16 EXPERT TESTIMONY ON THE QUALITY OF MEDICAL CARE

17 SENATOR ROMERO: On this next panel,

18 this particular panel is going to examine the quality

19 of medical care in our state institutions.

20 On behalf of the Commission on Safety

21 and Abuse in America's Prisons, I am honored to

22 welcome our next trio of panelists; Dr. Joe Goldenson,

23 Dr. Robert Cohen and Director Arthur Wallenstein.

24 Thank you so very much for joining with us.

25 This distinguished panel, the first of

1 three today to address medical and mental healthcare
2 issues, will explore the quality of correctional
3 healthcare. As a state senator from California, I
4 will say that I know firsthand how important the
5 following panels will be. In California, as many of
6 you may know, our correctional healthcare system has
7 been placed under a federal receivership. It's been
8 estimated that one inmate is dying a preventable death
9 every week in California. Federal Judge Thelton
10 Henderson called what we have in California a trained
11 incapacity. We simply cannot improve our own system
12 and is it of our own design? I would hope that the
13 panelists would address this when they speak.
14 However, California is not alone and
15 that is why the following panels are essential, not
16 only to our understanding of inmates' constitutional
17 right to healthcare, but of the responsibilities of
18 prison administrators, but also of the threat to the
19 public health, which is another form of public safety.
20 Our first panel this afternoon to
21 address medical and, later, taking a look at mental
22 health needs, will raise concerns raised by the
23 inadequacies of inmate healthcare and they will
24 address mental health issues and treatment. Together
25 we will explore the prevalence and causes of serious

1 medical care failures and their consequences and our
2 obligation, not only constitutional, but moral
3 obligations to address these problems as a
4 manifestation of abuse.
5 In conclusion, taking into account
6 known best practices, we hope the panelists will take
7 the time to address viable models for improved quality
8 of care.
9 We are joined today by three notable
10 experts in the field. The first, Dr. Robert Cohen was
11 the vice president of the Health and Hospitals
12 Corporation, where he oversaw the healthcare services
13 of New York City's prison units and public hospitals.
14 He has directed the medical services on Riker's Island
15 and acted as an expert consultant and monitor in
16 several prison systems around the country. Dr. Cohen
17 will testify to dramatic failures in providing
18 adequate care to prisoners and the tragic consequences
19 that can result.
20 Additionally, Dr. Joe Goldenson is an
21 expert in infectious disease and public health,
22 serving as an expert monitor in the California state
23 prisons and that is how I have come to know him and
24 greatly respect the work that he has done.
25 In partnership with the San Francisco

1 Department of Public Health, Dr. Goldenson currently
2 directs medical services for the San Francisco County
3 Jail. Dr. Goldenson will speak to significant
4 barriers to quality prison medical care and to the
5 current crisis that California state institutions are
6 facing in providing quality care.
7 I do want to note at this point that
8 Dr. Goldenson was one of the medical experts on the
9 panel that evaluated inmate healthcare in California
10 and his findings, his insight and recommendations were
11 instrumental to the appointment -- to the decision to
12 appoint a federal receiver in California.
13 Our final panelist is Mr. Art
14 Wallenstein, who is currently the director of
15 Maryland's Montgomery County Department of Correction
16 and Rehabilitation. Director Wallenstein brings with
17 him his vast knowledge of corrections techniques and
18 rehabilitation initiatives, honed from his previous
19 experiences as director of Washington's King County
20 Department of Adult Detention and is both a warden and
21 director of the Bucks County Pennsylvania Correctional
22 System. He will speak to the specific challenges
23 jails pose and the strategies he has employed to
24 provide quality care in a jail setting.
25 I want to thank you for joining with us

1 today. I want to remind each of you that we have
2 allocated 15 minutes each for you to present. We will
3 begin with Dr. Goldenson, followed by Dr. Cohen and
4 finally by Director Wallenstein. Upon conclusion of
5 their testimony -- and our timekeeper will be flashing
6 cards, please take note, zero means zero and it's a
7 zero tolerance policy at this point on.
8 Following your testimony, we will
9 engage in Q and A and dialogue from the panelists. I
10 would like to begin with some questions and then turn
11 it over to Steven Bright and Gary Maynard. We will
12 ask initial questions on healthcare and then we will
13 open it up for all commissioners to participate. We
14 have an hour and a half to review this very serious
15 matter. Let's not squander anymore time. Let's go
16 ahead and begin with Dr. Goldenson.
17 Thank you for traveling to New Jersey.
18 MR. WOOL: Excuse me, Senator. I think
19 it's ten to 12 minutes we're going to go with and
20 consult with your timekeeper next to you, but let's go
21 with 12.
22 SENATOR ROMERO: Okay. You've lost
23 three minutes, 12 minutes.
24 DR. GOLDENSON: Gained two, actually.
25 SENATOR ROMERO: If you can speak

1 directly into the mike, please.

2 DR. GOLDENSON: Can you hear me? Good

3 morning, Commissioners, and thank you for inviting me

4 to this testimony.

5 When discussing safety and abuse in

6 prisons healthcare is not the first and probably not

7 the second or even the third thing that immediately

8 comes to mind. When we're speaking about deaths and

9 injuries in correctional facilities, violence --

10 either prisoner against prisoner or staff against

11 prisoner -- is the usual suspect. The reality,

12 however, is that much of the morbidity and mortality

13 that we see in our nations' prisons is the result of

14 inadequate and poor medical care, and that's some of

15 the issues I want the talk about today.

16 As Senator Romero mentioned, I am one

17 of the medical experts appointed by the Federal Court

18 to look into the California system so a lot of what

19 I'll be talking about comes from our recent reports on

20 California, although I have also been a medical expert

21 in Ohio and involved in a number of other states in

22 terms of medical care, but, primarily, what I'll be

23 focusing on is what we found in California.

24 Just for some background, in 1976 the

25 United States Supreme Court in a case called Estelle

1 v. Gamble ruled that it was the government's
2 obligation to provide medical care for those whom it's
3 punishing by incarceration. In reaching this decision
4 the court referred back to the Eight Amendment's
5 prohibition against cruel and unusual punishment and
6 stated, basically, that if the state takes away
7 someone's freedom, then they're responsible for
8 providing for their healthcare and safety.
9 The court set a high standard, though,
10 in terms of how they would evaluate healthcare
11 programs within correctional facilities and,
12 basically, the standard is deliberate indifference to
13 a serious medical need. A serious medical need is one
14 which if not appropriately treated in a timely manner,
15 can lead to either death, measurable deterioration in
16 function, unnecessary pain or a risk to public health.
17 Deliberate indifference means that you
18 have to prove that either the medical staff or the
19 custody staff was aware of this risk to the individual
20 and didn't do anything so that just showing that
21 someone suffered harm because of poor medical care
22 doesn't rise to the standard that the Supreme Court
23 set. You have to show that someone in a position of
24 authority knew about this and still let it happen.
25 Unfortunately, 30 years after Estelle,

1 many correctional systems in this country still have
2 poor and inadequate medical care that does not meet
3 the constitutional standards set by the Supreme Court
4 over 30 years ago. And, in addition to that, many of
5 the systems in this country where there is good
6 medical care, the reason for that is that they have
7 had to deal with the courts and either the court has
8 set up court orders or there have been settlement
9 agreements whereby healthcare is prioritized and the
10 system is fixed.
11 In many of these cases either medical
12 experts or special masters are appointed to oversee
13 the medical programs while the state or the county is
14 fixing them and to ensure that the court's decrees are
15 being followed.
16 Recently in California, U.S. District
17 Judge Thelton Henderson came to the decision that the
18 California system was basically so broken and there
19 was so much suffering due to the poor medical care
20 that he came to, basically, the unprecedented decision
21 to appoint a receiver to be responsible for the entire
22 healthcare system in the California state prison
23 system, despite -- California has 160,000 prisoners in
24 33 prisons so that, by far, it's the largest system
25 and to go to the step of appointing a receiver was a

1 very difficult decision for the judge, but he felt
2 that it was something that was necessary, given the
3 gravity of the situation.
4 James Sterngold, who is a journalist
5 who writes for the San Francisco Chronicle who was
6 covering the hearings said that the decision by Judge
7 Henderson followed weeks of testimony from medical
8 experts that Henderson described as horrifying in its
9 depiction of barbaric medical conditions in some
10 prisons, resulting in as many as 64 preventable deaths
11 of inmates a year and injury to countless others.
12 Judge Henderson said he was most moved
13 by the, quote, uncontested statistic that a prisoner
14 needlessly dies an average of roughly once a week

