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GETTING MEDICAL ATTENTION IN PRISON:
A COMPARISON OF TWO PRISON SETTINGS

Anne M. Wallace

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MASSACHUSETTS
INSTITUTE OF TECHNOLOGY
50 MEMORIAL DRIVE
CAMBRIDGE, MASSACHUSETTS 02139

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Introduction

The average American knows little about prison life and prisoners. Only when the media periodically publicize such events as riots, escapes, murders or other sensational happenings do we pay attention to the problems of prisons. Such was the case about ten years ago when a major wave of prison riots swept across this country. Almost daily we were shocked with news of the serious events in places like Attica, Salem, Stateville, Walpole, San Quentin and numerous smaller prisons.

Historically, riots and inmate rebellion have been very much a part of U.S. prison life. Inmates have consistently demanded prison reform because the correctional system has always seemed to need it (Silberman, 1978). In the wake of the riots ten years ago, inmates once again demanded prison reform. This time, however, the "prisoners' rights movement" was born, and demands for reform were politicized.

Inmates were brought into a loose coalition with civil libertarians from traditionally supportive church-led groups like the Quakers and establishment organization like the American Bar Association. The coalition held promise. At long last inmates appeared to have captured the necessary public attention which had previously eluded them. For, as Goldfarb and Singer (1973) describe the problem of earlier reform efforts:

It would be generally agreed by penologists that one of the principal obstacles to prison reform has always been, and remains, public opinion. The man-in-the-street is at best apathetic,

commonly cynical, and at worst frankly hostile.
(p. 161-162).

This newest reform effort was directed toward the courts and took the form of demands that prisons grant inmates amenities consistent with their rights as guaranteed by the Eighth and Fourteenth Amendments to the Constitution. New public-interest law firms and other liberal lawyers began representing inmates in suits that challenged prison conditions. These suits come under 42 U.S.C. Section 1983 (1976) which the Supreme Court interpreted:

For state prisoners, eating, sleeping, dressing, washing, working and playing are all done under the watchful eye of the State. ...What for the private citizen would be a dispute with his landlord, with his employer, with his tailor, with his neighbor, or with his banker becomes for the prisoner, a dispute with the State. (Preiser v. Rodriguez, 411 U.S. 475, 492, 1973).

As a result of this liberal interpretation and the criminal procedure decisions of the Warren Court, prison section 1983 suits increased dramatically. In fact, Turner (1979) found that in 1966 only 218 such cases were filed compared to 9730 in 1978. A high percentage of these cases originated in maximum security prisons, and thirty-two categories of inmate claims were defined (Turner, 1979).

Of particular interest to this study are those inmate grievances about the poor quality of medical care in prison. Prisoners have charged that they are denied access to medical care, and that the care they do receive is inadequate. The Supreme Court decision in *Estelle v. Gamble*, 429 U.S. 97 (1976) provides the standard applied by most

courts today in prison medical care cases. This decision held that the government has an obligation to provide medical care to those it incarcerates. Furthermore, the court ruled that "deliberate indifference" to the medical needs of prisoners violates the Eighth Amendment's ban on cruel and unusual punishment (Turner, 1979).

This landmark case and those that followed opened prison practices up to judicial scrutiny. Inmate accounts of the often sordid details of these practices forced judges to abandon the dogma of the independence of prison authorities. However, judicial intervention has maintained a limited objective; namely, to bring prison conditions, including medical care, up to the minimum standard of constitutional acceptability (Hawkins, 1976).

Inevitably conflicts arise when judicial decisions must be translated into changes in prison practices. In an environment where maintaining custody and order by preventing riots and escapes is the paramount consideration, the potential impact of these decisions poses many problems to prison administrators (Harris & Spiller, 1976). Judicial intrusion into prison domains threatens the fabric of control prison officials have woven over years of nonintervention.

Published research on the impact of these decisions on prisons in general shows an increased bureaucratization of the prisons rather than any particular improvements. In their effort to avoid additional intrusions, prison officials

have created regulations, guidelines, policy statements and general orders that require forms, files and reports for innumerable practices. This bureaucratic paper flurry seems to be a response to perceived demands for accountability from the courts (Jacobs, 1977). Perhaps prison officials felt they needed documented proof to defend themselves against charges of denying medical care or confiscating prisoner property.

Despite the appearance of extensive scrutiny of prison life, certain practices, like medical care, have received only superficial attention. Inmates report that medical care is often inaccessible or of unsatisfactory quality. Summing up what many said, one inmate wrote:

To some, of course, it is an opportunity to game a little, to get a high from pills and to wheel and deal in contraband. To most, it is just another threatening part of the whole system--if you were really sick, they would just let you die (Packard, 1973, p. 19).

Such evidence is, however, considered subjective.

Some researchers, like Jones (1976) and Twaddle (1976), attempted to study the special health risks of imprisonment. Each found independently that prison life is dangerous to the physical health of inmates. Others, like Breecher and Della Penna (1975) for the National Advisory Commission on Criminal Justice Standards and Goals of the Justice Department and the American Public Health Association (1976) used the prestige of their sponsors in an effort to establish minimum standards for medical practices in prison. And still others,

such as Gapen (1979) and Goldsmith (1974), who have worked in prison hospitals have criticized the practices they found there.

No one has systematically studied the everyday practices of doctors and other health workers as they go about the business of providing medical care to inmates. These practices, not the equipment, nor the facilities, nor even the standards supposedly followed, are at the core of medical care in any setting. The person-to-person interactions constitute much of what is called medical care. The customary ways of dealing with inmates as patients have not been studied, and as a result little is known about them.

This research project studied these medical practices and describes them. Without such research there can be no genuine understanding of what takes place in prison hospitals. And, without this understanding, no recommendations for change can be considered valid. Jacobs' (1977) finding of increased bureaucratization at Stateville makes sense in this context. Prison officials could only respond in that way to the vague terminology of judicial orders "to bring prison conditions up to the minimum level assured all citizens by the Constitution."

This paper presents findings about the accessibility of medical attention to inmates at two 700-man prisons and begins a description of prison medical practices in general. Inaccessibility and unavailability of medical care have consistently

been specific inmate complaints. The study examines how inmates at a maximum security and a medium security prison get to see the doctor when they need or want to. Because getting medical attention is the first step in any kind of medical care, the paper reports the actual process inmates go through to get needed or desired medical attention.

Selected Literature Review

The extensive literature on prisons encompasses a diverse range from the works of inmates about their first-hand experiences to the research of social scientists about their observations of the consequences of prison life (Bagdikian, 1976; Braley, 1976; Cohen & Taylor, 1974; Johnston, et al., 1970; Milgram, 1974; Remick, 1975). In addition, journalists, political scientists and prison workers have written about prisons from their unique perspectives (Korn, 1971; Mitford, 1974; Silberman, 1979; Wright, 1973). Prison reformists have selected those views that support the changes they advocate and have written about programs to modify the status quo (Carlson, 1977; Duffee, 1975; Martinson, 1974; Menninger, 1969).

Prison literature, per se, will not be reviewed in this paper. Certain works informed and guided the study reported here; notably Foucault (1979), Goffman (1961), Irwin (1970), Jacobs (1977), Shover (1979), and Sykes (1958). The bent of this literature is sociological. As such the view is one of the prison as a social setting where certain structures and processes operate to produce patterns of observable behavior. The goal has been to understand the prison as a social context and the relationship of this context to the ideas or beliefs which inform the everyday practices of people on the scene.

Although I do not want to devote a lot of space in a paper of this length to extensively review and assess the

the prison literature, these works do serve as a background to the study of prison health care.¹ I cite it by way of locating this study rather than in an effort to analyze or evaluate its merits. Some of this literature and research is controversial. Most has taken the view of a particular prison as a whole or total system with identifiable consequences especially for inmates. (Shover, 1979). This generation of prison research as spawned the birth of yet another generation of prison research, the study of particular aspects or dimensions of prisons. Prison health care is one such aspect. This study could not have been done without the background of the earlier studies, yet the topic is one whose time has come.

Occasionally the prison literature does refer to the health and medical care of prisoners. For example, Sykes (1958) pinpoints the outbreak of the extensive riots at Rahway Prison to the lack of medical response to a young inmate's complaint of being ill. Silberman (1979) suggests that prison officials trade desirable jobs in prison hospitals to gain inmate cooperation. Mitford (1974) takes issue with the exploitation of inmates for medical experiments through doctors with prison connection, often the very ones responsible for medical care as well. Wright (1973) observes that although prisons have a duty to provide medical care to inmates, no one evaluates the adequacy of this care.

Although the above writings only refer to prison health care in casual, off-handed ways, most don't even mention it.

Two researchers in particular, Cohen and Taylor (1974) and Irwin (1970), neglect the topic to the detriment of their findings. Each categorizes the strategies inmates use to cope and adapt to the stresses of prison life. Both elaborately describe the range of behaviors available to inmates in each category. Yet, neither considers the potential or real criminal career and prison adaptation of inmates who use the medical system as a way to "do their time." This omission takes place even in the face of considerable evidence that links stress to bodily ailments (See for instance Mechanic, 1974).

Inmates and prison reformists, however, have raised the issue of adequate medical care as essential in their demands for change (See the list of inmate demands in the wake of the riots, Attica, 1972). Such demands come under the rubric of "standards of welfare" or those requirements that keep the human organism going (Goffman, 1961). Leinwand (1972) details the specifics of desirable prison medical care:

Prisoners should be given thorough initial and periodic physical examinations. Most prisoners are poor. Their health has long been neglected. They have been unable to provide themselves with any consistent medical attention. The time spent in prison should be spent in regaining physical health. When illness is evident, an attempt at therapy and care should at once be performed. Where teeth need to be treated, dentures provided, plastic surgery undertaken, these should be done. The process of caring for the physical welfare of prisoners has been notoriously lax. Correcting this situation would be a first step along the road to prison and prisoner reform. (p. 46-47).

This kind of a mandate is a far cry from the situation as it existed prior to the early 1970's when even systematic

medical malpractice was not held as unconstitutional (Wright, 1973). However, because the study of particular aspects of prison life is still in its infancy, there is little written about prison medical practices. The next section carefully reviews this limited literature in part to demonstrate the need for a thorough descriptive study of the everyday practices in prison hospitals.

Review of Literature on Prison Health Care

The literature on prison health care typically takes one of three forms. The first is a kind of exposé of disreputable practices written by people who at one time worked in prisons or prison hospitals (e.g. Goldsmith, 1972, 1974; Murton, 1972). Second are the standards for medical practices in prison, and these manuals of standards occasionally include supporting data from surveys of prison and jail hospitals (e.g. Breecher and Della Penna, 1975; Steinwald, et al., 1973). Finally, there are a few in-depth reports about individual prison health care settings (e.g. Jones, 1976; Twaddle, 1976).

One of the most outspoken critics of prison health care is Goldsmith (1972, 1974, 1975). As a physician he carries a certain credibility that others who have similarly exposed unsatisfactory practices don't have. For instance, Gopen (1979), Greenhouse (1979), and Murton (1973) are equally critical of prison medical practices. Yet when professionals write about changing these practices, they cite Goldsmith.²

Goldsmith hammers away at one central theme throughout his writings. Prison care is not just inadequate-- it is disgraceful. Citing report upon report of studies in California, Arkansas, Washington, Nebraska, Massachusetts and New York, he characterizes prison health care as a "...barren wasteland of medical care." (1974, p. 575). He further concludes that little has changed since Rector's (1929) year-long survey of prison health conditions.

Formerly the superintendent of Tucker Prison Farm in Arkansas, and later the Commissioner of the Arkansas Department of Correction, Murton (1973) writes of atrocities committed in state prisons there, much in the name of medical treatment:

The Cummins hospital was always the locus of power for exploiting the inmates. From here, the drug operations were controlled. Medical passes, bed space, and treatment were sold to prisoners who were sick. Here much of the torture, including that which led to death, was carried out. Generally, homosexuals retained control of the hospital and forced those in need of medical help, and who had no funds to pay, to submit to homosexual activities in return for medication. The hospital also provided the only legal escape from hard duty in the fields. For a price, processing of new inmates could be delayed or the files marked "light duty." (p. 199)

In addition, Murton found that most medical services available to Tucker inmates in their small infirmary were provided by a "convict doctor." This inmate had no medical training, but he treated physical disorders according to his intuition and past experience.

In an effort to rally the concern of the medical profession, Murton (1973) criticizes the prison doctors for their indifference. He chastises them for remaining silent and not wishing to become involved. Yet, he concludes that neither professional survival nor accumulation of wealth adequately explains the behavior of doctors on the scene. Rather, he feels the root of the problem stems from a structural source:

Therefore, for all intents and purposes, the prison physician views the prison system itself as his client and the inmate-patients as incidental to the relationship. (Emphasis in original, p. 205)

This simple statement of fact, according to Murton, resolves the apparent conflict of physicians failing to speak out against the brutality they knew existed.

Exposés, such as those above, have limited value. They shock their readers for the moment, but their effect is short-lived. Weisbuch (1977) notes that despite the medical and sociological concern over prison health care for the last 150 years, little has changed. He blames situational factors for the ongoing problems, specifically the overriding function of the prison administration to maintain security. He further observes that because prison administrators have been responsible for health care matters in addition to their other duties, prison health care has suffered. Out of necessity, security issues take precedence over all others.

Because the maintenance of security may appear to compete directly with access to the full array of health

services, Weisbuch (1977) argues that prison administrators should not be responsible for medical care in these settings. He advocates the transfer of inmate health care responsibility to public health professionals. Acknowledging the reluctance of prison administrators to relinquish authority over any institutional service, he urges the hiring of physicians or other public health professionals to not only provide health services but also to administer the prison health system.

As suggested earlier, the long-term effect of exposés is limited. Murton was fired as Commissioner of the Arkansas Correction Department, and to this day has not been able to find a job in the prison field. Weisbuch succeeded in becoming the first Director of Prison Health Services in Massachusetts, but less than a year after he left that post an investigative newsteam revealed unexplained discrepancies in the administration of that department (The Boston Globe, May 17, 1977). Even the recommendation of King, et al. (1977) to utilize former military medical corpsmen in prison hospitals as a way to compensate for the shortage of qualified health personnel has come under attack (Gapen, 1979).

