other government institutions. Inmates have fewer rights than non-incarcerated citizens, their interaction with others is limited, their free speech is curtailed, and, of course, they cannot own firearms. These restrictions exist to protect other inmates, guards, and visitors from bodily injury and to maintain order.

In the 1987 case of *Turner v. Safley* the United States Supreme Court addressed prisoners' access to marriage (declared a fundamental right of citizens in previous cases), between inmates or between an inmate and a non-prisoner and correspondence between inmates (a form of free speech) [1]. In deciding that certain restrictions on correspondence were permissible but that the restriction on marriage was not, the court declared that a regulation impinging on inmates' constitutional rights is "valid if it is reasonably related to legitimate penological interests" [2]. One year later, in *Harper v. State* the courts had occasion to apply this standard when reviewing a prison policy on forced medical treatment for a mentally ill prisoner.

#### *Harper v. State*

Walter Harper was imprisoned in 1976 for robbery and spent time in the prison's mental health unit where he was treated with antipsychotic drugs [3]. After assaulting two nurses while on parole, Harper returned to prison in 1981 to complete the remainder of his original sentence.

In 1982, after initially consenting to treatment that included antipsychotic medication, Harper refused the drugs. The treating physician sought to medicate Harper over his objections, following prison policy which permitted involuntary treatment if the prisoner suffered from a mental disorder and was gravely disabled or posed a likelihood of serious harm to himself, others, or their property. According to this policy, the prisoner was entitled to a hearing before a nontreating psychiatrist, psychologist, and the associate superintendent of the prison. If involuntary treatment was ordered as a result of the hearing, periodic review was also required.

In Harper's case, the prison's procedures were followed prior to his being forcibly given medication. His complaint, however, was that the procedures were not sufficient to protect his constitutional rights. He argued that a court hearing was

required before the involuntary administration of antipsychotics. The Washington Supreme Court agreed with Harper, noting that the treatment was of a “highly intrusive nature” and deserved greater procedural protections than provided in the prison policy. The court stipulated that the state must prove by “‘clear, cogent, and convincing’ evidence that the administration of antipsychotic medication was both necessary and effective for furthering a compelling state interest” [4].

The standard for restricting a prisoner’s rights used by the Washington Supreme Court was much more stringent than that set forth earlier in *Turner*. *Turner* had placed the burden on the *inmate* to prove that the policy was not “reasonably related” to prison interests and goals. According to *Harper*, when a constitutional liberty is at stake, the *government* has the heavy burden of showing that its rule is necessary. Thus, the Washington Supreme Court determined in *Harper* that the right to refuse medication, especially when it has known and potentially permanent side effects, is not diluted upon incarceration.

The state appealed to the United States Supreme Court, arguing that the prison’s policy sufficiently protected Harper’s rights under the *Turner* standard. The Supreme Court accepted the case, addressing two questions: may the state administer antipsychotic drugs involuntarily, and are the protections for the inmate under the prison policy sufficient?

### ***Washington v. Harper***

The U.S. Supreme Court reversed the state court decision, holding that, although individuals have an interest to be free from unwanted medical treatment, a prison environment may reasonably have a different set of rules and rights. If an inmate represents a danger to himself or others in the prison, forced treatment may be a justifiable alternative to risking the consequences of forgoing treatment.

The Supreme Court differed most from the state court with regard to the steps that must be taken before involuntary treatment could begin. It said that the prison hearing policy complied with constitutional mandates, even when a substantial individual liberty interest was taken into account. An individual may be entitled to a judicial hearing before being forced to undergo treatment while a free citizen, but, the Court said, the expertise of prison administrators who know the needs and dangers of the prison environment carries great weight substantially in favor of reduced procedural protections.

The Supreme Court believed that “an inmate’s interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge” [5]. Under the prison’s policy, a psychiatrist and psychologist were both involved in the decision, and Harper was provided with an independent lay advisor who had an understanding of medicine to ensure fairness in the hearing. These were sufficient procedural safeguards, according to the Court.