15 through medical neglect or cruelty. He went on to say
16 that the prison system offered and I'll call it again,
17 at times, outright depravity. So it's very clear from
18 California's example and other examples that the
19 failure to provide adequate medical care can and does
20 rise to the level of abuse in our prisons.
21 As a result of the testimony and the
22 findings, the judge decided that California was not
23 capable of managing its own healthcare system and
24 appointed a receiver.
25 In my written report I go through a

1 number of reasons why I felt that providing medical
2 care is so problematic in our correctional
3 institutions and I would like to go over a few of
4 those during my time here.
5 First of all, I think the major issue
6 is that healthcare is just not a priority. Most
7 correctional institutions, custody staff runs the
8 institutions as they should, security is their main
9 concern, again, as it should. The problem is that
10 that -- the medical staff often is three or four rungs
11 down on the supervisory chain so that a lot of the
12 decisions about medical care from decisions concerning
13 staffing, budgetary decisions, to the level of whether
14 a prisoner should have a crutch or not, whether a
15 prisoner can be transferred out of the facility for
16 necessary specialty or emergency care are all
17 controlled by the custody staff who really don't have
18 the training or the education or the skills to make
19 those decisions, but these are the people in many of
20 our institutions who are making those kind of medical
21 decisions or at least have control over the final
22 outcome of those decisions.
23 Again, referring back to Judge
24 Henderson, in his decision to appoint a receiver he
25 stated that we have seen too often in the records

1 before me, medical decisions give way and suffer
2 because of ill-advised security decisions so that
3 prisoners don't even get to their medical care because
4 of security decisions that hamper effective medical
5 care.
6 Kevin Carruth, who at the time was the
7 second highest ranking official in the Department of
8 Corrections in California, at an evidentiary hearing
9 stated that it is not the business of the California
10 Department of Corrections to provide medical care and
11 it never will be. He went to say that medical care is
12 not one of the department's core competencies.
13 So this breakdown in terms of who
14 really is managing the program and who is making the
15 decisions has a number of effects, one of which is
16 that many of the facilities lack appropriate funding
17 and resources.
18 Again, lots of times the budget will
19 come out, each facility will be responsible for its
20 own budget and the warden or the sheriff controls
21 those budgetary decisions and decides how much will go
22 to medical, how much will go to custody and how much
23 will go to other areas. Here again, custody concerns
24 take precedence over medical needs.
25 I have two minutes. One thing I wanted

1 to say is that when prisoners enter facilities, they
2 lose eligibility for Medicare and Medicaid, which
3 means that the total cost then falls either on the
4 county in the case of jails or the state in terms of
5 state prisons and, you know, except for a cost-saving
6 factor on the part of the federal government, there
7 really is no reason that should happen and it places
8 structural institutions at a real disadvantage in
9 terms of having access to funding that's available to
10 everyone else for healthcare.
11 In my report I document a number of
12 cases where the care was either incompetent to cruel
13 and we saw cases where it was just shocking to us that
14 medical professionals were involved in the cases. We
15 saw cases where on review it was clear the custody
16 staff had a better idea of what was going on than the
17 medical staff and the custody staff wanted people sent
18 to the emergency room outside of the jail facility or
19 the prison facility and the doctors were saying no,
20 this guy doesn't need to go and he would die within
21 two or three hours.
22 SENATOR ROMERO: Dr. Goldenson, your
23 time has expired. We'll come back to you in Q and A.
24 Thank you.
25 Dr. Cohen.

1 DR. COHEN: Good morning, Commissioner.
2 Thanks for the opportunity to be here. In my written
3 testimony, my discussion was fairly theoretical. I'm
4 going to be more concrete in my examples to you today
5 and just to say that the basis of my testimony, like
6 others here, is that for the past 25 years I have
7 worked in prisons, directing medical care in prisons,
8 monitoring medical care. I am currently appointed by
9 federal courts in Ohio, Michigan, Connecticut and New
10 York to monitor medical care based upon class action
11 suits which found that the medical -- which were
12 settled because everyone agreed that the medical care
13 failed to meet the constitutional standard that
14 Dr. Goldenson just mentioned.
15 And although I'm going to give examples
16 and anecdotes, I ask you to understand that these are
17 easy to find. These are not rare events. Some of the
18 things I will describe will be slightly horrific, but
19 they are not unusual and it's why you are here today
20 and I appreciate the work you are doing because there
21 is a serious problem of violence and abuse in the
22 prisons and, hopefully, your work will begin to
23 reverse it.
24 When we are ill, we hope that our
25 doctors will be there for us. They know, we know that

1 the experience of illness is frightening and
2 difficult, the outcomes can be adverse and privileged
3 citizens in this country expect their doctor to be an
4 advocate for them to make sure we get our medicines,
5 that we get the tests we need, that we will see the
6 specialist that we have to see if the situation is
7 complex and requires it, and we expect our doctors to
8 be responsive to our pain, to our suffering and to
9 listen to us, although many people feel their doctors
10 don't spend enough time with them, and to be on their
11 side.
12 And prisoners, of course, expect the
13 same thing. They expect that their complaints of pain
14 and suffering will be listened to sympathetically and
15 they expect they need medication, diagnostic testing,
16 access to specialists, they will get it too, but they
17 don't expect to get it. Their experience is the
18 experience that you have heard about and will continue
19 to describe today, that they fear if the care they
20 require is complex, expensive, requires trips outside
21 the prison, that they may not get what they need, and
22 they certainly won't get what they expect.
23 Now, there are doctors and other health
24 professionals in jails and prisons who do provide good
25 quality medical care, but there are others who don't

1 try. There are doctors working in prisons who do not
2 want to be working in prisons, who have a
3 fundamentally antagonistic relationship to their
4 patients and who do not advocate on their patients
5 behalf. These doctors approach their patients'
6 complaints by dismissing significant symptoms,
7 offering palliative treatment to them instead of
8 careful evaluation and they're also incompetent
9 doctors who don't know how to treat their patients.
10 And Dr. Goldenson has talked about the
11 California experience; there 25 percent of the doctors
12 are felt to be incompetent beyond remediation at the
13 present time, and I can't speak to the similar data in
14 other states, but that's unchallenged by the
15 California Department of Corrections, as well as by
16 the union of physicians in California.
17 Physicians may perceive their --
18 prisoners may perceive their physicians as remote and
19 hostile and doctors often view their patients as
20 manipulative and demanding. Prison administrators
21 view a prisoner's request for sick call with a
22 jaundice eye and support co-payments to discourage
23 frivolous use of care. Patients who complain are
24 viewed with skepticism and anger and their request for
25 pain medication may result in anger responses from

1 providers.

2 Physicians who treat pain are viewed as
3 prisoner friendly, which is not a -- which is not a
4 position that many doctors want to be in a
5 institution.

6 And when the patient's welfare no
7 longer becomes the primary goal of the physician's
8 activity, then we are faced with a discussion of how
9 do we achieve quality of care in prisons. I will
10 return to that point at the end.

11 I'm going to give a few examples right
12 now. Dr. Goldenson and I are co-appointed in Ohio to
13 monitor the medical care at the Ohio State Prison, a
14 supermax facility outside of Youngstown, Ohio. And,
15 of interest, I was the plaintiff's expert in this
16 case, Dr. Goldenson was defendant's expert in this
17 case.