The second set of prison health care literature grew out of a kind of frustration with the ineffectiveness of exposés and critiques of the system. These are the standards for medical practices in prisons. Some of the standards were preceded by surveys of prisons and jails to determine current practices and solicit recommendations. The American Correctional

Association issued one of the earliest sets of standards in 1966. These standards were revised in 1977. Although the manual includes general standards covering all aspects of the institution, forty of the 200 in the latest set deal with medical and health care services.

In order to be accredited by the A.C.A., a prison must comply with these standards. Most deal with broad, policy type issues, such as, "Written procedure specifies that appearance at daily sick call is an inmate right and not a privilege." Another states, "Institution provides inmates the medical and dental services needed to maintain basic health." With few exceptions there is much latitude to interpret these standards and translate them into practices. Furthermore, it is not clear how an accreditor from the A.C.A. would determine when such vaguely worded standards had been met.

In a joint undertaking, the American Medical Association and the American Bar Association surveyed 2,000 prisons and jails to determine available health services and inmate use of those services (Steinwald, 1973; Baker, 1974). Based on the findings of this survey, the Taskforce on Prison Health of the A.M.A. prepared its own set of standards for health care in prisons. The plan was to work through state and county medical societies to accomplish implementation of these standards in three years (Prout, 1973). To date, this has not happened anywhere in this country.³

A comparison of the A.C.A.'s standards with those of the A.M.A. reveals some important differences. The most striking

difference is the number of standards in each set, with nearly three times as many in the A.M.A. set which deals exclusively with health and medical matters. A second and more important difference has to do with the level of specificity each set addresses. Whereas the A.C.A. standards are mostly at a general policy level, the A.M.A.'s spell out a policy in actual practice and treatment terms. For example, both sets require physicians to be licensed and/or certified; however, the A.M.A. further requires written job descriptions for physicians and other health staff, autonomy of physicians from security functions, continuing education for all health staff and the regulation of treatment through standing order procedures.

Breecher and Della Penna (1975) provide yet another set of standards which they call a "prescriptive package." Their purpose was to provide some practical methods to modernize correctional health services. They collected data about practices at the time through on-site visits to correction departments and individual institutions as well as interviews with providers and administrators of prison health programs. The authors described their methodology as one which was less concerned to find shortcomings than to discover remedies for shortcomings.

The guidelines Breecher and Della Penna (1975) offer take into account the diverse range of problems inherent in prison health care. To begin with "The Elements of Sound Health

Care" which opens with the following statement:

To see correctional health care at its horse-and-buggy worst, it is only necessary to observe "sick call" at a correctional institution which has not yet modernized its services or organized its procedural routines effectively. If it is a small institution with 100 inmates, a dozen may be clamoring for the physician's attention during the half-hour he has to hear their complaints. In an institution with 1,000 inmates, 100 may have attended sick call yesterday, 100 more may stand in line today, and another 100 may be expected tomorrow. There is no possible way for a physician to diagnose illnesses accurately and prescribe effective treatment during the few brief minutes he has for each inmate. (p. 7).

Later on they deal with "Interpersonal Relationships in a Correctional Health System" where they describe the unique situation in prison hospitals:

In any health care system, there are the staff and the patients. A correctional health care system has a far more complicated tripartite structure: health care staff, correctional staff, and inmates. The different missions in life of the three groups walled in together exacerbate tensions. The prime mission of the correctional staff is to maintain security and good order--two sides of the same coin. The mission of the health care staff is to maintain and improve the health of the inmates. The prime goal of most inmates is get out at the earliest possible date--and, in the meantime, to secure whatever advantages are available under the conditions which prevail. The possibilities of open conflict among these disparate goals is unlimited. (p. 69)

This short text is comprehensive. It covers the broad issues, like how to organize a prison health care system, and the more specific, like the differences in health service needs for jails vs. juvenile centers vs. prisons of various security levels. It portrays the prison health system in ways that are consistent with those of health workers who know the

system well.⁴ The authors, however, try to take that last step of prescribing behavior to cope with the numerous subtleties of an extremely complex situation. Often their recommendations convey a Pollyannaish quality that few health care staffers could adopt.

The American Public Health Association (1976) provides the most recent set of standards for health care in correctional institutions. The Jail and Prison Task Force, which prepared the standards, stresses their intent is not to promote special treatment for the imprisoned but rather to insure that imprisonment "does not compromise the health care of inmates." In a more official and less descriptive way the task force recommends many of the same practices contained in standards from the A.M.A. (1973) and Breecher and Della Penna (1975). Almost as a way to demonstrate the fact that these are not unusual practices especially for prisoners, the authors precede each standard with the public health principle and rationale that mandate the components for satisfactory compliance.

By far the longest subset of the A.P.H.A. standards (1976) deals with "environmental concerns." Such details as prison grounds, structures, water supply, waste disposal, fire safety, housekeeping, food services and personal hygiene facilities are covered in this section. All clearly encroach on areas that have historically been the responsibility of prison administrators, the warden or superintendent. Although

public health officials have been responsible for these facets of public institutions in the past, one wonders how realistic it is to expect prison officials will comply, given their overriding concern with security matters. Furthermore, it is not clear that any wardens recognize the A.P.H.A. as an official agency with any right to dictate practices in their domains.

Standards, codes and regulations, no matter what group promulgates them, serve only as the starting point for health related services in any setting. At issue is how seriously standards are taken and to what extent they are followed. On the one hand medical staffers may view standards as so much idealized rhetoric prepared by people who don't really understand what goes on in prisons. On the other hand, another group of medical staffers may agree whole heartedly with recommended standards and try to comply with them but encounter endless conflict and frustration as they become enmeshed in the competing goals of inmates, security staff and health care providers. Lastly, standards can only tell us what ought to be and not what is the actual practice. Even when teams of accreditors visit institutions to check for compliance with standards, they are likely to get a snapshot of a situation that has been readied especially for their arrival, rather than the full picture of actual practices.

In order to get the full picture of the situation necessary for a thorough understanding of everyday practices called

prison medical care, one must observe in these settings for a prolonged period of time. Two social scientists did this, Jones (1976) and Twaddle (1976). Their reports and reports of studies done by experts in the fields of criminal law and criminology (Andrejew, 1973; Mueller, 1973; Szabo and Landreville, 1973) comprise the third category of literature on prison health care:

The three criminal law and criminology experts' reports were presented in London at a two-day symposium on the medical care of prisoners (Storr, 1973). Taking an international perspective, representatives from various European countries described in general terms how their agencies met, or failed to meet, the United Nations' Standard Minimum Rules for the Treatment of Prisoners (1955). Most presenters were either the physicians responsible for the medical care in prisons or from the policy level of governments in their countries. Only the three papers cited deal directly with studies of medical practices in prison.

Andrejew (1973) describes the response of Polish prisons to the unique psychiatric needs of inmates there in sketchy, broad terms. Although he states "The prison health service guarantees proper medical care," it is not clear how he knows this, nor what other care, besides psychiatric services, are encompassed. Likewise Szabo and Landreville (1973) define practices in Canadian prisons. Comparing the medical care of free citizens in Quebec with prisoners in Quebec, they conclude

that inmates do not enjoy the same rights as other citizens. This inequity stems from the denial of benefits guaranteed by the Health Insurance Act to inmates. Based on this finding, they recommend changes in the Health Insurance Act to accommodate the special situation of prisoners.

Mueller, a criminal lawyer, conducted a survey of inmates using questionnaires and interviews in a small New York City federal detention center (1973). He found that medical needs were a major factor in jail life and the lack of medical care was the result of personnel shortages. He, as others before and since, documented the lack of adequate medical care as one of the principal grievances of prisoners. At the same time, he observes the fear held by many inmates that medical programs which are directed more to the convenience of their custodians will be foisted upon them. He concludes that until the "hands-off" policy of American jurists that precludes their interference with the internal workings of prison administration is changed, little else will change.

Jones (1976) collected data for one year in the Tennessee State Penitentiary. He coded and analyzed medical records and interviewed three criminal-offender populations, inmates, probationers and parolees. His intent was neither to explain the causes of health problems among prisoners nor to assess the quality of health care delivery in prison. Rather, the focus of the study is the tabulation of morbidity and mortality statistics for each of the three populations to demonstrate that imprisonment itself is dangerous to the health of inmates.

Further, his findings suggest there is a relative quality to the dangerousness such that some inmates are in more jeopardy than others. And, the kind and degree of this dangerousness vary with the individual characteristics of the prisoner.

The report concludes with fifteen recommendations for changes to make prisons less dangerous to the health of inmates. Included are such timeworn items as:

All persons who are to be housed in an institution of confinement (prison or jail) should receive a mandatory and comprehensive physical examination from a licensed physician at the time of or prior to intake; and this examination should include the systematic use of such biological, chemical, and physical diagnostic evaluation techniques as laboratory tests and x-rays. (p. 178)

Another recommendation that has repeatedly appeared in other standards is:

A prison should provide both hospital and outpatient medical services to prisoners at all hours of the day and night, and on every day of the week; these services should include a registered nurse (not an inmate) present at the prison at all times; a licensed physician on call for the prison at all times for immediate and direct emergency transportation from the prison to the nearest outside hospital. (p. 182)

Jones' (1976) conclusions and implications are disappointing. No less so are those of Twaddle's five-month observational study in a 1600-man maximum security prison in the midwest (1976). He, like Jones, compares the illness rate of prisoners with another population, the free society of this country. Although Twaddle finds the rate of sick call visits in prison is more than four times the national average of physician visits per person in 1969, the more interesting comparison is between

his sample of inmates and reports of illness rates among Naval shipboard populations. Finding these rates very similar, Twaddle concludes, "... something in the characteristics of total institutions, rather than specific characteristics of the prison, produces these patterns." (p. 247)

Unfortunately, Twaddle relied on the prison medical records of inmates for his data. Because of the poor quality of these records, much of the data reported are simple counts of sick call utilization crosstabulated with simple counts of personal characteristics and disciplinary reports of inmates. Only in his discussion of the primary finding does he provide a glimpse of his observations. Even then, he carefully couches these first-hand observations in terms of "speculations" about practices. He hints that guards might prevent inmates from going to sick call, but quickly adds, "... it is doubtful if the guards would want to assume liability for denying access to anyone who appeared seriously ill." (p. 246). He dismisses the notion that inmates can and do use sick call for reasons other than medical needs simply on the basis of lower utilization rates for inmates who have been in prison more than a year. He argues that in order for inmates to use sick call to meet other inmates, or pass messages, or to be excused from work or just to have a break from the monotonous routine of prison life, they need to "...learn how to use sick call to work the system." (p. 245). The naive suggestion that such learning takes at least a year underestimates not only the powerful role of motivation in the

learning process, but also the obvious parallels in the use of the sick role in everyday life.

What seemed, at first, as at least one study of prison health care that went beyond statistical surveys, in fact does not. The literature on prison health care, though limited, follows the pattern of the literature on prisons in general. With few exceptions, notably Jacobs (1977), scholarly research on both topics has focused on the culture and social structure of prisoners. Their attitudes, behavior and personal characteristics have been studied from almost every angle. Yet, there is little research evidence about the people who staff the prisons, their characteristics, attitudes and practices (Shover, 1979).

The study reported in this paper takes on added importance. Not only does it provide the opportunity to begin to understand a heretofore neglected topic, prison health care, but also to focus attention on the practices of a subset of prison workers, medical staffers. The review of the three types of prison health care literature shows how understudied the topic is, and how little is known about it as a result.

Settings and Methods

The settings for this study were two 700-man state prisons and the central administrative offices where the officials responsible for prison health services work.⁵ Using the fieldwork method of participant observation, I collected data over a five month period at these sites. In addition to the usual problems involved with these methods and these settings, there was a compounding effect of the interaction of the approach to a study of prisons by a woman that further complicated matters. Gaining both primary and secondary access was problematic as a result.

Three Settings

Central Administrative Offices

The first setting was the central administrative offices of the state's correction department, specifically in that department's health service unit. A large state office building in the capital city houses these offices, along with various other service departments operated by the state. Here, my primary contacts were with the three top administrators of the correction health area. They and their small staff of assistants direct and supervise the health care received by all inmates in the state's prison system.

The space allocated for the correction health staff here was a small office intended for one person but shared by the three administrators. This cramped office and a section of the open hallway outside it were the work areas for the eight health staff people. Desks abut moveable partitions with

hardly enough room to walk from one place to another. The health unit's area is sandwiched between the correction department's legal offices and the offices of an associate commissioner's staff. Often, even an extra chair was hard to find.

Although this setting was not the focus of the study, from it I gained much background information about this system and a sense of direction for a topic about which so little is known. The background kinds of data came mostly from the director and his deputy director, both of whom rose through the security ranks of this correction department to their current positions. They knew the system well from first-hand experience with it. They also knew the security and health staffs well and often times many of the inmates.

Gradually, as the administrative staff came to know me, they shared some of their experiences. Over the course of these days they would tell what they called "war stories," their cautionary tales of prison work. These tales were always laced with dangers they felt were inherent in the job. The deputy director told especially lively tales about when he was a night guard on a cell block at the maximum security prison. He would embellish the stories with sounds of locking steel gates and brief histories of the serious crimes which his charges had committed. Through such accounts of prison work, I began to sense what it was like inside prison from the staff's perspective.

While in this setting, I also had the chance to read official prison health policies and procedures. These served as a point of departure and reference for the actual practices I would observe later. Budgets, annual reports, proposals for programs, intradepartmental memoranda about inmate health matters were all available. Together the written documents and extended contacts with experienced staff members provided much background information which I expected would guide the observations in the prisons.

Greenspoon

The next setting for data collection was the medium security prison, Greenspoon. The health service director felt, "It's the better place to ease you into the prisons. Things are much calmer there, and you can get a better feel by starting there." Besides a protective quality to his recommendation, he seemed to suggest that Greenspoon's health set-up was a more familiar kind of arrangement. Greenspoon's health unit administrator echoed this sentiment my first day there, "The guts of our operation is the same as any general hospital. We've got an in-patient service, out-patient and specialty clinics. The uniqueness is dealing with inmates."

