SENATOR ROMERO: On this next panel, this particular panel is going to examine the quality of medical care in our state institutions.

On behalf of the Commission on Safety and Abuse in America’s Prisons, I am honored to welcome our next trio of panelists; Dr. Joe Goldenson, Dr. Robert Cohen and Director Arthur Wallenstein.

Thank you so very much for joining with us.

This distinguished panel, the first of
three today to address medical and mental healthcare issues, will explore the quality of correctional healthcare. As a state senator from California, I will say that I know firsthand how important the following panels will be. In California, as many of you may know, our correctional healthcare system has been placed under a federal receivership. It's been estimated that one inmate is dying a preventable death every week in California. Federal Judge Thelton Henderson called what we have in California a trained incapacity. We simply cannot improve our own system and is it of our own design? I would hope that the panelists would address this when they speak.

However, California is not alone and that is why the following panels are essential, not only to our understanding of inmates' constitutional right to healthcare, but of the responsibilities of prison administrators, but also of the threat to the public health, which is another form of public safety. Our first panel this afternoon to address medical and, later, taking a look at mental health needs, will raise concerns raised by the inadequacies of inmate healthcare and they will address mental health issues and treatment. Together we will explore the prevalence and causes of serious
medical care failures and their consequences and our
obligation, not only constitutional, but moral
obligations to address these problems as a
manifestation of abuse.

In conclusion, taking into account
known best practices, we hope the panelists will take
the time to address viable models for improved quality
of care.

We are joined today by three notable
experts in the field. The first, Dr. Robert Cohen was
the vice president of the Health and Hospitals
Corporation, where he oversaw the healthcare services
of New York City's prison units and public hospitals.
He has directed the medical services on Riker's Island
and acted as an expert consultant and monitor in
several prison systems around the country. Dr. Cohen
will testify to dramatic failures in providing
adequate care to prisoners and the tragic consequences
that can result.

Additionally, Dr. Joe Goldenson is an
expert in infectious disease and public health,
Serving as an expert monitor in the California state
prisons and that is how I have come to know him and
greatly respect the work that he has done.

In partnership with the San Francisco
Department of Public Health, Dr. Goldenson currently directs medical services for the San Francisco County Jail. Dr. Goldenson will speak to significant barriers to quality prison medical care and to the current crisis that California state institutions are facing in providing quality care.

I do want to note at this point that Dr. Goldenson was one of the medical experts on the panel that evaluated inmate healthcare in California and his findings, his insight and recommendations were instrumental to the appointment -- to the decision to appoint a federal receiver in California.

Our final panelist is Mr. Art Wallenstein, who is currently the director of Maryland's Montgomery County Department of Correction and Rehabilitation. Director Wallenstein brings with him his vast knowledge of corrections techniques and rehabilitation initiatives, honed from his previous experiences as director of Washington's King County Department of Adult Detention and is both a warden and director of the Bucks County Pennsylvania Correctional System. He will speak to the specific challenges jails pose and the strategies he has employed to provide quality care in a jail setting.

I want to thank you for joining with us
today. I want to remind each of you that we have allocated 15 minutes each for you to present. We will begin with Dr. Goldenson, followed by Dr. Cohen and finally by Director Wallenstein. Upon conclusion of their testimony -- and our timekeeper will be flashing cards, please take note, zero means zero and it's a zero tolerance policy at this point on.

Following your testimony, we will engage in Q and A and dialogue from the panelists. I would like to begin with some questions and then turn it over to Steven Bright and Gary Maynard. We will ask initial questions on healthcare and then we will open it up for all commissioners to participate. We have an hour and a half to review this very serious matter. Let's not squander anymore time. Let's go ahead and begin with Dr. Goldenson.

Thank you for traveling to New Jersey.

MR. WOOL: Excuse me, Senator. I think it's ten to 12 minutes we're going to go with and consult with your timekeeper next to you, but let's go with 12.

SENATOR ROMERO: Okay. You've lost three minutes, 12 minutes.

DR. GOLDENSON: Gained two, actually.

SENATOR ROMERO: If you can speak
DR. GOLDENSON: Can you hear me? Good morning, Commissioners, and thank you for inviting me to this testimony.

When discussing safety and abuse in prisons healthcare is not the first and probably not the second or even the third thing that immediately comes to mind. When we're speaking about deaths and injuries in correctional facilities, violence -- either prisoner against prisoner or staff against prisoner -- is the usual suspect. The reality, however, is that much of the morbidity and mortality that we see in our nations' prisons is the result of inadequate and poor medical care, and that's some of the issues I want the talk about today.

As Senator Romero mentioned, I am one of the medical experts appointed by the Federal Court to look into the California system so a lot of what I'll be talking about comes from our recent reports on California, although I have also been a medical expert in Ohio and involved in a number of other states in terms of medical care, but, primarily, what I'll be focusing on is what we found in California.

Just for some background, in 1976 the United States Supreme Court in a case called Estelle
v. Gamble ruled that it was the government's obligation to provide medical care for those whom it's punishing by incarceration. In reaching this decision, the court referred back to the Eighth Amendment's prohibition against cruel and unusual punishment and stated, basically, that if the state takes away someone's freedom, then they're responsible for providing for their healthcare and safety.

The court set a high standard, though, in terms of how they would evaluate healthcare programs within correctional facilities and, basically, the standard is deliberate indifference to a serious medical need. A serious medical need is one which if not appropriately treated in a timely manner, can lead to either death, measurable deterioration in function, unnecessary pain or a risk to public health.

Deliberate indifference means that you have to prove that either the medical staff or the custody staff was aware of this risk to the individual and didn't do anything so that just showing that someone suffered harm because of poor medical care doesn't rise to the standard that the Supreme Court set. You have to show that someone in a position of authority knew about this and still let it happen.

Unfortunately, 30 years after Estelle,
many correctional systems in this country still have poor and inadequate medical care that does not meet the constitutional standards set by the Supreme Court over 30 years ago. And, in addition to that, many of the systems in this country where there is good medical care, the reason for that is that they have had to deal with the courts and either the court has set up court orders or there have been settlement agreements whereby healthcare is prioritized and the system is fixed.

In many of these cases either medical experts or special masters are appointed to oversee the medical programs while the state or the county is fixing them and to ensure that the court’s decrees are being followed.

Recently in California, U.S. District Judge Thelton Henderson came to the decision that the California system was basically so broken and there was so much suffering due to the poor medical care that he came to, basically, the unprecedented decision to appoint a receiver to be responsible for the entire healthcare system in the California state prison system, despite -- California has 160,000 prisoners in 33 prisons so that, by far, it's the largest system and to go to the step of appointing a receiver was a
very difficult decision for the judge, but he felt that it was something that was necessary, given the gravity of the situation.

James Sterngold, who is a journalist who writes for the San Francisco Chronicle who was covering the hearings said that the decision by Judge Henderson followed weeks of testimony from medical experts that Henderson described as horrifying in its depiction of barbaric medical conditions in some prisons, resulting in as many as 64 preventable deaths of inmates a year and injury to countless others.

