Improving Access to Health Care for California's Women Prisoners

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The prisoner stories which appear in shortened form throughout the report and in Appendix 2A were written by coders after they read charts. They reflect the assessment and reactions of the coders to the material they had just viewed.

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Improving Access to Health Care for California's Women Prisoners

Executive Summary

Maintaining and improving the health status of prisoners, as well as providing preventive health care during incarceration, can substantially reduce the economic, social, and health care burden for parolees, their families, and the state. This report examines access to health care for women who are incarcerated in California state prisons, through quantitative and qualitative analysis of a large database of interviews, medical records, legal documents, and judicial reports assembled in conjunction with prisoner's complaints during the past four years. The report's recommendations compare the California correctional health care model with "best practice" models for health care delivery to offer an empirical foundation on which to base deliberations on correctional health options.

A total of 1269 files of women prisoners' complaints made to various attorneys between 1996 and 1999 were reviewed and coded: 269 files of complaints from women housed at California Institution for Women (CIW), 555 from California Correctional Women's Facility (CCWF), 432 from Valley State Prison for Women (VSPW), and 2 from the Northern California Women's Facility (NCWF). In addition, we examined reports by the California Department of Health Services and the State Auditor, legal materials, and contemporary standards for medical care in prisons and jails. This research was supplemented with interviews with prisoners and health care specialists.

I. Health and Health Care Problems of California's Women Prisoners

Problems of Access to Care:

A large number of the reported health care problems are problems of access-both access to medications as well as access to the type of care needed. The fact that 'missed medications' was the most common complaint suggests that availability of medicines when needed is a serious problem. Nearly 22% of the women had missed important medications at least once, while many had missed them repeatedly. This was a common complaint from women with HIV/AIDS. Not ensuring proper and timely distribution of antiviral treatments can significantly shorten the lives and impact the

quality of life of women with HIV/AIDS. Women with diabetes, asthma heart disease, hypertension, cancer and a host of other ailments are also put at grave risk when prescribed medications are missed.

The third most frequent complaint was miscellaneous access problems: over 19% of the women complained of at least one problem accessing the health care system.

Gender-specific health diagnoses also appear frequently in the lists of care problems for each institution. Thirty-two percent of the women report gynecological and reproductive health problems. Almost 9% of the women complain about care associated with a pregnancy. These rates point to the urgent need for accessible and expert specialist care in obstetrics/gynecology and other areas of women's health.

Other frequent complaints concern access to care for asthma, high blood pressure, heart disease, headache, orthopedic problems including disc disease, seizures, epilepsy, and insulin dependent diabetes. These are all conditions that can be seriously debilitating, chronic, and in some cases, life-threatening, if not treated properly.

Based on reports by prisoners, the health care that is available can actually be detrimental. For over 13% of the women, the care provided by medical staff was harmful to the health, sometimes very seriously, as qualitative data also illustrate (See Appendix 2A in the full report for details).

Almost 26% of prisoners in the sample suffered from a wide array of miscellaneous symptoms that were uncodable due to inadequate diagnostic information in their files.

Problems Related to the Prison System:

Other reported health problems appear to be related more to prison deficiencies or abuse than to health care access issues. Among these are unintentional injuries, which are sufficiently commonplace to comprise the fourth most prevalent area of complaint among women in the sample. These injuries include broken bones, head injuries and lacerations. Good public health practice, including review and implementation of corrective safety measures in residential and work areas, could prevent many of these injuries.

Another important gender-specific issue is sexual harassment and abuse by guards. This is the number one complaint area from women at VSPW, and was reported at all three institutions studied: over 14% of the women in the sample experienced some form of sexual harassment from staff or doctors.

II. Current Department of Corrections Health Care Practice: Major Findings

Many of the access problems reported appear to result from the organization of health services at the women's prisons. The following aspects of the system of service were found to impede access to quality care.

1. Inadequate management system.

In a January 2000 report, the California State Auditor described the current system of care offered by the Department of Corrections as lacking a comprehensive process for review of health care operations, an adequate statewide management information structure, and system-wide treatment guidelines. This situation was confirmed in our review of prisoner complaints. Internal monitoring and quality improvement systems are weak.

2. Medical grievances and appeals processes are slow and uncertain in outcome.

For example, there are no time limitations for a response to an appeal for access to care.

3. California prison health services are not accredited.

Accreditation is the most common way that health services are guaranteed to meet a minimum standard of quality. Yet none of California's prisons, including those studied here, is accredited by a national body with expertise in prison health care.

4. Dependence on Medical Technical Assistants.

Medical technical assistants (MTAs) are Licensed Vocational Nurses who also work as correctional officers. They are usually the medical staff of first contact, serving as gatekeepers to health care access, particularly during non-clinic hours.. MTAs are also uniformed members of the custody staff. This dual role compromises the independent medical function of a nurse, in terms of confidentiality and priorities. Moreover, numerous complaints indicate that some MTAs make inadequate assessments and inappropriate decisions about emergency needs and urgent care.

5. Restrictive policies result in sub-standard dental care, resulting in a high rate of unnecessary tooth extractions. Prisoners are not permitted root canal procedures or dental crowns.

6. Restrictive policies prevent access to community-based experimental treatment protocols for patients with HIV, HCV, and cancer. There are no system-wide Hepatitis C prevention, treatment or counseling protocols.

7. The co-pay system, which requires prisoners to pay a fee of five dollars when seeking care, discourages utilization of services, creates a bureaucratic burden to the health service and an economic burden to the very poor prisoner, while providing no documented economic gain to the department.

8. Physicians perform unnecessary administrative, non-medical functions.

For example, physicians are required to authorize "chrono" forms which permit on-going adjustments in schedule or access to special services, equipment, or housing needed for medical reasons. This paperwork function diverts physicians from direct clinical work and could be done by a non-clinical assistant.

9. Translation services are inadequate.

In some cases, other prisoners or staff are asked to translate; in other cases, no one is available.

10. There is inadequate access to preventive health services.

Routine screening for breast and cervical cancer is unavailable on a call-up basis. Twice yearly dental prophylaxis is unavailable. HIV, STD, and HCV screening are limited. Inadequate counseling, lack of confidentiality, and visiting policies limit prisoner interest in testing for HIV and then gaining access to needed treatment.

III. Recommendations

We reviewed options for organization of medical services in prisons and jails used in other states and by the Federal Bureau of Prisons. Based on this review, the following recommendations are proposed to improve care for women prisoners under the jurisdiction of the California Department of Corrections.

1. Clinical services should be provided by an independent non-profit agency.

Responsibility for structuring, managing, staffing, and improving the health care services of the CDC should be transferred to another agency. Three possible options to achieve this goal include:

A. Placing oversight responsibility under the Department of Health Services (DHS) with contractual arrangements made for services in the different prisons.

This model is followed by the U.S. Bureau of Prisons (BOP), which utilizes the U.S. Public Health Service (PHS) as its primary provider for health care to prisoners. PHS clinical personnel are assigned to work within the Bureau and report to the Bureau's Health Care Division.

B. *A program should be developed by The University of California to provide medical services to prisoners.*

A growing number of U.S. public and private universities provide medical services to prisoners. The University of Texas Medical Branch (UTMB) at Galveston currently provides managed care to over half of Texas' prisoners, while a second medical school provides services to the rest. The University of Connecticut Medical Center provides managed care to Connecticut's prisoners. Yale University and Brown University have been active providers of HIV care for prisoners in New England.

Possible advantages of this approach include access to quality staff; greater confidence on the part of the prisoners; a depth of experience and greater opportunity for on-going education of staff in accord with current Continuing Medical Education standards; training opportunities for interns and residents; and separation of custody and treatment functions.

Potential problems with this approach include the difficulty of providing services throughout the state and the enormous expansion that the program would entail for the University.

C. *Privatization of medical service delivery.*

In the past 20 years, privatization has spread extensively in the U.S. correctional world. Private medical care provision has been a part of this growth. However, we do not recommend this option. A major concern with profit-based care is that an incentive exists to save money by providing less care or by paying low salaries, resulting in a significant reduction in the quality of service.

We recommend that the state undertake detailed research to explore these and other options to transfer provision of clinical services. Important issues to consider are cost,

quality, quality assurance programs, ability to provide a local focus to the care, and provisions for close monitoring by state agencies.

2. Internal monitoring and quality improvement systems are necessary.

Quality management and improvement in any prison health care service requires on-going review of procedures as well as key events (e.g., deaths). In a correctional system, the need for continuous quality improvement is critical because of custodial pressures that can prevent rapid treatment or access to community resources.

An independent unit of the state should conduct regular program review of the services and management in order to assure quality.

3. Location of ultimate authority for appeals concerning health care for prisoners should be moved out of the CDC to an independent agency.

The CDC is a correctional authority and not a medical system. Its primary goals are punishment, confinement, and security. California could consider an approach to health care appeals similar to that utilized in Florida, which has created the Correctional Medical Authority, an independent oversight commission.

4. California prisons should comply with national and international health care standards and be accredited by a national organization with expertise in prison health services.

The American Public Health Association, the National Commission on Correctional Health Care (NCCHC), the American Correctional Association (ACA), and the United Nations (UN) all have developed standards for health care in prisons. The UN standards are broadly focused on human rights minimums as the key to quality care. The APHA guidelines, which incorporate human rights, medical care, mental health, and public health concepts and include standards for adults and juveniles, are the most thorough of the U.S. standards. The NCCHC standards are part of a national accreditation program.

California should also require that a national professional association experienced in evaluating prison health care services accredit all prison health services. Two appropriate options are:

?? *The Joint Commission on Accreditation of Hospitals* (JCAHO). The U. S. Bureau of Prisons utilizes the JCAHO for its accreditation process.

?? *National Commission on Correctional Health Care* (NCCHC). This organization was initially established by the American Medical Association and is a prime force in accreditation and improvement of care in jails and prisons throughout the U.S.

5. Recruitment, retention, and further education of health care professionals should be improved.

Currently the CDC has difficulty recruiting and retaining physicians and other health care providers sufficient to meet its needs. One solution is the provision of medical school scholarships, which would be forgiven in return for state service. A California scholarship recipient could work one year in a California prison or jail health service for each year of scholarship. A similar plan is used by the federal government to finance medical school in return for service in the Public Health Service (PHS), including assignments to the Indian Health Service, the Federal Prison System, and other underserved areas..

Joint staff meetings, participation in local hospital Continuing Medical Education (CME), and grand rounds programs could integrate prison medical staffs with the local medical community. CDC health service rules could mandate physician discussion with the specialist in every referral case. Additionally, medical department staff should be encouraged or required to attend CME programs in correctional medicine. All supervisory staff should be encouraged and funded to obtain a credential from the National Commission on Correctional Health Care as Certified Correctional Health Providers within two years of their appointment. They should be encouraged to join the Society of Correctional Physicians or the American Correctional Health Services Association and attend their meetings in order to be in contact with other providers and be able to hear about the latest developments in their field.