The prison was built in the early 1930's in a rural town about 25 miles from the state capital. Its dark concrete walls, now moss-covered, and the neatly tended lawns and

flower beds belie its function. Once past the della Robia that decorates the outside doorframe, there is no doubt you are in a prison. Immediately inside is a large reception-waiting room, lined with small lockers and furnished with a few long wooden benches. Here, guards and clerks process all visitors and staff into the prison, by first checking the identifications of those wanting to enter. This procedure is done from behind an area enclosed by thick, bullet-proof glass called "outer control."

Once through this procedure, the staff member or visitor goes to another guard stationed around the corner. The second guard, often a woman, checks for contraband by examining the contents of pockets, folders, purses (when allowed), etc. for drugs and weapons. She signals approval for admittance to another guard posted in a tower over the "trap" area. The tower guard controls opening and closing the trap doors with levers, thus assuring he has sufficient time to observe the people in the trap.

Outside this area lies a part of the prison yard leading to the administration building. This building contains the offices of the top level prison officials, the visiting room, and a wing of locked cells. There is also an "inner control" area, sometimes called the nerve center of the prison. Guards assigned there constantly communicate with the various parts of the prison, and they regulate the rigid schedule of prison life by sounding whistles at certain hours of the day.

A gate off the short main corridor of the administration building leads to the "camp," or prison proper. On the other side of the gate there is a large grassy quadrangle around the perimeter of which are the fifteen houses where inmates live. Each house holds up to forty-five men and has a common kitchen and eating area. Along one side of the quad are a few buildings where industries, classrooms and meeting rooms for inmates are located.

Also off the main corridor of the administration building another gate leads into a four story wing known as Greenspoon's hospital. Entry through the locked gate is by a guard always on duty there. In the basement of the hospital are x-ray equipment, an eye examination room and a now defunct operating-room suite. The main or first floor has several offices for the administrator, secretaries, doctors and nurses as well as the pharmacy and the examining, treatment and emergency rooms. This is the first place Greenspoon inmates come when they need or want medical attention.

On the second floor of the hospital wing is the in-patient unit. Two open wards plus four locked rooms and two isolation rooms provide a twenty bed capacity for inmates from any of the state's prisons when they need round-the-clock nursing care or observation. A special diet kitchen and offices for dieticians occupy part of the third floor; the rest is used for storage.

The atmosphere at Greenspoon is subdued and above all civilized. Mitford's term the "pastel prison" seems especially suited to describe the prevailing climate here (1974). For, although Greenspoon looks good, inmates will tell you, and you can observe, the countless ways they are degraded and humiliated and kept in their places through a kind of psychological oppression (Cohen and Taylor, 1971). On the surface, Greenspoon appears to be the kind of prison imagined by reformers. Yet, underneath the thin veneer of niceties churns the animosity and lack of dignity toward inmates common to prisons everywhere. On this muted backdrop, inmates, guards and medical staff play out the scenes in the process of getting and giving medical attention.

Ceilgate

In sharp contrast to Greenspoon, Ceilgate stands as a prototypic maximum security prison. About a mile down the main road from Greenspoon, the white concrete buildings of Ceilgate reflect a different era of prison architecture, the mid-1950's. There is no question about this compound's function as you approach from the street and drive the long access road toward the buildings. When the sun glares off the white concrete, the harshness of the place is especially evident.

The arrangement of areas inside Ceilgate is quite similar to that at Greenspoon. The entrance leads immediately into the reception-waiting room where visitors and staff are

processed into the prison. Outer control occupies a large portion of this entrance area, most of which is visible through thick glass walls that extend from waist high to the ceiling. Guards screen would-be entrants to establish positive identification and determine the nature of their business in the prison.

Out of view behind outer control is the prison's pharmacy, unlike the pharmacy at Greenspoon which is on the main floor of the hospital. Ceilgate's pharmacy was moved to this protected location after the riots here in the early 1970's. During these riots, "inmates stormed the hospital and broke into the pharmacy, helping themselves to anything and everything we had. We decided not to let that ever happen again." staff explained.

As at Greenspoon, a Ceilgate guard, stationed just beyond outer control, check the persons and possessions of people wanting to enter the prison. One of the few women guards often performed this function. The particular woman usually assigned this duty has a reputation of "being able to smell drugs---she's caught more stuff coming in on visitors than anyone who's ever been in the job." She has the authority to order a skin search of anyone she suspects of concealing contraband.⁶ She signals passage through this checkpoint to a guard in the tower over the trap, usually when there are three or four people waiting to enter.

Outside the trap is the prison yard and a path to the administration building and the cell blocks of the prison

itself. High chainlink fences demark various sections of the yard watched over by strategically placed guards. Two guards sit at the doorway in the "ad building" to observe people as they enter. They direct visitors into the waiting room immediately inside to the right. Guards regulate the flow of all other people into the prison through a second kind of trap with locked bar gates. They control the opening and locking of these gates from within inner control which is a much larger and more visible hub of security activities than at Greenspoon.

Past the trap of inner control, a wide, high-ceilinged corridor stretches to the right and left connecting the several cell blocks and leading to the various special areas of the prison like the hospital. At strategic points along this corridor dividers of open bars extend from floor to ceiling. The upper part of the dividers is permanently closed and locked; the lower parts have open barred gates that can be closed electrically from inner control.

Just beyond one such divider, a barred doorway opens directly into Ceilgate's hospital. Although no one can enter unless the guard unlocks the gate from inside the hospital, the noises of heavy corridor traffic carry in easily. The volume is often further amplified when one of the inmate rock bands practices in the auditorium across the corridor from the hospital. Sounds reverberate off the structural steel and concrete, making the hospital a noisy place rather than quiet

and peaceful as expected.⁷

Inside the hospital gate the relative size difference from Greenspoon is immediately striking. The entire health service area at Ceilgate is smaller than just one of Greenspoon's four floors. Everything, except the pharmacy, related to medical care of inmates is located in designated spaces off an el-shaped hallway. The administrator has a cramped office at one end of the hallway, and the doctor's examining office is at the opposite end of the el. Also off this hallway are a small kitchen where meals are served, an x-ray room with a developing area, a small laboratory, and the main examining-treatment room. The bulk of the medical attention inmates receive takes place in this last room. Up to four medical staff work at the same time in this room with the door wide open.

Just outside the large examining-treatment room, strategically placed at the bend in the hallway's el, is the hospital guard station. No fewer than three guards are posted here; one for the hospital gate, one in charge of the hospital and the third responsible for a ten cell block at one end of the hospital. This block was formerly an infirmary used for inmates who were too sick to return to their cells but not sick enough to go to an outside hospital. Security administration decided the space was needed for an influx of protective custody inmates and took away the infirmary. The issue remains a bone of contention between security and medical staffs.

The setting at Ceilgate differs widely from its Greenspoon

counterpart. Cramped and limited space contribute to a lack of privacy when inmates are examined and treated. The noise level is consistently high, if not from the corridor outside the hospital, then from the guards or protective custody inmates in the back. Often a rough and tumble kind of horse-play between guards and inmates there for medical attention breaks out. One gets the sense that anything and everything goes and is condoned through its continued occurrence.

The sharp contrast between these two prison settings, especially in their hospitals, is striking. And, these differences become even sharper when one scrutinizes the processes each uses to deal with inmates. Getting medical attention is one such such process which on paper appears similar at both places but in practice differs markedly. In order to go beyond the surface comparisons, long-term first-hand involvement in both settings seemed the most promising approach to take. The techniques and difficulties of this approach to the study of these practices in prison settings are the topics of the next section.

Methods

Participant observation, the method used, represents a combination of techniques and methods that requires the repeated social interaction with people who are naturally in the setting under study. These people are not only the objects of the data collection, but they are also a part of the data gathering process (McCall and Simmons, 1969). They continue to play

their usual roles in the setting while the researcher observes and takes note of their actions. They provide their view of the explanations and justifications for current practices and behavior. In addition they inform the researcher of events that occur in her absence.

Techniques

The combination of techniques used for this study included first-hand observations of everyday occurrences for an intensive three month period. During this time I was in the settings for day-long periods, four or five days a week.⁸ Most often I stayed in and around the various parts of the prison hospitals. Occasionally I accompanied a medical staffer or guard into the prisons. The final two months of data collection were less intensive. I would typically go to both prisons and the central administrative offices once or twice a week to check on data I was analyzing.

A second technique used for data collection was interviewing. In the early weeks at each setting, these interviews took the form of short, informal conversations with the staff on the scene about an incident that just occurred. The rationale for this approach was to establish relationships with the staff who were initially quite tentative about my presence. Talking about something we had both just witnessed seemed less threatening. Also, it provided the chance to demonstrate my interest in the staff's perspective and their explanations for these incidents.

Toward the end of my intensive data collection times at

each setting, I interviewed each medical staff member formally. The focus of these interviews was the career history of each person as it led to his present job in the prison system. We discussed what they liked most and least about their jobs and their futures as best they could predict. Included in the group were doctors, nurses, physician assistants, medics, pharmacists, dieticians and administrators. In addition to describing their careers, they shared their experiences taking care of inmates and identified their views of the uniqueness of prison health care.

Each day I counted the number of inmates who were examined and treated. I augmented this simple count with information about the inmates' reasons for seeking medical attention. In some instances this information was sketchy or incomplete, even in the medical records. Sometimes staff members could recall what was done for an inmate. Other times this information was just unavailable from any source. Inmates had been examined and treated, but there was no record of it.

As indicated earlier, I collected documents like annual reports and budgets while at the central administrative offices. In the prisons, the documents collected were less formal. That is, they were less permanent types of documents, including such things as memoranda to the staff about internal matters, agenda and minutes of staff meetings and the like. No one item stood on its own as evidence, but collectively these documents supported emerging findings or provided direction for additional

data collection.

At the end of each day I wrote extensive field notes about observations, conversations and interviews. These field notes contain the bulk of the data used in the analytic description of the process of getting medical attention in prison. Notes include direct quotes of staff and inmates as they went about their business of giving and getting medical attention. Accounts of incidents and justifications for them are part of these notes as well.

Occasionally I was directly involved in the ongoing activities in the settings. The staff knew of my health background and felt justified in allowing this kind of participation. Most often these activities involved some kind of paperwork, such as checking inmates' charts for necessary signatures and filing them or drafting memoranda to someone in corrections outside the health area. At no time did I directly care for the inmates, though I often talked with them about their physical complaints and medical care.

This amalgam of techniques yielded much qualitative and some crude quantitative data about the medical care of inmates. These data were analyzed using strategies described by Glaser and Strauss (1967). I specifically refer to their "constant comparative" approach to the analysis of qualitative data. Incidents were coded and categorized according to shared properties in an effort to encompass the full range of types. Through several revisions of these categories, their dimensions and consequences, the constant comparison of incidents led to the

analytic description of this paper about the process of getting medical attention in prison.

Further analyses of these data should reveal other organizing themes as yet undiscovered. For example, one theme the data seem to suggest concerns the ways medical staff distinguish between inmates who are defined as "really sick" and those who are trying to "con" the staff. Another theme deals with the kinds of reasons or complaints inmates have that cause them to seek medical attention and the relationship between these ailments and certain situational factors like classification status. The findings reported in this paper suggest the need to further analyze the data at least along the above two lines.

For now the process of getting medical attention is the focus. However, the problems of gaining access to the settings and the subsequent difficulties encountered once there, preceded and colored data collection and analysis. In the next section these issues are highlighted as they affected the entire study. Some were easily solved. Others merely required perseverance. And still others demanded every bit of ingenuity I could muster.

Dilemmas and Problems

Initially and throughout the study the overriding problem of the research revolved around issues of access. At first the access issues took an official form as I tried to gain the formal approval of the state's correction department. Later, secondary access matters became paramount. Each type demanded a different approach and only succeeded some of the time.

A close friend who was deputy counsel for the correction department

spawned my interest to study health practices in prison. As an insider whom the director of prison health services respected, she offered early entry into the system. On her recommendation the director tentatively accepted me and the idea of my conducting research in the prison hospitals. However, her advocacy did not end there. When formal clearance procedures bogged down, she used her considerable influence with the attorney general's office to move things along. Without her the research could not have been done.

The ostensible purpose of the formal clearance procedure is to protect the privacy of inmates. I had to demonstrate to a committee the built-in assurances that no one nor any institution would be identified in any of the writings that resulted from the research. Furthermore, I had to prove beyond a doubt that no harm would come to anyone in the institutions as a result of the research. There would be no experiments and no drugs involved.

Approval, however, was not easily granted. During the month I spent at the central administrative offices, I chased down every possible lead in an effort to gain this elusive clearance and its attendant approval to observe in the prison hospitals. There were endless forms to complete and numerous phone calls and appointments with "key" people to gain this approval. Finally, I was cleared and given an institutional pass for both prisons. The permission came from none of the official department sources I sought out. Rather, it came as

a result of completing a one page form that required only the signature of the prison health services director.

It isn't clear why it took a month to discover this simple procedure. Perhaps it was simply a manifestation of the bureaucracy at work. Maybe none of my early contacts knew of this means to gain clearance until I happened upon the one person who suggested it. Alternatively some or all early contacts knew about it, but for one reason or another failed to mention it. My hunch is that at least one factor in the mostly unknown equation was the need for some kind of evidence of my acceptability to certain people who had something to lose if the research was carelessly done or indiscretely publicized. The correction department and its health unit have had their share of bad publicity. They don't actively look for more, and they needed to be sure "whose side I was on." (Becker, 1967)

Once I had the official sanction of the department, the health director wanted to introduce me to his prison medical staff at their monthly meeting. I prepared and distributed a one page proposal abstract, hoping it would stimulate some questions and discussion at the meeting. It seemed such a dialogue could give the staff a chance to begin to know me and ease some early tensions when I got to the prisons.

Instead, the director's introduction was very flowery, and he set the expectation that they "would cooperate in any way possible." There were no questions from any of the twenty

or so people at the meeting. I left not knowing what to expect the following week when I began at Greenspoon. Primary access was only the first hurdle, though without it all else was academic.

Secondary access issues involved the informal acceptance in the settings from people whose cooperation I needed to collect data. The medical staff primarily and the guards, to some extent, were not only the objects of the study but were integral to the data collection process. I had to develop different social roles and relationships in each setting at various stages in the research process (Gold, 1958; Olesen and Whittaker, 1967).

