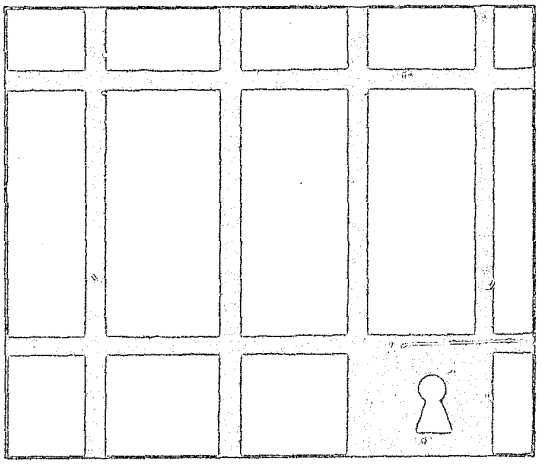
PROCEEDINGS

2nd National Conference on Medical Care and Health Services in Correctional Institutions



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HEALTH CARE NEEDS OF WOMEN*

Are female prisoners different from male prisoners? If so, how? And what are the implications of such differences for developing programs, including health care?

If these questions have been addressed by researchers, their findings are not revealed in the available literature. Those of us who work with incarcerated women operate on the assumption that there are differences; however, in the absence of documentation of needs, approaches to program development tend to be based on experience, hunch and/or personal bias. As a result, health care services most often evolve haphazardly with minimal planning. Evolution can, all too easily, result in health care which is expensive and inefficient. Perhaps our sharing of information here today can produce some guidelines for planning.

There are some pitfalls in seeking or emphasizing differences between men and women. In a correctional system women represent a small group in comparison with the number of men for whom the system is responsible. Historically, and understandably, attention and available resources have gone to the significantly larger group. Also historically, there has been an attitude that women are so different from men that programming for them is a whole separate exercise. Actually, men and women prisoners are much more alike than they are different: differences are far more often in degree than in kind.

The insistence upon difference is both good news and bad news from the point of view of the women affected. It has been good when it has produced more liveable, less severe facilities for women than for men. It has been bad when it has relegated women to the also-ran position in the race for attention and resources. It has been good when it has resulted in programming for women which is less formal, less militaristic, less security dominated. It has been bad when it has failed to recognize and provide for similarity of needs. A non-medical example of the latter relates to vocational training. This has been seen as highly desirable for men and has been provided, sometimes with almost spectacular diversity, while women have been, long and often, restricted to exposure to housekeeping, clerical or other "women's work" techniques. If greater emphasis had been placed on identifying the samenesses of needs, women could have participated in the attention and resource allocation much more and much longer ago.

A danger in emphasizing <u>special</u> health care needs of women is that it becomes too easy to ignore the fact that <u>most</u> of the health care needs of women are not special but are the same as those of men. The <u>standards</u> for health care are the same for both men and women. If we too often withdraw into separate groups to discuss the needs of women, we can raise the implication that the standards somehow don't apply equally and that would be bad news. We can make a great contribution by defining what, if any, real differences exist.

As a person not medically trained, I am not qualified to speak authoritatively on the question of medical differences between men and women. I can speak from the point of view of a woman experienced in management of correctional institutions for both men and women. On the basis of that experience, I am convinced that the only real differences are those related to reproductive

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functions.

For some years, when my day-to-day contacts were with women prisoners, I was of the opinion that women used health care services differently than men, tending more often to act out various problems through complaints of illness. Later, my work brought me into greatly increased contact with male prisoners, and I discovered that the differences were slight, if they existed at all. Men also overburden sick call, complain of bad nerves, change symptoms while walking down the hall from one medical person to another, bad-mouth staff, demand medicine they don't need and fail to take medicine they do need, conceal real illnesses and threaten to sue as much as women do.

What, then, are the special needs which bring us together in a separate workshop? I am sure my fellow panelists, both physicians, will discuss health care needs from the point of view of the medically trained; I have already declared my lack of expertise in this area. I would like, therefore, to discuss some of the management issues in which health care personnel ought to participate.

POLICY MAKING

In order that health care services meet the needs of patients with a high level of cost effectiveness, it is necessary that written policies be developed cooperatively among the managers of the system, the institution and the health care providers. Such policies would include statements as to the kinds of services to be provided, by whom and where. In general, the same kind of statement should be developed for men; however, this is an example of a situation in which the needs of women, usually, are separate, although not greatly different, from those of men. In a correctional system, there are usually several facilities for men while there is rarely more than one for women. A system might decide to designate one of the facilities as a medical center or elect to deliver various specialties at various facilities; I don't know of any system which has established within itself a coeducational medical center. The institution for women must be all things to its people.