Judge Henderson said he was most moved by the, quote, uncontested statistic that a prisoner needlessly dies an average of roughly once a week through medical neglect or cruelty. He went on to say that the prison system offered and I'll call it again, at times, outright depravity. So it's very clear from California's example and other examples that the failure to provide adequate medical care can and does rise to the level of abuse in our prisons.

As a result of the testimony and the findings, the judge decided that California was not capable of managing its own healthcare system and appointed a receiver.

In my written report I go through a
number of reasons why I felt that providing medical care is so problematic in our correctional institutions and I would like to go over a few of those during my time here.

First of all, I think the major issue is that healthcare is just not a priority. Most correctional institutions, custody staff runs the institutions as they should, security is their main concern, again, as it should. The problem is that -- the medical staff often is three or four rungs down on the supervisory chain so that a lot of the decisions about medical care from decisions concerning staffing, budgetary decisions, to the level of whether a prisoner should have a crutch or not, whether a prisoner can be transferred out of the facility for necessary specialty or emergency care are all controlled by the custody staff who really don't have the training or the education or the skills to make those decisions, but these are the people in many of our institutions who are making those kind of medical decisions or at least have control over the final outcome of those decisions.

Again, referring back to Judge Henderson, in his decision to appoint a receiver he stated that we have seen too often in the records
before me, medical decisions give way and suffer
because of ill-advised security decisions so that
prisoners don't even get to their medical care because
of security decisions that hamper effective medical
care.

Kevin Carruth, who at the time was the
second highest ranking official in the Department of
Corrections in California, at an evidentiary hearing
stated that it is not the business of the California
Department of Corrections to provide medical care and
it never will be. He went to say that medical care is
not one of the department's core competencies.

So this breakdown in terms of who
really is managing the program and who is making the
decisions has a number of effects, one of which is
that many of the facilities lack appropriate funding
and resources.

Again, lots of times the budget will
come out, each facility will be responsible for its
own budget and the warden or the sheriff controls
those budgetary decisions and decides how much will go
to medical, how much will go to custody and how much
will go to other areas. Here again, custody concerns
take precedence over medical needs.

I have two minutes. One thing I wanted
to say is that when prisoners enter facilities, they
lose eligibility for Medicare and Medicaid, which
means that the total cost then falls either on the
county in the case of jails or the state in terms of
state prisons and, you know, except for a cost-saving
factor on the part of the federal government, there
really is no reason that should happen and it places
structural institutions at a real disadvantage in
terms of having access to funding that's available to
everyone else for healthcare.

In my report I document a number of
cases where the care was either incompetent to cruel
and we saw cases where it was just shocking to us that
medical professionals were involved in the cases. We
saw cases where on review it was clear the custody
staff had a better idea of what was going on than the
medical staff and the custody staff wanted people sent
to the emergency room outside of the jail facility or
the prison facility and the doctors were saying no,
this guy doesn't need to go and he would die within
two or three hours.

SENATOR ROMERO: Dr. Goldenson, your
time has expired. We'll come back to you in Q and A.
Thank you.

Dr. Cohen.
DR. COHEN: Good morning, Commissioner.

Thanks for the opportunity to be here. In my written testimony, my discussion was fairly theoretical. I'm going to be more concrete in my examples to you today and just to say that the basis of my testimony, like others here, is that for the past 25 years I have worked in prisons, directing medical care in prisons, monitoring medical care. I am currently appointed by federal courts in Ohio, Michigan, Connecticut and New York to monitor medical care based upon class action suits which found that the medical -- which were settled because everyone agreed that the medical care failed to meet the constitutional standard that Dr. Goldenson just mentioned.

And although I'm going to give examples and anecdotes, I ask you to understand that these are easy to find. These are not rare events. Some of the things I will describe will be slightly horrific, but they are not unusual and it's why you are here today and I appreciate the work you are doing because there is a serious problem of violence and abuse in the prisons and, hopefully, your work will begin to reverse it.

When we are ill, we hope that our doctors will be there for us. They know, we know that
the experience of illness is frightening and
difficult, the outcomes can be adverse and privileged
citizens in this country expect their doctor to be an
advocate for them to make sure we get our medicines,
that we get the tests we need, that we will see the
specialist that we have to see if the situation is
complex and requires it, and we expect our doctors to
be responsive to our pain, to our suffering and to
listen to us, although many people feel their doctors
don't spend enough time with them, and to be on their
side.

And prisoners, of course, expect the
same thing. They expect that their complaints of pain
and suffering will be listened to sympathetically and
they expect they need medication, diagnostic testing,
access to specialists, they will get it too, but they
don't expect to get it. Their experience is the
experience that you have heard about and will continue
to describe today, that they fear if the care they
require is complex, expensive, requires trips outside
the prison, that they may not get what they need, and
they certainly won't get what they expect.

Now, there are doctors and other health
professionals in jails and prisons who do provide good
quality medical care, but there are others who don't
try. There are doctors working in prisons who do not
want to be working in prisons, who have a
fundamentally antagonistic relationship to their
patients and who do not advocate on their patients'
behalf. These doctors approach their patients'
complaints by dismissing significant symptoms,
offering palliative treatment to them instead of
careful evaluation and they're also incompetent
doctors who don't know how to treat their patients.

And Dr. Goldenson has talked about the
California experience; there 25 percent of the doctors
are felt to be incompetent beyond remediation at the
present time, and I can't speak to the similar data in
other states, but that's unchallenged by the
California Department of Corrections, as well as by
the union of physicians in California.

Physicians may perceive their --
prisoners may perceive their physicians as remote and
hostile and doctors often view their patients as
manipulative and demanding. Prison administrators
view a prisoner's request for sick call with a
jaundice eye and support co-payments to discourage
frivolous use of care. Patients who complain are
viewed with skepticism and anger and their request for
pain medication may result in anger responses from
Physicians who treat pain are viewed as prisoner friendly, which is not a position that many doctors want to be in an institution.

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

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

And we each toured the facility, we each wrote a report, we did not speak to each other about the reports, although we did communicate that we were doing this because we know each other, and we wrote the same report. We described the same thing and, understandably, the settlement agreement was to implement our reports. And the implementation, I think this is important, actually, in terms of some
point of the questions asked before, was that if the
two of us agreed, then the state had to do it. It was
not required to go back to a court to prove contempt
of the agreement that the parties had agreed to carry
out, but if the two of us agreed, then the state had
an obligation.

And when we got there, patients were
not being treated for pain, pain medicines were not
being prescribed. Patients were not allowed to be
diagnosed with hepatitis C. Insulin for patients with
diabetes -- it was the discussion earlier this morning
about diabetic treatment -- were receiving their
Insulin through the food slots in their steel doors,
which had a glass -- you know, a glass view place and
a food slot and the patients would put their belly up
to the food slot and receive their Insulin.

I found this out when I was reviewing
the medical record and the nurses are supposed to
chart where in the body the Insulin is being given so
there is a normal rotation so that areas of skin don't
become unable to absorb the Insulin, and I saw that
everyone was getting it in the same place over and
over and over again. And I asked the nurses and they
explained to me that's what they were doing.