When I began at each setting, I adopted a posture best described as friendly but innocuous. That is, I tried to convey the presence of someone who was pleasant but non-threatening. In the central administrative office this role quickly took on an assisting dimension in which I was able to help with some of the pressing paperwork the director faced. I drafted some outgoing written materials and abstracted certain incoming documents. The small staff was stretched so this role was somewhat useful to them.

At Greenspoon the approach was less successful. Although I tried to be friendly but innocuous, and people in the setting were pleasant in return, I encountered a phenomenon my few informants called the "state worker paranoia." The best explanation I could get for it was, "That's where people come in like

whatever they have always been, and within four or five months they've got it. They can't think for themselves and are afraid to do anything. Most of all they suspect everyone who isn't one of them." I was unable to bridge this gap with most of the medical staff at Greenspoon. All but a handful kept their distance throughout the month of daylong periods I was there. One informant confirmed my hunch the last day I was there:

It's been so interesting having you here. I've especially liked watching people and how they act when you're around and towards you. When someone comes into a room, they check around to see who's there before they start in talking. If you're there, they are different. I call it the state worker's paranoia -- it's the basic cover your ass and don't let any outsiders know anything's wrong.

The medical staff at Ceilgate was openly suspicious, certain that I was part of an internal department security group. About halfway through the month of intensive data collection there, I was cleared by one of the medical staff's sources inside the security group itself:

I knew for sure on April 13th that you were okay. Prior to then even the officers had taken me aside to tell me to be careful in front of you. We had you checked out, and you are who you say you are, so it's okay.

Prior to my clearance at Ceilgate, people had been more open than most had ever been at Greenspoon. I sensed that I observed most of the usual practices of everyday business at Ceilgate's hospital. Occasionally, I could be helpful in checking inmate records and filing tasks which relieved the pressure on the much smaller staff at Ceilgate. Because I

could be helpful, I was able to establish relationships with the staff more readily.

A final problem in data collection at Ceilgate resulted from my being the only woman on the scene most of the time.

Initially a medic warned me:

You should always plan to leave when one of us does, right at 3. And, while I'm on that subject, stay in sight of either one of the medics or a guard at all times. Don't get yourself cornered in a room with an inmate like one of our nurses did.

The only explicit constraint on data collection was the times when I could be in the prisons. I could go only during the day shift and leave Greenspoon by 5 p.m. and Ceilgate around 3 p.m. An implied constraint resulted from the traditional privacy between doctor and patient.⁹ Once a Ceilgate doctor invited me to sit in during his office hours. All other data about these interactions at both prisons are reports of doctors and others from their first-hand experiences and observations.

Summary: Settings and Methods

Throughout the twentieth century prison systems in general and wardens of prisons in particular have followed a kein eingang policy. The policy has served to keep all outsiders but the most doggedly persistent out of prisons (Jones, 1976). As a result, I viewed the chance to conduct this research, using fieldwork methods, as a rare opportunity. It seemed especially important to be able to study prison medical practices since so little is known about them.

As the primary research instrument and sole researcher, I was concerned about problems of "going native" and missing the real meanings of events (McCall and Simmons, 1969). At the same time there were concerns about making the distinction between "operational data" and "presentational data" or whose information I could trust as fact (Van Maanen, 1979). In an environment where "conning the other guy" is a way of life, very little can be considered certain.

The availability of three settings, particularly the opportunity to compare two prisons, offered the possibility of broadening an otherwise narrow research base. This comparison could increase the chances that what was discovered went beyond the idiosyncratic features of one prison. For, although these prisons shared certain characteristics, like size and location, they differed along the critical dimension of security level. Here, then, was the opportunity to determine not only the effects of a total institution on the medical care of inmates, but also to learn of any variance in these effects when the degree or extent of inmate control is varied.

Findings

The findings of this study show that inmates use three paths or routes to gain medical attention in prison. Along each of the paths there are decision points where guards and/or medical staff play a role in the process. An inmate may move along any one of these paths smoothly to get needed medical attention. However, various slip-ups, errors of both omission and commission, frequently occur along these paths, and these errors can have certain consequences for inmates.

The most serious consequences result when inmates don't get the medical attention they need or want. Several circumstances of prison life lead to this consequence. For example, an inmate may not get needed medical attention because he has been classified as a maximum security risk. In order for such an inmate to get medical attention, a guard must "escort" him from his cell block to the "hospital." Because these "escort" guards are often unavailable and always costly, maximum security inmates may not get needed medical attention. In other instances, the inevitable conflicts among guards, and between guards and medical staff, often catch inmates in the middle so they cannot get medical attention. Finally, some inmates get "lost in the cracks" so go without medical attention. For instance, request

slips may be misplaced, or there may be a lock-up on the inmate's block; in either case he doesn't get needed medical attention.

A second class of consequences can result when inmates get unneeded medical attention. Sometimes these inmates have learned how to work the medical system to their advantage. They would come to the hospital as often as they could by putting in slips every day. They complained of various general or non-specific symptoms like low back pain or persistent headaches which were problematic for the medical staff. Other inmates had medical conditions, such as diabetes, that predated imprisonment. These inmates would use their illnesses to get added medical attention and certain other privileges such as job changes or special diets. Medical staff and guards alike regard inmates who get unneeded medical attention as leeches on the system. They are further frustrated by their seeming inability to prevent these inmates from manipulating the system.

The third set of inmate consequences involve those known as preventive health services. They include such things as occupational safety, environmental sanitation and the like. Yet, inmates do not consider preventative health care as a necessity. Responsibility for providing preventative services is, therefore, an elusive problem. Is improper ventilation of an inmate's cell something the doctor should try to correct? Or, should a public health official order proper ventilation of the cell? Or, does such a matter fall under the purview of the warden or superintendent of each prison facility? What about the safety

of machinery used in the prison industries, who (or what agency) is responsible for that equipment?

These consequences result because inmates who need or want medical attention, must deal with an uncertain and complex process. Those wanting to reform medical practices in prison are directed toward standardization for just that reason. Indeed, in many legal suits lawyers for inmates charge that medical care is "inadequate" because it is inconsistent and unpredictable.

The findings report how inmates at two prisons get both needed and unneeded medical attention. The description begins with the medium-security prison, Greenspoon, where medical attention is more readily accessible than at Ceilgate, the maximum-security prison. The paths or routes at Greenspoon are shorter with fewer decision points along the way. In addition, guards there are rarely in the position of being able to deny inmates access to medical attention. That is not to say Greenspoon inmates always get the particular treatment they seek, but they can usually see a doctor or nurse when they want. Although the same basic paths are available at Ceilgate, these paths differ along critical dimensions leading to consequences described above.

Greenspoon

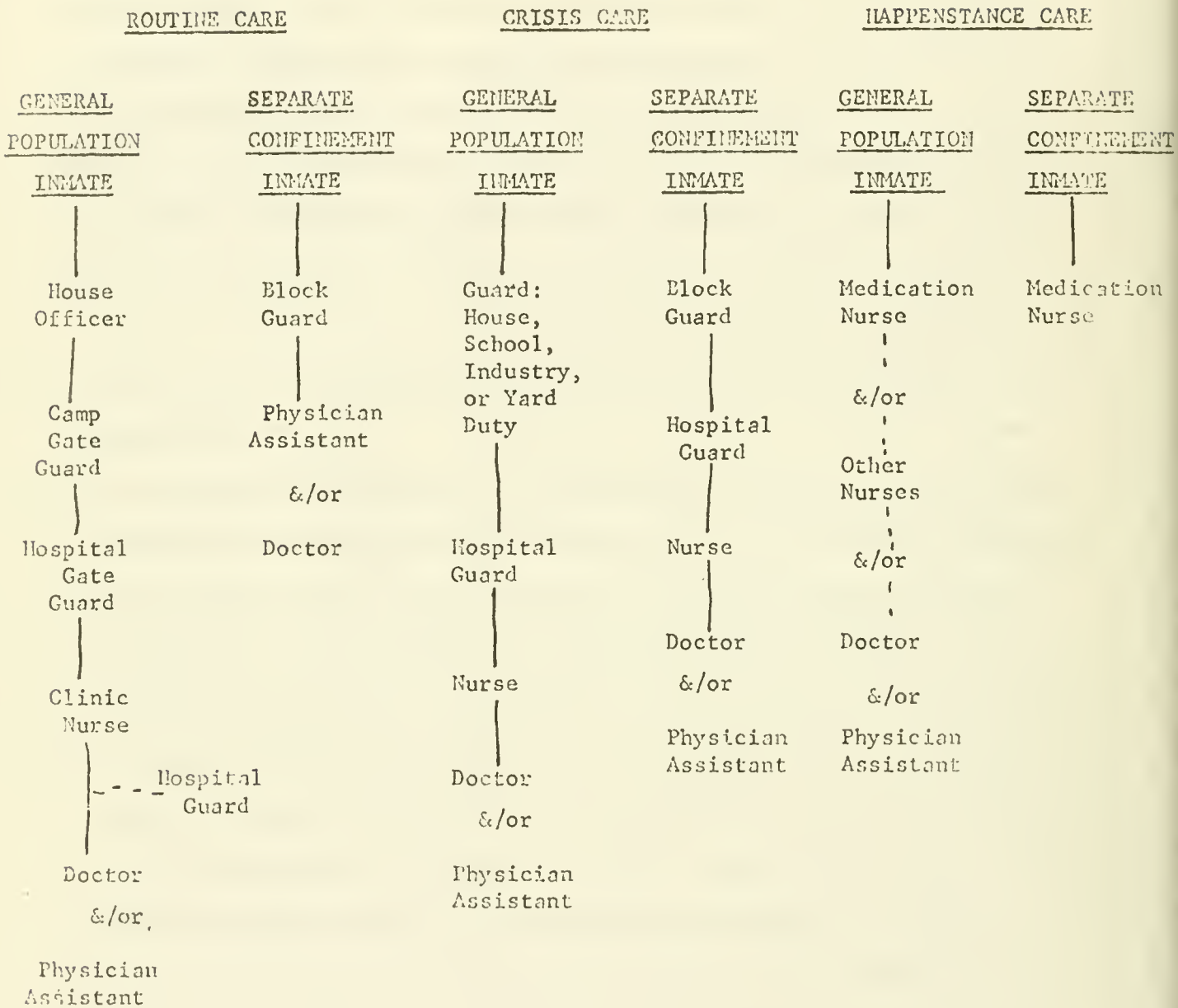
Greenspoon is the medium-security prison link in a total state correction system. Hence, all Greenspoon inmates have

served part of their sentences in a maximum-security prison. A high ranking officer explained, "They have to earn their way down here, and they can take advantage of all that we have to offer. If they can't meet our standards, they go out of here--back to 'Ceilgate.'" All but a few inmates here have the same classification status and are expected to meet the same responsibilities of work and school in order to enjoy the privileges of freedom from being locked up.

There is a small group of inmates, no more than fifteen or twenty, kept in "separate confinement." I was told, "Separate confinement is for inmates who are in danger from other inmates, inmates waiting to be transferred to higher security institution, and inmates who are 'rip-outs'--you know, the troublemakers." A small cell block houses these men who are locked in their cells 23 hours a day. Although on paper both classes of inmates have the same paths available to medical attention, in practice there are differences because guards can exercise their own initiative in the control of the locked unit.

Figure 1 schematically depicts the three paths or routes used to gain medical attention. The first is the Routine Care Route, known as "Sick Call" to the prison staff. For the most part, inmates initiate this process much as do patients on the outside who go to the doctor or to the hospital clinic for medical care. The Crisis Care Route represents the way inmates get medical attention through emergencies requiring immediate or urgent treatment. Guards usually send or bring these inmates

FIGURE 1 GREENSPOON: THREE ROUTES TO MEDICAL ATTENTION



to the hospital, but the guards decide whether an inmate's condition warrants "emergency" definition. A third way inmates get medical attention is via the Happenstance Care Route which most often takes place during the regularly scheduled hours when medicines are dispensed.

Routine Care Route; General Population

Taking each path in turn, I found the Routine Care Route was the longest but the most certain way to get medical attention. Every weekday morning, the doctor and/or a physician assistant (p.a.)¹⁰ holds office hours in the first floor clinic area of the hospital wing. If an inmate feels he needs to see the doctor, he tells his "house officer" at breakfast and fills out a "sick call slip."

The "house officer," is the first decision point on the way to medical attention. This guard has overall responsibility for the forty or so inmates assigned to his dormitory-like building of cells. A high ranking guard explained, "There is a house officer on duty 16 hours a day. They wake them up in the morning and put 'em to bed at night--just like a housemother." This guard provides the necessary passes to allow an inmate to be in the hospital and to excuse him from work or school where he is expected. Hence, this decision node is essentially a paperwork role performed by a "house officer" guard. Although it is conceivable he could refuse the inmate permission, there were no reports of this happening.

These passes and excuses admit the inmate through a gate out of the "camp" or prison proper into the main connecting building to other parts of the prison. A guard at this gate checks the inmate's pass and superficially frisks him before letting him in. Once inside this building, the inmate crosses less than twenty feet to the hospital gate where a second guard supposedly checks his pass and frisks him again. Often, because he has just watched a fellow guard perform this same procedure, the hospital gate guard just unlocks the gate for the inmate. Assuming that the inmate's pass is viewed as "legitimate" by both guards, passage through these two decision points is perfunctory.

Once inside the hospital, the inmate checks in with the nurse assigned to "clinic triage" for that day. Her role is to log on-to the day's "Sick Call List" the inmate's name, his unit number and his reason for coming to see the doctor. This nurse sends the inmate to the waiting room while she locates his record for the doctor. According to the published procedure, all inmates who want to see the doctor are expected to be assembled in the waiting room by 8 AM.

In the hall, strategically placed between the doorways of the waiting room and the triage/treatment rooms, the hospital guard sits at his desk. From this vantage point he can see and hear much of what happens in both areas, ready to intervene "should there be any trouble." He means that he is available to handle inter-inmate conflicts which I never observed, but

which were reported as happening on occasion.

Primarily, the hospital guard is there to protect the medical staff from inmate violence which could erupt when the treatment is not what the inmate wanted. This happened one morning during sick call when an inmate, whom the staff knew well, came to sick call but left without seeing the doctor. After calling his unit several times, a nurse finally convinced him to return to the clinic. He was, however, quite agitated and verbally abused the staff. The hospital guard stepped in to protect the staff members and called for reinforcement guards to help control the inmate. This guard also loosely keeps track of inmates, noting those who leave after seeing the doctor and those who leave without seeing the doctor. Often, however, when the morning session was over, he needed to check with the clinic nurse because he was missing information about the disposition of some inmates.