18 And we each toured the facility, we
19 each wrote a report, we did not speak to each other
20 about the reports, although we did communicate that we
21 were doing this because we know each other, and we
22 wrote the same report. We described the same thing
23 and, understandably, the settlement agreement was to
24 implement our reports. And the implementation, I
25 think this is important, actually, in terms of some

1 point of the questions asked before, was that if the
2 two of us agreed, then the state had to do it. It was
3 not required to go back to a court to prove contempt
4 of the agreement that the parties had agreed to carry
5 out, but if the two of us agreed, then the state had
6 an obligation.
7 And when we got there, patients were
8 not being treated for pain, pain medicines were not
9 being prescribed. Patients were not allowed to be
10 diagnosed with hepatitis C. Insulin for patients with
11 diabetes -- it was the discussion earlier this morning
12 about diabetic treatment -- were receiving their
13 Insulin through the food slots in their steel doors,
14 which had a glass -- you know, a glass view place and
15 a food slot and the patients would put their belly up
16 to the food slot and receive their Insulin.
17 I found this out when I was reviewing
18 the medical record and the nurses are supposed to
19 chart where in the body the Insulin is being given so
20 there is a normal rotation so that areas of skin don't
21 become unable to absorb the Insulin, and I saw that
22 everyone was getting it in the same place over and
23 over and over again. And I asked the nurses and they
24 explained to me that's what they were doing.
25 I can't understand that, although I

1 can, it's very important for us to understand how can
2 that happen? You know, what nurse goes through their
3 training in order to do that? And I will answer that
4 in questions, I think but I'll -- patients who were
5 examined in Ohio state prison were rare and when they
6 were examined, they were brought by a guard -- a
7 guard -- by three guards. First they were chained,
8 their hands were chained behind their back, their legs
9 chained, their legs chained to their hands and
10 shuffled down a hallway to a medical examining area
11 where they were then chained to the wall and led --
12 and sitting on a table with their -- and we asked the
13 doctor, how did you examine -- individually we asked
14 the doctor, how did you examine the patients if they
15 had abdominal pain, because they were like this
16 (indicating), and he said it was difficult.
17 That's changed, although it was very
18 difficult to change it. And the doctor who came in
19 and started insisting that the patients have their
20 chains removed when he examined them was subsequently
21 fired and then rehired.
22 In Michigan, where I monitor medical
23 care at the Southern Michigan Facility, which is the
24 old Jackson Penitentiary, which was at that time the
25 largest single prison in the United States, housing

1 5,000 men in a five story cagneist(ph.) facility.
2 Today -- or hopefully not today -- but, certainly,
3 recently, you know, patients with life-threatening
4 medical illnesses who were known to have cancer would
5 have their treatment delayed for three, six, nine
6 months and every month a doctor would review the chart
7 and be asked is it okay for them to wait another
8 month, and every month the doctor would say yes. Why?
9 I don't know.
10 I've talked to them and I thought and I
11 believe, as did the judge in this case, that this is a
12 serious, serious problem, although it's of note that
13 the attorney general's representatives in one of the
14 hearings in which I brought this to the judge's
15 attention said what are your standards, Dr. Cohen, you
16 know, are you using malpractice standards, is it a
17 deliberate indifference standard, because we win these
18 cases in court. They're losing right now, but that
19 was the attorney general's, you know, position and one
20 could understand how that could get transmitted back
21 through to the medical staff.
22 I have some pictures here which I would
23 like to have the Commission to see, you don't have to
24 look at them right now, although you can. There are
25 five copies of four pictures. And they are pictures

1 of a young man named Gregory Lee who was arrested a
2 year -- little over -- about two years ago in
3 Louisiana and he was convicted of a crime. He had
4 been -- he had HIV infection, he had two T-cells when
5 he came into prison and he was initially worked up at
6 the New Orleans Parish Prison and then he was
7 transmitted -- he was transferred to another prison
8 and then, finally, to a private prison called
9 Southwest Louisiana Correctional Center, where he
10 never received any medical evaluation, where he was
11 never seen by a doctor, where he was never seen by a
12 nurse and where he one day was accused of escaping by
13 walking from one place to another. There was no
14 possibility of escape, but he was accused of escaping.
15 He was beaten for 12 hours and then he
16 was -- and there are pictures which show him as he was
17 transferred from Southwest Louisiana Correctional to
18 Elaine Hunt Correctional Facility, which is a
19 Louisiana state prison. And there is a picture of him
20 with a rag in his mouth, with his arms bound behind
21 his back, his legs bound together and his arms and
22 legs chained together in a hog-tied position and
23 that's how he was brought to Elaine Hunt, where they
24 took this picture, for whatever reason.
25 And he was then placed in suicide -- he

1 was accused of escaping and said to be a suicide risk.
2 He was placed in four-point restrain at Elaine Hunt
3 for three days and then on the fourth day he was
4 released from his restraints and a few hours later
5 died. And there is a picture of him naked in his
6 cell, dead, in Louisiana.
7 He never received any medical care,
8 except for a lot of tranquilizers when he got to
9 Elaine Hunt, and although medical tests were taken on
10 admission there, they were never looked at.
11 These look like Abu Ghraib pictures
12 when you see them, and I don't have a lot of pictures
13 like that, but I have these pictures and they are --
14 they're the worst thing I have ever seen, but this
15 happens in Louisiana regularly and this private prison
16 company has been indicted for torturing prisoners on a
17 number of occasions.
18 Few other points I would make, if I had
19 more time, would be that there should not be
20 unlicensed doctors in positions in prisons. In
21 Mississippi, where I review the medical care for HIV
22 prisoners five years ago, while under the direct
23 control of the University of Mississippi Medical
24 School, all of the doctors that -- whose credentials I
25 could review, and I think it was all of them, had lost

1 their license to practice medicine in Mississippi, but
2 were allowed to practice in Parchman Farms and in a
3 women's facility and they were providing medical care
4 to people with HIV infection completely in
5 contradiction to the required standards, which are
6 national in this.
7 Patients who had been on three drugs
8 were taken off of their three drugs, placed on two
9 medications, required to take the two medicines for
10 six months and then a third drug was added. I guess
11 my time is up, but I will --
12 SENATOR ROMERO: We'll return to you on
13 Q and A. Thank you.
14 Director Wallenstein.
15 MR. WALLENSTEIN: Thank you. I would
16 like to agree initially with Judge Gibbons who noted
17 that this is a patchwork issue. It isn't all
18 negative, it is certainly not all positive and,
19 hopefully, the members of the Commission are able to
20 engage this question of healthcare and mental
21 healthcare as you look for solutions, advocacy,
22 prescriptive packages and things that you can urge the
23 profession, not simply of corrections, but of public
24 policy to take. So I think I appreciate the patchwork
25 notation.

1 There is no question, there is no doubt
2 that correctional healthcare is a core competency in
3 this profession. The statement of a colleague I'm
4 sure was properly quoted, and I need to ensure that
5 this Commission is aware, that to the great majority
6 of correctional administrators, this is mainstream
7 practice, as we move to becoming a de facto mental
8 health system in the United States, that may be
9 another issue, but medical care represents as core a
10 practice within correctional operations certainly as
11 security and it has been accepted and largely been in
12 that domain since Justice Byron White, I believe,
13 spoke in 1974 in the case of Wolff versus McDonnell.
14 And while he was talking about disciplinary issues at
15 the time, he noted as persuasively certainly as any
16 decision that prisoners were not beyond the scope of
17 the Constitution of the United States. And while the
18 exigencies of an institutional environment may cause
19 some issues to be considered, the Constitution was not
20 thrown away. And he noted very directly that there
21 was no iron curtain separating the prisons of this
22 country from the Constitution of the United States.
23 Now, one value of being 60 is that I
24 was here pre-Wolff versus McDonnell and pre-Estelle
25 and I was there when these practices were, let's say,

1 wholly inappropriate, even in well-intentioned
2 environments, because we lacked guidance, direction
3 and standards. That's a big difference from
4 deliberate indifference or uncaring, but simply the
5 tools had not yet been developed and I feel that was
6 certainly one of the things that I bring to this
7 testimony is that I don't come from simply a rarefied
8 environment in a wealthy Maryland County. I served as
9 the assistant warden at the Illinois State
10 Penitentiary at Joliet in Stateville -- I doubt that
11 there are anymore difficult correctional environments
12 in this country -- and had a chance to see the
13 pre-Estelle practices and know the value of judicial
14 involvement and know what has happened as a result of
15 that judicial involvement.
16 I will return to that, but I want to
17 make a few comments very briefly on jails. The title
18 of this Commission is The Commission on Safety and
19 Abuse in America's Prisons. When I was reading
20 through the website just ten days ago I said, woops,
21 the jail issue has been missed again, like it always
22 is, and that's no criticism, and that led me to call
23 the Commission and ask if I might testify because I
24 saw your list of witnesses and they were highly
25 competent and certainly could say all the things that

1 I might have said.

2 Allen Beck is one of the most credible
3 people in this country in criminal justice and he did
4 a brilliant job yesterday of talking about basic data.
5 In the most recent report that his office publishes,
6 prisoners at mid year, there is a discussion of
7 713,000 people in our jails on a given day and
8 1.3 million people in our prisons.

9 That says nothing about the number of
10 people who filter through the jail system. The number
11 is 10 million. It's only 650,000 to 700,000 who enter
12 the American prison system each year and we know from
13 the President's State of the Union address, about
14 650,000 depart. Folks, please consider the 10 million
15 who go through the jail system in this country. You
16 talk about infectious disease at the prison level,
17 imagine the impact for the large number of these folks
18 are quickly back on the streets of local communities
19 and bring enormous difficulties and enormous
20 consequences to local communities.