6. Separate the functions of custody and medical care.

Decisions about whether a medical situation is an emergency or needs urgent attention should be made by a registered nurse (RN). The licensed vocational nurse (LVN) training of MTAs is inadequate for diagnosis or triage.

All national correctional health standards and accrediting bodies prohibit medical providers from having custody roles. If LVNs are to be used on the medical team they should not be members of the custody staff. Institutions could hire on-call registered nurses who are trained in triage to act as the first responder in an emergency. Appropriate institutional staffing should include at least one RN

at each skilled nursing facility or outpatient housing unit (OPHU) and a second one who could move around to see women in their housing units. The duties assigned to people in the current MTA position should be limited to those that are within the LVN scope of practices, such as taking vital signs and managing clerical tasks.

7. End the use of the co-pay system, as recommended by the State Auditor.

Until the co-pay system is dismantled, the monies generated should be used to improve services for prisoners, including health education programs and preventive services.

8. Change the organization of local services so that health clinicians are not performing non-medical functions.

Once a physician has indicated a particular health need in a medical record, the preparation of the appropriate authorization and paperwork should be handled by a non-clinical staff person.

9. Change the training of medical professionals hired by the CDC.

The training of medical professionals should be evaluated and upgraded to better meet the changing demands placed on the system.

10. Provide translation services.

Other jurisdictions provide needed translating through various combinations of on-site translators and assistance via telephone services. Prisoners and custodial staff should not be used as translators.

11. Institute new services such as increased access to special diets.

Simple solutions like a low-fat, low-salt salad bar would assist prisoners with special dietary needs, relieve burden the food service of the burden of preparing individual trays, and allow otherwise healthy prisoners to live outside of special units.

12. Respond to the Hepatitis C epidemic.

It has been estimated that 40% of California women prisoners are HCV positive and that 30% of those with HCV are behind bars. The state should introduce a comprehensive screening program, provide access to testing for all prisoners at risk of infection, train its medical staff in the

current treatment of HCV, institute broad education programs concerning HCV, and provide clinic services for patients with this illness.

13. Provide greater patient education and preventative care.

There is a broad need both for more patient education and for routine preventive services Regular checkups should be scheduled and reminders sent to patients. Women prisoners should be screened and treated according to community standards for breast and cervical cancer, dental prophylaxis (twice yearly), and routine tuberculosis testing (currently this is the only preventive screening which is on schedule at the studied institutions).

14. Expand peer education by HIV and HCV positive women.

Many studies have demonstrated that the most effective approaches to HIV prevention and motivation to survive are via peer education. Established peer education programs at the California Medical Facility at Vacaville and at other women's prisons (e.g., Bedford Hills in New York) have been very effective in helping prisoners make life-saving decisions about prevention and deal with difficulties of HIV medication regimens.

15. Establish protocols and policies to protect prisoners from sexual harassment.

Given the potential for sexual exploitation of prisoners as well as the high rates of previous sexual abuse that many women prisoners have suffered, the state should make strong efforts to hire female physicians for all direct clinical care. A corollary to this suggestion would be to end the practice of male correctional officers having contact with women prisoners in residential and medical areas.

16. Compassionate release should be much more broadly applied.

Compassionate release should be considered part of providing overall medical care and as a palliative medical procedure similar to providing pain medications. Evaluation for compassionate release should be part of a prisoner's medical work-up and women with very serious illnesses should be frequently assessed for their eligibility. Not only is compassionate release humane, it is also cost effective and can save the state monies by placing gravely ill patients in more appropriate locations.

17. Promote alternatives to incarceration.

California's increase in incarcerate rates during the last 25 years has resulted in many problems, one of which is the imprisonment of thousands of people who are physically and mentally ill, as well as imprisonment of persons who could be more appropriately treated in alternative facilities.

An increase in the use of community facilities for pregnant prisoners is greatly overdue. The state has long had legislation requiring the CDC to allow pregnant prisoners to reside in such facilities prior to birthing and to care for their infants in them for up to a year and a half. However, the Department has restricted access to these programs, and the state has provided little funding. Consequently, they are almost unused. Instead, women give birth in prison where they undergo dangerous pregnancies and births. The infant is then separated from its mother within one day. Provision of community care in half-way houses for pregnant prisoners would greatly improve the quality of prenatal care for mothers and the first months of life for their babies, who would then have the opportunity to receive the health benefits of nursing and bonding with their mothers.

Background to the Study

Coder's Summary of File “Marie Compton”(Name changed):

> *‘Marie Compton’ suffered severe burns on over 50% of her body. When she was incarcerated, she had only one pair of custom-made pressure garments. Outside contacts attempted to send in other prescribed pressure garments, but these packages were refused and sent back. As a result, her burns began to show massive scarring. She was forced to wear the same garment for months without washing it. She described this as completely unhygienic and dangerous to her condition. She likened it to wearing the same pair of underwear for months on end. Ms. Compton was also denied physical therapy. As a result, her muscles tightened up and she was unable to walk. She spent most of her time in a wheelchair that was unsafe and difficult to maneuver on her own. When she was finally able to stand up, she could only do so on the tips of her toes because her leg muscles had contracted. She also had extreme difficulty getting the medications she needed. Pain meds and lotions to help the burns heal were prescribed by specialists, but often they were not ordered by pharmacy staff. She wasn't even able to get olive oil to help loosen the skin."*

This report examines access to health care for low-income, minority and immigrant women who are incarcerated in California state prisons. Maintaining and improving the health status of prisoners, as well as providing preventive health measures (such as HIV education, pap smears, and mammography) during incarceration can substantially reduce the economic, social, and health care burden for parolees, their families, and the state. Through analysis of a large data base of interviews, medical records, legal documents, and judicial reports assembled in conjunction with prisoner complaints during the past four years, we have developed a quantitative and qualitative report on the problems encountered by women prisoners in regard to health care access. We also reviewed a variety of models of health care delivery for prisoners in use in the U.S. in other jurisdictions than California. In our recommendations we provide a comparison of the California correctional health care model with "best practice" models for health care delivery to women prisoners in other local, state and federal jurisdictions to offer an empirical foundation on which to base deliberations on correctional health options for California.

The Health Needs of Women in California's Prisons

Adequate provision of health care for women prisoners sets a standard which encompasses the standard necessary for men as well. Women generally report more medical problems and utilize health services at higher rates than men.[i] Women have unique health care needs associated with pregnancy, childbirth, and gynecological and breast health. They are also more likely to report drug addictions, as well as histories as victims of violence and sexual assault.[ii] In other words, the range of needs and services that are relevant to women will include and extend beyond many of those which are needed by men. When health access policies are formulated primarily with men in mind or are designed with a research base that slights women's experiences (which is quite often the case in correctional health, given the small percentage of prisoners who are women),[iii] such policies may overlook significant health care needs of women. More than 70% of women in state prisons are single mothers of children under 18.[iv] The health needs of these mothers while incarcerated and on release will impact the next generation.

Critical to the initiation of this project was the existence of an extensive, but unanalyzed set of materials concerning women's health in California prisons generated by a lawsuit, *Shumate v. Wilson,* and by a second set of prisoner interviews from Valley State Prison for Women (VSPW) collected in preparation for a class action lawsuit. Together, these two sets of files contained information on almost 1200 women prisoners, most of whom reported problems with access to medical care while incarcerated between 1995 and 1999. Among the on-going problems described in the materials and confirmed by the oversight magistrate in the *Shumate* case were lack of access to trained health care providers, including physicians; inadequate diagnostic follow-up; inadequate and seriously delayed provision of medications while incarcerated; non-availability of special diets to women who are not in the infirmary (where they would be unable to participate in educational and/or work programs); lack of continuity of

prescriptions on admission, transfer, and release; inadequate timely referrals to specialists; and a lack of translators.

The Contemporary Policy Crisis in Prison Health Care in California

Before 1996, one of the most important forces in improving health conditions for women prisoners was litigation, not legislation. The Prison Litigation Reform Act (PLRA) of 1996 made individual lawsuits about health concerns more difficult for prisoners to pursue. It also limited class action suits. However, the PLRA has not reduced the number of illnesses or health access problems. The State of California must still contend with the costs of medical needs of prisoners and it must also confront these needs when prisoners are released. Consequently, with a decrease in litigation, legislative oversight concerning health conditions for prisoners becomes more crucial than ever.

Three strikes legislation, sentences with mandatory minimums and determinate lengths, and the expanded criminalization of drug use have dramatically increased the size of the prison population in California and the length of the average sentence. State policies in regard to health care services which may have been more appropriate for short term convicts may be less appropriate now that many serve longer sentences. “Short-term” policies which are in need of revision include prioritization of extractions over dental repair; inadequate routine provision of yearly pap smears and regular mammograms for older incarcerated women; and $5 charges for medical visits.

A new set of health needs is emerging in California's prisons. The female population is growing and aging. Many women felons enter the correctional system with multiple illnesses, drug dependency, and as survivors of sexual and physical abuse. Because of their fear of arrest or the severity of their drug problems, many are untreated on the outside and arrive in need of care. More women are approaching or passing through menopause and growing old while

incarcerated. Newer illnesses in the general population are also found in generally higher rates among prisoners. HIV, Hepatitis C, and breast cancer diagnoses continue to rise among women prisoners.[v]

Findings

A. Prisoner Complaints

Data was obtained from redacted legal files concerning prisoners housed at CIW, CCWF, and VSPW. The files came to us from three sources:

a. The *Shumate et al v. Wilson* lawsuit:

On April 4 1995, a class-action lawsuit (*Shumate et al. v. Wilson*) was filed in U.S. District Court in Sacramento on behalf of incarcerated women alleging that the inadequacy of the medical care they received and continue to receive within their institutions constitutes a violation of the constitutional ban on cruel and unusual punishment (Eighth Amendment).[vi] The lawsuit represented prisoners at the two largest women's prisons in California: the Central California Women's Facility (CCWF) in Chowchilla, and the California Institution for Women (CIW) in Corona. Representing the 3,800 women at CCWF and the 1,600 at CIW were a number of attorneys from private law firms and public interest law offices. A subclass addressed the specific issues and difficulties faced by incarcerated HIV+ women. Three years later, in January 1998, prisoner-plaintiffs in *Shumate v. Wilson* entered into a settlement agreement with the defendants. According to this settlement, the California Department of Corrections (CDC) agreed to implement 57 recommendations to improve the quality of medical care within CCWF and CIW.[vii] An independent assessor, with the assistance of a group of experts[viii] who were nominated and mutually-approved by both defendants and plaintiffs, was assigned to investigate the extent to which the CDC complied with the recommendations. The monitoring was scheduled to span a period of eight to eighteen months, depending upon whether or not the defendants were found in substantial compliance with the provisions of the settlement during the first monitoring phase (nine months). The first phase of the monitoring period began in January 1998 and ended in November 1998. Due to the fact that defendants were found in noncompliance at both CCWF and CIW with 11 of the 57

recommendations, a second phase of assessment took place, lasting from January 1999 to December 1999.