I can't understand that, although I
can, it's very important for us to understand how can that happen? You know, what nurse goes through their training in order to do that? And I will answer that in questions, I think but I'll -- patients who were examined in Ohio state prison were rare and when they were examined, they were brought by a guard -- a guard -- by three guards. First they were chained, their hands were chained behind their back, their legs chained, their legs chained to their hands and shuffled down a hallway to a medical examining area where they were then chained to the wall and led -- and sitting on a table with their -- and we asked the doctor, how did you examine -- individually we asked the doctor, how did you examine the patients if they had abdominal pain, because they were like this (indicating), and he said it was difficult.

That's changed, although it was very difficult to change it. And the doctor who came in and started insisting that the patients have their chains removed when he examined them was subsequently fired and then rehired.

In Michigan, where I monitor medical care at the Southern Michigan Facility, which is the old Jackson Penitentiary, which was at that time the largest single prison in the United States, housing
5,000 men in a five story cagneist (ph.) facility.

Today -- or hopefully not today -- but, certainly, recently, you know, patients with life-threatening medical illnesses who were known to have cancer would have their treatment delayed for three, six, nine months and every month a doctor would review the chart and be asked is it okay for them to wait another month, and every month the doctor would say yes. Why? I don't know.

I've talked to them and I thought and I believe, as did the judge in this case, that this is a serious, serious problem, although it's of note that the attorney general's representatives in one of the hearings in which I brought this to the judge's attention said what are your standards, Dr. Cohen, you know, are you using malpractice standards, is it a deliberate indifference standard, because we win these cases in court. They're losing right now, but that was the attorney general's, you know, position and one could understand how that could get transmitted back through to the medical staff.

I have some pictures here which I would like to have the Commission to see, you don't have to look at them right now, although you can. There are five copies of four pictures. And they are pictures
of a young man named Gregory Lee who was arrested a few years ago in Louisiana and he was convicted of a crime. He had been -- he had HIV infection, he had two T-cells when he came into prison and he was initially worked up at the New Orleans Parish Prison and then he was transmitted -- he was transferred to another prison and then, finally, to a private prison called Southwest Louisiana Correctional Center, where he never received any medical evaluation, where he was never seen by a doctor, where he was never seen by a nurse and where he one day was accused of escaping by walking from one place to another. There was no possibility of escape, but he was accused of escaping. He was beaten for 12 hours and then he was -- and there are pictures which show him as he was transferred from Southwest Louisiana Correctional to Elaine Hunt Correctional Facility, which is a Louisiana state prison. And there is a picture of him with a rag in his mouth, with his arms bound behind his back, his legs bound together and his arms and legs chained together in a hog-tied position and that's how he was brought to Elaine Hunt, where they took this picture, for whatever reason. And he was then placed in suicide -- he
was accused of escaping and said to be a suicide risk.
He was placed in four-point restrain at Elaine Hunt for three days and then on the fourth day he was released from his restraints and a few hours later died. And there is a picture of him naked in his cell, dead, in Louisiana.

He never received any medical care, except for a lot of tranquilizers when he got to Elaine Hunt, and although medical tests were taken on admission there, they were never looked at.

These look like Abu Ghraib pictures when you see them, and I don't have a lot of pictures like that, but I have these pictures and they are -- they're the worst thing I have ever seen, but this happens in Louisiana regularly and this private prison company has been indicted for torturing prisoners on a number of occasions.

Few other points I would make, if I had more time, would be that there should not be unlicensed doctors in positions in prisons. In Mississippi, where I review the medical care for HIV prisoners five years ago, while under the direct control of the University of Mississippi Medical School, all of the doctors that -- whose credentials I could review, and I think it was all of them, had lost
their license to practice medicine in Mississippi, but were allowed to practice in Parchman Farms and in a women's facility and they were providing medical care to people with HIV infection completely in contradiction to the required standards, which are national in this.

Patients who had been on three drugs were taken off of their three drugs, placed on two medications, required to take the two medicines for six months and then a third drug was added. I guess my time is up, but I will --

SENATOR ROMERO: We'll return to you on Q and A. Thank you.

Director Wallenstein.

MR. WALLENSTEIN: Thank you. I would like to agree initially with Judge Gibbons who noted that this is a patchwork issue. It isn't all negative, it is certainly not all positive and, hopefully, the members of the Commission are able to engage this question of healthcare and mental healthcare as you look for solutions, advocacy, prescriptive packages and things that you can urge the profession, not simply of corrections, but of public policy to take. So I think I appreciate the patchwork notation.
There is no question, there is no doubt that correctional healthcare is a core competency in this profession. The statement of a colleague I'm sure was properly quoted, and I need to ensure that this Commission is aware, that to the great majority of correctional administrators, this is mainstream practice, as we move to becoming a de facto mental health system in the United States, that may be another issue, but medical care represents as core a practice within correctional operations certainly as security and it has been accepted and largely been in that domain since Justice Byron White, I believe, spoke in 1974 in the case of Wolff versus McDonnell. And while he was talking about disciplinary issues at the time, he noted as persuasively certainly as any decision that prisoners were not beyond the scope of the Constitution of the United States. And while the exigencies of an institutional environment may cause some issues to be considered, the Constitution was not thrown away. And he noted very directly that there was no iron curtain separating the prisons of this country from the Constitution of the United States.

Now, one value of being 60 is that I was here pre-Wolff versus McDonnell and pre-Estelle and I was there when these practices were, let's say,
wholly inappropriate, even in well-intentioned
environments, because we lacked guidance, direction
and standards. That's a big difference from
deliberate indifference or uncaring, but simply the
tools had not yet been developed and I feel that was
certainly one of the things that I bring to this
testimony is that I don't come from simply a rarefied
environment in a wealthy Maryland County. I served as
the assistant warden at the Illinois State
Penitentiary at Joliet in Stateville -- I doubt that
there are anymore difficult correctional environments
in this country -- and had a chance to see the
pre-Estelle practices and know the value of judicial
involvement and know what has happened as a result of
that judicial involvement.
I will return to that, but I want to
make a few comments very briefly on jails. The title
of this Commission is The Commission on Safety and
Abuse in America's Prisons. When I was reading
through the website just ten days ago I said, woops,
the jail issue has been missed again, like it always
is, and that's no criticism, and that led me to call
the Commission and ask if I might testify because I
saw your list of witnesses and they were highly
competent and certainly could say all the things that
I might have said.

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

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

I need to reiterate this point because we find ourselves having to advocate for the jails. And my guess is it's because of the larger size of daily prison populations and the fact that part one crime is largely involved. But many of us, of course,
have read the broken windows approach and know that lesser crimes may have the dominant impact on public safety perceptions in the United States and jails are in a unique position to engage these issues because of their proximity to local communities.

When Judge White, from my perspective, exploded the issue of prison and jail conditions as a valid constitutional issue, he opened the door for the period 1974 through 1991 when virtually every aspect of corrections became open to constitutional practice. And you heard from Vince Nathan and Fred Cohen, veterans of the shop floor of those incredible years, where hundreds of Federal Court decisions were rendered, establishing core, basic floor practices and whether one colleague disagrees or not, healthcare is smack in the middle of those core practices.