21 I need to reiterate this point because
22 we find ourselves having to advocate for the jails.
23 And my guess is it's because of the larger size of
24 daily prison populations and the fact that part one
25 crime is largely involved. But many of us, of course,

1 have read the broken windows approach and know that
2 lesser crimes may have the dominant impact on public
3 safety perceptions in the United States and jails are
4 in a unique position to engage these issues because of
5 their proximity to local communities.
6 When Judge White, from my perspective,
7 exploded the issue of prison and jail conditions as a
8 valid constitutional issue, he opened the door for the
9 period 1974 through 1991 when virtually every aspect
10 of corrections became open to constitutional practice.
11 And you heard from Vince Nathan and Fred Cohen,
12 veterans of the shop floor of those incredible years,
13 where hundreds of Federal Court decisions were
14 rendered, establishing core, basic floor practices and
15 whether one colleague disagrees or not, healthcare is
16 smack in the middle of those core practices.
17 In '76, as my colleague, Mr. Goldenson,
18 so ably noted, Mr. Justice Marshall wrote for an
19 undivided court in Estelle versus Gamble that there
20 was no doubt that healthcare was mandated and while
21 the deliberate indifference standard may have required
22 a high degree of proof that there was significant
23 violation to the folks on the shop floor myself, there
24 was never a question that constitutional practices had
25 to be carried out. Done, agreed to and buyer beware

1 if quality healthcare wasn't going to be provided.
2 The American Medical Association
3 engaged this issue and established the first core
4 standards program and that's something I really wanted
5 to note to the members of the Commission. They
6 prescribed and developed prescriptive packages,
7 everything from what you do at the front door and to
8 what you are supposed to do to refer clients to
9 community-based programs upon their release. Those
10 standards exist today and, if universally implemented,
11 while there will still be some abuse, of course,
12 day-to-day lack of concern will diminish.
13 The National Commission on Correctional
14 Healthcare took over for the AMA, they exist today and
15 their work is certainly instrumental in establishing
16 core quality healthcare practices around this country.
17 They don't obviate the need for, certainly, intensive
18 attention and accountability, but no one in this
19 profession could possibly say that healthcare is not a
20 core element of correctional operations and
21 correctional practices.
22 The American Correctional Association
23 has adopted strict healthcare standards. Perhaps in
24 part gleaned from NCCHC, but now independently as part
25 of their standards program.

1 As of yesterday, in the jail side of
2 the house there were only 124 jails in America that
3 had received ACA accreditation. There were 242 jails
4 in this country that had been accredited by the
5 National Commission on Correctional Healthcare. Why
6 do I note this? Kudos to those who do, but this
7 Commission needs to reinforce that every correctional
8 institution in this country needs to follow those
9 standards. The public health service had a chance to
10 buy into this many years ago, sort of chose not to
11 and, hopefully, we can get the public health service
12 back into this business.
13 That doesn't mean that everything is
14 perfect, but it does mean that the standards exist to
15 monitor core basic practices in this country regarding
16 healthcare and they offer a template and they offer
17 standards and they offer a road map and it means that
18 community standards of care are brought into the
19 institutions and there can be no debate any further
20 about what quality practices are and they do establish
21 constitutional minimum.
22 And while federal courts have been
23 reluctant to say that accreditation is a core
24 practice, those who are accredited and have followed
25 the standards of NCCHC and the American Correctional

1 Association generally are not before federal district
2 courts, don't have consent decrees entered against
3 them and are generally working with individual cases
4 where better care might have been provided, which is,
5 hopefully, where correctional services as a whole
6 should be on an ongoing and regular basis.
7 You learn from the exceptional case,
8 you don't deal with death on a daily basis because you
9 have standards and practices and protocols that are
10 carried out, that are implemented and that are the
11 subject of high accountability.
12 Let me begin where I ended and thank
13 Dr. Goldenson for just mentioning that one comment;
14 healthcare is a core, a nondebateable core practice in
15 the area of corrections in this country. Accept
16 nothing else and render your judgements in your report
17 that mandate and allow no other tolerance of anything
18 but quality healthcare.
19 SENATOR ROMERO: Thank you, Director.
20 Commissioner Bright, do you want to
21 begin the dialogue?
22 MR. BRIGHT: Sure. I will be glad to.
23 I want to ask with regard to
24 Dr. Goldenson, you are in San Francisco and, I assume,
25 work for the jail authority there; is that right?

1 DR. GOLDENSON: No. Actually, in San
2 Francisco the healthcare services are provided through
3 the public health department.
4 MR. BRIGHT: The public health
5 department.
6 DR. GOLDENSON: So I work for the
7 public health department.
8 MR. BRIGHT: And Dr. Cohen was at
9 Riker's and, I assume, worked for the New York
10 Department of Corrections?
11 DR. COHEN: New York City Department of
12 Health, right, but for the city, yes.
13 MR. BRIGHT: And my question is this,
14 and it's two sort of related questions, which is we
15 see in this area of private healthcare providers, the
16 largest being I think Prison Health Services, which
17 we've had some experience with, and I just wanted to
18 get what your comments were, all of you, with regard
19 to private healthcare providers, both in jails and in
20 prisons, and sort of related to that that in the very
21 remote areas, where a lot of prisons are, particularly
22 the supermax prisons and so forth, often way down in
23 places where nobody much goes, the difficulty of
24 finding doctors and nurses and the utilization of
25 people, healthcare professionals, who are not able to

1 practice in the public at large, who have prior
2 convictions or have been defrocked or someone spoke at
3 the earlier panel about language and cultural
4 differences of people --
5 DR. COHEN: On the for-profit area.
6 When I worked on Riker's Island I actually was a
7 contract, but a not-for-profit contract. I worked for
8 Montefiore Medical Center in New York City, which had
9 a contract with the City and we did not have a profit
10 built into our thing.
11 I think that the recent New York Times
12 story by Paul Vonzielbauer on PHS in New York City,
13 I'm sure the Commission has access to that, you know,
14 showed some serious problems with PHS care using
15 unlicensed psychiatrists in a very intensive mental
16 health program.
17 In general, whenever there is a
18 contract which -- in which there is a risk contract --
19 "risk contract" in medicine means that every dollar
20 you pay you don't keep yourself, then there is a
21 incentive to provide less care.
22 Sometimes the for-profit contracts are
23 written to avoid that by only paying for -- by
24 encouraging the utilization of services and limiting
25 the profits that can be made by not providing care, in

1 fact, sometimes even debiting dollars for unfilled
2 positions. But, in general, my experience has been
3 quite negative in this.
4 In Philadelphia, where I monitor the GL
5 medical care for a number of years, PHS had the
6 contract, and they refused to ever put in the bid that
7 they needed to meet the care levels that were required
8 because they knew they would be underbid by next
9 year's bidder and that was a very serious problem.
10 And in Michigan, where I currently
11 monitor, where Correctional Medical Services provides
12 the medical components, that's the physicians, the
13 hospital care and the specialty care, although they
14 have an incentive to supposedly a cost-plus contract,
15 they still have a relationship with the State of
16 Michigan, which is not interested in paying cost plus
17 for everything. And my experience is access to that
18 specialty care is extremely limited in this group,
19 less than half our patients get their care in the time
20 it's allocated.
21 There are other questions but I will
22 let my other panelist answer.
23 DR. GOLDENSON: I agree with Dr. Cohen
24 in terms of the private medical services. I think one
25 of the major problems with them is that when there is

1 a profit motivation, there is less likelihood that
2 patients are going to be sent off-site for specialty
3 services that are often only available in the
4 community or for emergency services so that a number
5 of cases I have reviewed where people have died, it's
6 because they haven't been sent out in a timely manner
7 to an emergency room and I think there's -- from
8 talking to staff who work in these institutions,
9 there's not a rule, but, basically, an understanding
10 that you should try to avoid, as much as possible,
11 sending people out.
12 You know, by contrast, in San
13 Francisco, as I said, we're part of the public health
14 department, the hospital that we send people to is
15 part of the health department so it's all one system
16 and, you know, what I tell my staff is if there's any
17 question, you send someone to the emergency room, just
18 to make sure that we're not missing something.
19 So it really is a difference in
20 philosophy and what your motivation is, whether it's
21 to provide the best possible care or to try to make a
22 profit on it.
23 MR. BRIGHT: Is that fairly rare, to
24 have the whole system together; the public health
25 system, the public hospital and the jail all in one