For this project we reviewed all the prisoner files generated by the *Shumate* lawsuit between January 1996 and July 1999. Legal staff redacted all files to protect prisoner identities. Each file contained some combination of interview material, prisoner letters, medical records, medical chart reviews, release of information and interview request forms, and in a few cases letters from prisoners' family or friends or records of phone conversations with prisoners or their family members and legal staff. While many of the files were quite full, with two each filling up nearly an entire file drawer, others were practically empty, containing only an interview request or a release of information form. Prior to our study, no one in any of the law offices had ever even counted the files.

From April 1998 to July 1999, many of the medical charts of the women interviewed at CCWF and CIW were examined. Doctors, nurses, and plaintiffs' counsel reviewed the medical charts of every named plaintiff and witness, as well as those with serious medical complaints. As researchers, we had also access to these redacted reviews.

b. Files associated with medical and other complaints at Valley State Prison for Women (VSPW)

In May 1995, VSPW began to hold women prisoners. Prisoners complained of guard brutality, sexual harassment, inadequate mental health care, and other aspects of medical care. Their complaints were taken down by attorneys. We were able to obtain access to these (redacted) files as well.

c. An additional set of files was made available to us by another law firm representing women who had chronic, acute, and life-threatening illnesses. These prisoners were located at CIW, CCWF, and VSPW.

We have combined the three sources of data and conducted an analysis that identifies general patterns as well as differences at the three institutions. Demographic and functional differences

between the three institutions account for some of the variation in the types of complaints recorded at each. For example, VSPW houses most CDC prisoners who are pregnant. Therefore, more frequent comments about pregnancy care are naturally found at that institution.

Our analysis begins with these complaints, which describe situations in which the medical care system, and in some cases the custodial system as well, did not work. Of course, not every prisoner complains about her care and many do not use the health care system at all. However, examination of the failures of the system reveals its weak points and points the way to changes that can help prevent such failures in the future. This approach, similar to pathology rounds in medicine and a cornerstone of quality improvement, can lead to important revisions in protocols, procedures, and policies which help prevent improper care and improve the system for those who use it and work in it.

Although these women's complaints do not come from a sample randomly selected from the total CIW, CCWF, and VSPW populations, we think they do reflect the health profiles, if not the frequency of illness or trauma, for women in California prisons, at least in a rough way. For several reasons, we believe that these complaints represent only a small proportion of the women with inadequately treated health problems in California prisons.

First, the co-pay system in place at all three institutions requires that non-indigent prisoners pay $5 for each doctor visit made, and prisoners are permitted treatment of only one health problem per visit. A second example of restricted access to care is the current CDC policy that prisoners are not to be treated for viral infections which will resolve themselves. Therefore, prisoners are rejected from clinic attendance if Medical Technical Assistants (MTAs) believe that they have 'colds' or 'flu'. These rules, in combination with the fact that doctors visits are often difficult to obtain due to bureaucratic and security delays, mean that many women do not even try to access health care for anything short of the most urgent problems. They often do not report their "minor" problems to

correctional medical staff. We can expect, therefore, that many health problems are underreported on prison medical records, a prime source of data on frequency of diagnosis.

Thirdly, it is also likely that prisoner interviews and letters we rely on for health information do not itemize all the health care problems of each woman, given that the interview schedule did not ask women to list every problem and letters to attorneys were not generally concerned with disclosing all exiting health problems but were more focused on one current problem.

Finally, we know that many women fear reprisal for 'blowing the whistle' on medical and other correctional staff or for participating in class action lawsuits claiming medical neglect or abuse. Some women are reluctant even to file an internal complaint such as a 602. The health problems and complaints we analyzed were from women who were brave enough to risk the retaliation and harassment that might result from participation in legal action against the California Department of Corrections.

There is no evidence to suggest that the patterns of health problems seen in our sample our radically different from those in the general population of prisoners from which it was drawn. In fact, we think that the access problems reported by the present sample may be the tip of the iceberg.

In the data analysis that follows, we examine the types of complaints made by prisoners concerning their treatment and their access to effective health care. For a more detailed and personal look at the substance of some of these complaints, we urge the reader to examine Appendix 2A, Prisoner Stories, which contains summaries of women's stories.

In all, 1269 files were reviewed and coded: 269 referring to women housed at California Institution for Women (CIW), 555 to women at California Correctional Women's Facility (CCWF), 432 to women at VSPW, and 2 to women at Northern California Women's Facility (NCWF).

The project's medical consultant provided a list of diagnostic categories, which were organized into a "Health Access Study Log Sheet." (see Appendix 3A2), used as the first draft of the research instrument for the present research. Drafts of the log sheet were reviewed by all members of the research team whose comments informed numerous revisions to the instrument. The final draft of the log sheet contained 168 diagnosis/complaint options, as well as spaces provided for prisoner information—e.g., name, I.D. number, housing status—and coding information. To understand operationalization of key terms and other methodological details, see Appendix 3E. Working from the log sheets, data was entered into SPSS for analysis.

B. Prevalence of Health and Health Care Access Problems

The mean number of health care access problems, treatment complaints, and illness concerns reported by prisoners in the entire sample is 3.92, with a minimum of 1 and a maximum of 30. The median number of problems is 3, the modal number 2 (see Table 1a).

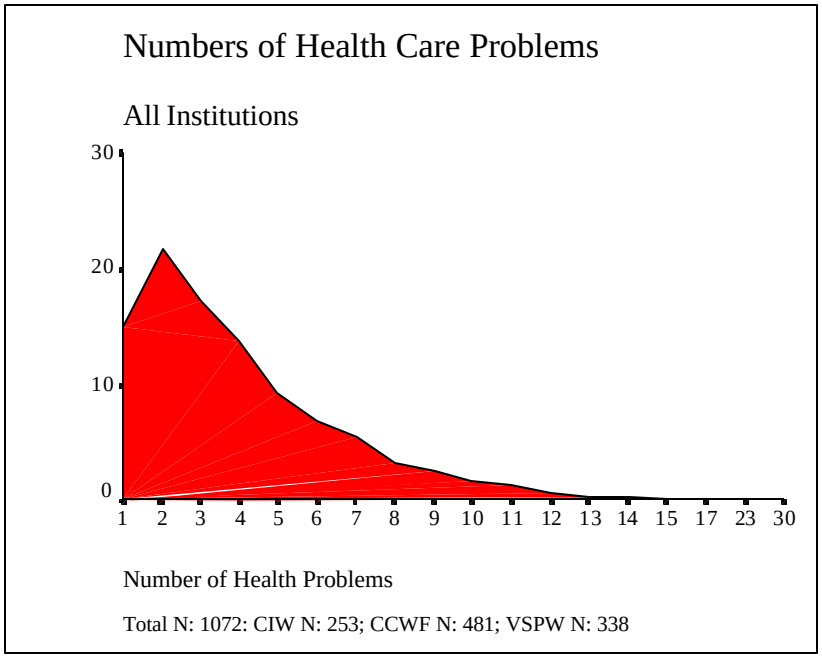
Table 1a. Numbers of Health Problems per Prisoner: All Institutions

Total N	Minimum	Maximum	Mean	Median	Mode
1072	**1**	**30**	**3.92**	**3**	**2**

The total N is the total number of cases in the sample, i.e., the number of prisoner files examined and containing analyzable data. The minimum number of complaints is one, the maximum number 30.

Figure 1 represents the distribution of numbers of health complaints of all prisoners in the sample.

Figure 1
Distribution of Numbers of Health Problems per Prisoner: All Institutions



Numbers on the vertical axis indicate the percentage of women with specific numbers of health problems. Numbers across the horizontal axis indicate the numbers of problems of prisoners in the sample. This chart refers to all prisoners in the sample at three institutions: N = 1072.

This distribution changes when examining the three prisons separately. As Table 1b illustrates, the mean number of complaints for women at CIW is 4.89, while the mean numbers for CCWF and VSPW respectively are 3.68 and 3.72. The median number of problems per woman is 3 at CCWF and VSPW, and 4 at CIW, and the modal number of problems is 2 across all three subsamples. The ranges in numbers also change when viewed by institution. The minimum number of complaints by a prisoner at each institution is one, but the maximums are 30 at CIW, 23 at CCWF, and 14 at VSPW.

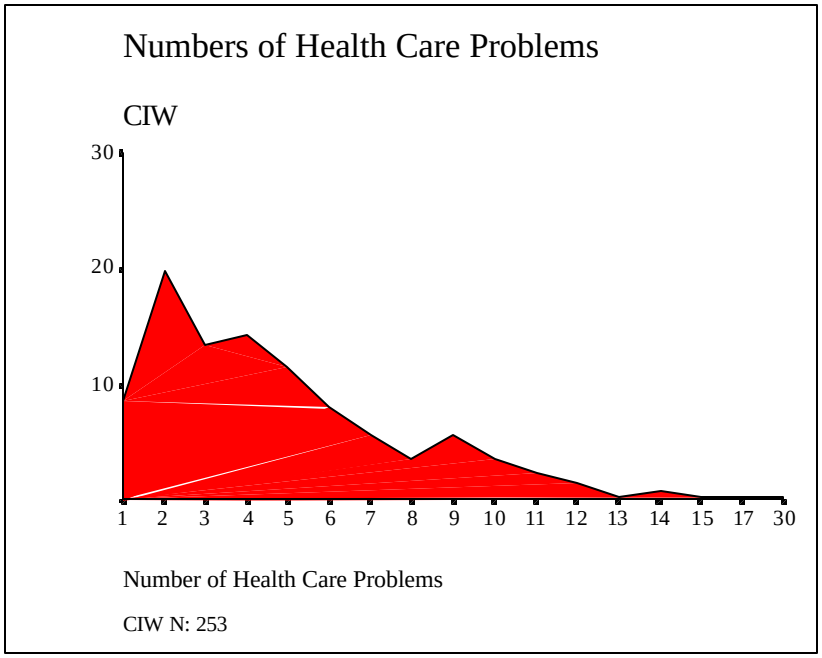
Table 1b. Numbers of Health Problems per Prisoner: Institution by Institution

Prison	N	Minimum	Maximum	Mean	Median	Mode
CIW	**253**	**1**	**30**	**4.89**	**4**	**2**
CCWF	**481**	**1**	**23**	**3.68**	**3**	**2**
VSP	**338**	**1**	**14**	**3.72**	**3**	**2**

The Ns are the total numbers of cases in each institutional subsample.