In '76, as my colleague, Mr. Goldenson, so ably noted, Mr. Justice Marshall wrote for an undivided court in Estelle versus Gamble that there was no doubt that healthcare was mandated and while the deliberate indifference standard may have required a high degree of proof that there was significant violation to the folks on the shop floor myself, there was never a question that constitutional practices had to be carried out. Done, agreed to and buyer beware
if quality healthcare wasn't going to be provided.

The American Medical Association engaged this issue and established the first core standards program and that's something I really wanted to note to the members of the Commission. They prescribed and developed prescriptive packages, everything from what you do at the front door and to what you are supposed to do to refer clients to community-based programs upon their release. Those standards exist today and, if universally implemented, while there will still be some abuse, of course, day-to-day lack of concern will diminish.

The National Commission on Correctional Healthcare took over for the AMA, they exist today and their work is certainly instrumental in establishing core quality healthcare practices around this country. They don't obviate the need for, certainly, intensive attention and accountability, but no one in this profession could possibly say that healthcare is not a core element of correctional operations and correctional practices.

The American Correctional Association has adopted strict healthcare standards. Perhaps in part gleaned from NCCHC, but now independently as part of their standards program.
As of yesterday, in the jail side of the house there were only 124 jails in America that had received ACA accreditation. There were 242 jails in this country that had been accredited by the National Commission on Correctional Healthcare. Why do I note this? Kudos to those who do, but this Commission needs to reinforce that every correctional institution in this country needs to follow those standards. The public health service had a chance to buy into this many years ago, sort of chose not to and, hopefully, we can get the public health service back into this business.

That doesn't mean that everything is perfect, but it does mean that the standards exist to monitor core basic practices in this country regarding healthcare and they offer a template and they offer standards and they offer a road map and it means that community standards of care are brought into the institutions and there can be no debate any further about what quality practices are and they do establish constitutional minimum.

And while federal courts have been reluctant to say that accreditation is a core practice, those who are accredited and have followed the standards of NCCHC and the American Correctional
Association generally are not before federal district courts, don't have consent decrees entered against them and are generally working with individual cases where better care might have been provided, which is, hopefully, where correctional services as a whole should be on an ongoing and regular basis.

You learn from the exceptional case, you don't deal with death on a daily basis because you have standards and practices and protocols that are carried out, that are implemented and that are the subject of high accountability.

Let me begin where I ended and thank Dr. Goldenson for just mentioning that one comment; healthcare is a core, a nondebateable core practice in the area of corrections in this country. Accept nothing else and render your judgements in your report that mandate and allow no other tolerance of anything but quality healthcare.

SENATOR ROMERO: Thank you, Director.

Commissioner Bright, do you want to begin the dialogue?

MR. BRIGHT: Sure. I will be glad to.

I want to ask with regard to Dr. Goldenson, you are in San Francisco and, I assume, work for the jail authority there; is that right?
DR. GOLDENSON: No. Actually, in San Francisco the healthcare services are provided through the public health department.

MR. BRIGHT: The public health department.

DR. GOLDENSON: So I work for the public health department.

MR. BRIGHT: And Dr. Cohen was at Riker's and, I assume, worked for the New York Department of Corrections?

DR. COHEN: New York City Department of Health, right, but for the city, yes.

MR. BRIGHT: And my question is this, and it's two sort of related questions, which is we see in this area of private healthcare providers, the largest being I think Prison Health Services, which we've had some experience with, and I just wanted to get what your comments were, all of you, with regard to private healthcare providers, both in jails and in prisons, and sort of related to that that in the very remote areas, where a lot of prisons are, particularly the supermax prisons and so forth, often way down in places where nobody much goes, the difficulty of finding doctors and nurses and the utilization of people, healthcare professionals, who are not able to
practice in the public at large, who have prior
convictions or have been defrocked or someone spoke at
the earlier panel about language and cultural
differences of people --

    DR. COHEN: On the for-profit area.

When I worked on Riker's Island I actually was a
contract, but a not-for-profit contract. I worked for
Montefiore Medical Center in New York City, which had
a contract with the City and we did not have a profit
built into our thing.

    I think that the recent New York Times
story by Paul Vonzielbauer on PHS in New York City,
I'm sure the Commission has access to that, you know,
showed some serious problems with PHS care using
unlicensed psychiatrists in a very intensive mental
health program.

    In general, whenever there is a
contract which -- in which there is a risk contract --
"risk contract" in medicine means that every dollar
you pay you don't keep yourself, then there is a
incentive to provide less care.

    Sometimes the for-profit contracts are
written to avoid that by only paying for -- by
encouraging the utilization of services and limiting
the profits that can be made by not providing care, in
fact, sometimes even debiting dollars for unfilled
positions. But, in general, my experience has been
quite negative in this.

In Philadelphia, where I monitor the GL
medical care for a number of years, PHS had the
contract, and they refused to ever put in the bid that
they needed to meet the care levels that were required
because they knew they would be underbid by next
year's bidder and that was a very serious problem.

And in Michigan, where I currently
monitor, where Correctional Medical Services provides
the medical components, that's the physicians, the
hospital care and the specialty care, although they
have an incentive to supposedly a cost-plus contract,
they still have a relationship with the State of
Michigan, which is not interested in paying cost plus
for everything. And my experience is access to that
specialty care is extremely limited in this group,
less than half our patients get their care in the time
it's allocated.

There are other questions but I will
let my other panelist answer.

DR. GOLDENSON: I agree with Dr. Cohen
in terms of the private medical services. I think one
of the major problems with them is that when there is
a profit motivation, there is less likelihood that
patients are going to be sent off-site for specialty
services that are often only available in the
community or for emergency services so that a number
of cases I have reviewed where people have died, it's
because they haven't been sent out in a timely manner
to an emergency room and I think there's -- from
talking to staff who work in these institutions,
there's not a rule, but, basically, an understanding
that you should try to avoid, as much as possible,
sending people out.

You know, by contrast, in San
Francisco, as I said, we're part of the public health
department, the hospital that we send people to is
part of the health department so it's all one system
and, you know, what I tell my staff is if there's any
question, you send someone to the emergency room, just
to make sure that we're not missing something.

So it really is a difference in
philosophy and what your motivation is, whether it's
to provide the best possible care or to try to make a
profit on it.

MR. BRIGHT: Is that fairly rare, to
have the whole system together; the public health
system, the public hospital and the jail all in one
unified system of healthcare delivery or do you know.

DR. GOLDENSON: It's not the usual model, but I know in California, at least, there are a number of counties where that is the model. I'm not aware of any state prison system where that's the model, but at least in California a number of the jail systems -- I mean the predominant number are still health services are run through the sheriff's department, but there are a significant number where it's provided through the health department.

In terms of your second question, I think that's a major concern in terms of having -- finding qualified physicians who are willing to work in what is often not very good working conditions and very isolated areas and at the same time not being paid what they could make in other places. And it's one of the questions that we're looking at in California because of the large number of institutions, many of which are in remote areas and not only for physicians but for nursing, there's huge numbers of vacancies in some of these facilities. Facilities with maybe four, 5,000 people where they only have two or three doctors currently.