1 unified system of healthcare delivery or do you know.
2 DR. GOLDENSON: It's not the usual
3 model, but I know in California, at least, there are a
4 number of counties where that is the model. I'm not
5 aware of any state prison system where that's the
6 model, but at least in California a number of the jail
7 systems -- I mean the predominant number are still
8 health services are run through the sheriff's
9 department, but there are a significant number where
10 it's provided through the health department.
11 In terms of your second question, I
12 think that's a major concern in terms of having --
13 finding qualified physicians who are willing to work
14 in what is often not very good working conditions and
15 very isolated areas and at the same time not being
16 paid what they could make in other places. And it's
17 one of the questions that we're looking at in
18 California because of the large number of
19 institutions, many of which are in remote areas and
20 not only for physicians but for nursing, there's huge
21 numbers of vacancies in some of these facilities.
22 Facilities with maybe four, 5,000 people where they
23 only have two or three doctors currently.
24 You know, unfortunately, I think the
25 answer is that you have to pay people more to attract

1 them to work in those situations. The other things
2 we're looking at is a lot of these rural areas do have
3 medical schools or residency programs in family
4 practice, trying to connect the family practice
5 programs with the prison systems to use some of these
6 resources and make it part of the training program so
7 that the residents and the faculty from these
8 different residencies, part of the time, while they're
9 in training, will be spent in the correctional
10 facility.
11 MR. BRIGHT: What about using doctors
12 who aren't licensed, generally?
13 DR. GOLDENSON: Well, I mean, I think
14 that should not be allowed. The physicians working in
15 correctional institutions need to have the same
16 qualifications, the same licensure as someone working
17 anywhere else.
18 One other point I wanted to make is
19 that a lot of systems are starting to make more use of
20 mid-level practitioners, such as nurse practitioners
21 and physician's assistants, and in some of the more
22 rural areas in San Francisco even we utilize nurse
23 practitioners to a very large extent in providing the
24 care. My experience has been that they're younger,
25 they're more motivated, they're excited about working

1 and taking care of patients so that we've had a very
2 good experience using nurse practitioners. And in
3 California they're starting to make an effort to do
4 that also because, unfortunately, a lot of the
5 physicians that we're finding in the California prison
6 system are retired physicians who may have been
7 anesthesiologists, radiologists, pathologists,
8 positions where they really didn't have primary care
9 responsibility and so cardiothoracic surgeons dealing
10 with some very complex medical problems.
11 So it's not only a question of what
12 their licensure is or -- it's also are the people who
13 are seeing -- are they trained in the skills that they
14 need to -- are they credentialed and do they have the
15 current privileges to really provide the care that's
16 necessary and, unfortunately, as Bobby said, our
17 findings were upwards of 25 percent of the doctors
18 working in the California system were either
19 incompetent or inappropriately credentialed doing the
20 kind of care they're doing.
21 SENATOR ROMERO: Commissioner Maynard.
22 MR. MAYNARD: Thank you. I have a
23 question for Dr. Goldstein and Dr. Cohen both, and
24 following up on Mr. Wallenstein's testimony about
25 accreditation of ACA or NCCHC accreditation in support

1 of that, I would like to know what your position would
2 be about that type of accreditation and if not that
3 type, what type of standards do you think that the
4 healthcare should have? And you can be very brief in
5 your answer.
6 DR. COHEN: I'm a member -- I'm on the
7 board of the National Commission For Correctional
8 Healthcare, I represent the American Public Health
9 Association, and the American Public Health
10 Association also issues standards from medical care.
11 It just issued its third edition. The standards are a
12 positive thing. The national commission standards are
13 too easy sometimes, the American Correctional
14 Association standards, historically, have been not
15 adequate, although they're making an effort to improve
16 that right now. It's not sufficient, though. I mean,
17 it definitely improves it.
18 I do think that it's important to
19 recognize that even if medical care is a core
20 competency of correctional administration, there is a
21 fundamental conflict between medical care and the
22 other competencies, which are control and punishment.
23 And these are -- medical care is not about punishment,
24 it's about palliation and support, and these are in
25 conflict. And when the medical staff don't realize

1 that they have to be in conflict, then in order to
2 achieve their goals they have to -- this doesn't have
3 to be ungentlemanly or ungentlewomanly, it can be
4 respectful, but it can't be simple, it can't be that
5 everything is okay.
6 When you send someone out of the
7 facility, it means you are disrupting the facility.
8 When you are ordering pain medication, you are
9 potentially allowing pain medication to be in the
10 institutions. When you are declaring an emergency,
11 you are moving people around who perhaps should not be
12 routinely moved around. So there is fundamental
13 conflict.
14 MR. MAYNARD: What would be your
15 solution to those problems?
16 DR. COHEN: Well, just -- my solution
17 is to make sure the medical staff value their
18 competency and the importance of maintaining this
19 conflictual yet workable relationship. That they
20 understand that if they need to do something and
21 correction says no, if they really need to do it, they
22 have to fight for it.
23 SENATOR ROMERO: Director.
24 MR. WALLENSTEIN: I agree with my
25 colleague, but the remediation is enhanced management.

1 I mean, it is a top-down issue.
2 The Supreme Court told us you do it or
3 you pay and you pay and you pay. So if administrators
4 are selected who don't understand that it's a core
5 competency or don't work with the staff so that
6 conflict can be mitigated, as you so appropriately
7 stated, you are not doing your job as an
8 administrator.
9 Sure, we have staff, does John have to
10 go out for the eighth time? NCCHC took care of that,
11 they said nonmedical personnel shall not intrude in
12 providing medical services. So a warden doesn't
13 determine who needs to go out. Yes, you might wait
14 for four police cars if the person is an escape risk,
15 but the issue of the going is a healthcare decision
16 and you either do it or you pay the penalty for
17 failing to do it. That's why I make the point of core
18 competency.
19 The modern manager today, given the
20 Supreme Court engagement and involvement, knows you
21 must blend the two, it's part of doing business.
22 SENATOR ROMERO: Commissioner Rippe,
23 followed by Commissioner Schwarz.
24 MR. RIPPE: Yeah. One of the issues
25 that the United States military faces is otherwise

1 healthy young men and women coming in really need
2 dental care and it's mandatory after that to have a
3 dental checkup.
4 Can you all address how we do dental
5 care for inmates, especially long term ones?
6 DR. COHEN: It's -- there are -- most
7 places, most states do a dental evaluation on intake
8 for all prisoners. There are too many teeth pulled
9 versus restorative work. I think it -- in some of the
10 systems I have seen when under court order it's been
11 okay, but I think -- it has not been litigated a lot,
12 in my experience. I think it's probably nowhere near
13 what it should be. There are a lot of extractions.
14 SENATOR ROMERO: Commissioner
15 Schwarz.SchwarzI have one question for Dr. Goldenson
16 and one question for Dr. Cohen.
17 Dr. Goldenson, for you -- maybe I'll do
18 both questions and then turn it over to you.
19 For you it's -- you mentioned that the
20 federal government will not supply Medicaid or
21 Medicare payments to people who are incarcerated. Is
22 that also the case for other people who are in
23 institutional settings or are custodial settings
24 singled out?
25 And the question to you, Dr. Cohen, is

1 about abuse and whether doctors see abuse and report
2 it and, more generally, if you could comment based on
3 your experience on whether there are difficulties or
4 barriers to a group like us assessing the evidence on
5 the extent to which there is or is not abuse in
6 facilities.
7 DR. GOLDENSON: As far as I know, the
8 loss of the health benefits is only for people who are
9 incarcerated. People who are in mental hospitals, for
10 example, maintain their benefits and that's how a lot
11 of the care gets paid for, for people who don't have
12 money. So that, again, I could be wrong on this, but
13 my understanding is that it's the fact that someone is
14 arrested and put into a correctional facility, they
15 automatically lose their benefits.
16 DR. COHEN: I am sure that there is a
17 substantial underreporting of violence in America's
18 prisons right now. Traditionally, when there is an
19 injury, there is a requirement for a report and
20 medical staff have a component to that report. These
21 reports actually usually end up being 20 to 50 pages
22 of multiple observers.
23 What's important in terms of the data
24 that's being collected is that the prisoners are not
25 asked what happened, as part of the -- by the

1 physician or by the nurse examining them. There is
2 some analysis, perhaps, by corrections, but the
3 medical staff don't ask what happened.
4 And, for example, when I worked on
5 Riker's Island, there was an epidemic of people
6 falling out of their bunks and there was also an
7 epidemic of people who were slipping in showers. This
8 happens in prisons throughout the country. So there
9 is lots of violence which is described as

10 nonintentional violence, which is actually intentional
11 violence, and I think it's very important that prisons
12 begin specifically understanding it's a public health
13 issue, which actually our country is engaged in for
14 CDC in terms of they have a whole section on violence,
15 but intentional versus unintentional violence, to
16 identify that within prisons.
17 Also, there is -- medical staff do not,
18 in this country, on a routine basis report violence
19 that they observe. This was clearly a problem in
20 Iraq, Afghanistan and Guantanamo and is also a problem
21 in our country. I think one of the solutions to that
22 is to bring into the United States international
23 conventions against torture which specifically are
24 designed to talk about conditions in prison, and make
25 a requirement that medical staff report any

1 observations of violence to appropriate authorities
2 within the institution. And the corollary of that
3 would be that failure to make those reports should
4 bring sanctions on to physicians.
5 SENATOR ROMERO: Commissioner
6 Schlanger.
7 MS. SCHLANGER: My question is about
8 private providers of healthcare services. And what
9 Dr. Goldenson and Dr. Cohen said before is pretty
10 uniformly negative about for-profit providers.