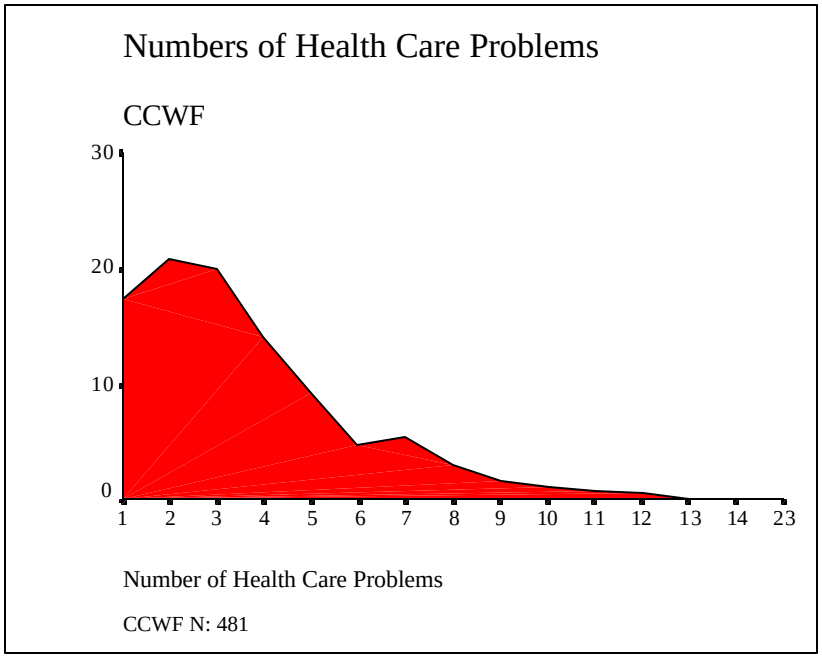
The distribution of numbers of complaints also changes when viewed by institution. Figures 2a, b, and c show the distributions in numbers of complaints for CIW, CCWF, and VSPW respectively.

Figure 2a. Distribution of Numbers of Health Problems per Prisoner: CIW



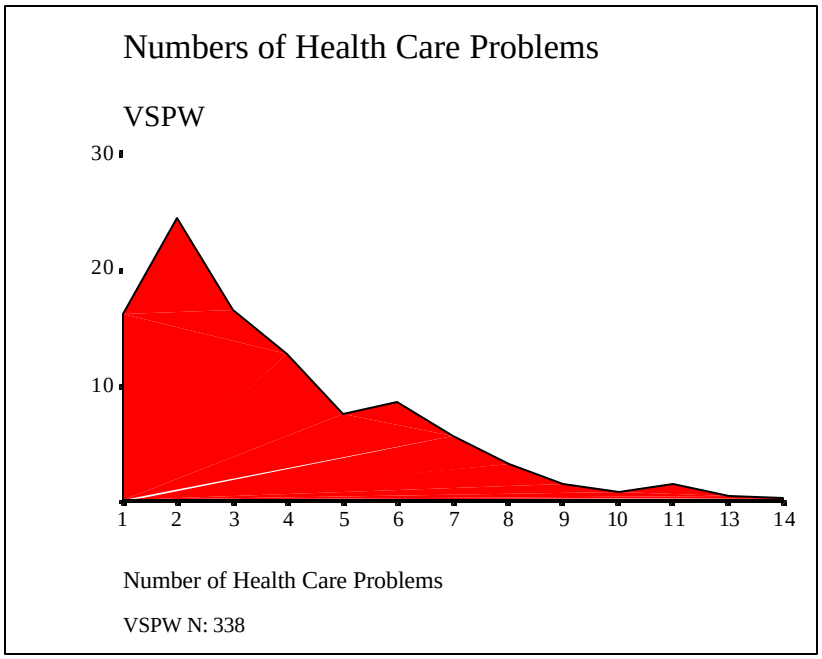
The above chart refers to all prisoners in the sample at CIW: N = 253. See Figure 1 legend for explanation of vertical and horizontal axes of chart.

Figure 2b. Distribution of Numbers of Health Problems per Prisoner: CCWF



The above chart refers to all prisoners in the sample at CCWF: N = 481. See Figure 1 legend for explanation of vertical and horizontal axes of chart.

Figure 2c. Distribution of Numbers of Health Problems per Prisoner: VSPW



The above chart refers to all prisoners in the sample at VSPW: N = 338. See Figure 1 legend for explanation of vertical and horizontal axes of chart.

Prisoners at CIW on average have roughly five reported health problems, whereas prisoners at CCWF and VSPW on average have four. This indicates that the health care needs may be greatest at CIW, at least in terms of numbers of problems. That the prisoners at all three sites typically have multiple health diagnoses and complaints underscores problems inherent in the co-pay system. The co-pay system requires payment for each prisoner-initiated doctor visit, and allows prisoners treatment of only one health problem per visit. The co-pay system makes accessing health care unduly difficult, especially for women with multiple illnesses or conditions. Multiple illnesses are the norm for women in California prisons. There is a pressing need at these institutions for extensive, accessible, free health care services that can provide treatment for as many illnesses as exist in the populations.

C. Health and Health Care Problems of Prisoners

Although our data set includes 158 separate health care problem variables, these can be grouped into 29 major health categories. The following enumerates the percentages of prisoners whose complaints fall within these major health categories: Almost 37% complained of iatrogenic problems (treatment errors with negative health consequences), and another 31.9% of gynecological/reproductive problems. Mental illness affected 25.5% of the sample, respiratory disease 24.4%, and injury 21.1%. Over 19% complained of problems accessing health care in prison. (See Appendix 3D for a full list of the kinds of access problems included.) Nineteen percent complained of orthopedic ailments, and just under 19% complained of sexual harassment. Almost fourteen percent have gastrointestinal complaints, 13.7% have headaches or neurological troubles, and 12.2% suffer from liver disease. Twelve percent suffer from some type of cardiovascular disease, almost 11% are HIV positive or have AIDS, 10.4% have some sort of dental problem, and 10.4% have high blood pressure or hypertension. Seizures of some variety afflict 10.2% of the sample, 10% are diagnosed with sexually transmitted diseases

(STDs), 8.9% have some type of cancer, and more than 7% have rheumatic disease or arthritis. Problems of the eye affect 6.6% of the women in our sample, and 5.7% suffer from some type of skin problem, while another 5.6% have diabetes. Almost five percent complain of drug abuse, 4.1% of urinary problems, 3.4% of ear ailments, and 3.1% of hormonal problems (nonreproductive). Seven of the 1072 prisoners in our sample died while incarcerated (0.7%). And 0.4% have problems of the throat. Additionally, almost 26% suffer from what we refer to in this analysis as "miscellaneous health" problems—symptoms that do not fit within any of our diagnostic categories or health complaints that were uncodable due to insufficient information in the files. Table 2a displays the frequencies and percentages of prisoner complaints.

Table 2a. General Categories of Health Care Problems: All Institutions

Diagnosis/Complaint	Frequency	Percentage†	**Ns**
Iatrogenic Problems	393	36.6	Total N: 1072
Gynecological/Reproductive	343	31.9	CIW N: 253
Miscellaneous Health*	278	25.9	CCWF N: 481
Mental Illness	273	25.5	VSPW N: 338
Respiratory	260	24.4	
Injury	226	21.1	
Miscellaneous Access	206	19.2	
Orthopedic	203	19.0	
Sexual and Other Harassment	203	18.9	
Gastrointestinal	149	13.9	
Headache/Neurological	148	13.7	
Liver Disease	130	12.2	
Cardiovascular Disease	128	12.0	
HIV/AIDS	116	10.8	
Dental	112	10.4	
High Blood Pressure	112	10.4	
Seizures	109	10.2	
STD	107	10.0	
Cancer	94	8.9	
Rheumatic Disease/Arthritis	80	7.5	
Eye	70	6.6	
Skin	60	5.7	
Diabetes	60	5.6	
Drug Abuse	53	4.9	
Urinary	44	4.1	
Ear	36	3.4	
Hormonal (not reproductive)	33	3.1	
Death	7	0.7	
Throat	4	0.4	

* Miscellaneous symptoms which were not diagnosed into a codable category of illness or disease.
† Percentages add up to more than 100 because some prisoners report multiple problems.

D. Special Issues:

Almost 26% of prisoners in the sample suffered from a wide array of miscellaneous symptoms that were uncodable due to inadequate diagnostic information in their files. We refer to these throughout this report as "miscellaneous health" problems. That these symptoms and uncodable complaints are the most frequently reported problems points to the need for broad and extensive health care services equipped to diagnose and treat a wide array of symptoms. It may also indicate a general malaise and discomfort shared by prisoners.

Missed medications is the second leading complaint overall, first at CIW, second at CCWF, and third at VSPW. Nearly 22% of the women in our sample had missed important medications at least once, many had missed them repeatedly. This has important health implications. For example, this was a common complaint from women with HIV/AIDS. When antiviral medications for HIV/AIDS are not taken regularly, the virus can mutate into drug resistant strains. Not ensuring proper and timely distribution of antiviral treatments can significantly shorten the lives of women with HIV/AIDS. Diabetics, asthmatics, and persons with heart disease, hypertension, cancer and a host of other ailments are also put at grave risk when prescribed medications are missed. Serious complications, hospitalizations, permanent deleterious health effects can be averted with prompt and regular distribution of medications.

The third most frequent complaint is miscellaneous access problems. Over 19% of the women complained of at least one problem accessing the health care system itself in the wide sample, 26.9% of the CIW sample, 14.8% of the CCWF sample, and 19.8% of the VSP sample. Many women in California prisons are meeting prohibitive obstacles in their attempts to access health care. Non-treatment; delayed treatment; and failure to provide follow-up and routine care put the health of women in California prisons at risk.

Unintentional injuries are commonplace in these prisons, comprising the fourth most prevalent area of complaint among women in the sample, fourth at CIW, and fifth at both CCWF

and VSPW. Such injuries typically occur during seizures, while working (especially in agricultural work), during sports, and from falls associated with inadequate wheelchair access. These injuries include broken bones, head injuries, and lacerations—problems that demand an immediate and adequate health care response. Good public health practice, including review and implementation of corrective safety measures, could prevent most unintentional injuries of the types reported by these women.

HIV/AIDS was the fifth most common category of health complaint in the sample. It is fifth at CIW and third at CCWF, with a much lower frequency at VSPW. Indeed, HIV/AIDS is the most frequently occurring serious illness in the full sample, topping the list at CIW and CCWF, and coming in eighth at VSPW. (Transfer policies of the CDC have concentrated women with HIV at CIW and CCWF.) Persons with HIV/AIDS require close and consistent care from knowledgeable and compassionate health professionals. Such care was not routinely provided for the women in this study, as both the quantitative and qualitative data affirm. The high rate of HIV/AIDS in this population also underlines the importance of widely accessible support group services, HIV education programs, and counseling services.

