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Corrections — the Best Kept Secret in Medicine

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THE CONCEPT OF "don't do the crime if you can't do the time," or incarceration as punishment for crime, has only recently become the accepted mode of dealing with criminal behavior. Throughout history, society incarcerated criminals only long enough to pass judgment.

The Romans became one of the earliest societies to attempt to develop a system of uniform laws to govern the populace. They plagiarized codes from the conquered Greeks, Etruscans and Byzantines and adapted them to suit the needs of the state. Many of our laws have come down to us from the Romans and other ancient and medieval societies. While the structure of our legal system came from these societies, the punishments routinely meted out to the guilty or those who confessed to guilt after torture thankfully remain in the past.

Punishment for crimes, even those we consider petty today, came swiftly. Justice meant excruciating pain and, usually, a slow and lingering death. The theory behind the brutality used in meting out justice was that witnesses present when the sentence was carried out would be deterred from committing similar crimes. The Romans found much to their dismay that the daily smorgasbord of criminals offered up to the wild animals of the Coliseum for lunch did little to slow criminal activity in their cities. Even the use of criminals as slow burning torches to light city streets failed to stem the tide of crime.

The beginnings of our current system of justice began in Europe during the 11th and 12th centuries with the institution of jury trials and the appointment of magistrates to deal with criminal matters. Organized police forces, jail and prison as they exist today, didn't emerge until the late 18th and early 19th centuries. The workhouse, an innovation of the 17th century for punishment of debtors and petty criminals became the embryonic blueprint for our modern prisons.

The earliest punishments of execution and mutilation gave way to transportation and hard labor. The movement toward rehabilitation began during the Age of Enlightenment at the end of the 18th century. The name *penitentiary* was coined at this time. Prisoners were often isolated and forced to maintain silence so they could dwell upon and repent their sins. This did little to deter crime but did result in prisoners succumbing to insanity or committing suicide.

In the late 19th century, the penal system became more organized. Outrage at conditions led to the separation of adults from children and women from men. Early rehabilitation models were instituted.

Education and counseling along with variable sentences were thought to help mold criminals into upstanding citizens.

The 20th century saw changes in prison architecture and the emergence of large penal institutions - hence the term "big house." Conditions remained for the most part deplorable with each state mandating the type of treatment received by its criminal population. Prisoners were essentially "slaves of the state."

In the 1950s and 1960s, prisoner abuse led to formation of prisoner's rights movements, but until the 1970s the courts pretty much maintained a "hands off" attitude toward corrections or the quality of medical care for inmates.

In 1976, the United States Supreme Court ruled in the case of *Estelle v. Gamble* that prisoners had a right to care for serious medical needs, as well as other rights. Failure to provide care as stated was ruled a violation of the 8th Amendment to the Constitution and considered cruel and unusual punishment.

After *Estelle v. Gamble*, a number of other cases were heard by the courts. These cases further defined the inmate's right to care. In 1995, after a number of frivolous lawsuits brought by inmates for issues such as providing salsa at meals, the Prison Litigation Reform Act was passed, making it more difficult for prisoners to sue.

During the 1970s, the government provided funding to the American Medical Association and other organizations to study conditions and recommend standards of care for prisons and jails nationwide. Out of these beginnings came organizations such as the National Commission on Correctional Health Care, American Correctional Health Services Association and in California, The Institute for Medical Quality which is associated with the California Medical Association. These organizations have worked together to develop national and state standards for the provision of care to inmate patients as well as to develop guidelines for the accreditation of jails and prisons.

According to Department of Justice statistics in the year 2007, local jails handled 13 million admissions. By mid-year there were an estimated 762 per 100,000 residents in American penal institutions.

The days of staffing our jails and prisons with unlicensed, apathetic medical professionals are long over. Many medical professionals have joined the movement and have dedicated their lives to provide quality care to a population that has traditionally received inadequate and substandard care.

Those not involved in correctional medicine may disagree with the need to provide quality medical care to this population but those involved in the delivery of care to incarcerated patients see the benefit to society as a whole.

Prisoners are generally poor and uninsured. They may abuse drugs or alcohol, live a high risk lifestyle and generally are unable or unwilling to obtain care for chronic medical problems.

Once incarcerated, prisoners receive a medical screening; diseases that put the public health at risk, such as tuberculosis, venereal diseases, and HIV, can be identified and treated, slowing their spread. Those with severe mental health conditions can receive appropriate medication and therapy. Once identified, chronic and acute medical conditions can be evaluated and stabilized.

With the closing of the mental health hospitals and a shift to community-based mental health care, the nation's jails and prisons have become a repository for the mentally ill. Psychiatric patients diagnosed and treated while in custody suffer from fewer acute exacerbations and can be transitioned into the community when released. Inmates with chronic medical problems who receive medication and

community referrals on release are less likely to suffer deterioration of their medical condition requiring expensive hospitalization and save taxpayer dollars.

Medical professionals who accept the challenge offered by correctional medicine are rewarded with the opportunity to see and treat conditions not often seen in the middle class community today. Conditions such as tertiary syphilis, active drug resistant tuberculosis, acute tetanus and typhus, as well as orphan diseases, while rare in middle class practice, are not uncommon in corrections.

Those who choose correctional medicine as a career constantly struggle with overcrowding, lack of funds, lack of staff and antiquated facilities while still attempting to provide the standard of care found in the community. While inmate patients often present as manipulative, hostile and have the potential to be extremely volatile and dangerous, caregivers will discover that this population has a great deal to teach us about humanity.

Practicing medicine in a correctional setting is the practice of medicine in its purest form. It is the provision of care without judgment. Those who chose accept the challenge will find a rewarding and fascinating career.

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