Some of the Court's reasoning raises questions about the adequacy of the prison's policy. When discussing outside independent experts or judges as decision makers, the majority of the Court argued that a "review of the literature indicates that outside decisionmakers concur with the treating physician's decision to treat a patient involuntarily in most, if not all, cases" [6]. Apparently, if outside experts agree with involuntary treatment decisions most of the time, that is sufficient to deny inmates access to those experts or other decision makers.

Inmates were permitted to have only advisors—not attorneys—assist them during the hearing before the prison panel. According to the dissenting opinion in the case, this advisor was appointed by the prison authorities, raising a question of bias. If the panel and the inmate's advisor were all employed by, or in some way related to, the prison, could the prisoner be assured a fair hearing in a procedure that could result in the loss of a constitutional right?

The Supreme Court's decision in *Harper* reaffirmed its previous opinion in *Turner*. Although the Washington Supreme Court decided that the right to refuse medical treatment, even in the prison context, deserved additional procedural safeguards before being overridden, the U.S. Supreme Court took a broader view of its precedence. *Turner* "applies to all circumstances in which the needs of prison administration implicate constitutional rights" even when the right is fundamental [7]. The prison policy satisfied the Supreme Court's requirements, and it was decided that Harper could be involuntarily medicated without a judicial hearing.

### **Conclusion**

As it stands today the law permits the violation of rights of the incarcerated so long as the prison policy is reasonably related to legitimate penologic interests. This standard is not difficult to satisfy, especially when the prison argues that the policy is necessary for the safety of others in the prison environment.

In the civilian context, involuntary treatment is undertaken only after exhaustive judicial proceedings and internal review that presently may not be permitted in many prisons. For physicians, this means that particular care must be taken when making a recommendation about involuntary medical treatment for inmates because it is likely to be accepted with little opposition.

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## POLICY FORUM

### Condoms in Prison: The Ethical Dilemma

Robert E. Fullilove, EdD

The high rate of HIV infection and AIDS in U.S. prisons has increasingly focused attention on the role that these institutions play as drivers of our domestic epidemic, particularly among communities of color. With black and Latino inmates comprising almost two-thirds of the U.S. state and federal prison population, and with rates of HIV infection for the incarcerated standing at three times the rate in the general population, the question of whether we could advance the nation's HIV prevention agenda by making condoms available to inmates in prison is often posed.

The first question, of course, is how much HIV transmission takes place within the walls of our correctional facilities? If jails and prisons are risk environments for consensual and nonconsensual sexual relations, and if this sexual activity accounts for the high seroprevalence rates “on the inside,” then creating interventions that promote safe sex would ostensibly be a public health priority of the first order. If inmates arrive in prison already infected, then the urgency to introduce condoms into these environments may be misplaced, and the most effective public health intervention might well be to test and treat those who are living with the virus during their period of incarceration. There is significant evidence that prison health care—when appropriately funded and aggressively offered—is as good, and at times better, than what exists in many of the poor communities of color to which most inmates will return. If good prison care is linked to appropriate medical interventions in the community, an ex-prisoner may well have a positive prognosis.

The most important study to date of HIV transmission behind bars was conducted by the Centers for Disease Control and published in the *Morbidity and Mortality Weekly Report (MMWR)* in 2006. In an examination of inmates in Georgia's Department of Corrections, all of whom are tested for HIV when they enter the system, it was possible to recruit a sample of volunteers to be tested again for HIV antibodies to determine whether, among those who entered HIV-negative, seroconversion had occurred during the course of their imprisonment.

Two conclusions might be drawn from the study's findings. First, the rate of infection in this system was high at the point of entry, the result of exposure prior to incarceration. Second, there was evidence that some transmission had, in fact, occurred on the inside, and that much of it was the result of sexual activity among inmates and, it appears, with members of the prison staff [1].



These findings provide what mathematicians describe as an “existence proof,” that is, they provide support for the assertion that HIV-risk activity is present in at least one state prison system, and, quite probably, in other systems of incarceration nationwide.

Identifying conditions for safe sexual encounters is by now a public health no-brainer. HIV prevention interventions must be instituted in both prisons and jails without further delay. Condoms are an obvious element of such interventions, and, given that we have findings from a rigorously conducted study that demonstrate the existence of the problem, we are, as a nation, ethically obligated to act.

