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OP-ED

Delivering Care in a Non-Health-Care Space

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"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 Sates 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.

References

1. For citations for these statements and for a review of the demographics of criminal justice process and sentencing see Gostin LO, Vanchieri C, Pope A, eds. *Ethical Considerations for Research Involving Prisoners*. Washington, DC: Institute of Medicine; 2006.
2. *Estelle v Gamble*, 429 US 97 (1976).
3. United States: Mentally ill mistreated in prison [press release]. New York, NY: Human Rights Watch; October 22, 2003. http://hrw.org/english/docs/2003/10/22/usdom6472.htm. Accessed January 14, 2008.
4. Gostin LO, Vanchieri C, 38.
5. Gostin LO, Vanchieri C, 39.

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