You know, unfortunately, I think the answer is that you have to pay people more to attract
them to work in those situations. The other things we're looking at is a lot of these rural areas do have medical schools or residency programs in family practice, trying to connect the family practice programs with the prison systems to use some of these resources and make it part of the training program so that the residents and the faculty from these different residencies, part of the time, while they're in training, will be spent in the correctional facility.

MR. BRIGHT: What about using doctors who aren't licensed, generally?

DR. GOLDENSON: Well, I mean, I think that should not be allowed. The physicians working in correctional institutions need to have the same qualifications, the same licensure as someone working anywhere else.

One other point I wanted to make is that a lot of systems are starting to make more use of mid-level practitioners, such as nurse practitioners and physician's assistants, and in some of the more rural areas in San Francisco even we utilize nurse practitioners to a very large extent in providing the care. My experience has been that they're younger, they're more motivated, they're excited about working
and taking care of patients so that we've had a very
good experience using nurse practitioners. And in
California they're starting to make an effort to do
that also because, unfortunately, a lot of the
physicians that we're finding in the California prison
system are retired physicians who may have been
anesthesiologists, radiologists, pathologists,
positions where they really didn't have primary care
responsibility and so cardiothoracic surgeons dealing
with some very complex medical problems.

So it's not only a question of what
their licensure is or -- it's also are the people who
are seeing -- are they trained in the skills that they
need to -- are they credentialed and do they have the
current privileges to really provide the care that's
necessary and, unfortunately, as Bobby said, our
findings were upwards of 25 percent of the doctors
working in the California system were either
incompetent or inappropriately credentialed doing the
kind of care they're doing.

SENATOR ROMERO: Commissioner Maynard.

MR. MAYNARD: Thank you. I have a
question for Dr. Goldstein and Dr. Cohen both, and
following up on Mr. Wallenstein's testimony about
accreditation of ACA or NCCHC accreditation in support
of that, I would like to know what your position would
be about that type of accreditation and if not that
type, what type of standards do you think that the
healthcare should have? And you can be very brief in
your answer.

DR. COHEN: I'm a member -- I'm on the
board of the National Commission For Correctional
Healthcare, I represent the American Public Health
Association, and the American Public Health
Association also issues standards from medical care.
It just issued its third edition. The standards are a
positive thing. The national commission standards are
too easy sometimes, the American Correctional
Association standards, historically, have been not
adequate, although they're making an effort to improve
that right now. It's not sufficient, though. I mean,
it definitely improves it.

I do think that it's important to
recognize that even if medical care is a core
competency of correctional administration, there is a
fundamental conflict between medical care and the
other competencies, which are control and punishment.
And these are -- medical care is not about punishment,
it's about palliation and support, and these are in
conflict. And when the medical staff don't realize
that they have to be in conflict, then in order to
achieve their goals they have to -- this doesn't have
to be ungentlemanly or ungentlewomanly, it can be
respectful, but it can't be simple, it can't be that
everything is okay.

When you send someone out of the
facility, it means you are disrupting the facility.
When you are ordering pain medication, you are
potentially allowing pain medication to be in the
institutions. When you are declaring an emergency,
you are moving people around who perhaps should not be
routinely moved around. So there is fundamental
conflict.

MR. MAYNARD: What would be your
solution to those problems?

DR. COHEN: Well, just -- my solution
is to make sure the medical staff value their
competency and the importance of maintaining this
conflictual yet workable relationship. That they
understand that if they need to do something and
correction says no, if they really need to do it, they
have to fight for it.

SENATOR ROMERO: Director.

MR. WALLENSTEIN: I agree with my
colleague, but the remediation is enhanced management.
I mean, it is a top-down issue. The Supreme Court told us you do it or you pay and you pay and you pay. So if administrators are selected who don't understand that it's a core competency or don't work with the staff so that conflict can be mitigated, as you so appropriately stated, you are not doing your job as an administrator.

Sure, we have staff, does John have to go out for the eighth time? NCCHC took care of that, they said nonmedical personnel shall not intrude in providing medical services. So a warden doesn't determine who needs to go out. Yes, you might wait for four police cars if the person is an escape risk, but the issue of the going is a healthcare decision and you either do it or you pay the penalty for failing to do it. That's why I make the point of core competency.

The modern manager today, given the Supreme Court engagement and involvement, knows you must blend the two, it's part of doing business.

SENATOR ROMERO: Commissioner Rippe, followed by Commissioner Schwarz.

MR. RIPPE: Yeah. One of the issues that the United States military faces is otherwise
Can you all address how we do dental care for inmates, especially long term ones?

DR. COHEN: It's -- there are -- most places, most states do a dental evaluation on intake for all prisoners. There are too many teeth pulled versus restorative work. I think it -- in some of the systems I have seen when under court order it's been okay, but I think -- it has not been litigated a lot, in my experience. I think it's probably nowhere near what it should be. There are a lot of extractions.

SENATOR ROMERO: Commissioner Schwarz, I have one question for Dr. Goldenson and one question for Dr. Cohen.

Dr. Goldenson, for you -- maybe I'll do both questions and then turn it over to you.

For you it's -- you mentioned that the federal government will not supply Medicaid or Medicare payments to people who are incarcerated. Is that also the case for other people who are in institutional settings or are custodial settings singled out?

And the question to you, Dr. Cohen, is
about abuse and whether doctors see abuse and report it and, more generally, if you could comment based on your experience on whether there are difficulties or barriers to a group like us assessing the evidence on the extent to which there is or is not abuse in facilities.

DR. GOLDENSON: As far as I know, the loss of the health benefits is only for people who are incarcerated. People who are in mental hospitals, for example, maintain their benefits and that's how a lot of the care gets paid for, for people who don't have money. So that, again, I could be wrong on this, but my understanding is that it's the fact that someone is arrested and put into a correctional facility, they automatically lose their benefits.

DR. COHEN: I am sure that there is a substantial underreporting of violence in America's prisons right now. Traditionally, when there is an injury, there is a requirement for a report and medical staff have a component to that report. These reports actually usually end up being 20 to 50 pages of multiple observers.

What's important in terms of the data that's being collected is that the prisoners are not asked what happened, as part of the -- by the
physician or by the nurse examining them. There is
some analysis, perhaps, by corrections, but the
medical staff don't ask what happened.

And, for example, when I worked on
Riker's Island, there was an epidemic of people
falling out of their bunks and there was also an
epidemic of people who were slipping in showers. This
happens in prisons throughout the country. So there
is lots of violence which is described as

nonintentional violence, which is actually intentional
violence, and I think it's very important that prisons
begin specifically understanding it's a public health
issue, which actually our country is engaged in for
CDC in terms of they have a whole section on violence,
but intentional versus unintentional violence, to
identify that within prisons.

Also, there is -- medical staff do not,
in this country, on a routine basis report violence
that they observe. This was clearly a problem in
Iraq, Afghanistan and Guantanamo and is also a problem
in our country. I think one of the solutions to that
is to bring into the United States international
conventions against torture which specifically are
designed to talk about conditions in prison, and make
a requirement that medical staff report any
observations of violence to appropriate authorities within the institution. And the corollary of that would be that failure to make those reports should bring sanctions on to physicians.