Should condom distribution be the primary tool of prevention? I would argue it need not be. We already know that significant numbers of sexually active men are not skilled at using condoms effectively. Thus, providing condoms without the HIV education—including a broad range of topics and risk factors such as unsafe tattooing practices—means that we are not doing our utmost to assure that the distribution results in satisfactory condom use.

Further, there is evidence that in many facilities, condom distribution would cause problems for the inmates who requested them. Sex behind bars may be prevalent in most prisons, but sex between inmates is illegal in almost every state. Thus, requesting a condom might be considered probable cause for investigating whether or not an inmate is engaged in illegal activity. Ex-prisoners have insisted, in informal conversations with me, that accepting a condom might result in reprisals by prison officials who are not always fair in their treatment of the incarcerated population. Accepting a condom, in other words, might cause greater harm than good in some facilities.

Finally, if our prisons are a reservoir for HIV infection and AIDS, then appropriate and aggressive medical interventions are probably a more urgent ethical imperative than distributing condoms. While condom distribution might limit exposure to infection while an individual is incarcerated, the risk that requires more attention is the risk to the community into which infected inmates—who are neither aware of their serostatus nor getting appropriate monitoring and treatment—are released. In this instance, our greater concern is for the members of communities with whom ex-prisoners will interact upon their return. Our primary obligation to “do no harm,” therefore, must begin by offering HIV testing at the time of entry into and prior to release from all jails and prisons and a systematic plan of care that ensures effective treatment in prison and seamless linkage to care upon the inmate’s return to the community.

Distribution of condoms are not the primary ethical obligation we confront as we consider strategies to reduce the burden of high HIV/AIDS rates in jails and prisons. The time when such a strategy might have worked has passed. With large numbers of sick inmates, effective medical interventions are nothing less than a categorical imperative.

## Reference

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# Virtual Mentor

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## MEDICINE AND SOCIETY

### Why Prisoners Deserve Health Care

Joseph E. Paris, PhD, MD

Proponents of the state's being the single payer of medical care reimbursement for U.S. residents often quip that prisoners are assured necessary care while law-abiding citizens are not. They make the argument that such a dichotomy is morally intolerable and that all U.S. residents (citizens and non-citizens alike) should also be assured health care. The challenges of providing health care to all U.S. residents are complex and continue to be debated nationwide. A few states have legislation that approaches universal coverage, but implementation requires political will and an agreement on the part of the public to finance the care of large groups of residents—including noncitizens—with low or moderate incomes.

There are legal, ethical, social, and public health reasons why prisoners, as wards of the state, must be supplied with health care. The legal reasons for providing health care to prisoners were stipulated in the 1976 Supreme Court *Estelle v. Gamble* decision, in which the Court held that deprivation of health care constituted cruel and unusual punishment [1], a violation of the Eighth Amendment to the Constitution. This interpretation created a de facto right to health care for all persons in custody, whether convicted (prisoners) or not (pretrial detainees). The decision also brought forth the concept of "deliberate indifference," a legal definition that prohibits ignoring the plight of prisoners who need care and translates into a mandate to provide all persons in custody with access to medical care and a professional medical opinion. Correctional authorities and health care professionals who infringe this right do so at their peril and may be prosecuted in federal or state courts [1].

Beyond the legal mandate, there are fundamental ethical reasons why prisoners should be given medical care. Free persons may or may not have health insurance, based, at least in part, on their decisions about how to prioritize the use of their money. Some who decide against buying insurance have the option to pay cash for the health services they seek. The very poor, the aged, and the disabled are generally provided with assistance in the form of federal and state Medicare and Medicaid programs. Even the so-called "working poor," loosely defined as those who earn too much to qualify for assistance and too little to afford to pay for health care, have the option to use or borrow cash when they need medical treatment. Moreover, federal law requires that hospitals provide medically necessary emergency health services regardless of a patient's health insurance status or ability to pay.