Between 8:30 and 9 AM the doctor arrives at the prison hospital to begin his office hours. The clinic triage nurse tells the hospital guard to call the first patient into the doctor's office and sick call is underway. The "Sick Call List" is ordered on a first-come-first-served basis. Hence, inmates usually know when their turns will come according to who was waiting ahead of him. If an inmate is willing to wait for his turn, thirty minutes to three hours, he can see the doctor for medical attention.

Two mornings a week the doctor goes to the "separate confinement" unit for sick call there. On those days, the physician assistant examines and treats inmates at the clinic until the doctor returns, usually within an hour or two. Any inmate who doesn't want to see the p.a. can wait for the doctor. Alternatively, the p.a. may leave certain inmates for the doctor to see. When asked how he decided which inmates the doctor should see, the p.a. listed specific cases: "This guy is here for a medication renewal, and I don't like to see them. I let him (doctor) handle those guys. This one has had stomach problems before, and I've seen him; he's just a complainer. Here's another one who only wants narcotics."

Occasionally, perhaps once every two weeks, there is an especially long Sick Call List. Then, the doctor and p.a. see inmates concurrently, deciding who will see each one in an ad hoc, case by case fashion as described above. One p.a. recounted the protocol to justify this practice, "When I take care of them, they really get twice the care because the doctor has to sign off on all my charts and the treatments I order. Plus, anytime I'm not sure of what the problem is, I ask for his advice."

Routine Care Route, Separate Confinement

Guards control the Routine Care Route for inmates in "separate confinement" at Greenspoon. "First thing in the morning, if anyone needs care, he tells the on-duty officer. We call the

hospital to turn in their names, and the doctor or p.a. comes here and sees the patients in a separate room." Although I heard no reports of it, guards could conceivably keep inmates from getting needed medical attention. Errors of omission, like forgetting to take note of an inmate's request, can easily occur. Conversely, there is nothing to prevent guards from deliberately neglecting to notify the hospital of an inmate's request. Hence, this short decision path to medical attention appears deceptively simple though fraught with uncertainty for inmates.

The vast majority of Greenspoon inmates use the Routine Care Route to get medical attention. In addition to the Monday through Friday sick call sessions, certain specialists hold scheduled clinic sessions. These include, among others, a dermatologist and an optometrist once a week, and an orthopedist once a month. The doctor or p.a. refers inmates to these specialists. There is also a full-time dentist at the hospital who runs his area completely himself with a part-time inmate assistant.

As was suggested earlier, access to medical attention for Greenspoon inmates is relatively direct and easily gained. A long-time nurse there compared her clinic with clinics on the outside:

We can't run this clinic any different than you run any other O.P.D. You come in and wait your turn. If we have an emergency like an injury or an acute problem, you take them

ahead of everyone else. There's always the problem of 'I got here first,' but what else have these guys got but time? They can wait.

Crisis Care Route, General Population

The second path to medical attention is the Crisis Care Route used for inmates who suddenly become ill or injured. The interesting feature of this path is that a guard decides when an inmate needs this kind of attention and sends or brings him to the hospital. Alternatively, the guard may call for a doctor or nurse to come to the injured inmate, although this is rarely done.

Typical of the sorts of problems seen as "emergencies" was the man who while working in one of the industries got an asbestos particle in his eye. The guard in the factory called the hospital to tell a nurse that the inmate was on his way over. She told the hospital guard to let the hospital gate guard know he was coming. When the inmate arrived, he was immediately admitted to the hospital clinic area and taken to the treatment room where his eye was examined and treated.

Other times, inmates used this path when they chose not to wait for their turn at "sick call." If, for example, an inmate were to come to sick call early in the morning and find there was a large group of inmates waiting, he might leave, planning to return toward the end of the morning for his care. One inmate needed to have the bandage on his thumb changed; another

came because he was having "stomach pain." Both left when they saw how many were ahead of them and returned later when the wait would be shorter.

Although the medical staff knew this happened, they often could not prevent it. One morning one of the administrative types discovered that two inmates had left, planning to return later. He said,

Like any hospital or clinic in the military or whatever, you have sick call--report in and wait your turn. We had two 'mates in here who didn't want to wait, so they left, saying they'd come back later and get a pass from their house officers. Well, we just can't have that. We're not running an all day sick call. We handle emergencies anytime, but these guys aren't emergencies, so they'll find out when they try to get back in.

He told the hospital gate guard not to let either inmate back in. Later, one got past this roadblock and was treated; the other never came back that day. When asked about this, the staff member shrugged, "you just can't keep track of everything."

Occasionally there were bona fide emergencies, such as the inmate who "fell in his room and hit his head on the corner of his TV," cutting his forehead just above his eye, or, another inmate "fell down the stairs" and sprained his ankle. Both got medical attention through the Crisis Care Route. Still others came for care using this route with sudden flare-ups of chronic conditions like diabetes or asthma or epilepsy.

Most often these "emergencies" were treated in Greenspoon's clinic. The man with the cut had it stitched there; the one with the sprained ankle had it wrapped and was given crutches.

When inmates with diabetes had problems, their insulin imbalance was regulated in the prison "hospital." Sometimes, however, the medical staff would send an inmate by ambulance to a local hospital emergency room for treatment. For instance, one morning an inmate with epilepsy was brought to Greenspoon's clinic with sustained, uncontrollable seizures. After treating him for two hours "unsuccessfully," the doctor sent him to an outside hospital emergency room. In the evenings, at night and over the week-ends, when there is no doctor or p.a. at Greenspoon, the nurse on duty sends inmates with "emergency" problems to outside hospital emergency rooms. This happens after the nurse has examined the inmate and discussed her observations with an on-call doctor; together they would decide whether to send the inmate to an outside hospital.

The Crisis Care Route to medical attention can be a direct and quick path for inmates under certain conditions. The first and most critical condition is that a guard must decide when an inmate's physical state warrants immediate treatment. Such a conclusion requires more from a guard than he has been trained to do. Yet, despite this lack of medical training, guards are expected to define what constitutes an "emergency" requiring immediate care and what is not an emergency and can wait. Thus, mistakes are inevitable. Such a mistake happened early one morning when a guard misjudged the extent of breathing difficulty a new inmate was having. An hour and a half elapsed between the time the guard first called the hospital to report this inmate's condition and the time the inmate arrived in the hospital for

treatment. He died about an hour later, just as the ambulance for him pulled into the main prison gates. The consensus among the guards was, "He [the deceased inmate] was a new man; no one really knew him very well."

Although no one expressed the possibility, perhaps this was an example of guard misjudgement resulting from a lack of training but called something else. The guards' collective explanation of what happened assumes that if the inmate were not new, the guard would have known him better and could have been able to tell that he needed immediate treatment. However, given the guard's limited experience with this particular inmate, he couldn't be expected to know how serious the problem was. The lack of guard training as a legitimate cause for what happened was never raised.

A second condition for inmates to use the Crisis Care Route requires the explicit cooperation of a guard who gives an inmate a pass to come to the hospital at a time other than early morning sick call. Such cooperation is particularly necessary for inmates who use this path because they don't want to or cannot wait for their turn in early morning. They must have some assurance that they can get a pass to return to the "hospital" at a later time that day. Here again, the guard must decide whether an inmate's reason for not waiting is "good enough." The best reasons are school or work related. If an inmate expresses concern that waiting in the hospital all morning could

jeopardize his job, the guard is more likely to cooperate by issuing a pass for him to come later on in the morning.

A final condition for inmates to use this route is that a medical staffer accept the guard's definition of a certain condition as an "emergency." Alternatively, for inmates using this route instead of waiting their turn at sick call, they must have the sanction of the medical staff in order to get some attention. The latter seemed to be less of a problem with the providers of care than with the administrators who saw their role as promulgating and enforcing the rules. Such a blatant rule violation rankles their authority.

Crisis Care Route, Separate Confinement

Inmates in Greenspoon's "separate confinement" unit are constrained in their use of the Crisis Care Route--they are in their cells nearly all day, and are totally dependent on guards. The stated practice when someone is acutely sick or injured: "We carry them over to the hospital, or someone escorts them over." Again, unless the illness or injury is obvious to an untrained eye, guards decide about the urgency of an inmate's need for medical attention based on limited training.

Because inmates on this unit are locked in cells behind solid steel doors, a further complication arises. Guards cannot see the inmates in their charge. Meals are passed through a slot in the door, and there is virtually no interaction between guards and inmates, except for a discretionary exercise hour when an inmate may be out of his cell. "Separate confinement"

resulted in one inmate reporting that he had had a severe insulin reaction one morning, "It was so bad, all I could do was stand at the sink and keep drinking Tang as fast as I could fix it." Had a guard been able to see into this inmate's cell, he might have decided that this was an emergency that required immediate treatment. Instead, the inmate treated himself and seemed to have recovered by early afternoon.

The Crisis Care Route for the majority of Greenspoon's inmates, as well as those in "separate confinement," is a more uncertain path to medical attention than the Routine Care Route. Because guards play such active roles at their decision points along this path, and because they are not trained to make such decisions, inmates sometimes do not get needed medical attention. Also, there are inmates whose illnesses do not warrant "emergency" treatment, but they get it when they can meet the conditions specified above.

Happenstance Care Route, General Population

The HaPpenstance Care Route provides a third path to medical attention. Known to prison staff as the "pill line," a non-medical professional described its use, "The pill line is always an option. I think of it as the safety valve in the system. The inmate can always go there for care." Figure 1 depicts this path, showing how short and direct it is.

At four specified times a day (8 AM, 12:30 PM, 4 PM and 8 PM) seven days a week, the end of the clinic furthest from the hospital gate entrance is closed off with a locked iron gate of

bars. A special door from the "camp " opens directly into this end of the clinic to admit inmates for their medicines. Most often, inmates come for prescription medicines the doctor has ordered for them. Sometimes they come for vitamins, aspirin, antacids--over-the-counter types of drugs which they cannot keep in their cells.

All inmates who get to the hospital within this half hour have direct access to medical attention. This may only be to the nurse who dispenses these medicines through a small barred window from inside a locked treatment room. But, if an inmate needs to have his blood pressure taken or wants to check on an x-ray report, he can wait until the end of the line and speak to this nurse about the problem.

Sometimes, especially during the noon line, other medical staff are around, finishing up the morning sick call or getting ready for an afternoon specialty clinic. In this case, the inmate can catch the staff member's attention for a few minutes about a problem. For example, one day during the noon pill line an inmate stopped a nurse on her way down the hall to tell her, "I'm always hungry because I can't eat the regular kitchen's food. It gives me acid stomach." She explained that his x-ray report wasn't back yet and he could not have a special diet until the results came back. She advised him to pick and choose what he could eat from the regular kitchen without getting acid stomach. The inmate, though frustrated in his attempt to get the special diet he wanted, was none-the-less able to get

medical attention using the Happenstance Care Route.

The hospital guard is posted at the window where the medicines are dispensed to "make sure they take the drugs and don't palm them or tongue them." Although he could prevent the admission of inmates who were not there for medicines, he does not. There were no reports nor observations of this guard's keeping any inmates out of the hospital during these times. For this half hour, four times a day, there is free access to medical attention; however, this attention is both capricious and random. Inmates can't know in advance who will be available, besides the medication nurse, nor how receptive anyone will be. Inmates do know that they won't have to wait any longer than a half hour. Also, they know that if they are unsuccessful in getting medical attention at this pill line, they can try again at one of the other times.

Happenstance Care Route, Separate Confinement

A nurse delivers the medicines to inmates in "separate confinement" at about the same four times a day as pill line. One nurse prepares the tray of prescription drugs in the hospital for those inmates and usually takes along some vitamins and aspirin in case someone wants them. One of the male nurses usually assigned this job laid out the process:

There's only a slot in their doors, and all I do is shove it into the slots. It's not my job to make sure they take it--let the officers do that. All I'm supposed to do is get the right stuff up there to their cells. The officers can worry

about whether they take it or don't.

Later, I had a chance to observe this pill delivery and found his description accurate. A guard accompanied the nurse, pointing out inmate cells when necessary. There is very little chance for the inmate to make contact with the nurse, unless he crouches at the slot in his door and waits for pill delivery. Then he could call to the nurse through the opened slot. The Happenstance Care Route for these inmates, thus, exists only as a remote possibility which could be used, but usually is not.

Summary of Routes at Greenspoon

Greenspoon inmates use three paths or routes to gain medical attention. Each route is characterized by certain decision points along it, some occupied by medical staff, others by guards. For the vast majority of the prison's "general population" inmates, they can usually get medical attention through one path or another. Because guards define what constitutes an "emergency," the Crisis Care Route is the most uncertain meaning inmates may not get needed medical attention. The Routine Care Route can lead to inmates getting unneeded medical attention. Inmates may spend the morning in the hospital to get out of a "bad job," or they may use this path to get the reputed better food from a special diet. The Happenstance Care Route is always available, completely free of any guard decisions. Yet, despite its ease, few inmates use it perhaps because other routes are readily available. The minority group of inmates in "separate confinement," have limited access to

medical attention because guards tightly control this block and have the power to deny access via any route.