11 I wonder -- it seems like that's not
12 going away so that uniform negativity is not --
13 hopefully, there's some opportunity there as well and
14 I wonder where that might be and one idea that I have
15 is about jails. I wonder if the private providers of
16 healthcare, in small facilities especially, have the
17 potential to bring in some kind of larger scale
18 expertise that small jails just don't develop because
19 they don't have sufficient people. And if that's
20 something that there's any policy or recommendation or
21 something that could move further in that direction,
22 if there's anything constructive that could come out
23 of this increasing privatization of healthcare in
24 jails or prisons.
25 So I don't exactly know who is best to

1 answer that so I wonder what all three of you think.
2 MR. WALLENSTEIN: I've chosen not to
3 utilize private providers. That doesn't mean there
4 are not some that are not quite competent and,
5 frankly, most of it relates to the development of the
6 RFP and the degree of accountability. You get what
7 you ask for and if you haven't built in core
8 competencies and very detailed protocols, then you
9 shouldn't expect to receive them.
10 Many jurisdictions are not very good at
11 writing RFPs or requests for proposals and then in
12 having highly competent contracted administrators
13 review the nature of the work.
14 So I think there needs to be -- before
15 a local jurisdiction embarks upon this there needs to
16 be a real recognition that this request must be highly
17 professional and must include, in total, the standards
18 of the National Commission on Correctional Healthcare,
19 the American Correctional Association or, frankly, it
20 isn't worth engaging in that course at all.
21 I happen to believe public employees
22 can do it better, and that's just a personal prejudice
23 of mine, it does not mean there are not some very
24 well-intentioned private providers but you need to
25 monitor these issues until they drop.

1 DR. COHEN: I agree that the contract
2 is -- I mean the important thing is the contract and
3 the RFP. I mean if there is an ability to make money
4 by not providing services, then that's going to
5 happen. Small jails can -- could utilize the -- you
6 know, potentially I mean, PHS or CMS or all these
7 places will, in an hour, give you a proposal which
8 will be very, very impressive, and Power Point, but
9 whether that actually means anything within a
10 facility, I'm not sure.
11 And, again, in the New York Times
12 articles where the deaths were reported in small jails
13 in New York state, these were almost all for-profit
14 providers that were running the services at those
15 times.
16 SENATOR ROMERO: Commissioner Sessions.
17 JUDGE SESSIONS: We've heard testimony
18 over the last two days about the involvement of
19 federal courts in mandating certain things.
20 Are there also mandates from state
21 courts that relate to medical care that you have
22 discussed?
23 DR. COHEN: In Pennsylvania, the
24 Philadelphia -- there are two consent agreements in
25 Philadelphia simultaneously, one federal and one

1 state, and I monitor the state, and it was very
2 helpful, I think, to the system.
3 I think -- I'm not a lawyer, but I --
4 but my sense is that depending upon where the courts
5 are, what the district is like, that state courts can
6 be used as a forum for improving healthcare.
7 JUDGE SESSIONS: Is that true in
8 California?
9 DR. GOLDENSON: I don't know if they
10 can be used. I'm not aware of it ever happening and I
11 know the state -- all of the -- there have been a
12 number of lawsuits around healthcare, mental
13 healthcare in the state prison system, dental care is
14 one, Americans with Disabilities, and they have all
15 gone through the federal courts and then most of the
16 individual counties where -- that I am aware of with
17 that consent decree, it has also been through the
18 federal court.
19 JUDGE SESSIONS: Director.
20 MR. WALLENSTEIN: Over half of the
21 states have state standards for jails.
22 JUDGE SESSIONS: Yes.
23 MR. WALLENSTEIN: Those standards can
24 be enforced generally through the administrative
25 process and then through state courts, but I will tell

1 you, the standards that are mandated in those
2 documents inevitably came down through federal court
3 intervention at one time or another. So the federal
4 court is still a very friendly forum, not only for
5 prisoners and their advocates, frankly, but for
6 institutional administrators like myself, who want to
7 be ordered to do things in an appropriate way.
8 It's almost striking to me because I
9 thought this issue of healthcare, absent individual
10 cases of problems, had been put to bed 25 years ago
11 about the importance of healthcare in correctional
12 institutions.
13 JUDGE SESSIONS: Dr. Goldenson, we have
14 talked about the receiver appointed by Judge
15 Henderson. Who was that appointed, do you know?
16 DR. GOLDENSON: The decision hasn't
17 been made yet as to exactly who it is. The judge is
18 considering a number of possibilities right now.
19 JUDGE SESSIONS: Talking about Medicare
20 and Medicaid being taken away at the time they become
21 incarcerated, is it restored when they are back out,
22 even on parole, or is it still unavailable?
23 DR. GOLDENSON: Well, once someone is
24 released from custody, then it is restored, so it's
25 really suspended while they're in custody. Once

1 they're out of custody they can -- in most situations
2 it's been suspended so that it's not difficult to get
3 it started up again.
4 A lot of places I've been to are not
5 aware that you can suspend it so it does get
6 terminated, which means then the person has to reapply
7 and that can take months to happen. So that it
8 depends what jurisdiction is and what they're doing,
9 but it really is for the period of time that the
10 person is incarcerated that they lose it.
11 JUDGE SESSIONS: So this is nationally
12 and not just California?
13 DR. GOLDENSON: Right, it's a federal
14 law. From what I understand, it's the federal law
15 that distributes the funding, mandating that the
16 states cannot use it for anyone who is in a
17 correctional facility.
18 JUDGE SESSIONS: Yes?
19 MR. WALLENSTEIN: I would like to
20 respond on the county level. This is an unbelievable
21 issue and I hope the Commission understands it. To
22 take away benefits at the jail level from a person who
23 has not been found guilty, to me has always raised an
24 equal protection argument. Two people who are
25 mentally ill, both arrested on the same day of the

1 same crime, one makes bail, one goes home, one goes to
2 his provider and the other is removed from benefits.
3 It makes no sense for the 10 million who are engaged
4 at the local level.
5 Plus, remember, taking mentally ill
6 people -- and that's a topic for this afternoon, which
7 is a far more serious issue in my estimation, it isn't
8 like us getting in our car and going to a location.
9 Simply getting from point A to point B for most
10 offenders, as you heard this morning for the gentleman
11 from New Jersey, may arrive at a level of
12 sophistication that simply isn't done.
13 Frankly, these benefits should be
14 restored before the persons leave and it should be
15 required that every institution in the country bring
16 in social service, Social Security Administration,
17 whatever is required so the benefit card is present
18 the day they walk out.
19 MR. SCHWARZ: Did you actually say that
20 someone losses their Medicaid and Medicare when
21 they're put in a jail before they have been convicted?
22 MR. WALLENSTEIN: Yes, they are,
23 suspended the day they walk in and, in many cases, it
24 is revoked, not suspended. Many of us believe it
25 should be suspended, fine, but, certainly, go into

1 practice the day they set foot back in the community.
2 JUDGE SESSIONS: Dr. Goldenson or
3 Dr. Cohen or Director, what is the percentage,
4 generally, of inmates who actually would otherwise be
5 in mental institutions or have mental problems?
6 DR. GOLDENSON: National statistics are
7 that anywhere from 12 to 20 percent of people in
8 correctional institutions have serious mental health
9 problems, which is like severe depression or psychosis
10 or something like that. So not all those people would
11 be in another institution, they might be in community
12 care, but they would be on medications, they would be
13 in residential programs, maybe mental hospitals, but
14 they certainly do not belong in jail or prison.
15 And one of the things I was going to
16 say, if I had more time, is the big issue is really,
17 to me, the overcrowding of our jails and prisons and
18 that there are so many people now incarcerated. Some
19 of the prisons in California have five, 6,000
20 individuals in one facility that was supposed to hold
21 two or 3,000. There's just no way you can develop a
22 medical system that's going to be able to adequately
23 function in that kind of setting. And so many of the
24 individuals who are currently incarcerated either have
25 mental health problems or substance abuse problems