SENATOR ROMERO: Commissioner Schlanger.

MS. SCHLANGER: My question is about private providers of healthcare services. And what Dr. Goldenson and Dr. Cohen said before is pretty uniformly negative about for-profit providers.

I wonder -- it seems like that's not going away so that uniform negativity is not -- hopefully, there's some opportunity there as well and I wonder where that might be and one idea that I have is about jails. I wonder if the private providers of healthcare, in small facilities especially, have the potential to bring in some kind of larger scale expertise that small jails just don't develop because they don't have sufficient people. And if that's something that there's any policy or recommendation or something that could move further in that direction, if there's anything constructive that could come out of this increasing privatization of healthcare in jails or prisons.

So I don't exactly know who is best to
answer that so I wonder what all three of you think.

MR. WALLENSTEIN: I've chosen not to utilize private providers. That doesn't mean there are not some that are not quite competent and, frankly, most of it relates to the development of the RFP and the degree of accountability. You get what you ask for and if you haven't built in core competencies and very detailed protocols, then you shouldn't expect to receive them.

Many jurisdictions are not very good at writing RFPs or requests for proposals and then in having highly competent contracted administrators review the nature of the work.

So I think there needs to be -- before a local jurisdiction embarks upon this there needs to be a real recognition that this request must be highly professional and must include, in total, the standards of the National Commission on Correctional Healthcare, the American Correctional Association or, frankly, it isn't worth engaging in that course at all.

I happen to believe public employees can do it better, and that's just a personal prejudice of mine, it does not mean there are not some very well-intentioned private providers but you need to monitor these issues until they drop.
DR. COHEN: I agree that the contract is -- I mean the important thing is the contract and the RFP. I mean if there is an ability to make money by not providing services, then that's going to happen. Small jails can -- could utilize the -- you know, potentially I mean, PHS or CMS or all these places will, in an hour, give you a proposal which will be very, very impressive, and Power Point, but whether that actually means anything within a facility, I'm not sure.

And, again, in the New York Times articles where the deaths were reported in small jails in New York state, these were almost all for-profit providers that were running the services at those times.

SENATOR ROMERO: Commissioner Sessions.

JUDGE SESSIONS: We've heard testimony over the last two days about the involvement of federal courts in mandating certain things.

Are there also mandates from state courts that relate to medical care that you have discussed?

DR. COHEN: In Pennsylvania, the Philadelphia -- there are two consent agreements in Philadelphia simultaneously, one federal and one
state, and I monitor the state, and it was very helpful, I think, to the system.

I think -- I'm not a lawyer, but I -- but my sense is that depending upon where the courts are, what the district is like, that state courts can be used as a forum for improving healthcare.

JUDGE SESSIONS: Is that true in California?

DR. GOLDENSON: I don't know if they can be used. I'm not aware of it ever happening and I know the state -- all of the -- there have been a number of lawsuits around healthcare, mental healthcare in the state prison system, dental care is one, Americans with Disabilities, and they have all gone through the federal courts and then most of the individual counties where -- that I am aware of with that consent decree, it has also been through the federal court.

JUDGE SESSIONS: Director.

MR. WALLENSTEIN: Over half of the states have state standards for jails.

JUDGE SESSIONS: Yes.

MR. WALLENSTEIN: Those standards can be enforced generally through the administrative process and then through state courts, but I will tell
you, the standards that are mandated in those
documents inevitably came down through federal court
intervention at one time or another. So the federal
court is still a very friendly forum, not only for
prisoners and their advocates, frankly, but for
institutional administrators like myself, who want to
be ordered to do things in an appropriate way.

It's almost striking to me because I
thought this issue of healthcare, absent individual
cases of problems, had been put to bed 25 years ago
about the importance of healthcare in correctional
institutions.

JUDGE SESSIONS: Dr. Goldenson, we have
talked about the receiver appointed by Judge
Henderson. Who was that appointed, do you know?

DR. GOLDENSON: The decision hasn't
been made yet as to exactly who it is. The judge is
considering a number of possibilities right now.

JUDGE SESSIONS: Talking about Medicare
and Medicaid being taken away at the time they become
incarcerated, is it restored when they are back out,
even on parole, or is it still unavailable?

DR. GOLDENSON: Well, once someone is
released from custody, then it is restored, so it's
really suspended while they're in custody. Once
they're out of custody they can -- in most situations
it's been suspended so that it's not difficult to get
it started up again.

A lot of places I've been to are not
aware that you can suspend it so it does get
terminated, which means then the person has to reapply
and that can take months to happen. So that it
depends what jurisdiction is and what they're doing,
but it really is for the period of time that the
person is incarcerated that they lose it.

JUDGE SESSIONS: So this is nationally
and not just California?

DR. GOLDENSON: Right, it's a federal
law. From what I understand, it's the federal law
that distributes the funding, mandating that the
states cannot use it for anyone who is in a
correctional facility.

JUDGE SESSIONS: Yes?

MR. WALLENSTEIN: I would like to
respond on the county level. This is an unbelievable
issue and I hope the Commission understands it. To
take away benefits at the jail level from a person who
has not been found guilty, to me has always raised an
equal protection argument. Two people who are
mentally ill, both arrested on the same day of the
same crime, one makes bail, one goes home, one goes to
his provider and the other is removed from benefits.
It makes no sense for the 10 million who are engaged
at the local level.

Plus, remember, taking mentally ill
people -- and that's a topic for this afternoon, which
is a far more serious issue in my estimation, it isn't
like us getting in our car and going to a location.
Simply getting from point A to point B for most
offenders, as you heard this morning for the gentleman
from New Jersey, may arrive at a level of
sophistication that simply isn't done.

Frankly, these benefits should be
restored before the persons leave and it should be
required that every institution in the country bring
in social service, Social Security Administration,
whatever is required so the benefit card is present
the day they walk out.

MR. SCHWARZ:  Did you actually say that
someone losses their Medicaid and Medicare when
they're put in a jail before they have been convicted?

MR. WALLENSTEIN:  Yes, they are,
suspended the day they walk in and, in many cases, it
is revoked, not suspended. Many of us believe it
should be suspended, fine, but, certainly, go into
practice the day they set foot back in the community.

JUDGE SESSIONS: Dr. Goldenson or
Dr. Cohen or Director, what is the percentage,
generally, of inmates who actually would otherwise be
in mental institutions or have mental problems?

DR. GOLDENSON: National statistics are
that anywhere from 12 to 20 percent of people in
correctional institutions have serious mental health
problems, which is like severe depression or psychosis
or something like that. So not all those people would
be in another institution, they might be in community
care, but they would be on medications, they would be
in residential programs, maybe mental hospitals, but
they certainly do not belong in jail or prison.