Women-specific health diagnoses show up again and again in the top ten lists of care problems for each institution: gynecological problems of the uterus and ovaries (in addition to menstrual irregularities, cysts, fibroids, menopause complications, and pregnancy) makes the top ten health care problems and top ten primary complaints lists for the entire sample and for the CCWF and VSPW subsamples. Pregnancy is the second most prevalent primary complaint in the VSPW data, the eighth at CCWF, and the fourth across the entire sample. (Pregnant prisoners are often sent to VSPW for their care.) Breast lumps are among the CIW top ten primary complaints. Reproductive cancers show up in 5.4% of the entire sample. Taken together, gynecological health problems affect 31.9% of the sample, and sexually transmitted diseases identified while in

the correctional system affect 10%. These high rates of woman-specific health care point to the urgent need for accessible and expert specialist care in obstetrics/gynecology and other areas of women's health.

Another issue largely specific to women is sexual harassment and abuse by guards. This problem emerges as a leading complaint at VSPW. Harassment is the fourth most prevalent primary complaint at VSPW; verbal sexual harassment is ninth. However, the problem is not limited to VSPW. Sexual harassment is present at all three institutions: over 19% of the women in the full sample experienced some form of harassment at the hands of their keepers and doctors; ten percent reported sexual harassment per se. Eleven women complained that inappropriate pap smears were conducted. Similar complaints and the atmosphere enabling such abuse were further documented by reporter Ted Koppel in an *Nightline* investigative report of November 1999. Following that investigation, the Chief Medical Officer at VSPW was transferred out of the prison and assigned to non-clinical duties.

The preponderance of iatrogenic complaints also speaks to the need for a reorganization of medical services in women's prisons in California. For over 13% of the women, the care provided by medical staff was harmful to their health, sometimes very seriously, as our qualitative data illustrates (see Appendix 2A for details). Of the 21.6% of the women who missed medications, an unknown number suffered health complications as a result; this is in addition to the 13% who suffered as a result of the wrong treatment.

Psychiatric medications are another important health issue for prisoners. Nine percent of the women take these medications. Other frequent complaints address care for asthma, high blood pressure, heart disease, headache, orthopedic problems including disc disease, seizures, epilepsy, and insulin dependent diabetes. These are all conditions which can be serious and, other than disc disease, life-threatening if not treated properly.

Appendices 3B1-4 and 3C1-4 contain tables presenting frequency distributions of complaints at the three prisons.

E. Current Department of Corrections Health Care Practice

The California Department of Corrections is the primary provider of health care to its prisoners. Each institution has a Chief Medical Officer who is technically responsible to the central office of the Department. The salient features of the system that affect women's health care access include:

1. Inadequate management system.

In a January 2000 report, the California State Auditor described the current system of care offered by the Department of Corrections as lacking a comprehensive process for review of health care operations, an adequate statewide management information structure, and system-wide treatment guidelines. This situation was confirmed in our review of prisoner complaints.

In addition to its conflicting priorities (security vs. health care), the department lacks the expertise to manage a large-scale medical service. A long-term solution appears to require the use of a modern sophisticated system of care provided by experts with a primary commitment to health care, not to custody.

2. Internal monitoring and quality improvement systems are weak.

CDC has had various internal monitoring programs. The January 2000 audit indicates that the CDC quality management program does not have a data management system which allows it to effectively monitor the quality of its health care. For example, the CDC and the Madera County Coroner have an agreement not to perform autopsies on HIV positive prisoners from CCWF or VSPW. This is one aspect of an inadequate approach to death

reviews. The CDC also has systematic restrictions on full investigations of deaths while in custody. In the case described in Appendix 2B the lack of autopsy left the specific cause of death unknown.

3. Medical grievances and appeals processes are slow and uncertain in outcome.

When prisoners have problems with health care, they are forced to appeal within a system that is primarily structured to confine them. There are no time limitations on a response to an appeal for access to care. However, under the terms of the Prison Litigation Reform Act, prisoners must complete a full internal appeal, however long it takes, before turning to the court.

4. California prison health services are not accredited.

Accreditation is the most common way that health services are guaranteed to meet a minimum standard of quality. Yet none of California's prisons, including those studied here, is accredited by a national body with expertise in prison health care.

5. Dependence on Medical Technical Assistants.

Medical technical assistants (MTAs) are Licensed Vocational Nurses who also work as correctional officers. They fulfill both custodial and health functions. They carry out routine technical tasks as ordered by physicians and organize care such as distributing medications, taking vital signs, and serving as clinic clerks. In these roles and in other capacities they are usually the medical staff of first contact. MTAs are the gatekeepers to health care access, especially during non-clinic hours. Numerous complaints to lawyers indicate that some MTAs make inadequate assessments and inappropriate decisions about emergency needs and urgent care. MTAs are also uniformed members of the custody staff. This dual role compromises the independent medical function of a nurse, in terms of confidentiality and priorities. The first priority of every health care provider should be the health of the patient. For the MTA, there is a co-existing priority of custody functions. This problem was highlighted in the 1996 report of the state's Task Force on Female Inmate Health Issues, which opposed the use of MTAs working

beyond their licensed capability as LVNs and also criticized their joint custodial and health responsibilities as inappropriate.

5. Restrictive access policies.

Dental care: In the current system prisoners are not allowed to have root canal procedures or dental crowns. This policy results in sub-standard dental care and a high rate of unnecessary tooth extractions and a much higher utilization of dentures than in the community at large.

Terminal Illness: While palliative care is allowed, access to experimental protocols in use in community settings, and utilization of life prolongation methods are contrary to CDC policy. This denies prisoners access to a community level of care. In addition, the quality of care in the skilled nursing facility (SNF) at CCWF, where terminally ill patients are housed, as documented by a California Department of Health Services review in a March 10, 2000 visit, is grossly inadequate. The investigator found that physician's orders were not always carried out, nutritional reviews were inadequate, lab test results were late or missing, basic pharmacy requirements were not met, and patients dignity was violated. [ix] Prisoners also report that MTA staff are sometimes unwilling to touch seriously ill patients who are left alone and un-cared for, other than by other prisoners, for hours or days at a time.

Hepatitis C:. There are no system-wide Hepatitis C prevention, treatment or counseling protocols. Prisoners at risk are not given routine access to Hepatitis C testing, counseling and/or treatment.

HIV Treatment access: Family visiting policy requires that a prisoner who has tested positive for HIV while in the California correctional system be denied Family Living Unit visits with her spouse. Her children can only visit in the FLU if accompanied by another (non-spouse) adult relative who has been informed of the prisoner's HIV status. These rules compromise the

prisoner's ability to visit with her family. Some prisoners choose not to be tested (and therefore to go without treatment) rather than give up their visits and their confidentiality. This is a medically unsound choice to impose on a person with HIV, as it prevents free decision-making about HIV treatment.

Self-resolving viral infections (e.g. flu): Prisoners are denied treatment for self resolving viral infections. They are discouraged from attending clinic, denied prescriptions for analgesics and other symptomatic relief, on the basis that these medications can be purchased in the commissary.

6. The co-pay system.

The Department currently requires prisoners to pay a fee of five dollars when they seek care. The State Auditor's report on management practices in the department found that this system had not demonstrated any savings to the department.[x] On the other hand, it is a disincentive to care-seeking, especially for poor prisoners.

7. Physicians perform unnecessary administrative, non-medical functions.

Physicians are required to authorize "chrono" forms which permit on-going adjustments in schedule or access to special services, equipment, or housing needed for medical reasons. This paperwork function diverts physicians from direct clinical work, reducing the access of prisoners, and could be done by a non-clinical assistant.

8. Translation services are inadequate.

In some cases, other prisoners or staff are asked to translate; in other cases, no one is available.

9. There is inadequate access to preventive health services.

Routine screening for breast and cervical cancer is unavailable on a call-up basis. Twice yearly dental prophylaxis is unavailable. HIV, STD, and HCV screening are limited. Inadequate

counseling, lack of confidentiality, and visiting policies limit prisoner interest in testing for HIV and then gaining access to needed treatment.

Recommendations

After conducting our analysis of the complaints by women in three institutions, we reviewed a variety of options for organization of medical services in prisons and jails (such as

are used in other states and by the Federal Bureau of Prisons). We propose the following interventions to improve care for women prisoners under jurisdiction of the California Department of Corrections.

It should be noted that a variety of individual and class action lawsuits (including *Shumate*) have attempted to address deficiencies in the California system. Litigation is one way to apply pressure for change. However, there are also important limitations inherent in litigation. One of these limitations is that litigation usually does not fundamentally change a system, as it often fixes the easily identified aspects of a deeply flawed system. Additionally, the solutions are more often based on constitutional minimums than on contemporary health care systems theory and practice. Even though prison conditions may improve as the result of lawsuits, over time they usually deteriorate to the previous level of poor quality due to a lack of continuing independent monitoring. Litigation can also be particularly difficult and detrimental for the women involved, as the level of retaliation against prisoners involved in litigation can be great.

The California legislature has also investigated some aspects of medical care for women and men prisoners. However, no significant improvements have occurred throughout the system and in many ways conditions have deteriorated as the state has housed more and more prisoners every year. Existing regulations such as those which mandate the removal of exercise equipment, allow the systematic unavailability of root canals and crowns, and deny treatment for illnesses which cannot be "cured" all contribute to a system which inevitably prevents the achievement of a healthy population. Given the high level of need and risk for women prisoners intersecting with such a system, major changes are required.

1. Clinical services should be provided by an independent non-profit agency.

Responsibility for structuring, managing, staffing, and improving the health care services of the CDC should be transferred to another agency. A review of clinical care options should include review of management options as well. Three options that the state might consider are:

A. *The Department of Health Services (DHS) has oversight and signs contracts with various agencies for services for the different prisons.*

The U.S. Bureau of Prisons (BOP) utilizes the U.S. Public Health Service (PHS) as its provider for health care to prisoners. Clinical personnel are assigned to work within the Bureau and report within the Bureau's system to its Health Care Division. However, they are expected to promote the values and standards of the PHS. The care delivered to prisoners in the federal system is a mix of services directly delivered by PHS employees and indirectly provided by private providers through contracts. Most of the services are currently delivered by PHS and BOP employees. The BOP and PHS are currently studying the mix of private and public programs in the state systems to understand the economics and quality issues associated with privatization of medical care in correctional settings.

While BOP health care has been challenged as inadequate, it has a generally good reputation within corrections. This may stem from the more adequate funding it receives as well as from the professional identity and greater independence of its physicians. The medical school scholarship program associated with the PHS has also enabled the BOP to recruit some excellent doctors who have stayed and worked in the system.