My point is not that all U.S. residents have the resources they need to cover their medical care; certainly many do not. My point is that prisoners have none of the choices just enumerated. If the correctional institution's staff denied care, the inmate would have no alternatives. In the past two decades, a substantial number of prisons and jails have decreed that prisoners must pay at least part of the bill for their medical services [2]. These policies always include the provision that indigent prisoners will receive medically necessary, urgent care regardless of their financial status. It is evident that society has embraced the concept that, when incarcerated, a person cannot see to his or her own medical needs, and, therefore, society must do so.

Health care is given to prisoners for social reasons too. The vast majority of inmates will return to society within a few years. Proper care helps to preserve their physical function, which makes it possible for ex-inmates reintegrating into society to embark on productive activities and avoid becoming a burden to all. For example, hypertension and diabetes treatment are known to prevent strokes, heart attacks, and other sequelae that would burden society with long-term care of disabled persons. It is in society's best interest that recently released prisoners be free of disabling diseases.

Public health reasons for providing care to prisoners are so strong that many view correctional medicine and public health medicine as essentially two approaches to the same problem [3]. As a class, prisoners include a larger share of risk-taking individuals than a similar sampling of free persons, and statistics show that they have a larger proportion of the health problems associated with risk taking—hepatitis B and C, HIV, TB, and syphilis, to name a few [4-6]. If any of these diseases is to be eradicated, or even contained, it makes sense that public health officers would develop prevention strategies in the prisons and jails, where large numbers of infected subjects reside. Disease prevention education, vaccination where appropriate, and disease surveillance are basic public health tools that can be used in the correctional setting with public health goals in mind.

I have shown that it makes sense from a legal, ethical, social, and public health point of view to provide health care to prisoners, but doing so creates the perceived injustice that those who behave badly are rewarded with free medical care, while those who soldier on working for low pay and resist the temptation to resort to crime are punished by not receiving free care. Why is it, we ask, that the health of prisoners seems more important to the state than the health of other U.S. residents? I have no solution to the apparent paradox. And the inequity does not even stop there. Under U.S. law, prisoners have the right to food, clothing, shelter, and so on. None of these rights applies to free persons.

Prisoners are expensive to maintain. The average prisoner in a southern state institution costs about \$34,000 a year. Of note, about 16 percent of that sum is allocated to health care. Why, then, is this relatively small amount of a prison system's budget a lightning rod? I believe that the public's desire for affordable or

free health insurance as part of a societal package for all is deep-seated and leads us to envy for the prisoner's status, if only because of medical care coverage. Civilized, highly developed countries such as England, Canada, Germany, and the Scandinavian countries have long endowed all their residents with medical care coverage. The fact that the U.S. lags behind riles a number of people, and especially those who understand how universal coverage applies to all U.S. prisoners. This dilemma will persist until health insurance is available to all U.S. residents. Meanwhile, coverage of all U.S. prisoners continues and it is a good thing.

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5. Greifinger, 174-211.
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### MEDICINE AND SOCIETY

#### Hard Time and Health Care: The Squeeze on Medicine Behind Bars

E. Bernadette McKinney, JD, PhD

The physician who treats incarcerated criminals is often in an uncomfortable position. His or her practice is rife with uncertainty and restrictions. What duties—beyond urgent care—do correctional health professionals have to prisoners? Patient and physician do not choose one another, and health care is offered on a take-it-or-leave-it basis. Prisoners' access to care is severely constrained. Physicians must consider all the patients in the system rather than just the one with an immediate need. The prison environment compromises patient autonomy, privacy, confidentiality, and even the ability to avoid harm. Conflicts are inherent in the system. Spending on prisoner health care is unpopular; providing health care to people who have violated society's norms and rules, especially when resources are extremely scarce, invites anger and criticism and sometimes results in inappropriate and unethical compromise. Now, more than ever before, these challenges in caring for prison inmates require that physicians maintain a clear view of their legal and ethical obligations to prisoner-patients.

Why now? The 1976 case of *Estelle v. Gamble* and related U.S. Supreme Court decisions have made it clear that the state is obligated to provide prisoners with necessary care for known, serious medical needs [1]. Failure to do so violates the prisoner's Eighth Amendment right to be free from cruel and unusual punishment, and there are a number of reasons why pressures in prison medical care are increasing. A central reason is cost; health care grows more expensive by the day. New technologies, drugs, and standards of care are driving up costs for everyone. Prison physicians are in the awkward position of trying to keep costs low while observing the civil rights of a nearly voiceless population and fulfilling their own professional obligations.