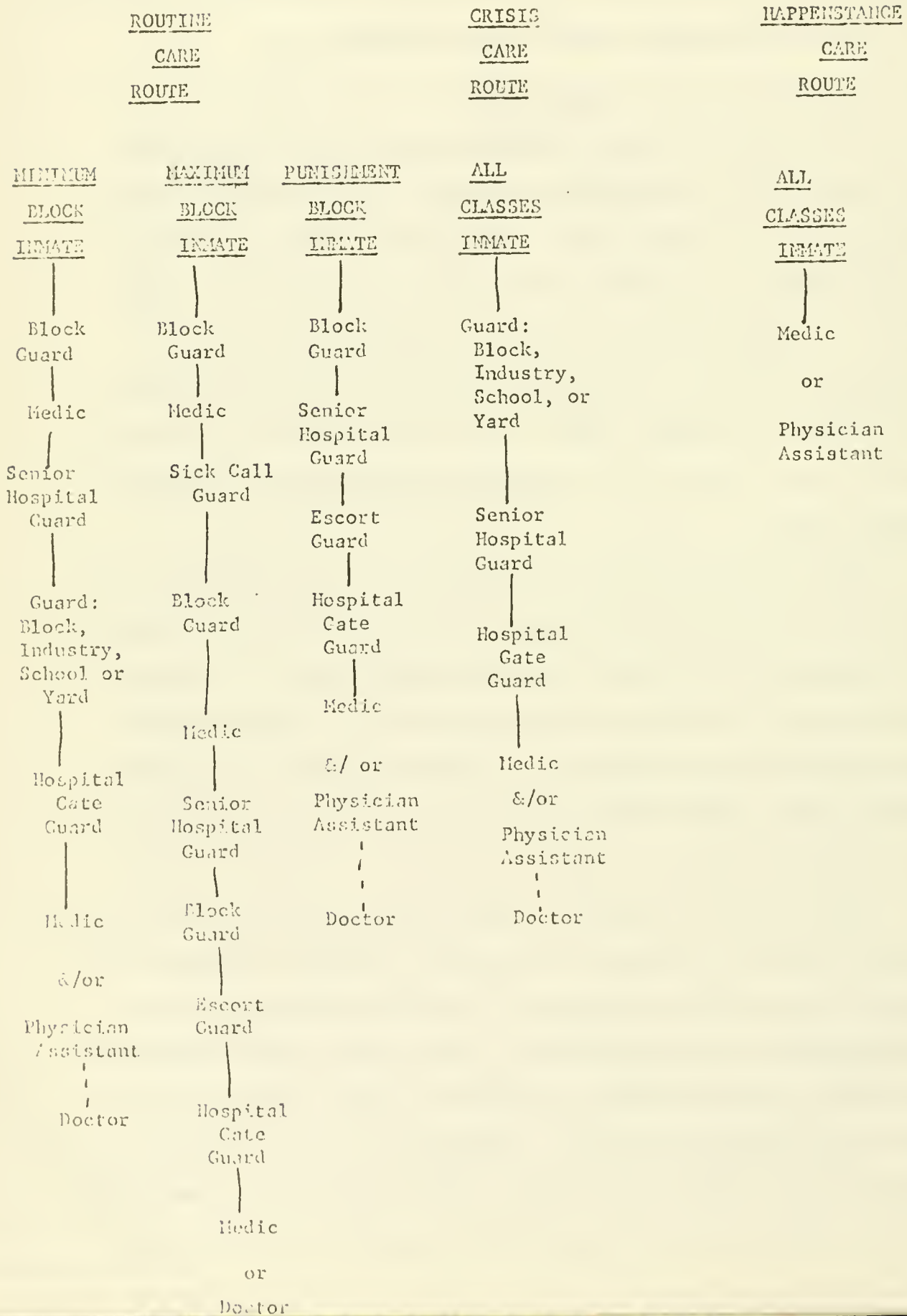
Ceilgate

As the state's only maximum-security prison for adult male felons, Ceilgate embodies all the trappings we have come to expect of an institution of this kind. Ceilgate, as described earlier, looks like the prison portrayed in the mass media. In addition to its outward appearance, Ceilgate's conspicuous feature is the omnipresence of numerous guards at every turn. And these guards insert their primary concern for security into every prison activity, including the delivery of medical care.

Figure 2 shows that the same three paths to medical attention used at Greenspoon are also available to Ceilgate inmates. The analysis of each path, however, demonstrates the qualitative differences in both the availability and use of these paths. This analysis takes each class of inmate through the process of each path, highlighting the roles performed at each decision node along the way.

Recall that at Greenspoon there were two classes of inmates: the vast majority living in the open or general population and a very small minority locked in "separate confinement." At Ceilgate there are three classes. The first, called "minimum" or "mini" by prison staff, comprises about sixty per cent of the total Ceilgate population. Because they are allowed out of their cells for most of the day, "mini" inmates are considered

FIGURE 2 CELLGATE: THREE ROUTES TO MEDICAL ATTENTION



the privileged class in this prison. All, except in the two thirty day "new-man" blocks, have jobs in one of the prison industries. All have access to certain educational programs from remedial reading to a few college level courses. All can participate in any of a few extracurricular activities like music groups and art programs.

"Max block men" is this prison's vernacular for the second class of inmates here, representing about a third of the total Ceilgate population. Of this group, about two-thirds were assigned to these blocks by Classification Boards which judged a need for constant surveillance. The other third of the group are inmates who themselves requested this assignment for their own personal safety. These latter inmates, known as "protective custody or p.c.'s," have real or imagined enemies at Ceilgate whom they fear.

The final class of inmates are those on the punishment block, which can house up to sixty men or about ten per cent of the total prison population. "This place is the end of the line, a warehouse for the incorrigibles that nobody knows what to do with," summed up a long-time guard on this cellblock. When an inmate violates prison rules, the accusing guard files a disciplinary report which a special board reviews. Depending¹¹ on the severity of the offense charged, the inmate may be sent to this cell block during the board's deliberations or he may stay in his cell elsewhere in the prison. If the board finds the inmate guilty of a major offense, such as stealing or setting fires or carrying drugs, he is sentenced to this

cell block for a period of time. He may spend some or all of this time in isolation, in which case he loses all privileges.

Routine Care Route, Minimum Security

Beginning with the longest, most complex path to medical attention, the Routine Care Route, the analysis follows inmates of each class as they attempt to gain medical attention. For inmates classified as "minimum," the first decision node in the process is the medic¹² who, in the course of delivering medicines to the blocks in the morning, picks up the inmate request slips for "sick call." In the past, inmates gave these slips to their block officers, the guards who have overall responsibility for a particular cell block. I was told, "We changed this procedure in response to inmate complaints that the officers weren't turning the slips in." Despite the assertion of a procedure change, there is much evidence to suggest that the old way is still in practice on many blocks. Crude indicators support this. For instance, on any given day numerous inmates call the hospital or stop at the hospital gate to complain that they put in slips and weren't called to come to the hospital.

Inmates are supposed to give their slips to the medic, but it seems they often give them to the block officer. This guard, in turn, is expected to give the slips to the medic. Whoever performs this role, it should be a simple paper handling function. Instead, the guards may complicate the procedure and withhold medical attention as a means of controlling or punishing inmates.

When all pill deliverers return to the hospital from the blocks, one medic takes these hastily collected handfuls of request slips and from them compiles the "Daily Sick Call List." There appears to be no particular order to the way inmates are listed. They are classified according to their security-level, but not according to their medical needs. Indeed, the medic who often performed this role said as much, "It's just a matter of getting the list out. Then, we see whoever the guard calls down when he gets here." Hence, this second decision node is essentially a clerk-type paperwork role that a medic happens to perform.

While the general sick call list is prepared, another medic prepares a list of inmates scheduled to see the doctor that day. Copies of both lists go to the "senior hospital guard," the next node in the Routine Care Route decision chain. Before describing this guard's function, it is important to elaborate on a critical difference from practices at Greenspoon. There, all inmates who reported to sick call had a good chance of seeing the doctor. At Ceilgate:

All patients are seen by a medic first. Then, if they want to or need to see the doctor, they get put on the list to see him, usually not that day but two or three days later. The only exception is if he's just a chronic pain in the ass. Like we've got this one guy who wants Valium (tranquilizer)--nuthin' else. He's seen the doctor three times, and he said no every time. We won't give him any more appointments with the doctor.

The important feature of this difference centers around the access to medical attention available to inmates. At Greenspoon, inmates have direct access, by and large. However, at Ceilgate this access is controlled by both guards and medical staff through a subjective, often ad hoc procedure that can be manipulated. As a result, inmates may not receive needed medical attention.

Returning to the decision chains for the Routine Care Route to medical attention, Figure 2, we see that the process for all classes of inmates at Ceilgate is the same up to this point. However, at this point, an inmate's classification and resulting block assignment become determining factors. Indeed, this classification has a direct bearing on whether an inmate gets medical attention, when he gets it, and how. If, for example, there happens to be a "lock-up" on one of the maximum blocks, a not infrequent occurrence, and guards are searching each cell for contraband, no inmates can leave their cells. Hence, none receives medical attention for the duration of the "lock-up."¹³

It could be argued that an inmate's security classification is a primary decision node in the process of getting medical attention. This classification has the explicit effect of increasing the number of decision nodes for both maximum-block and punishment block inmates. The increased number of nodes not only lengthens the process, but also increases the likelihood of deliberate mistakes as well as other kinds of slip-ups

and human errors.

For the "mini block" inmate who has submitted his request slip and whose name has made it to the "Daily Sick Call List," it is a matter of waiting to be called to come to the hospital. Often these inmates go to their regular work assignments to be summoned from there. The guard in the next decision node is designated as the "senior hospital officer." In the prison's organizational hierarchy this guard is in charge of the hospital area and has two junior officers to assist him. During my observations, one particular man was always in charge when he was on duty during the day. A medic described him, "It's a bid job which means seniority gets it. He's got 17 years in here; nobody tells him what to do."

The role of the guard occupying this node is pivotal. He sits at the only desk in the wide corridor that is the hospital area, positioned in the middle of all the action. He has one of only a few phones in the hospital, and from this post he regulates the flow of inmates in and out of this area. He decides whom to call from the lists and when. On the one hand, this guard tries to keep as few inmates waiting in the hospital as possible, "No more than we could handle, if they should decide to try some funny business." The implication intended is that, from the guard's perspective, too many inmates gathered in one place could lead to insurrection.

On the other hand, this charge guard views it as his responsibility to keep all medical personnel who are available to

see inmates busy doing just that. He regularly checked the examining and treatment rooms to see whether staff members were free and often commented on their laziness. One day in exasperation he expressed his frustration, "I feel like a damned medical secretary with these lists, trying to keep them straight. And, then I've got all these weasels ducking out of work whenever they can."

This guard, despite his alledged frustration, holds a very powerful position in the overall scheme of Ceilgate's prison hospital. As noted above, his primary function is to regulate the flow of inmates into and out of the hospital. He accomplishes this regulation by phoning the various blocks, industries or other areas where inmates might be to order them sent to the hospital for medical care. He contacts the guard on duty in the area phoned, and he tells that guard to send the designated inmate.

The block, school or work guard who relays the message, gives the inmate the necessary pass out of this area and to the hospital. This guard represents the next decision node in the process. On the surface it seems to be a fairly simple matter; however, sometimes when an inmate was called, he didn't show up. One possible explanation for this breakdown suggests that the inmate never got the message. Perhaps it was an especially busy time in the work area, and it would have been inconvenient for that inmate to leave just then. Or, maybe there was so much

confusion on the block at the time the call came that the block officer forgot to give the inmate the message. Another possible explanation could be that the guard receiving the message decided that the inmate didn't deserve to go to the hospital, either because he had abused this privilege in the past or had been a disciplinary problem recently. In any of these hypothetical cases the guard fails to pass the message along to the inmate. The inmate has missed his chance to get medical attention and must begin the process all over again.

Assuming the inmate gets the message and the required pass from the guard, he proceeds along the path to the next decision node, the hospital gate guard. The guard assigned to this duty is supposed to check the inmate's pass and frisk him before he enters or leaves the hospital. What typically happens is that this guard sits at the side of the senior hospital guard's desk, which is out of view of the gate. When someone wants to come in, he calls out "on the hospital gate," to get this guard's attention. The guard comes to the gate, a set of locked open bars, which he unlocks. He checks the inmate's pass and superficially pats him down. If he is in doubt about whether to let an inmate in, he yells down to the senior guard to ask if he called for this man.

Sometimes one of the medical staff would have called for an inmate to come to the hospital. This was a source of added frustration to the senior guard, particularly as one of the p.a.'s was in the habit of doing this. When the senior guard had not called for an inmate, someone had to vouch for

the inmate's report of having been called. If, by chance, the staff member was at the gate or within earshot, he could take care of the matter. Otherwise, the hospital gate guard had to decide whether to let the inmate in or not. Sometimes the inmate was sent back to his block or work area. Other times, the gate guard took the inmate's word. This contingency seemed to depend on the gate guard's past experience with individual inmates, "We have a fairly stable population here, and of course you get to know who's trying to con you and who you can pay attention to."

The senior guard and the gate guard jointly share the function of keeping track of inmates who come and go in the hospital. The gate guard is supposed to tell his superior what inmate has arrived and when. The senior guard then notes the name and time. When the inmate is finished and leaves the hospital, the senior guard again is supposed to note this. Neither procedure is regularly followed, for as was repeatedly pointed out and directly observed, "When this place gets going, the phone is ringing, there's three or four people seeing patients, plus the extra guards bringing inmates down from max. There's no way you can keep track of who's comin' and goin'."

Once past the hospital gate guard, the inmate arrives at the last decision node, the medic or p.a. When there is an especially long Sick Call List, the p.a. pitches in with the medics to take care of some inmates. The inmate has reached medical attention as it is generally available at Ceilgate. Occasionally,

during the course of examining an inmate, the medic has a question about the "correct" way to handle a medical problem. He checks either with one of the other medics or a p.a. about it. Sometimes, the medic consults the doctor, if it happens to be when the doctor is there. Mostly, the medic listens to the inmate's description of the complaint, and decides on a course of treatment.

On any given day, the medic refers up to to a fourth of the inmates he has seen to the doctor for further examination and treatment. Such problems as an inmate's request for a work assignment change can only be recommended by the doctor. But first the inmate must see the medic, who then schedules an appointment with the doctor. Inmates who are maintained on long-term medications for chronic illnesses, like diabetes or epilepsy, regularly see the doctor. "If we think an inmate needs reassurance, we send him to the doctor. Even when we know he's going to tell the inmate the same thing we did, coming from the doctor it carries more weight," was another reason given.

The most typical reason for sending an inmate to the doctor, however, is drug-related. Medical staff estimates of the proportion of inmates sent for this reason ranged from 60 to 95 percent. All inmates who request tranquilizers or drugs classified as "pain killers," like narcotics and barbituates are sent to the doctor. One long-time Coalgate medic summed up the drug problem:

The three main drugs we have problems with are Valium, Chloral Hydrate and Darvon. Another is Talwin, though it's getting

scarce. I'd say 70 to 75 per cent of all the patients we see here are for medication requests and renewals. We send them to the doctor; he handles them.