B. A program could be developed by the University of California to provide services.

While this model utilizes the prestige of the university and its access to quality physicians, nurses, and other ancillary personnel and skill, it is important to consider exactly what the University might be providing. There are several examples of public universities providing medical services to prisoners. The University of Texas Medical Branch (UTMB) at Galveston currently provides managed care to over half of Texas' prisoners, while a second medical school provides services to the rest. The University of Connecticut is currently providing managed care to Connecticut's prisoners. For a number of years Montefiore Medical Center provided care for prisoners at New York City's Rikers Island.

Advantages of using a university include:

- access to quality,
- prestige for the service which can help in recruitment of staff,
- greater confidence on the part of the prisoners,
- a depth of experience in providing care through its hospitals,
- the opportunity to bring in interns and residents to provide care for prisoners, thereby exposing prisoners to the latest knowledge and standards of care,
- independence from the ethics of custody, and
- greater opportunity for on-going education of staff in accord with current Continuing Medical Education standards.

The potential problems include:

- the difficulty of providing services throughout the state,
- the enormous expansion that the program would entail for the University,

- the question of whether it would be appropriate to have the University provide managed care to prisoners,
- the necessity of developing the administrative, management, ethical, and clinical skills to provide health care to prisoners.

When Montefiore provided care at Rikers Island, the services came through the Medical Center's Social Medicine Department, which had a specific commitment to services for the poor. The service was designed on a fee-for-service basis for outside care (at Elmwood Hospital), although there was maximum allowable funding per year. Such a system is more likely to encourage than to deny care. The St. Barnabas Hospital system, which replaced Montefiore, was based on a per-capita basis for all care. Such a system has a built-in incentive to reduce hospitalization. Rikers Island experienced a temporary rise in deaths after St. Barnabas took over the contract.

The University of Texas Medical Branch program is a for-profit managed care program located within a non-profit university. Because of their current success and profit, they are hoping to expand to correctional facilities in neighboring states.

C. Privatization of medical service delivery.

In the past 20 years, privatization has spread extensively in the U.S. correctional world. Prisons and jails are built, managed, and staffed by ever-larger corporations. It is evident that the "prison industrial complex" has an enormous private component, which grows every year. Private medical care provision has been a part of this growth. Correctional Medical Services and Prison Health Services are two of the largest private medical providers. In California, the Forensic Medical Services Group works in a number of counties providing care to detained and sentenced prisoners. Many other managed care providers operate throughout the country. In addition, there are specialized pharmacy,

mental health, substance abuse, dental, optometry, telemedicine, drug testing, medical records, and other services available for a fee.

A major concern with profit-based care is the incentive to save money by providing less care or by paying such low salaries that the quality of the staff suffers significantly. The argument for both private corrections and private correctional medical services is that they are more efficient than public services. This argument has not been proven. Prisoners are very concerned about the contract model and its effect on their ability to complain to a public authority. Finally, there is an economic incentive for private corporations to hide problems because of the profit making concern. For these reasons a non-profit provider may be preferable.

To explore these options further, the state should undertake detailed research. Important issues to consider are cost, quality, quality assurance programs, ability to provide a local focus to the care (many large providers seek economies of scale by having "circuit rider specialists"), and provisions for close monitoring by state agencies.

2. Internal monitoring and quality improvement systems are necessary.

Quality management and improvement in prison health care service require on-going review of procedures as well as key events (e.g., deaths). Even in hospitals and medical centers outside of correctional systems, the possibility of medical errors and inadequate service can create risks and lower quality of care. In a correctional system with security pressures that can prevent rapid treatment, where there are high rates of serious chronic disease and where there is potential for rapid spread of infectious diseases, the need for continuous quality improvement is even greater.

A comprehensive system of quality management should be instituted. A system similar to the one which is used by the U.S. Veterans' Administration to monitor its hospitals could provide the confidentiality which would encourage health care workers to openly discuss their errors in order to improve care. The VA system requires the submission of reports concerning errors and improvement strategies to its monitoring agency, the Department of Health Services (DHS), for review concerning the appropriateness of the solutions. Program review of this type should be conducted by an independent unit of the state in order to assure quality. At the same time, a good quality management program within each facility would involve both medical and correctional staff at the highest levels of authority.

3. Location of ultimate authority for appeals concerning health care for prisoners should be moved out of the CDC to an independent agency.

The CDC is a correctional authority and not a medical system. Its primary goals are punishment, confinement, and security. As demonstrated by the materials reviewed in this study, the CDC does not have a strong record of prioritization of patients' medical needs. Some improvements in the quality of health care for California prisoners have come as the result of litigation. However, creating improvements of care through litigation is not a rational, planned method for providing lasting quality health care.

The review of complaints and monitoring of quality of care in the prison system should reside outside of and above the security apparatus. Oversight should be reasserted and more firmly managed by the legislature. Direct oversight could be the responsibility of the Department of Health Services (DHS) or a specially constituted agency working with the DHS. The review

agency should not be under the authority of the CDC, although it would need to work closely with the CDC administration.

California could consider an approach utilized in Florida: an independent oversight commission, known in Florida as the Correctional Medical Authority (CMA) (see Appendix 5). The purpose of the CMA is to monitor and evaluate the quality of physical and mental health care services provided to prisoners in Florida's state and privately operated correctional institutions. Evaluations are accomplished through on-site visits (called surveys) and are conducted to ensure that health services provided by the Department of Corrections meet minimum standards of care as defined by state and federal law and are consistent with generally accepted community standards. Currently, over 300 health care professionals contribute to the CMA. They serve as board members, consultants and advisory committee participants.

4. California prisons should comply with national and international standards and be accredited by a national organization with expertise in prison health services.

Standards for health care in prisons have been developed by the American Public Health Association (APHA), the National Commission on Correctional Health Care (NCCHC), the American Correctional Association (ACA), and the United Nations (UN). The UN standards are broadly focused on human rights minimums as the key to quality care. The APHA guidelines, which incorporate human rights, medical care, mental health, and public health concepts and include standards for adults and juveniles, are the most thorough of the U.S. standards. The NCCHC standards are part of a national accreditation program.

Another option to improve care in California prisons is to require that all health services be accredited by professional associations. There are several options for this:

Joint Commission on Accreditation of Hospitals (JCAHO). This is appropriate for all hospitals and infirmaries. The U. S. Bureau of Prisons utilizes the JCAHO for its accreditation process.

California Medical Association (CMA). The CMA has a medical quality service which currently reviews and accredits county jails in the state. The CMA could be utilized for this accreditation service. The negative side of using the CMA is that it is regional in scope and limits its correctional work to California and to jails. There might be too much overlap between reviewers and staff in the correctional medical services.

National Commission on Correctional Health Care (NCCHC). This organization was established by the American Medical Association in the 1970s and is a prime force in accreditation and improvement of care in jails and prisons around the U.S. A limitation of NCCHC is that it is supported by fees provided by the correctional institutions it reviews. Consequently, it does not have true economic independence.

American Correctional Association (ACA). Although the ACA accredits prisons and includes medical services, it is not specialized in clinical care issues. It does not provide the detailed focus that is needed to ascertain that a community level of care is available.

5. Recruitment and retention of health care professionals must be improved.

Currently the CDC has difficulty recruiting and retaining physicians and other health care providers sufficient to meet its needs. One solution might be the provision of medical school scholarships, which would be forgiven in return for state service. A similar plan is used by the federal government to finance medical school in return for service in the Public Health Service

(PHS), including assignments to the Indian Health Service, the Federal Prison System, and other underserved areas. Under this proposal, the California scholarship recipient would work one year for a California prison or jail health service for each year of scholarship. A scholarship to a University of California medical school would add the additional benefit of greater access to the latest knowledge and research advances and have appeal to health professionals.

6. Continuing Medical Education (CME) and other ways to raise the level of professionalism among the medical staff should be pursued.

There are many ways that prison medical staffs could integrate their members into the medical community surrounding the prisons. The Health Services Division could initiate joint staff meetings, participation in local hospital Continuing Medical Education (CME), and grand rounds with local physicians. Health service rules could mandate discussion with the specialist on every referral case. (Documentation in medical charts and reports from specialists indicate that local community specialists and hospital staffs are currently untapped resources who are eager to communicate with the health care providers inside prisons.)

Additionally, medical department staff should be encouraged or required to attend CME programs in correctional medicine. All supervisorial staff should be encouraged and funded to obtain a credential from the National Commission on Correctional Health Care as Certified Correctional Health Providers within two years of their appointment. They should be encouraged to join the Society of Correctional Physicians or the American Correctional Health Services Association and attend their meetings in order to be in contact with other providers and be able to hear about the latest developments in their field.

7. Separate the functions of custody and medical care.

Decisions about whether a medical situation is an emergency or needs urgent attention should be made by a registered nurse (RN). The licensed vocational nurse (LVN) training of MTAs is inadequate for diagnosis or triage.

All national correctional health standards and accrediting bodies prohibit medical providers from having custody roles. If LVNs are to be used on the medical team they should not be members of the custody staff nor should they be represented by the California Correctional Peace Officers Association (CCPOA).

Ultimately, the MTA position should be eliminated. Institutions could hire on-call registered nurses who are trained in triage and act as the first responder in an emergency. The duties assigned to people in the current MTA position could be changed to include taking vital signs, managing clerical tasks, staffing the appointment desk, etc. Considering that there are as many as 3000 women in each of these institutions, many of whom have chronic and difficult health problems, this change seems quite reasonable. Appropriate institutional staffing should include at least one RN at each skilled nursing facility (SNF) or outpatient housing unit (OPHU) and a second one who could move around to see women in their housing units.

8. Upgrade the care at other California women's correctional institutions to the level of CIW and CCWF, as mandated by the *Shumate* settlement, as part of a plan to raise the level at all facilities to a community standard.

While this is a first step for improving health care for women in other California prisons, many observers have concluded that the current level of care at CIW and CCWF is still below

the community standard of care. The CDC's most recent budget request indicated that it had no money set aside for maintenance of the improvements it made to meet the mandates of the *Shumate* settlement. The current level of care for California prisoners is not one which would be acceptable in a managed care service (as the State Auditor's report of Jan. 2000 has made clear).

The state is under additional mandates as well to improve care: *Armstrong v Wilson* requires that the state comply with federal Americans with Disabilities Act legislation. *Madrid v Gomez* covers health conditions at one of the men's institutions (Pelican Bay); *Coleman v Wilson* covers mental health services for all prisoners. The lack of information management by the CDC concerning medical and mental health care means that the department itself does not know to what extent it is meeting these mandates.