Exacerbating the ordinary cost pressure is the fact that the people in U.S. prisons and jails— numbering more than 2.2 million [2]—are less healthy than the general population. They are far more likely to have engaged in high-risk behaviors that can result in organ damage, exposure to serious infectious diseases (e.g., HIV, hepatitis C virus, hepatitis B Virus, TB, and MRSA (methicillin-resistant *Staphylococcus aureus*)), and untreated injuries that develop into disabilities [3]. The majority of state prisoners are from low income groups, have less education than the general population, and have lacked routine health care for most of their lives [4]. Furthermore, the prison population ages more rapidly than unincarcerated individuals do [5]. A prisoner is often considered geriatric at age 50-55, because he

or she experiences age-related ailments and disabilities typically observed in much older individuals. The ethnic make-up of the prison population is also a contributing factor. Prison inmates are disproportionately black and Hispanic—groups that are more likely than whites to suffer from chronic diseases like hypertension and diabetes [6]. Finally, due to their premature aging and serious illnesses, many people in prison face death while incarcerated.

### **Social Pressure to Limit Health Care for Prisoners**

For the most part, the public is unsympathetic to the plight of the sick prisoner or to that of the beleaguered physician who is expected to do more with less while being true to professional ideals. Adequate health care for prisoners adds up to an unwanted tax burden for what some view as a luxury for an undeserving group.

Lack of sympathy can turn to outrage at the idea that a prisoner might receive an organ transplant, especially when the need is the consequence of illegal substance abuse or other socially unacceptable behavior. Donor organs are scarce. Critics argue that many law-abiding citizens with organ failure cannot afford the extensive testing required to qualify for placement on a transplant list, much less the large up-front lump sum payment transplant centers require before listing the patient with the United Network for Organ Sharing (UNOS), the group responsible for distributing cadaveric organs that have been donated. These opponents stress that the prisoner who actually receives the transplant is profiting from his crime and potentially gaining a new lease on life, while another, who some consider more worthy, may die for want of a donor organ [7].

Built into this argument is the assumption that a person's moral worth derives from his or her benefit to society. If one takes this way of thinking, the argument is a slippery slope. Reckoning a benefit to society depends on vantage point of the observer/judge. Worth must be measured in concrete terms, be it wealth, beauty, notoriety, heritage, service, talent, might, or some other attribute or set of attributes. One's perceived social worth also depends on the society. UNOS recognized this problem when it adopted its approach to the allocation of organs. Its policy with regard to organs needed for survival (e.g., liver) is to attend to medical need rather than to social factors. Its decision grew out of the much-criticized practices of the so-called god squads, the committees created in the early days of dialysis to decide who would receive dialysis and live and who would die due to kidney failure. Perhaps it is not surprising that the typical beneficiary of god squad deliberation was a married male churchgoer with children [8].

### **Internal Obstacles to Prisoner Health Care**

The tax-paying public and their political representatives are not the only sources of stress for physicians who treat prisoners; pressures also come from within the prison. Prisoners who ask for care—sometimes care that they do not need—strain the system. Drug-seeking behavior is not unusual, malingering occurs. Some prisoners seek health care for no other reason than to break up the monotony of the prison routine. These actions cause many medical professionals to react with suspicion to

every complaint. The suspicion can become so great that the physician begins to assume that all prisoners are exaggerating their discomfort.

Prisoner-patients also make assumptions. They fear that the care they receive will be inadequate, that medical staff and prison officials will deliberately ignore their needs, even to the point of hastening death through medical neglect [9]. Prisoners' assumptions contribute to poor communication which can result in less-effective care.