And one of the things I was going to
say, if I had more time, is the big issue is really,
to me, the overcrowding of our jails and prisons and
that there are so many people now incarcerated. Some
of the prisons in California have five, 6,000
individuals in one facility that was supposed to hold
two or 3,000. There's just no way you can develop a
medical system that's going to be able to adequately
function in that kind of setting. And so many of the
individuals who are currently incarcerated either have
mental health problems or substance abuse problems
that can and should be treated in the community or, at 
a minimum, have treatment -- they'll talk about this 
this afternoon I'm sure -- treatment in the facilities 
so that these folks don't get released and come back.
I mean, within those two groups the rates of 
recidivism are extremely high.

JUDGE SESSIONS: Dr. Cohen.

DR. COHEN: I know the Commission 
understands, but I just want to stress that this 
discussion is taking place in aberration. That there 
are 2.2 million people in prison and jail in the 
United States today, with a rate of approximately 750 
per hundred thousand and in France the rate is 75 per 
hundred thousand, in England the rate is 120 per 
hundred thousand, as it was in this country a number 
of years ago, and their rates of increase have been 
dramatically less than ours. The murder rates in 
Europe are one-fifth of what they are in our country 
and it becomes difficult or impossible, I think, to 
ratchet up, to scale up, to use sort of these 
industrial metaphors from Dell, you know, about their 
servers, when we're talking about humans in prison.

These institutions change qualitatively 
when they have so many of our people in it and, again, 
you know, this issue, I'm sure, the Commission is
addressing, you know, it's not just random people. 
You know, the chance of a black man being in prison is six times greater than a white man being in prison, but these numbers create the problems that you are describing today and there is no reason why there needs to be 2.2 million people in prison.

When all of us began our work, some of us felt that if we could take Belvy(ph.) -- (inaudible) -- and Estelle and say we had some equivalence principle of care, that the cost was going to be the same for prisoners or more because of the turnover than it would be for people outside of prison and by getting prisons to provide adequate care, forcing them to spend the amount of money that was required to do it right, that we would stop the growth of prison because it would be too expensive. Wrong.

JUDGE SESSIONS: Thank you. Let me give you another question --

SENATOR ROMERO: Commissioner Sessions --

JUDGE SESSIONS: I just got to ask.

This may be incidental, but when an inmate goes into a clinic, does he become the patient of a doctor or does he become patient of the clinic?

DR. COHEN: It depends on the place.
Some places have a model where people are regularly seen by the same doctor, some places they're not.

JUDGE SESSIONS: You said that they could not be treated for hepatitis C. Can they be tested for hepatitis C and are they?

DR. COHEN: In OSP, when we started there --

JUDGE SESSIONS: OSP?

DR. COHEN: Ohio State Prison, they were not being tested or treated. They are now being treated, but that was because of the court intervention. The rest of Ohio would not be treated.

SENATOR ROMERO: Commissioner Nolan.

MR. NOLAN: Two issues, one is about dental care. My understanding from a lot of discussions on this, one of the reasons there are so few lawsuits about dental care is it's not life-threatening so it doesn't raise to the level of scrutiny. My experience is teeth are pulled -- either let them rot or they're pulled. In fact, when I was in prison I never saw so much flossing in my life because they're very protective of their teeth, they know they only have one set issued and they'll lose it. But that is a substantial problem of discomfort, pain.
Now, the second prison I was at they did send out for dental care, they put dentures. It was a much healthier system for the esteem of the inmates for their visits.

But the second issue, I would really compliment Director Wallenstein on the superior institution that he runs and at the risk of overstepping my bound, I visited his facilities right near Washington, D.C. and I know many of the commissioners come into Washington and walking through it, talking to the inmates, talking to staff, which I was totally free to do, it's astounding a jail, the lack of noise, compared to the noise level in most jails, it's just astounding, but the respect with which the inmates treat each other and the staff is remarkable and it's because of Director Wallenstein's leadership.

So I would hope that at some point when your travels take you near DC, it's not very far outside of it, and he was most hospitable and it was very instructive.

SENATOR ROMERO: Commissioner Green.

MR. GREEN: This is a question that's directed to Dr. Cohen and Dr. Goldenson, or maybe both will comment on it.
It's hard for me, and I guess as many
of us on this Commission, to understand how healthcare
is administered in a prison. I mean, we know what
happens when we go to the doctor or when we end up in
a hospital and I think about this in light of I think
it was Dr. Cohen talked about how diabetes was handled
in terms of the administration of Insulin and the
person who was shackled to be examined.

How close to what we consider typical
is medicine administered and at what impact does that
have on the quality of the doctors or nurses who come
in and our ability to recruit doctors and nurses into
the setting; are there danger issues? What is the
relationship like to administer medicine?

DR. COHEN: Well, the routine is that
if the prisoner wants to get medical care, they
request it through some process, which is called a
kite or a sick call slip or they sign a piece of
paper, and in most -- I don't know in most -- in
increasing numbers of prisons and jails in the United
States today once they do that, they're committing to
pay for their care. There is a co-payment which is
required in Ohio, in Michigan, not in New York state,
but in many, many, many, many facilities right now.
So they are now committed to pay three to $5 for the
care, which is a barrier, which is a barrier that we face also and I -- but so they put in the slip and then they -- usually a nurse, in some systems, in California, I believe, a nonmedical -- a non-nurse, a medical technician would review that and decide whether they can treat it or they need to refer to -- a nurse had to see the patient or a doctor had to see the patient and there would be time delays, depending upon the situation, how long someone would be seen.

I don't think that the medical staff feel that they're endangered in prison, although they fully accede to policies which make it appear as if they are in danger. So, for example, in segregation units doctors and nurses will allow for the kind of shackling that I described on a routine basis, even though they know the prisoners are not dangerous to them. Maybe I'm just -- you want to add to it?

DR. GOLDENSON: I will just say in terms of some of the more chronic diseases, like diabetes, that in the better systems there will be chronic care programs set up so that people will be seen on a regular basis, that they will get their medications, that it's not dependent on the patient him or herself putting in a slip for those kinds of problems, but once they get enrolled in the program,
then they're seen on a regular basis, the same as if you or I went to see our doctor and they said come back in three months.

Unfortunately, that's not true in a lot of systems. It's true in some and not true in others. It's what the direction things are moving, but I think a big problem still exists in facilities that I've seen with people getting their medications so that people who need Insulin or blood pressure medications are not routinely getting them all the time, that people who need to be seen and treated for their blood pressure aren't getting seen.

So that one of the things we found in California was not only were people dying -- you know, the acute, medical emergency type problems, but that people with diabetes, hypertension were dying from strokes and other things that were complications of their chronic illnesses that if those illnesses had been appropriately treated, they wouldn't have ended up dying. So that the deaths we were seeing were both preventable, some of them, if they just got appropriate emergency care; others, if they got appropriate care for their chronic illnesses.

SENATOR ROMERO: Commissioner Dudley; and then we are running out of time. We've got two
more commissioners wishing to speak and then we'll probably conclude the panel.

DR. DUDLEY: Putting aside the population of unlicensed or grossly incompetent doctors, I get the impression you are saying there are still going to be some good doctors in the system and some who have a variety of other issues that they bridge and I'm wondering what is your thinking about whether that group, you know, whether training or education or something can be done to better develop that group or should we get rid of them too, number one.