1 that can and should be treated in the community or, at
2 a minimum, have treatment -- they'll talk about this
3 this afternoon I'm sure -- treatment in the facilities
4 so that these folks don't get released and come back.
5 I mean, within those two groups the rates of
6 recidivism are extremely high.
7 JUDGE SESSIONS: Dr. Cohen.
8 DR. COHEN: I know the Commission
9 understands, but I just want to stress that this
10 discussion is taking place in aberration. That there
11 are 2.2 million people in prison and jail in the
12 United States today, with a rate of approximately 750
13 per hundred thousand and in France the rate is 75 per
14 hundred thousand, in England the rate is 120 per
15 hundred thousand, as it was in this country a number
16 of years ago, and their rates of increase have been
17 dramatically less than ours. The murder rates in
18 Europe are one-fifth of what they are in our country
19 and it becomes difficult or impossible, I think, to
20 ratchet up, to scale up, to use sort of these
21 industrial metaphors from Dell, you know, about their
22 servers, when we're talking about humans in prison.
23 These institutions change qualitatively
24 when they have so many of our people in it and, again,
25 you know, this issue, I'm sure, the Commission is

1 addressing, you know, it's not just random people.
2 You know, the chance of a black man being in prison is
3 six times greater than a white man being in prison,
4 but these numbers create the problems that you are
5 describing today and there is no reason why there
6 needs to be 2.2 million people in prison.
7 When all of us began our work, some of
8 us felt that if we could take Belvy(ph.) --
9 (inaudible) -- and Estelle and say we had some
10 equivalence principle of care, that the cost was going
11 to be the same for prisoners or more because of the
12 turnover than it would be for people outside of prison
13 and by getting prisons to provide adequate care,
14 forcing them to spend the amount of money that was
15 required to do it right, that we would stop the growth
16 of prison because it would be too expensive. Wrong.
17 JUDGE SESSIONS: Thank you. Let me
18 give you another question --
19 SENATOR ROMERO: Commissioner
20 Sessions --
21 JUDGE SESSIONS: I just got to ask.
22 This may be incidental, but when an inmate goes into a
23 clinic, does he become the patient of a doctor or does
24 he become patient of the clinic?
25 DR. COHEN: It depends on the place.

1 Some places have a model where people are regularly
2 seen by the same doctor, some places they're not.
3 JUDGE SESSIONS: You said that they
4 could not be treated for hepatitis C. Can they be
5 tested for hepatitis C and are they?
6 DR. COHEN: In OSP, when we started
7 there --
8 JUDGE SESSIONS: OSP?
9 DR. COHEN: Ohio State Prison, they
10 were not being tested or treated. They are now being
11 treated, but that was because of the court
12 intervention. The rest of Ohio would not be treated.
13 SENATOR ROMERO: Commissioner Nolan.
14 MR. NOLAN: Two issues, one is about
15 dental care. My understanding from a lot of
16 discussions on this, one of the reasons there are so
17 few lawsuits about dental care is it's not
18 life-threatening so it doesn't raise to the level of
19 scrutiny. My experience is teeth are pulled -- either
20 let them rot or they're pulled. In fact, when I was
21 in prison I never saw so much flossing in my life
22 because they're very protective of their teeth, they
23 know they only have one set issued and they'll lose
24 it. But that is a substantial problem of discomfort,
25 pain.

1 Now, the second prison I was at they
2 did send out for dental care, they put dentures. It
3 was a much healthier system for the esteem of the
4 inmates for their visits.
5 But the second issue, I would really
6 compliment Director Wallenstein on the superior
7 institution that he runs and at the risk of
8 overstepping my bound, I visited his facilities right
9 near Washington, D.C. and I know many of the
10 commissioners come into Washington and walking through
11 it, talking to the inmates, talking to staff, which I
12 was totally free to do, it's astounding a jail, the
13 lack of noise, compared to the noise level in most
14 jails, it's just astounding, but the respect with
15 which the inmates treat each other and the staff is
16 remarkable and it's because of Director Wallenstein's
17 leadership.
18 So I would hope that at some point when
19 your travels take you near DC, it's not very far
20 outside of it, and he was most hospitable and it was
21 very instructive.
22 SENATOR ROMERO: Commissioner Green.
23 MR. GREEN: This is a question that's
24 directed to Dr. Cohen and Dr. Goldenson, or maybe both
25 will comment on it.

1 It's hard for me, and I guess as many
2 of us on this Commission, to understand how healthcare
3 is administered in a prison. I mean, we know what
4 happens when we go to the doctor or when we end up in
5 a hospital and I think about this in light of I think
6 it was Dr. Cohen talked about how diabetes was handled
7 in terms of the administration of Insulin and the
8 person who was shackled to be examined.
9 How close to what we consider typical
10 is medicine administered and at what impact does that
11 have on the quality of the doctors or nurses who come
12 in and our ability to recruit doctors and nurses into
13 the setting; are there danger issues? What is the
14 relationship like to administer medicine?
15 DR. COHEN: Well, the routine is that
16 if the prisoner wants to get medical care, they
17 request it through some process, which is called a
18 kite or a sick call slip or they sign a piece of
19 paper, and in most -- I don't know in most -- in
20 increasing numbers of prisons and jails in the United
21 States today once they do that, they're committing to
22 pay for their care. There is a co-payment which is
23 required in Ohio, in Michigan, not in New York state,
24 but in many, many, many, many facilities right now.
25 So they are now committed to pay three to $5 for the

1 care, which is a barrier, which is a barrier that we
2 face also and I -- but so they put in the slip and
3 then they -- usually a nurse, in some systems, in
4 California, I believe, a nonmedical -- a non-nurse, a
5 medical technician would review that and decide
6 whether they can treat it or they need to refer to --
7 a nurse had to see the patient or a doctor had to see
8 the patient and there would be time delays, depending
9 upon the situation, how long someone would be seen.
10 I don't think that the medical staff
11 feel that they're endangered in prison, although they
12 fully accede to policies which make it appear as if
13 they are in danger. So, for example, in segregation
14 units doctors and nurses will allow for the kind of
15 shackling that I described on a routine basis, even
16 though they know the prisoners are not dangerous to
17 them. Maybe I'm just -- you want to add to it?
18 DR. GOLDENSON: I will just say in
19 terms of some of the more chronic diseases, like
20 diabetes, that in the better systems there will be
21 chronic care programs set up so that people will be
22 seen on a regular basis, that they will get their
23 medications, that it's not dependent on the patient
24 him or herself putting in a slip for those kinds of
25 problems, but once they get enrolled in the program,

1 then they're seen on a regular basis, the same as if
2 you or I went to see our doctor and they said come
3 back in three months.
4 Unfortunately, that's not true in a lot
5 of systems. It's true in some and not true in others.
6 It's what the direction things are moving, but I think
7 a big problem still exists in facilities that I've
8 seen with people getting their medications so that
9 people who need Insulin or blood pressure medications
10 are not routinely getting them all the time, that
11 people who need to be seen and treated for their blood
12 pressure aren't getting seen.
13 So that one of the things we found in
14 California was not only were people dying -- you know,
15 the acute, medical emergency type problems, but that
16 people with diabetes, hypertension were dying from
17 strokes and other things that were complications of
18 their chronic illnesses that if those illnesses had
19 been appropriately treated, they wouldn't have ended
20 up dying. So that the deaths we were seeing were both
21 preventable, some of them, if they just got
22 appropriate emergency care; others, if they got
23 appropriate care for their chronic illnesses.
24 SENATOR ROMERO: Commissioner Dudley;
25 and then we are running out of time. We've got two