Prisoners' suspicions and fears can be encouraged and enhanced by correctional personnel whose goals are at odds with the goals of medicine. Correctional personnel have two major sets of duties. First, they set and enforce prison policies by maintaining discipline and security, encouraging rehabilitation, and using the taxpayer's money responsibly. The second duty is to prevent violations of prisoners' civil rights. This function entails protecting prisoners from known dangers, providing access to basic needs including health care, and avoiding discrimination, retaliation, violation of certain privacy rights, and interference with access to the courts. Simply put, the goals of correctional officers are to control prisoners and maintain order while operating within the limits of the law. The easiest way to achieve these goals is to assume a kind of military model of regimentation and hierarchy and to deal with prisoners as a group rather than as individuals with specialized needs. Coercion is a common tool for achieving these ends.

The staff attitude that accompanies the goals of discipline and security may be among the most serious challenges the prison physician faces. Prisoners are often viewed as malicious, manipulative, violent threats to the power structure, a structure that is rigidly maintained through punitive action. Many physicians are better able to identify and have rapport with prison personnel than with the prisoners. After all, the incarcerated have been convicted of wrongful acts. Responding to them as inferiors who deserve less than full attention and care is easy to do. Correctional officers and other prison officials may be inflexible, but they represent the good guys. Like most health care professionals, most correctional personnel are law-abiding citizens who take on the potentially dangerous task of limiting the effects of harmful agents in society. The methods are different from those of the military, yet the roles are still cast as authority figure versus underling or battle warrior versus threatening enemy.

A physician is supposed to see the prisoner as an individual who has personal needs, a right to privacy and confidentiality, and a right to autonomy in health care decision making. Yet security personnel accompany the prisoner to the physician, so that there is no real opportunity to preserve the patient's privacy or confidentiality. Ordinarily, a physician is supposed to advocate for the patient, to prevent harm when possible, and to hold the patient's interests above his or her own. These obligations become difficult due to the opposition from those outside of medicine and the limited freedoms afforded to prisoners. Staff suspicion and animosity toward prisoners have the potential to color each medical encounter.



When the needed health care is an organ transplant or some other procedure that is expensive, the physician must be especially diligent about maintaining perspective. Enduring illness is not part of the prisoner's sentence any more than starvation is, or torture. The law is clear on this point. A physician's professional judgment about what care is medically necessary does not depend on whether the patient is likeable, where he lives, what he has done that has contributed to his need for health care, or whether he is an upstanding member of the community.

Many prison systems have had difficulty coming to grips with these terms of care. But the numbers of prisoners with end-stage organ failure can no longer be ignored. The economic trade-off between supplying the necessary health care and defending and losing Eighth Amendment lawsuits may be tipping in favor of providing the care.

### Notes and References

1. *Estelle v Gamble*, 429 US 97 (1976). The U.S. Supreme Court's language is as follows: "deliberate indifference to serious medical needs." Imbedded in this phrase are two elements that form the test used in subsequent cases to determine whether a prisoner's right to be free from cruel and unusual punishment has been violated. First, the court must determine whether the prisoner's health care need is serious. The easiest way to establish that the need is serious is for a prison physician to officially indicate that the prisoner needs treatment. If there is disagreement based on reasonable medical judgment among prison physicians about the need, this prong of the test is not met. The second part of the test requires the prisoner-plaintiff to show that the individual(s) who denied or interfered with the necessary care did so with awareness of the risk of harm.
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they exhibit an appalling lack of regard for the basic rights and well-being of their victims. In my view, they thereby forfeit any future claim to a heart transplant.” See also, Associated Press. Prisoner gets \$1M heart transplant: should convicts receive hard-to-get organs? Sacramento, CA: January 31, 2002. <http://www.cbsnews.com/stories/2002/01/31/health/main326305.shtml>. Accessed July 17, 2007. The article states, “You have to wonder if a law-abiding, taxpaying citizen drew one last breath while Jailhouse Joe was getting a second wind.” California State Senator Jeff Denham of California proposed a bill that would give Californians the freedom to decide whether they wanted their donated organs to be available to prison inmates. The bill failed despite the emotional force provided by the senator, whose father died while awaiting a liver transplant. Finally, see Lee WV. A new heart, or liver, for a convict. *The Tech*. January 29, 2003. [www-tech.mit.edu/V122/N66/lizteeth66.66c.html](http://www-tech.mit.edu/V122/N66/lizteeth66.66c.html). Accessed July 17, 2007.