And, number two, what is your thinking about the responsibility of the profession to do more with regard to the training and development of a core physicians who -- should this be a specialty, for example, I mean, should there be something that's going on to develop a real interest in a pool of physicians who might be able to work in this setting?

DR. GOLDENSON: In response to your first part of your question, the competency of the physicians, one of the things that I think I found most shocking in terms of my involvement in the correctional medicine is the number of physicians and nurses that I have come across who, you know, clearly
are competent, they're educated, they know what to do, but they really dislike the patients, they feel the patients don't deserve medical care, they think they're all manipulating, trying to get drugs or trying to not work, and they just have a total disregard for the patients they're taking care of. And, you know, on one level, I will accept that there are people who are not going to like prisoners.

What's shocking to me is why someone like that, who has a medical education, who spent all that time learning a profession where they can help people would choose to work in a correctional facility. And if they have that attitude, I don't agree with it, I think it's wrong, but they can have the attitude, but then they shouldn't be working in corrections.

And I think a lot of it gets back to what you were saying earlier about the -- what's the messages coming from management and all too often that kind of an attitude is accepted by the officials higher up because it means it's less work for them, it means that you are not going to be sending people out, you are going to have cheaper medication costs.

I mean, one of the things that we saw in Ohio, when they brought in -- urging a physician
who really wanted to take care of the patients started ordering more medications is the nurses got very upset because, partly, it meant more work for them; they had to start going out, giving out more medications, they had to respond to what the patients were complaining about.

So I think there is, in addition to all the other problems we've discussed, there is a real problem in terms of attitudes and I think there needs to be a very strong message from administration that that's not going to be accepted and that when you are hiring people, that that needs to be part of what you are looking at, is what are peoples' attitudes about the population they are going to be working with.

DR. COHEN: I think that it's important to recognize that these are closed to forming institutions and that there are rare individuals who can professionally -- who can spend a career in them and not be hurt by the daily violence that takes place in prisons and I don't encourage -- the fact that someone has a lot of correctional experience does not look good to me on a resume. It might be fine, it might be terrific, but it might be a problem, and that's not to say there aren't spectacular nurses and doctors who have spent their lives trying to help
people, but it's everybody and it's a lot of people who can't.

And I think one of the things that needs to be done is to figure out how to identify failures. And I think one of the problems with the national commission and other standards is that they look at the institutional function and don't use, as the unit of quality, the individual patient. And that's not easy to do, it takes a lot more work, but if you don't do that, then people will suffer and the institution can look okay because so much of the volume of material is routine and will come out okay anyway.

If 90 percent of the people get their specialty consults, that looks okay if you say 90 percent is okay, but those ten percent who didn't were people who really had the complex problems that required urgent care, then you get the kind of things we all find.

SENATOR ROMERO: Director.

MR. WALLENSTEIN: I am very much opposed to a specialty in correctional medicine. NCCHC has argued we must meet community standards of care and the way you maintain that is by filling your institution with people with community experience.
DR. COHEN: I agree with that.

SENATOR ROMERO: Commissioner Gibbons.

JUDGE GIBBONS: Two quick questions.

First of all, we have a lot of private prison contractors in this country today. Do those contracts typically specify in any detail the obligation of the private contractor to provide healthcare?

The second question I have is are there any studies that we can be referred to with respect to the economics of private healthcare provider contracts as distinguished from the public health department model?

DR. COHEN: I don't think there are too many -- there are barely studies which compare state by state -- you know, adequately in terms of looking at the actual dollars, so I don't think that that is available for you. And I think we -- you know, we -- my experience, and Dr. Wallenstein's also, is that the contract can describe in great detail the amount of care and I think it's important that those contracts and settlement agreements micromanage the kind and quality of medical care that's being sought.

SENATOR ROMERO: And then I have one last question, we'll conclude the panel, although I
know that many others have other questions and we can
follow-up during the lunch, I would hope.

Precedent was set in California with
the appointment of the receiver. What message does
this send to the rest of the state, both state prisons
and jails; is that good news or is it bad news?

MR. WALLENSTEIN: I have no problem
telling you that in large measure it's a return to
practice of the late '70s and the early '80s when
major class action suits were filed in this country.

Hopefully, my generation of
administrators and my colleagues on this panel don't
need that because we know what it is we have to do and
we can manage to the exception not to having to see
the entire house tumble down. So it's most likely an
excellent wake up call, if, indeed, the practices were
so negative.

DR. COHEN: I think there is another
message. Although it wasn't a unanimous decision,
Justice Stevens wrote a separate opinion in Estelle v.
Gamble and he criticized the majority for requiring
deliberate indifference rather than just doing the
right thing. And, additionally, he quoted from a
report from a legislative commission in California in
1972 which described exactly what Judge Henderson
described in his report today with actually malicious behavior on the part of doctors towards patients and unqualified medical technicians delivering a large amount of medical care.

So I think we have to say not that there's management failure, although there are management failures, but 30 years later what have we accomplished and what's happened in California during that time? The population is 165,000 people. You may not be able to do it and maybe you shouldn't and maybe there are other ways to organize society without having so many people in prison. I think that's the lesson that the constitutional solution has not succeeded to this point.

MR. WALLENSTEIN: Robert has raised a really good issue and a tough one for the Commission. Are you going to recommend that we meet standards for this incredibly inflated prison condition or is the Commission also going to engage in the issue of why we have so many people in custody? That's your issue to deal with.

No doubt, when Justice Marshall wrote his opinion in 1976 he never anticipated the size of the American correctional system that we have today and that's a very difficult issue.
SENATOR ROMERO: Dr. Goldenson, you have the last word.

DR. GOLDENSON: I think it's a very strong and a very good message to both the California system because I think it's a very hopeful message to me. I mean, we're going around telling people that, look, this is an opportunity to take a system that's totally broken and turn it into a quality system and we're going to work with you to do that.

And I think one of the things that's important to recognize is that the state did not oppose the appointment of the receivership at all and almost welcomed the assistance from the court in dealing with something which they acknowledge was something that they were not doing very well. And I think it's a message to other states that, one, they need to make sure that they're providing appropriate care; otherwise, the courts will also get involved in those situations.

So I see it as a very strong move forward by the judge and my concern is the same concern that's been raised here, that given the magnitude of the problem in terms of the numbers of people who are incarcerated in California, estimates are from the state itself that immediately they need
to hire 150 qualified physicians. You know, I
question whether with a receiver or with whatever
you're going to be able to find, today, 150 physicians
who want to work in the situation that California is
currently in. And my feeling is, and I've said this
to the judge and at the status conferences, that
healthcare is a constitutional issue and if you can't
provide the level of healthcare that's necessary, then
you have to reduce the population. I mean, it's
either one or the other and you just can't keep
building these facilities, knowing that you are not
providing the necessary care.

SENATOR ROMERO: Dr. Goldenson,
Dr. Cohen, Director Wallenstein, we want to thank you
very much for your very informative and expert
testimony. I think you saw all commissioners were
engaged in questioning. We appreciate the insight
you've given to us. We look forward to hearing
additional recommendations from you as we go forward.

And I think is it? All right. It's
lunch. Thank you.