9. End the use of the co-pay system, as recommended by the State Auditor.

Until the co-pay system is completely dismantled, the monies generated could be used to improve services for prisoners. It seems appropriate that since the system was designed to keep prisoners out of the clinic the money could be used for health education or preventive services which directly assist prisoners in the struggle to stay healthy.

10. Change the delivery of care so that health care providers are not performing non-medical functions.

For example, physicians' time should not be used to fill out forms approving or renewing requests for lower bunk assignments or permission for special shoes. Once a physician has indicated a particular health need in a medical record, the preparation of the appropriate authorization should be handled by a non-clinical staff person according to a clear protocol. Similarly, if the prisoner continues to sustain an illness or condition that requires adaptive

equipment or schedule changes, as documented in the medical record, the renewal of the "chrono" (a medical authorization for medically necessary items) should be handled in a routine manner. The signature of the physician should not be required for something which is essentially the responsibility of the correctional side of the system: providing appropriate accommodations, clothing, and work for persons with temporary and long-term disability.

One recent change by the CDC in the policy governing the determination of disability for work is not appropriate however. The new policy gives final authority over work disability to the Classification Committee with the Medical Department in an advisory role. This policy is medically inappropriate. The Medical Department should have final authority over work disability decisions as they are strictly medical in nature. The prison administration has the responsibility to provide work opportunities to all who can work, including those with special needs due to disability.

11. Change the training of medical professionals hired by the CDC.

Currently medical professionals are given 40 hours of training before they begin work. The training should be evaluated to better meet the changing demands placed on the system. It should also be integrated with new attempts to meet prisoner needs. Specific changes to extend and reformulate the training which we recommend include:

?? Educate on common health problems of prisoners. For those who will be working with women, education is needed about women's specific health needs, especially the needs of women who are incarcerated.

?? Emphasize the important protective role of the health care practitioner within the criminal justice system. Health care providers are often the first non-prisoner or non-security personnel to see signs of sexual abuse or violence. Health care providers need instruction

about their obligations to report such injuries and abuse; they should also be trained in reporting methods which protect the prisoner from further harm.

?? Train health care providers to solve potential conflicts between medical and custody issues, with an emphasis on the responsibility to the patient.

?? Hire medical experts from outside the CDC to provide the education and training, in order to obtain the most current knowledge concerning the treatment of serious diseases and health problems found in prison populations (e.g. HIV, HCV, post-traumatic stress from surviving sexual and physical abuse) and to emphasize the importance of independent medical decision-making.

12. Provide translation services.

Medical diagnosis is simply inadequate when the provider and the patient do not speak the same language. The CDC should immediately provide adequate translation service. Other states do this with various combinations of on-site translators and assistance via telephone services. Prisoners and custodial staff should not be used as translators.

13. Institute new services such as access to special diets.

Currently at CCWF, a prisoner has to be in the Skilled Nursing Facility to get a special diet. Many women need special diets, but don't need to be in the SNF for any other reason. Simple solutions like a low-fat, low-salt salad bar would assist prisoners with special dietary needs and not burden the food service with preparing individual trays for each prisoner with special needs.

14. Respond to the Hepatitis C epidemic.

It has been estimated that 40% of California women prisoners are HCV positive and that 30% of all persons with HIV are behind bars. This is an important opportunity for public health work which can affect the state's residents. The state should introduce a comprehensive screening program, train its medical staff in the current treatment of HCV, institute broad education programs concerning HCV, and provide clinic services for patients with this illness, as it does for patients with HIV.

15. Review dental care needs.

Current policies preventing root canals, limiting partial bridges, and providing inadequate access to prophylaxis should be revised as soon as possible. A complete review of dental care is very important, given complaints about access and quality of treatment, even within the limitations of current state services.

16. Provide patient education and preventative care.

In terms of preventative measures, there is a broad need both for more patient education and for routine preventive services with regular checkups scheduled and reminders sent to patients. Women prisoners should be screened and treated according to community standards for breast and cervical cancer; receive dental prophylaxis twice yearly; routine tuberculosis testing (currently the only preventive screening which seems to be on schedule at the studied institutions); and access to a chronic care program with regular checkups for chronic illnesses.

17. Expand peer education by HIV and HCV positive women, and remove barriers to treatment for HIV-positive patients.

Many studies have demonstrated that the most effective on-going education and support concerning HIV prevention and survival is via peer education. Established peer education programs at the California Medical Facility at Vacaville and at other women's prisons (e.g., Bedford Hills in New York) have been very effective in helping prisoners make decisions about prevention and deal with difficulties of HIV medication regimens.

Removal of restrictions on Family Living Unit visits for HIV positive patients would end the current forced choice of treatment or family visiting.

18. Protect prisoners from harassment.

Given prisoners' inability to choose their physicians, the potential for sexual exploitation of prisoners, and the high rates of previous sexual abuse that many women prisoners have suffered, the state should make strong efforts to hire female physicians for all direct clinical care. (At a recent visit to CIW, when two prisoners were asked what should be done to improve health care there, one immediately made this suggestion. The other agreed.)

A corollary to this suggestion, and perhaps even more basic, is to end the practice of male correctional officers having contact with women prisoners. There are repeated investigations within the CDC regarding sexual assault and harassment of women prisoners by custody staff. According to international penal standards, the single exception to equal employment laws is the prohibition of male custody staff in women's prisons. All male correctional officers should be removed from custody work in housing units in women's facilities.

19. Compassionate release should be much more broadly applied.

Compassionate release is a legal procedure through which a terminally ill prisoner who has not completed her sentence can be released on parole for her remaining days or weeks of life. Compassionate release should be considered as part of providing overall medical care and as a palliative procedure similar to providing pain medications. Evaluation for compassionate release should be part of a prisoner's medical work-up and women with very serious illnesses should be frequently assessed for their eligibility. Prison medical staff should be trained in the meaning of the Penal Codes on this issue and on the diagnostic signs that would generate initiation of this procedure. Not only is compassionate release humane, it can also save the state money by placing gravely ill patients in more appropriate locations. Unfortunately, its use has been greatly restricted in recent years.

20. Consider alternatives to incarceration.

California's rush to incarcerate in the last 25 years has resulted in many problems, one of which is the imprisonment of thousands of people who are physically and mentally ill. The majority of these prisoners would be found innocent of any crime if they were judged by the laws of 1970. The physical and emotional damage done by this enormous increase in the population of incarcerated adults and young people could be reduced quite simply by releasing as many prisoners as possible. Reinstituting judicial discretion could save many prisoners from years of medical neglect and poor treatment of their illnesses.

Most women in prison are serving time for nonviolent economic crimes and victimless crimes associated with drug use. Decarceration could move them to facilities in which they would be eligible for Medi-Cal or other forms of health insurance, thereby affording them direct access to the community standard of care. This option is especially important for women with

serious illnesses that are difficult to treat and may be exacerbated in prison. For women with HIV, the requirements for complex medication regimens are directly at odds with prison schedule requirements, such as counts, regulated times for meals and medications. In addition, access to doctors and to pharmacy services in prisons can be suddenly interrupted due to factors completely unrelated to the prisoner's needs, such as a sudden lock-down or a physician's inability to get to the prison on a specific day. In the civilian community, patients can see another doctor, eat when necessary, take their pills to work, sleep on a regular bed, organize their diet appropriately, receive physical therapy, and attend support groups.

At a minimum, the state should consider transferring nonviolent prisoners convicted of victimless crimes who are also suffering from chronic illnesses—HIV, diabetes, cancer, HCV, tuberculosis, and heart disease—to community programs where they can receive rehabilitative care for their "criminal" behavior and medical care for their illnesses.

For pregnant women, an increase in the use of community facilities is greatly overdue. The state has long had legislation requiring the CDC to allow pregnant prisoners to reside in such facilities prior to birthing and to care for their infants in them for up to a year and a half. But the Department has restricted access to these programs, and the state has provided little funding for them. Consequently, they are almost unused. Instead women are forced to give birth in prison where they undergo dangerous pregnancies and births. The infant is then abruptly separated from its mother in one day. Provision of community care in half-way houses for pregnant prisoners would improve the quality of prenatal care for mothers and for babies, who would have the opportunity to receive the health benefits of nursing and bonding with their mothers.

Appendix 1

Glossary of Terms

ADSEG	Administrative Segregation
CAT scan	Computerized Axial Tomography
CCCMS	Correctional Clinical Case Management Services
CCP	Chronic Care Program
CCWF	Central California Women's Facility
CDC	California Department of Corrections
COPC	Chronic Obstructive Pulmonary Disease
Chrono	Authorization for medically necessary items
CIW	California Institution for Women
CMB	California Medical Board
CMO	Chief Medical Officer
CO	Corrections Officer
Co-pay	$5.00 fee charged each prisoner for each medical visit, unless indigent (one health problem addressed each visit only)
DHS	Department of Health Services

Doc	Doctor (M. D.)
Ducat	Official permission slip
EKG	Electrocardiogram
HBP	High blood pressure
HCV	Hepatitis C virus
LSPC	Legal Services for Prisoners with Children
MAR	Medical Authorization Review
MCH	Madera Community Hospital (serves CCWF & VSPW)
Meds	Medications
MRI	Magnetic Resonance Imaging
MS	Multiple Sclerosis
MTA	Medical Technical Assistant
NCWF	Northern California Women's Facility
OB/GYN	Obstetrics and Gynecology
PCP	Pneumocystis Cardiii Pneumonia (indicative of immune system failure)
PID	Pelvic Inflammatory Disease
Psych	Mental Health Staff (usually refers to psychiatrist)
PT	Physical Therapy
RGH	Riverside General Hospital (serves CIW)
RN	Registered nurse
R & R	Receiving and Release
SHU	Security Housing Unit
Shumate	*Shumate v. Wilson* – 1996 Class Action Lawsuit filed on behalf of prisoners at CIW and CCWF

SNF	Skilled Nursing Facility
TB	Tuberculosis
VD	Venereal Disease
VSPW	Valley State Prison for Women
115	Disciplinary form filed by CO against a prisoner
602	Grievance procedure form

Appendix 2A

Prisoner Stories: Suffering and Death

Note: These prisoner stories are selected from stories excerpted from the reviewed files. The stories were written by the coders following file reviews and reflect the assessment and reactions of the coders to the material they had just reviewed. All names and some other details have been changed to protect the identity and confidentiality of the prisoners.

Coder's Summary of File 2432: Consuelo Rodriguez

"Consuelo Rodriguez suffers from grand mal seizures. Nine months ago she showed signs of stroke or toxic medication levels. Her psych asked her why she had not seen a doctor, and she responded that the doctor was on vacation. The psych called the ER for her and told them that he was looking at a woman with a deteriorating condition. He filled out the consult and sent her to the ER. When she returned from the hospital, medical staff at the SNF removed her catheter and put her in diapers. A month later an MTA told her that they were putting the catheter back in because "you wet too much." She complained about this catheter immediately because it was painful and her family also noticed some blood in the urine on one of her visits. The following month an MTA removed the catheter and said "you'll regret what you asked for." She didn't get a new catheter and was not given diapers and therefore was left to urinate on herself.