The doctor is at Ceilgate for three to four hours Monday through Friday. During that time, he examines and treats about a dozen inmates. In addition, he reviews all the medical records of all inmates examined and treated by medics and p.a.'s. He countersigns each note, signifying his concurrence with the examination and treatment as recorded. Now, given the relatively short time the doctor is there, and given the fact that the hospital operates 24 hours a day, seven days a week, the volume of charts for his review usually exceeds the time he has to thoroughly review them. Hence, this procedure is usually performed in a perfunctory manner that in essence defeats the purpose intended.

Routine Care Route, Maximum Security

For "max block" inmates seeking medical attention through the Routine Care Route, the process through the first two decision nodes is the same as for minimum block inmates. Medics pick up request slips from either inmates or block officers during the early morning pill deliveries. Back in the hospital, one medic compiles the day's lists. At this point, however, the process differs because the initial medic screening of these inmates takes place in the basement of the maximum blocks, not in the hospital.

The medic assigned to this duty must bring with him any equipment he might need in order to perform his examinations. The area designated for this screening is a small multi-purpose room furnished with only a desk and a couple of chairs. On two mornings I observed two different medics as they prepared to go to the maximum block for such a screening session. One took a stethoscope, blood pressure cuff, thermometer, bandaging gauze, adhesive tape, medical dictionary, drug description book, otoscope, ophthalmoscope,¹⁴ and the medical records of inmates on the list. The second medic took only a stethoscope and a blood pressure cuff the day he was assigned this duty. Based on equipment available alone, the extent of medical attention these two medics could be expected to provide varied widely. The first medic could, for example, examine the ears, nose and throat and take the temperature of an inmate complaining of "cold symptoms." Whereas, the second medic would not be able to get any information about the same inmate's condition beyond the complaint description.

In addition to the medic and whatever equipment he brings with him, the process requires a guard from the maximum blocks who has been assigned to this "maximum sick call" duty. The medic sits inside the room and waits for inmates to be brought to him one at a time. The guard, posted just outside the door, arranges with the guards up on the blocks for inmates to come down.

As noted earlier, the access of medical attention to a

maximum block inmate is highly contingent upon the happenings on his cell block at the time. I observed one session when only one out of the nine scheduled inmates came for his appointment. The guard who was posted at the door reported, "There's a lock-up and shake-down going on. Nobody else can come down." The rest of the inmates on the list would either be called to come over to the hospital, or they would have to put in request slips for another day.

In those cases where inmates could not be seen in the medic screening session just described, or if the medic felt an inmate needed to be examined in the hospital, the process depicted in Figure 2 was followed. That is, supposing the medic examined an inmate with an injured ankle which could have been sprained or broken. The medic would refer this inmate to the hospital where the ankle could be x-rayed and the correct treatment provided. Or, in another instance, the medic just wasn't certain about how to interpret an inmate's continued complaint of "head-aches," so he sent this inmate to the hospital. In the meantime, the medic could confer with one of the other medics or the p.a. about this inmate's condition and be prepared to deal with the problem when and if the inmate came to the hospital.

As is the case for minimum inmates, maximum inmates are summoned to the hospital by the senior hospital guard who notifies the inmate's block guard. In addition to passing the message along to the inmate, however, the block guard must also arrange an "escort guard" to bring the inmate down. This added

function is one of the most problematic in the process. It typically takes at least two days to arrange escort guards because there are a limited number available, and they are very much in demand. The reasons are easy to understand,

All max inmates have to be escorted anywhere outside their cell block. Escort guards are regular officers who work a double shift. It's not a bad way to pick up an extra hundred bucks, so a lot of guys do it. Now, the problem comes when there's no money in the pot to pay for these escorts, like at the end of the month. Then, they cut back on the frills, like bringing inmates to the hospital.

The escort guard, the next decision node in the process, performs the role of accompanying the inmate from his cell to the hospital. He waits there while the inmate receives medical attention, and then brings him back to his cell. The one decision he makes is whether to handcuff the inmate during this trip from the cell to the hospital and back. Most often these inmates are not handcuffed.

As expected, the presence of the escort guard with the inmate facilitates entry to the hospital from the gate guard. Once inside, these inmates go directly to the examining room to be cared for by the medic or p.a. Although the escort guard waits for the inmate, usually he hangs around the senior hospital guard's desk. He does not go with the inmate during this examination and treatment. Should an inmate's condition warrant consultation with the doctor, he may become involved at this point

in the process. This involvement may include a brief conversation with the medic in the doctor's office, or the doctor may come into the examining room where the inmate is to have a firsthand look at the problem.

Routine Care Route, Punishment Block

The Routine Care Route, as available to punishment block inmates, in theory operates as depicted in Figure 2. It differs insofar as the guards on that block treat every inmate activity as a privilege which can be withheld. These "privileges" include such mundane activities as showers and meals as well as the more serious like medical care and visits. Because punishment block inmates are confined to their cells at least 23 hours a day, they usually have no contact with the medic during pill delivery. Hence, they must give their request slips for sick call to the block guard, who supposedly gives them to the medic. This medic turns any slips in to another medic who compiles the Daily Sick Call List as above. So far this process is the same as for both minimum and maximum inmates.

In fact, this process was rarely, if ever, followed. During the period of observation, no inmate names from this cell block ever appeared on the Daily Sick Call List. Their names did, however, appear on the "Doctor's List" some days. On those occasions, the rest of the decision path was followed with the senior hospital guard calling the block officer to bring the inmate. The block officer would arrange for an escort guard

who often handcuffed the inmate while transporting him to the hospital. The hospital gate guard admits them without question. When it was the inmate's turn to see the doctor, he was turned over to a guard stationed in the doctor's room during office hours. Medics and p.a.'s sometimes treated punishment block inmates. The informal process more closely resembled the Crisis Care Route for these inmates. That is, the block officer would call the senior hospital guard and together they arranged the inmate's visit to the hospital.

This completes the long, uncertain and frequently disappointing process of the Routine Care Route to medical attention at Ceilgate. Inmates frustrated by this process and their inability to do anything about it have limited options. The Crisis Care and Happenstance Care Routes are two possibilities described in the next sections. None of these routes assures medical attention. The guards seem to view such attention as just another privilege to be manipulated in an effort to control inmates. It is, therefore, easy to understand what prompted one inmate to say explicitly what many inmates implied, "If you're an inmate, and you get sick, you're scared."

Crisis Care Route, All Security Levels

The Crisis Care Route is the second path available to Ceilgate inmates to gain medical attention (See Fig. 2). The path

begins with a guard's definition of an inmate's condition as an "emergency," just as was found at Greenspoon. For minimum security inmates, this guard may be the inmate's block officer or the guard on duty in one of the industries where inmates work or in the school or the prison yard. The block officer tends to play this guard's role for inmates on either maximum or punishment blocks, by virtue of the fact that these inmates are so rarely out of their cells.

The incidence of "emergency-type" cases at Ceilgate was frequent; indeed hardly a day passed without at least one such case. This incidence differs sharply from Greenspoon where "emergencies" were infrequent. A long-term medical staff member commented on his work experience at both prisons. He explained the sources of Ceilgate's pandemic "emergencies,"

It's (Ceilgate) a very volatile place. First, you have all the new commitments, and they're angry they were sentenced. They stay angry for a couple of years. Then, you've got the problem of guys having to pair up or team up with other inmates for their own protection, and these gangs fight each other. Finally, there's a big drug problem, and people collect on bad debts. Eventually, when and if these guys calm down, they come to 'Greenspoon.'

Inmates who were brought or sent to the hospital with "emergencies," bore out the accuracy of this staff member's description. One day an inmate was carried to the hospital by two guards who had been on duty in the exercise yard. The inmate was pale and shivering, covered with mud, and had a deep cut over his right eye. Although he reported he was

". . .playing football and fell on a fence," the consensus among the guards was that this was just the first of numerous fights they expected to result from the "gang war" recently triggered between two minimum security inmate groups.

The process of getting medical attention followed the normal decision path. The guards in the exercise yard saw this inmate, presumably after he was injured. They called to the senior hospital guard to notify the hospital staff that they were on their way over with an injured inmate. The hospital guard told the medical staff who were ready when the inmate arrived. While one medic cleaned and stitched the cut on his head, another medic checked the inmate's general condition looking for other body wounds and treating his shock-like symptoms. The doctor happened to be at the prison hospital at that time, and he was summoned to check the inmate for signs of a concussion. The senior hospital guard was asked to call for an ambulance, and the inmate was sent to a local hospital for observation.

An example of the sort of "emergency" from one of the maximum blocks took place one day during the "noon count."¹⁵ A block officer called the senior hospital guard to have a medic sent with a wheelchair for an inmate who had overdosed on drugs. Just as the medic was leaving the hospital, a guard arrived with the sick inmate in tow. This inmate, along with three others treated the night before, had reportedly taken "Haldol" (a strong tranquilizer) in unknown amounts. Like they,

he experienced the severe side effects of this drug, uncontrolled muscle spasms which affected his breathing, heart rate and blood pressure (Physicians' Desk Reference, 1977). The doctor had left the prison for the day, but a medic paged him and took an order to give the inmate a drug to counteract the symptoms. Later that afternoon, the inmate returned to his cell to let the effects "wear off."

Here again, the process followed the decision path as depicted for all three classes of inmates, in this case a maximum security man. A guard defines an inmate's condition as an "emergency," requiring immediate treatment, just as at Greenspoon. Even during a major count, typically a sacrosanct time when there is no movement of inmates or staff within the prison, a seriously ill inmate got medical attention through the Crisis Care Route. This finding suggests that this route may be the most effective way to get medical care at Ceilgate; whereas at Greenspoon this route worked less effectively. Perhaps the training and socialization of guards at each prison results in this difference. At Ceilgate violence is commonplace and guards learn quickly how to handle it; at Greenspoon, on the other hand, there is little violence, and guards mismanage it.

A noteworthy feature of the violent injuries inmates have involves the explicit code that inmates never tell what really happened or who was responsible. Even though it is perfectly obvious that falling on a fence or accidentally bumping someone's elbow couldn't possibly result in the severe injuries inmates

come in with, they refuse to tell. Both guards and medical staff honor this code by accepting the inmate's condition at face value and treating him symptomatically, and in most cases, humanely. Indeed, to the extent that the medical staff expressed genuine concern for an inmate's condition and showed any evidence of kindness or tenderness toward inmates, it was for those who suffered from the physical violence of other inmates.

Although the process of getting medical attention via the Crisis Care Route is the same for inmates confined on the punishment block, the kinds of "emergencies" they have tend to be different. Many inmates have been on this block for years, locked in their cells at least 23 hours a day. As a result, many injuries are self-inflicted. Some attempt suicide by slashing their wrists with razors or broken glass, and they often persist in their attempts. One afternoon a call came from a guard in this block to the senior hospital guard, "John B. has cut up again." ("Cut up" is prison argot for wrist slashing.) He was brought into the hospital by a guard who reported he found him during a routine cell check. The medic put him on the examining table and prepared to stitch the fresh cuts on an area that was already heavily marked with scars from previous slashings.

Other kinds of injuries inmates in this punishment block have seem to reflect the frustration and boredom of existence there. For example, inmates are cut when they kick out or punch out windows in their cells. They overdose on unknown or poor quality

drugs. One man came to the hospital at least twice a week with a large open wound on his knuckle that he reportedly rubbed against the concrete wall of his cell, thus keeping it from healing.

The conventional wisdom, shared by both guards and medical staff, about most self-inflicted injuries is that inmates only do this to get drugs. One guard gave an especially animated account of how inmates injure their ankles to get drugs:

You tell one of your buddies, 'when I'm not looking, I want you to give me a swift kick in the ankle.' They do it, and the guy ends up here in excruciating pain with a swelled ankle. Maybe he even waits for a while til it gets really swelled up. Then, they come down and say they got hurt going down stairs or whatever.

Even inmates who attempt suicide are suspect -- "When they don't get their own way and the drugs they want, they cut up."

Only inmates who are beaten up by other inmates seem to be immune from this suspicion. The Crisis Care Route works most effectively for such inmates provided a guard finds them in time to be treated. Many times they do not. For the five years preceding this study, the most frequent cause of death at Ceilgate was "trauma, secondary to physical beating." There is even some evidence to suggest that some inmates who were classified as having committed suicide were actually killed by other inmates.

Although I only observed "emergency" cases who came to the hospital, sometimes medics went to the blocks to give first

aid and emergency treatment. The evening shift medics in particular reported numerous instances when they performed this role. It seemed to them that when a guard thought an inmate was dead, or close to it, he would call for a medic. Some of this difference could be simply the result of fewer guards on evening duty, compared to days. In addition, when an inmate dies, there are numerous time-consuming procedures required by the medical examiner's office which guards prefer not to do.

Happenstance Care Route, All Security Levels

The final path to medical attention, like that at Greenspoon, is the Happenstance Care Route. Yet, unlike this path at Greenspoon, there is no certainty of getting medical attention through it at Ceilgate. As noted earlier, Ceilgate has no "pill lines." Instead, medics deliver prescription medicines to the various cell blocks four times a day, seven days a week. Figure 2 shows this route in a deceptively simple light because it would appear that inmates could have direct access to the primary medical care provider, the medic.

Pill delivery was the only hospital related activity I was not allowed to observe, a curious fact given the several other occasions when I visited in the blocks. One possible explanation is that the medics don't give the medicines to inmates. Rather, the medics give the pill envelopes to the block guard who dispenses them. If this were the case, then this practice directly violates all rules and standards, a good reason to keep

someone from observing it.

Another, more sinister, reason could be that the medics deal in drugs; that is, they sell or provide for sale drugs to a reputed highly drug dependent population. I sense that this explanation is unlikely, but not impossible. Only direct observation over time could prove or refute it.

I observed the medics before and after they delivered the medicines to the blocks around noon every day. By 11:30, the guards had cleared all the inmates out of the hospital. One of the medics would go to the pharmacy, located in another building, to pick up the medicines which a pharmacist had prepared in small envelopes for individual inmates. Back in the hospital, medics sorted these envelopes according to blocks, and each took the pile of envelopes for inmates on his assigned blocks.