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# Virtual Mentor

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## MEDICAL NARRATIVE

### Breaking Down Walls

Julie Dombrowski, MD, MPH

When I first walked onto the prison campus, I was surprised that it looked nothing like the blocks of rooms behind bars so often portrayed in the movies. It more closely resembled a college campus with its large stretches of green between many small buildings. As I approached, I saw a line of women waiting at the snack bar and a few mingling outside the salon next door. An unassuming structure, separate from the others, housed the women on death row. The dormitories were named, ironically, after birds.

The orange jumpsuit was ubiquitous, but a notable minority of women wore blue dresses. These were the pregnant ones, at least a few of whom arrived with each new cohort. I learned from a social worker that many women on parole who become pregnant commit a violation in order to return to the relative safety of the prison where they can obtain free prenatal care, a commentary on both the U.S. health care system and the environment in which these women struggle to survive.

Prisons offer a unique opportunity for connecting with marginalized women. Along with a few of my medical school classmates, I facilitated a series of discussions we called Healthy Transitions. The group was open to women who had just arrived at the prison, even if they had been incarcerated previously. Our aim was to provide an environment that would allow the women to share their stories, learn from each other and from us, and, ultimately, be empowered to lead healthier lives. These were lofty goals. Although I am often doubtful of the long-term effect that health education curricula have, I have no doubt that we succeeded in connecting with the women. In my mind, that was enough to make the endeavor worthwhile.

How could a group of female inmates, most of whom were undereducated, poor, struggling with addiction and mental health problems, and separated from their children connect with a group of female medical students who were possibly overeducated, generally healthy, and usually childless? I still ask myself that question, and to this day I do not know the answer. So I will simply describe what happened.

A group of three or more medical students facilitated each group session attended by about 10 inmates. The participants were, on both sides, racially diverse and often close in age. We always began with introductions and negotiation of the group rules. The rights of confidentiality, being heard, and holding your own opinion were

cornerstones. A mutual agreement was made to withhold assumptions about each other's life experiences.

Each of our sessions centered on a theme—domestic violence, mental illness, parenting, and sexual health. We usually opened with a movie clip to stimulate discussion. Then, as moderators, we listened and occasionally redirected the discussion. We had a confidential question and feedback box which yielded endlessly surprising queries, confessions, self-reflections, apologies, and expressions of gratitude.

My favorite session was always the one on sexual health. During our discussions of anatomy, symptoms of sexually transmitted diseases, and pregnancy, the women were riveted. They were fascinated by the plastic pelvic model we brought with us, and asked questions about everything. These sessions were far more interesting and rewarding than discussions of similar topics I had engaged in with mostly bored and very quiet adolescents in the context of a school-based curriculum.

Our introductory classes began, predictably, with a group of quiet women, eyebrows skeptically raised and arms folded across their chests, watching us closely. The first breakthrough in gaining their trust came when the women learned we weren't getting money or class credit to be there. They thought that strange, and it increased their curiosity. Somewhere along the way, as the women shared their stories, the dynamic changed. Trust grew. It was not a perfect process, of course, and it was uncomfortable at times. On all sides of the table, though, we were gaining knowledge and understanding.

The need inside prison for quality health care, particularly addiction and mental health services, is extraordinary. In the same way that many of our society's problems are crystallized within the walls of the hospital, so too are they inside the walls of a prison. And just as bad decisions can cause people to land in the hospital, so can those choices in conjunction with sociopolitical factors lead a vulnerable woman to a prison.

Julia Dombrowski, MD, MPH, is a fellow in infectious diseases at the University of Washington in Seattle. Her research interests include the epidemiology and prevention of infectious diseases in vulnerable populations. She was the *Virtual Mentor* theme issue editor in May 2004.

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## OP-ED

### Delivering Care in a Non-Health-Care Space

Nancy Neveloff Dubler, LLB

*“The degree of civilization in a society can be judged by entering its prisons.”*  
—Fyodor Mikhailovich Dostoevsky (1821-1881)

If prisons provide a lens to judge our civilization then we, as a society, fail that test. Consider these facts about incarceration in U.S. prisons and jails.