There is no universal model for the structure by which health care can be effectively and economically delivered. It is only possible to point out some of the possible options which can be considered. For example, who is going to serve as the medical authority for the institution? A full-time physician employed by the institution? A hospital administrator employed by the system? A group of physicians (a corporation?) under contract? A part-time physician who also has a private practice? A general practitioner or a specialist?

What kinds of services will be delivered? Clearly, the institution for women must be prepared to cope with any kind of health situation which may arise. It goes without saying that facilities must be provided for OB-GYN. Will there also be need for infant care? Pediatrics? What about elective surgery? Plastic surgery? Dental care? Mental health care?

Where will the services be delivered? Will the institution operate a hospital? An infirmary? Or will it be limited to an out-patient clinic with in-patient care elsewhere? If elsewhere, can women be incorporated into facilities provided for male prisoners? Will arrangements be made with a nearby hospital? Wil there be a ward set aside as a prison ward for women,

or will they be admitted as if private patients? What will be the need for providing guards for hospitalized women?

The staffing of health care services needs to be determined with consideration of the level of services to be delivered. Decisions need to be made assigning responsibility for and authority over the budget; clear lines of supervision and authority need to be drawn in relation to non-medical personnel assigned to health care functions.

It should be obvious that this kind of cooperative planning should be carried out for both male and female prisoners. The processes are not really different but need to be separate, partly because of the OB-GYN needs of women but mostly because of the separated nature of the system. It is urged that careful thought be given to the integration of services where it is possible. For example, could both male and female patients be economically and efficiently served by the same laboratory or cardiologist or orthopedist? Once again, sameness should be identified and dealt with as such.

Neither health care personnel nor correctional management should finalize the kind of planning just described without close consultation and agreement with each other. Unless all parties subscribe to an understanding of what is to be done, where, how and by whom, the result can be sabotage, frustration and disillusionment to the special detriment of the patients.

SERVICE DELIVERY PROCEDURES

This, too, is an area which is not fundamentally different for women than for men. In both cases, it is necessary to agree on the procedures by which prisoners gain access to health care services; differences in the procedures themselves may arise because facilities for women are usually much smaller than those for men and provide for more informality of communication. In a very small facility with trained health care personnel available around the clock (e.g., a nurse on duty), it might be possible to provide attention on demand. Usually, however, it is necessary to establish clear procedures for sick calls, "triage," referrals for follow-up or special care and the like. The establishment of these procedures requires close cooperation between health care and other institution staff to be sure that the interests of all concerned are being appropriately served. It is an intricate juggling act to maintain unimpeded access of prisoners to needed health care while preserving the orderly operation of the total institution community and protecting the health care services from misuse. Here, again, there is no universal model for proper procedures. The Standards issued by the AMA for health care in jails and being developed for prisons speak to the subject, especially in terms of frequency of availability and kinds of services mandated, but leaves the specific procedures in the hands of the persons responsible for the facility.

It is essential that procedures be developed cooperatively by persons who have clear understanding of the purposes and functions of the total institution as well as health care services. Unless everyone involved can live reasonably comfortably with the procedures, they will not work. A fundamental requirement is that the custodial functions of the institution shall not prevent the proper practice of medicine. A corollary is that health care personnel shall know enough about the functioning of the total institution

not to require the impossible. Mutual respect, knowledge, compassion, flexibility and a sense of humor are all helpful qualities in those who get together to work out the routines.

One of the knottiest problems in the prison setting is the control of medications. Certainly there are purely medical decisions to be made as to the appropriate prescription of various kinds of substances; there are also some serious custodial implications. In the "free world" most patients are expected to get their prescriptions filled and take the medicine as instructed. If they don't do it, that's their problem. In prison, we see a whole different sense of responsibility, from both medical and custodial points of view. It is incumbent upon us to get together and take a good, hard look at why we do what we do. For most of us a trip to the doctor or an emergency room is a fairly occasional thing. If we have a minor cut or a cold or a headache or the cramps, we don't go to the doctor -- we go to the medicine cabinet or the drug store. Are there some ways we could simplify everyone's life by making it easier to do likewise in prison? I'm not answering this question; I'm just asking that you, with your medical and custodial colleagues, consider it. This, again, is not a problem peculiar to women, but the smaller, less regimented facility might permit some different procedures than the larger, male facility.