What seemed to happen was the medics tried to arrive on the blocks when inmates were most likely to be locked in their cells for the count, "It just cuts down on the hassle." Depending on the success of this strategy, medics could return to the hospital from pill delivery very quickly and report having had "no problems." Alternatively, they were gone much longer and returned looking irritated and worn out. When asked about this, they reported, "Those guys want to know why they didn't get a particular drug they were expecting, or 'where's my special soap the doctor ordered,' or how come they haven't been called down for sick call. It just goes on and on; every one has a beef."

Shortly after noon, when the major count was completed, inmates or their block guards would call the hospital to complain about the medicines just delivered. Sometimes these calls continued incessantly for an hour or more. Often the medic who had delivered the medicines took the call, explaining as best he could why there was a delay in filling a prescription or why a drug dosage was changed. Occasionally, the medic would yell a response to the senior guard who would, in turn, relay this answer to the caller.

It was a noisy, confusing time and seemed unsatisfactory to everyone involved. The medics felt "hassled;" the guard felt "put upon;" and the inmates felt frustrated. Yet, each day it was the same and demonstrated how uncertain the Happenstance Care Route is for Ceilgate inmates.

Summary of Routes at Ceilgate

Because Ceilgate is a maximum security prison, all other functions and inmate matters are subordinate to the primary goal of maintaining a secure institution. Procedures and practices are designed with security in mind, and medical attention is no exception. As a result, the three routes to medical attention here are unpredictable with uncertain outcomes. Inmates cannot count on any one of these routes as a sure way to get needed medical attention. Guards can thwart inmate efforts on each route. The medical staff, in most cases, are powerless to prevent guard interventions. Besides, they need the guards' cooperation, such as it is, in order to function even at the current

minimal level. The Routine Care Route is the longest path of the three with numerous points where both human error and deliberate interruptions can occur. The Crisis Care Route offers the best chance for medical attention, but it requires a life-threatening condition. Finally, the Happenstance Care Route is the least likely to lead to medical attention because the medics are hurried and don't want to be bothered.

Summary of Findings

Comparing the process of getting medical attention at these two prisons highlights the differences in the situations and the resulting effects. At Greenspoon, a medium-security prison, any of the three routes is likely to lead to some kind of medical attention. Often it is not what the inmate wanted or thinks he needs, but nonetheless he gets something for his efforts. It is a different story at Ceilgate, the maximum-security prison, where medical attention is less readily available. There, guards unquestionably control the medical process just as they control everything else, and the inmates know it.

To some extent these findings might have been predicted given the differences between the two settings. Inmates who have served time in both places best capture the essence of these differences. The first inmate recently returned to Ceilgate from Greenspoon. This return was his punishment for representing inmates during their work strike:

Over there (Greenspoon) it's a head game, always trying to trip you up and catch you. At least

here (Ceilgate) you know where you stand. You may not like it, in fact you probably won't like it, but you know it. There's no trying to trick you and fool you with words--it's all action here, and it's out in the open. And, that's the big difference. Over there you're always trying to figure out what they mean. Here there's no question. I'd rather be here.

The second inmate, now at Greenspoon, has had a long prison career in different states as well as at Ceilgate. He echoed the first inmate's sentiments:

Here's the trouble with so-called "open" places like 'Greenspoon.' When you're in a prison like 'Ceilgate,' all the rules are very clear. There's no question about whether something is maybe okay, or if you can maybe get away with something. Here (Greenspoon) is a whole different thing. They keep you in the dark about what to expect--it's a mental thing instead of physical punishment. I was in a jail once where guard brutality was very common. They broke my jaw in three places because I talked back to an officer. That was my punishment. Here, I had a knife I kept in my locker ever since I got here. Everybody knew I had it--it was never hidden in a drawer--it was right out in the open on the shelf. Every time my room was searched there it was. All of a sudden somebody new is making a search, and they see it, and they raise hell cuz you're not supposed to have a knife in your room. So, it's that never knowing what's okay and what's not that gets you. It's like they went from physical abuse to a mental type of thing. If I had to choose, I'd take the physical because you can count on it.

As expected, the medical staff play out these differences in each prison's hospital. At Greenspoon they give a lot of lip service to medical attention. Indeed, they all but say to inmates, "Come to the hospital anytime, for any reason, via any of the ways

we make available." However, in an emergency they buckle under the pressure and rely heavily on outside hospitals for care they should be able to provide themselves. They string inmates along by making them wait for everything and by having them return time after time to see the doctor or some specialist or another. They even send inmates to different hospitals for diagnostic tests without telling them anything in advance. In the end many inmates give up trying to get the medical attention they feel they need. Some inmates refuse to be subjected to this treatment and the associated degradation of being shackled and skin searched to go to an outside hospital. This is how the "head game" is played by the medical staff at Greenspoon.

At Ceilgate, on the other hand, there are no such pretenses. Medical attention is scarce and hard to get. Inmates know what they have to do to get it, and they can decide whether it is worth the effort or not. But when inmates really need medical attention for an emergency, they get it right on the spot. The medics know what to do for the usual injuries inmates have, and they are trained to do it. The whole system mobilizes in response to these crises so that inmates get the care they need, when they need it. Other inmate requests for medical attention, however, are often neglected or else handled capriciously.

The practices at each hospital reflect the tenor and prevailing situation of its host prison. Greenspoon is subdued,

"pastel." Inmates are rarely denied their requests for medical attention openly. Instead, they are kept in the dark hoping but never knowing for sure. Ceilgate is boisterous, wide open. Inmates know what to expect and are rarely disappointed.

Conclusions

The primary conclusion drawn from the findings is the high level of uncertainty surrounding the process of getting medical attention in prison, the very complaint that sparked many of the recent riots. However, this uncertainty can take many forms. In some instances inmates get the medical attention they need without any difficulty. Most times getting medical attention is problematic. Inmates may get no medical attention or the care they do get falls short of what is needed. The pivotal issue is that inmates can never be sure which of the possibilities will prevail at any given time.

The most serious consequences of this uncertainty result when inmates do not get needed medical attention. In some measure these consequences may result from other inmates who clog the system getting unneeded medical attention, another consequence of uncertainty. The impact is even greater if we include in this group inmates who, according to the staff, want only drugs to support a habit. Inmates such as these not only tax the system to the limit of its capabilities, they also contribute to the prevailing notion that most inmates use the medical system to advance their own wanton desires.

At each prison studied medical and security staffs use different approaches to control inmates and minimize these excesses. Greenspoon's staff tests the sincerity of an inmate's need for medical attention by making care available only to those who are willing to follow the rules and withstand the

numerous, often lengthy waiting times. To be sure, much medical attention is both available and utilized in this prison, often by inmates who do not need it. As a result, when an inmate is acutely ill, the system is so bogged down it cannot respond as it should.

Ceilgate, on the other hand, creates such a complicated maze to medical attention that many inmates are lost along the way and do not get needed care. Yet, when inmates are seriously ill or injured, the system springs into action. Guards and medical staff join together in a usually successful effort to give such inmates the necessary attention demanded by their life-threatening conditions.

I have argued that the approaches evolve from the situational contexts of each prison hospital. At Greenspoon the "head game" played throughout the prison is played in the hospital as well. Medical attention there is of uneven quality, and inmates are frequently "in the dark" about what to expect. The system, as a result, is open to abuse by inmates who can misuse it for reasons other than illness or health needs. But, when inmates need medical attention in a crisis, the response is sluggish and sometimes inappropriate.

At Ceilgate where violence is the rule rather than the exception, everything including medical care is considered a privilege. Security matters are paramount; all other considerations are subordinate. Guards actively manipulate the process as a part of a constant effort to control inmates. There are no rules about getting medical attention per se except those the

guards construct in a case by case fashion. Ceilgate inmates know this and act accordingly. They expect little and are seldom disappointed.

The most obvious implication of these findings is that the singular condition of confinement or membership in a total institution is insufficient to accurately or completely predict the medical care of inmates. Within the different gradations of security levels there is variance in both the extent and manner of control exercised. And, this variance leads to different consequences for both inmates and medical staff. It is reasonable to conclude that within the broad classification of total institutions called prisons there are distinct subsets or types of prisons with certain features that contribute significantly to the everyday practices of their members. If this is true of the medical care practices, then there must be other specific aspects of prison life similarly affected by these differences. This research has shown how the process of getting medical attention in two prisons of different security levels varies. Other prison practices and processes remain to be scrutinized.

Another, less obvious implication of the findings relates to the parallels between the prison situation and society-at-large. Many prison experts argue that life behind the walls is merely a reflection of life on the outside.¹⁶ They contend that whatever problems prevail generally in society are mirrored in prisons, citing widespread drug abuse as a typical example.

Assuming one accepts this "mirror" premise, there should be parallels to the process of getting medical attention on the outside, and indeed there are. Social scientists have amply documented the uncertainty that surrounds medical care at all steps in the process, including the first step of gaining access to medical attention.¹⁷ Problems, not unlike those inmates confront, impede the access of urban poor, elderly and rural populations to medical attention. And, solutions to these problems are no less elusive.

Simplistic codes and standards cannot mandate the necessary changes to rectify situations that have evolved over the years inside or outside prisons. There should be no recommendations to change a given situation without first understanding that situation. Lastly, that understanding should be grounded in the everyday practices that constitute the person-to-person give and take called medical attention.

Notes

1. In no way does this decision reflect any attempt to minimize the importance of this literature or the significant effect it has had on this study and my thinking about the topic. The prison literature will be reviewed in depth in a longer and more comprehensive paper I plan to write on prison health care.
2. See, for example, Buffam (1976), Keys to Health in a Padlocked Society (1977), and Prout (1975).
3. This is based on conversations with J. Harkness, Director, Office of Health Care, Michigan Department of Correction and C. Prout, Chairman, Massachusetts Medical Society Advisory Committee on Health Care in Correctional Facilities.
4. In discussing the Breecher and Della Penna (1975) text with prison health care workers who knew it, they confirmed its accuracy. This was also corroborated by speakers at a conference on health care in correctional institutions, sponsored by the American Medical Association, February 28, 1979.
5. As part of my agreement with this state department of correction, I assured anonymity for all individuals and institutions; hence, pseudonyms are used in all cases.
6. The purpose of a skin search is to thoroughly check the nude body of an inmate or visitor for concealed drugs or weapons. Inmates and visitors have charged that guards use the skin

search as one more means of harassment and degradation.

7. Sykes (1958) observes that noise level in a prison is "... a significant indicator of tension within the walls."
(p. 112)
8. The correction department placed surprisingly few restrictions on my activities while I conducted the study.
Besides those described in the paper, I was not to be in the prisons in the evenings or at night, but otherwise I could come and go as I needed.
9. Danziger (1979) describes similar access problems that she encountered in her study of the social control in doctor-patient interactions.
10. The physician assistants in these settings have been trained in 18-month university programs and are licensed to practice under the supervision of the physician. Breecher and Della Penna (1975) advocate the use of personnel called "physician extenders." They define the term as any of a number of allied health professionals who are trained to handle many routine tasks formerly done by physicians in order to free up physicians for those tasks that demand their expertise.
11. In this prison, the superintendent appoints the three-member Disciplinary Board for an indefinite term. In addition, the superintendent or the Commissioner of the correction department may appoint a special board to hear a particular case or class of disciplinary matters.

12. Most medics in this prison hospital were trained as medical corpsmen in the military; one was trained as a civilian emergency technician. They serve as the primary health care providers in much the way King, et al. (1977) recommend.
13. The lock-up is an administrative measure taken either when prison officials suspect inmate trouble, like riots, is brewing or when an incident, like an inmate death or gang fights, occur that could precipitate inmate rebellion. Also, when contraband, particularly drugs or weapons, are found or suspected to be in the hands of inmates, a lock-up can be called. In effect, prison officials can lock up the prison any time they want.
14. These are specialized medical equipment routinely used to examine patients' eyes and ears.
15. As its name implies, the count is a time when all inmates must be in their cells, and guards must account for all inmates in their charge. At Ceilgate there are five "major counts" spaced throughout the day in addition to several other ones on individual cell blocks.
16. See, for example, discussions of this topic in Hawkins (1976), Johnson, et al. (1970), Kwartler (1977), Menninger (1968), and Shover (1977).
17. Mechanic (1974) provides a thorough description of these issues and takes into account the political as well as the social origins of the current state of medical care in this country.

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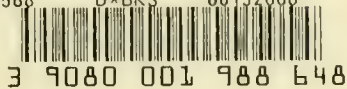
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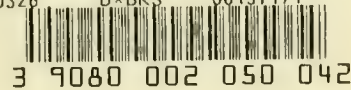
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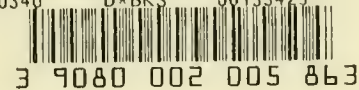
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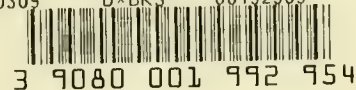
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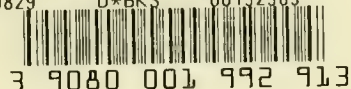
(1137, 1138, 1139 not pub'd)

HD28.M414 no.1140- 80
Schmalensee, R/Product differentiation
740333 D*BKS 00132649



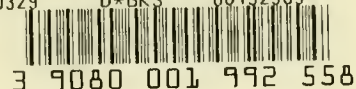
3 9080 001 996 187

HD28.M414 no.1141- 80
Buer, Terje K./Investigation of make o
740829 D*BKS 00132383



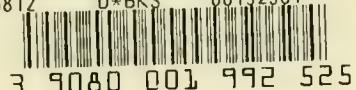
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HD28.M414 no.1142- 80
Nevis, Edwin C/Gestalt awareness proce
740329 D*BKS 00132363



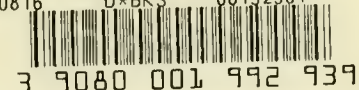
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Kolb, Deborah /Onstage with labor medi
740812 D*BKS 00132361



3 9080 001 992 525

HD28.M414 no.1144- 80
Berndt, Ernst /Short run labor product
740816 D*BKS 00132384



3 9080 001 992 939



3 9080 004 178 924

1145-80

HD28.M414 no.1146- 80
Wallace, Anne /Getting medical attent
740836 D*BKS 00132387



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