1 more commissioners wishing to speak and then we'll
2 probably conclude the panel.
3 DR. DUDLEY: Putting aside the
4 population of unlicensed or grossly incompetent
5 doctors, I get the impression you are saying there are
6 still going to be some good doctors in the system and
7 some who have a variety of other issues that they
8 bridge and I'm wondering what is your thinking about
9 whether that group, you know, whether training or
10 education or something can be done to better develop
11 that group or should we get rid of them too, number
12 one.
13 And, number two, what is your thinking
14 about the responsibility of the profession to do more
15 with regard to the training and development of a core
16 physicians who -- should this be a specialty, for
17 example, I mean, should there be something that's
18 going on to develop a real interest in a pool of
19 physicians who might be able to work in this setting?
20 DR. GOLDENSON: In response to your
21 first part of your question, the competency of the
22 physicians, one of the things that I think I found
23 most shocking in terms of my involvement in the
24 correctional medicine is the number of physicians and
25 nurses that I have come across who, you know, clearly

1 are competent, they're educated, they know what to do,
2 but they really dislike the patients, they feel the
3 patients don't deserve medical care, they think
4 they're all manipulating, trying to get drugs or
5 trying to not work, and they just have a total
6 disregard for the patients they're taking care of.
7 And, you know, on one level, I will accept that there
8 are people who are not going to like prisoners.
9 What's shocking to me is why someone
10 like that, who has a medical education, who spent all
11 that time learning a profession where they can help
12 people would choose to work in a correctional
13 facility. And if they have that attitude, I don't
14 agree with it, I think it's wrong, but they can have
15 the attitude, but then they shouldn't be working in
16 corrections.
17 And I think a lot of it gets back to
18 what you were saying earlier about the -- what's the
19 messages coming from management and all too often that
20 kind of an attitude is accepted by the officials
21 higher up because it means it's less work for them, it
22 means that you are not going to be sending people out,
23 you are going to have cheaper medication costs.
24 I mean, one of the things that we saw
25 in Ohio, when they brought in -- urging a physician

1 who really wanted to take care of the patients started
2 ordering more medications is the nurses got very upset
3 because, partly, it meant more work for them; they had
4 to start going out, giving out more medications, they
5 had to respond to what the patients were complaining
6 about.
7 So I think there is, in addition to all
8 the other problems we've discussed, there is a real
9 problem in terms of attitudes and I think there needs
10 to be a very strong message from administration that
11 that's not going to be accepted and that when you are
12 hiring people, that that needs to be part of what you
13 are looking at, is what are peoples' attitudes about
14 the population they are going to be working with.
15 DR. COHEN: I think that it's important
16 to recognize that these are closed to forming
17 institutions and that there are rare individuals who
18 can professionally -- who can spend a career in them
19 and not be hurt by the daily violence that takes place
20 in prisons and I don't encourage -- the fact that
21 someone has a lot of correctional experience does not
22 look good to me on a resume. It might be fine, it
23 might be terrific, but it might be a problem, and
24 that's not to say there aren't spectacular nurses and
25 doctors who have spent their lives trying to help

1 people, but it's everybody and it's a lot of people
2 who can't.
3 And I think one of the things that
4 needs to be done is to figure out how to identify
5 failures. And I think one of the problems with the
6 national commission and other standards is that they
7 look at the institutional function and don't use, as
8 the unit of quality, the individual patient. And
9 that's not easy to do, it takes a lot more work, but
10 if you don't do that, then people will suffer and the
11 institution can look okay because so much of the
12 volume of material is routine and will come out okay
13 anyway.
14 If 90 percent of the people get their
15 specialty consults, that looks okay if you say
16 90 percent is okay, but those ten percent who didn't
17 were people who really had the complex problems that
18 required urgent care, then you get the kind of things
19 we all find.
20 SENATOR ROMERO: Director.
21 MR. WALLENSTEIN: I am very much
22 opposed to a specialty in correctional medicine.
23 NCCHC has argued we must meet community standards of
24 care and the way you maintain that is by filling your
25 institution with people with community experience.

1 DR. COHEN: I agree with that.
2 SENATOR ROMERO: Commissioner Gibbons.
3 JUDGE GIBBONS: Two quick questions.
4 First of all, we have a lot of private
5 prison contractors in this country today. Do those
6 contracts typically specify in any detail the
7 obligation of the private contractor to provide
8 healthcare?
9 The second question I have is are there
10 any studies that we can be referred to with respect to
11 the economics of private healthcare provider contracts
12 as distinguished from the public health department
13 model?
14 DR. COHEN: I don't think there are too
15 many -- there are barely studies which compare state
16 by state -- you know, adequately in terms of looking
17 at the actual dollars, so I don't think that that is
18 available for you. And I think we -- you know, we --
19 my experience, and Dr. Wallenstein's also, is that the
20 contract can describe in great detail the amount of
21 care and I think it's important that those contracts
22 and settlement agreements micromanage the kind and
23 quality of medical care that's being sought.
24 SENATOR ROMERO: And then I have one
25 last question, we'll conclude the panel, although I

1 know that many others have other questions and we can
2 follow-up during the lunch, I would hope.
3 Precedent was set in California with
4 the appointment of the receiver. What message does
5 this send to the rest of the state, both state prisons
6 and jails; is that good news or is it bad news?
7 MR. WALLENSTEIN: I have no problem
8 telling you that in large measure it's a return to
9 practice of the late '70s and the early '80s when
10 major class action suits were filed in this country.
11 Hopefully, my generation of
12 administrators and my colleagues on this panel don't
13 need that because we know what it is we have to do and
14 we can manage to the exception not to having to see
15 the entire house tumble down. So it's most likely an
16 excellent wake up call, if, indeed, the practices were
17 so negative.
18 DR. COHEN: I think there is another
19 message. Although it wasn't a unanimous decision,
20 Justice Stevens wrote a separate opinion in Estelle v.
21 Gamble and he criticized the majority for requiring
22 deliberate indifference rather than just doing the
23 right thing. And, additionally, he quoted from a
24 report from a legislative commission in California in
25 1972 which described exactly what Judge Henderson

1 described in his report today with actually malicious
2 behavior on the part of doctors towards patients and
3 unqualified medical technicians delivering a large
4 amount of medical care.
5 So I think we have to say not that
6 there's management failure, although there are
7 management failures, but 30 years later what have we
8 accomplished and what's happened in California during
9 that time? The population is 165,000 people. You may
10 not be able to do it and maybe you shouldn't and maybe
11 there are other ways to organize society without
12 having so many people in prison. I think that's the
13 lesson that the constitutional solution has not
14 succeeded to this point.
15 MR. WALLENSTEIN: Robert has raised a
16 really good issue and a tough one for the Commission.
17 Are you going to recommend that we meet standards for
18 this incredibly inflated prison condition or is the
19 Commission also going to engage in the issue of why we
20 have so many people in custody? That's your issue to
21 deal with.
22 No doubt, when Justice Marshall wrote
23 his opinion in 1976 he never anticipated the size of
24 the American correctional system that we have today
25 and that's a very difficult issue.

1 SENATOR ROMERO: Dr. Goldenson, you
2 have the last word.
3 DR. GOLDENSON: I think it's a very
4 strong and a very good message to both the California
5 system because I think it's a very hopeful message to
6 me. I mean, we're going around telling people that,
7 look, this is an opportunity to take a system that's
8 totally broken and turn it into a quality system and
9 we're going to work with you to do that.
10 And I think one of the things that's
11 important to recognize is that the state did not
12 oppose the appointment of the receivership at all and
13 almost welcomed the assistance from the court in
14 dealing with something which they acknowledge was
15 something that they were not doing very well. And I
16 think it's a message to other states that, one, they
17 need to make sure that they're providing appropriate
18 care; otherwise, the courts will also get involved in
19 those situations.
20 So I see it as a very strong move
21 forward by the judge and my concern is the same
22 concern that's been raised here, that given the
23 magnitude of the problem in terms of the numbers of
24 people who are incarcerated in California, estimates
25 are from the state itself that immediately they need

1 to hire 150 qualified physicians. You know, I
2 question whether with a receiver or with whatever
3 you're going to be able to find, today, 150 physicians
4 who want to work in the situation that California is
5 currently in. And my feeling is, and I've said this
6 to the judge and at the status conferences, that
7 healthcare is a constitutional issue and if you can't
8 provide the level of healthcare that's necessary, then
9 you have to reduce the population. I mean, it's
10 either one or the other and you just can't keep
11 building these facilities, knowing that you are not
12 providing the necessary care.
13 SENATOR ROMERO: Dr. Goldenson,
14 Dr. Cohen, Director Wallenstein, we want to thank you
15 very much for your very informative and expert
16 testimony. I think you saw all commissioners were
17 engaged in questioning. We appreciate the insight
18 you've given to us. We look forward to hearing
19 additional recommendations from you as we go forward.
20 And I think is it? All right. It's
21 lunch. Thank you.