Another problem relating to medication is that of the availability of a registered pharmacist for the small institution for women. The part of the system which deals with males is usually large enough to convince the purse string-holders that the expense of a pharmacist is justified; the small institution for women may have a problem. Health care personnel should insist that some arrangement be made, whether by sharing with another institution, a part-time employee, a contractor or whatever.

PREGNANCY

Obviously, provision must be made for caring for women through pregnancy, delivery and the post-natal period; the medical aspects will, I am sure, be addressed by the other panelists. Some management decisions around this must be made, however. Where will the baby be delivered? At the institution? Elsewhere? By whom - the institution physician or a specialist in obstetrics? Will the staff regularly include an OB-GYN specialist or will it be on a referral or contractual basis?

Will the baby be cared for in the institution? If so, where, by whom and for how long? To what kind of care will the baby be released and who makes the decision that the release plan is acceptable? These questions, while not purely medical in nature, certainly have implications for the health care personnel. If the institution is to assume responsibility for infants, health care services must be prepared. I confess to a personal bias for minimal involvement of the institution in the care of children. I would prefer to see an extra-institutional agency involved with the expectant mother in planning for the care of the child after birth, delivery at a hospital away from the institution and placement of the child in its setting by an appropriate agency without returning to the institution.

Within the past few years, termination of pregnancy by abortion has become

a reality to be faced by correctional institutions for women. Health care personnel need to be closely involved with institution managers in developing the policies and procedures in this area. The situation may differ markedly from one jurisdiction to another, depending on budgetary provisions or local laws affecting the expenditure of public funds for abortion. All personnel need to be thoroughly informed as to the legal position of the prison. Can abortions be arranged on demand? Financed how? Can referrals be made to other, community agencies? How is the whole question affected by legislation, departmental policy, institutional operation? Policies and procedures should be clearly defined, written and known to all employees and prisoners.

Similar consideration needs to be given to the question of prevention of pregnancy. Does the institution provide birth control information and equipment? What kind? To whom? By whom? When? Again, policies and procedures must be clearly defined, written and known to all employees and prisoners.

EDUCATION

Are health education needs for women different from those for men? Perhaps not ideally but, realistically, I think so. For one thing, women continue to be the primary nurturers of children, and it is more important that they be informed about the maintenance of health. Both men and women are ill-informed about their bodies and how they operate, and both can benefit from education; however, women are in a better position to use their knowledge to benefit their children as well as themselves. They are also more likely to be able to provide better nutrition for the family and to use any home nursing skills they may acquire. It is certainly important for women to understand the perils of drug use at any time but particularly during pregnancy. Menstruation and self-examination, especially of breasts, are clearly subjects for health education for women.

Health care professionals ought to be active in promoting health education programs in the institution. This is not necessarily an instructional activity reserved to health care personnel; non-medical persons may develop, coordinate or teach such subjects. Health care personnel ought actively to support the program, however, and participate to the extent that primary duties permit.

I have another personal hobby horse to which I would like to refer, in passing. This relates to the intake function of the institution. Very often, the admissions unit is close to - or even a part of - the health care area of the institution. It may even, to a considerable extent, be administered by health care personnel. I think this is a mistake. Most women committed to us have the potential, at least, for being reasonably healthy, not sick, persons. I think it is an error to establish the implication that they have been admitted to a facility for the sick. It would be better if we established that it is a total community, including the capability to maintain health and cope with illness.

As you have seen, the thrust of this paper has been to point out some of the management areas which call for the closest possible cooperation among health care providers and those responsible for the system and the institution. Health care does not stand along but functions within the institutional community which

is, most usually, part of a system of such communities. All of these must learn to identify and dovetail more closely their relationships to each other as well as to the larger community, the "free world." If health care personnel find that they are not being consulted about matters which affect them, they must be energetic about insisting that they be made a part of the policy making or procedure designing. By the same token, health care personnel must be knowledgable about the total institution and be sensitive to the impacts which their practices make upon it and all its inhabitants. There are many occasions on which cross-purposes can develop. Only a close, warm, mutually respectful and understanding relationship can minimize conflicts and ensure the delivery of high grade health care.

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