- America imprisons more people per capita than any other society;
- A disproportionate number of those incarcerated are people of color, and almost all are poor;
- The correctional population—those on probation, on parole, in prison, or in jail—was over 7 million in 2004;
- The growth in confined populations over the last two decades reflects sentencing policy, the “war” on drugs, minimum mandatory sentencing, and “three strikes” laws, which can place someone in prison for life without parole for stealing a bicycle, if doing so is a third offense;
- Prisons are the largest mental health institutions in the country;
- The reading and educational level of inmates is far below the national average;
- Care in some prisons is so bad that the correctional health care system for the entire state of California was placed under federal court receivership in 2005 [1].

All of the above demonstrate the reality of prison existence and experience. Yet it is often pointed out that prisoners are the only group in America with a constitutionally protected right to health care. The United States Supreme Court reasoned in 1976 that to confine persons in a prison or jail, which precludes their gaining access to private medical care, and not to provide that care, could, and did, result in precisely the cruel and unusual punishment that the Eighth Amendment of the Constitution was designed to prohibit [2]. Despite this formal protection, medical care in prison is often inadequate, and suffering can still be great. This is especially true for mentally ill inmates who are punished for behaviors that reflect the very nature of their diseases [3].

Here are a few lessons learned from almost three decades of working in prisons and jails.

*To deliver health care in a prison or jail is to deliver care in a “non-health-care” space.* Physicians and other health care professionals are accustomed to controlling the time, place, and conditions under which they meet, examine, diagnose, and care for patients. But in correctional health care services, patients are never alone and never without supervision and rules that govern behaviors. The patient-doctor relationship can become crowded and distorted by the setting and the administration that controls patient movement, behavior, and autonomy.

In correctional settings the medical staff is always negotiating its power with the administration. Can physicians hear an inmate’s complaint that he was raped and not report the act to the authorities? If they report, will their doing so be “leaked” to the inmates, and will fear of retaliation discourage later victims from seeking care? How can the institutional authorities and the medical care providers structure their antithetical goals?

*The goal of medicine is to diagnose, comfort, and cure; the goal of the correction system is to confine and punish.* These are incompatible ends that require incommensurable means.

*Everything hurts more behind bars.* The purpose of confinement is to protect others from the bad behaviors of the prisoner. But segregating an inmate from the outside world focuses his or her attention inward on the feelings and space that comprise the narrow world of the prisoner. If one of the readers of this commentary gets up one morning with a cold, a bit of the sniffles, or some aches and pains, chances are he or she will go on to classes or work. But if work is unsatisfying, if classes have regularly been eliminated by budget cuts, if life is dismal, why not go to the infirmary? Is this malingering? I would argue that it is accommodating reality.

*It is hard to distinguish between a refusal of care and a denial of care in a prison or jail.* Suppose an inmate does not arrive at the infirmary for treatment; was she sent for a court date? Did the guard block her path? Was she punished? Or was she exercising her right to refuse care? It is difficult to know.

Where does this set of lessons leave committed physicians who care about the health and welfare of the incarcerated? My answer would be: working for social reforms. Prisons and jails reflect decisions made by society. Consider the following:

- On any given day in America one in eight black men in their late 20s is incarcerated [4];
- Education has been removed from most correctional systems although it is the only factor that correlates with lower rates of recidivism among those released from prison [5];
- Prisons contain increasing numbers of “graying” inmates who will live out their lives with disease and disability in prison;
- The health of to-be-released inmates is compromised by extremely high rates of STDs and HIV in prison, and many will have no access to medical care after release.

It might be possible to provide decent medical care in correctional settings if the populations were lower; if prisoners were housed closer to their relatives—who could provide contact—rather than at the borders of civilization where prison jobs keep the region economically viable; if the task of prison was primarily rehabilitation rather than punishment; and if men and women used education to improve themselves and their health. But these suppositions are counter-factual.

Prisons reflect the values of society. We cannot make changes in the former without attending to the morality of the latter.

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### Suggested Readings and Resources

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# Virtual Mentor

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