Ms. Rodriguez is not being adequately cared for in the SNF. She is bathed when her family comes to visit; otherwise she is not bathed at all. She receives almost no physical therapy for her stroke. She sees the physical therapist about three times a week but only for about five minutes each visit. She is forced to feed herself, brush her own teeth, and change her own diapers; she does so only with the greatest difficulty.

An investigator from the State Department of Health Services investigated the SNF because they received a complaint about substandard conditions. The day of the announced DHS visit, the staff removed Ms. Rodriguez from the SNF, put her in her old unit on the yard, and told the CO just leave her there. Fortunately, the investigator returned the next day on an unannounced surprise visit when Ms. Rodriguez was back at the SNF and conditions were "normal." The DHS report condemned the deplorable condition of the patients in the SNF and stated that their basic human dignity was being denied."

In the process of coding, we were deeply moved by the accounts that emerged from prisoners' letters and interviews. Coders would sometimes cry as they read through the files. Eventually, we instructed our coders to write summaries of files that struck them as particularly egregious cases of medical mistreatment or neglect. These stories are personal testimonies to the extreme difficulties women in California prisons routinely face as they attempt to access health care. They emphasize how traumatic—and often futile—such attempts are, and they provide detailed accounts of cases in which adequate health care was not provided, as well as disturbing accounts of the dire consequences of such mistreatment or nontreatment. Quantitative data cannot adequately represent these stories of suffering, and even death, as well as qualitative stories do.

Medical neglect is a prime theme that runs through the stories: Missed medications, woefully inadequate or denied treatment, lack of follow-up treatment, and inadequate screening for common ailments. Women with HIV/AIDS, gynecological problems (including pregnancy), hypertension, asthma, orthopedic problems, injuries, and a wide array of other health problems report forbidding obstacles as they seek effective and humane treatment. In some stories medically necessary medications and treatments are often simply denied. In other stories we hear extensive about extensive and unexplained delays between an order for testing for treatment and its actual provision. Some delays are even years in length. The stories also describe some of the ways that the denial of health care to women prisoners or medical mistreatment can have disastrous health effects. The story of one prisoner in this study who died as a result of the medical neglect and abuse is included in Appendix 2B. Many, many others suffered and continue to suffer as a consequence of their inadequate treatment.

Additionally, callous treatment and sexually inappropriate comments and examinations by prison health workers show up repeatedly.

We strongly urge readers to peruse the full text of these stories. They illustrate the hardships endured by women prisoners in need of health care with a force and power that numbers and charts cannot convey. And they provide invaluable insight into the day-to-day workings of correctional medicine in the California Department of Corrections. Our analysis and recommendations are based primarily on cases in which the medical care system did not work. Not every prisoner complains about her care and many do not use the health care system at all. However, examination of the failures of the system reveals its weak points and points the way to changes which can help prevent such failures in the future. This approach, similar to pathology rounds in medicine and a cornerstone of quality improvement, can lead to important revisions in protocols, procedures, and policies which can help prevent improper care and improve the system for those who use it and work in it.

These summaries are constructed from redacted files, with details changed when necessary to protect the confidentiality and identity of the prisoner.

Summary of file no. 1032: Amber Fish

Amber Fish suffers from the AIDS virus and was told by Dr. _____ of the prison that, "You have a disease you suffer from, you need to learn to suffer."

Summary of file no. 1036: Myra Galvez

Myra Galvez was found to have cancerous cells lining her reproductive system and was ordered to have an immediate hysterectomy in order to avoid full-blown cancer. Though the order was put in, she was not assigned a surgical date for months. Finally, after many requests, the medical board reviewed her file only to reject her plea for surgery. They stated that it would simply cost too much.

Summary of file no. 1040: Margaret Long

Margaret Long suffered a broken wrist at the prison. Staff denied it was broken and initially wouldn't treat it. The wrist healed improperly. It took a month to see a doctor about this improper healing. By then surgery on the wrist was necessary, complete with the insertion of pins.

Summary of file no. 1044: Lenice Jones

Lenice Jones has active hepatitis C and is experiencing serious complications associated with it. She has chronic liver dysfunction, a low blood platelet count (thrombocytopenia), shrinkage of the liver, enlargement of the spleen, and the HCV had influenced her bone marrow. It's unclear just how long she had to wait for interferon by reading the file, but it seems the wait was significant and this prisoner had to make numerous requests before finally receiving the medic ation.

Summary of file no. 1046: Abra Baker

Abra Baker has full-blown AIDS. She reports major difficulties in getting her AIDS medications. The line is so long that in order to get her meds she must be late for work, etc., and she complains that staff threaten to write her up for this. She complains of hostile staff giving out meds. Ms. Baker found the task of getting her meds so stressful (mainly because of hostile staff) that she discontinued her meds.

Summary of file no. 1054: Abira Danson

It's unclear precisely how from reading the file, but it appears that a treatment for arrhythmia by a prison doctor may have induced partial paralysis. Also, Abira Danson was in urgent need of surgical removal of fibroids. Meanwhile, Dr. _____ said her pain was psychosomatic.

Summary of file no. 1132: Kamilah Wynne

Kamilah Wynne was diagnosed with a tumor in her brain and immediate surgery was recommended to remove it. Two months went by with no surgery, and when they finally checked her head again, the tumor had gotten so large that it had begun to grow into her skull. When they finally got around to her surgery, not only did they have to remove the tumor but also part of her skull!

Summary of file no. 1194: Leia Prince

Leia Prince's file contains a letter describing a pap smear and pelvic exam performed by Dr. _____ during which he inflicted undue pain and made sexual comments. Her letter suggests that the doctor continued to insert his fingers even while she complained and finally screamed. She reports bleeding for 18 hours after the exam. Having recently undergone surgery for cervical cancer, Ms. Prince had begun the healing process. The exam completely undid this healing, the prisoner reports. The letter is clear, concise, and convincing.

Summary of file no. 1195: Dolores Galinda

Dolores Galinda writes a lucid and detailed letter describing an inappropriate exam performed by Dr. _____. Ms. Galinda reports that she went to see the doctor for indigestion and asked for Pepto Bismol. He put his hands down her pants. He then pulled her pants down and pulled her buttocks apart and inspected her bottom—telling everything looked unproblematic. She reports feeling utterly humiliated afterward. The letter is both vivid and moving and should be used as qualitative data in the study, I think.

Summary of file no. 1211: Tara Watson

Tara Watson has high blood pressure. She went to get her high blood pressure meds refilled and the doctor refused because on the day he saw her, her blood pressure was normal. After two days without her medication, her blood pressure soared, requiring a trip to the emergency room at the local hospital. Similarly, when the prisoner complained of pain in her heart she was denied a doctor's visit. About three weeks later she had heart attacks. And finally, while in receiving she was denied her meds, causing her to have difficulties moving. Still, she was placed on a top bunk.

Summary of file no. 2015: Hope Bradley

Hope Bradley has spent a good deal of time in the SNF. She has terminal cancer and has received chemotherapy. While in the SNF she has had difficulty maneuvering. In August, she attempted to get into her wheelchair and into the shower, but somehow she slipped, fell onto the floor, and hit her head. She was given an ice pack and Tylenol. Five weeks later, she experienced severe nausea, which

caused her extreme difficulty in eating. She had developed esophageal candidiaisis which caused pain and difficulty swallowing. She had two episodes of subdural hemorrhage resulting from a fall due to fainting spells. She was hospitalized and had surgery for evacuation of blood clots in her head. While her attorney has fought for her compassionate release, she has been bedridden, on oxygen, and fed intravenously.

Summary of file no. 2034: Heavenly Jones

At 6 a.m. Heavenly Jones woke her roommate by tapping on her bed. The roommate jumped down from her bunk to find Ms. Jones breathing with much difficulty, phlegm running from her mouth and her eyes glazed. One side of her body was paralyzed, and she was waving her other arm uncontrollably. She had also urinated on her person.

The roommate hit the emergency button and pounded on the window. CO _____ was the first to respond. She asked him to get the MTA and the MTA then called an RN, who refused to come. He told the CO to see if it was really a stroke and, if it was, to call the fire department. The CO said the MTA did not want to come unless it was an emergency. The roommate informed him that it was an emergency, so he proceeded to call the fire department.

The fire department arrived with two prisoners and the driver. The roommate does not know if any of them had medical training. They came with one oxygen tank that they did not use. By the time an ambulance arrived at approximately 7 p.m. (13 hours after Ms. Jones' stroke), she was paralyzed and unable to speak. She was transferred to the infirmary about two weeks later, and the roommate is afraid she will not receive any physical or speech therapy.

Summary of file no. 2036: Gladys Bryant

Gladys Bryant was transferred from another institution after she was badly beaten up by a guard. The beating resulted in five loose teeth (two lower front teeth are gone and two to three teeth are very loose), bruised ribs, a broken big toe on her right foot, and a head injury that required 14 butterfly stitches. She was initially locked up without a general exam; after her arrival she saw a dentist but no doctor. She wanted an HIV test because of a blood transfusion, but at the time of the interview had been waiting for nearly three months.

Ms. Bryant "fellout" (fainted) and woke up looking at the paramedics. They took her blood pressure, told her she was okay, and that she would see a doctor the next day although this visit never occurred. She is not sure why she fainted. She was given "sugar tablets" for diabetes, although she has not been treated or diagnosed for diabetes by a physician since her arrival and also does not know if her previous medical records are available.

The attack:
She was first attacked at 8:30 (p.m.?) while handcuffed, remembers being in the infirmary at 12:30 a.m., and going out in the ambulance "as the light was just coming in."

She needs physical therapy for her ribs, back, and toe. She also needs an extra mattress so she can sleep while propped up and although she periodically gets one, it then gets taken away.

Summary of file no. 2041: Charmaine Lewis

Prior to her arrival at the prison, Charmaine Lewis had a pin in her ankle from a past surgery. The standard issue boots she was required to wear rubbed against her ankle, causing her much pain and swelling. She tried to obtain relief without success. She submitted a request to see an orthopedic doctor, but the x-ray did not reveal a problem with the pin. When she had the surgery a few years earlier, she was told that she might have a limp, but she had not developed one until the prison.

Summary of file no. 2044: Phoebe Mullins

Phoebe Mullins came to prison disabled resulting from gunshot wounds to her head. She also suffered from chronic obstructive pulmonary disease (a lung disorder) and emphysema as well as a seizure disorder. She had glaucoma in her left eye and had undergone head surgery for the gunshot wounds. She continued to suffer from headaches because of bullet fragments left in her head. All medication except Phenobarbital, Dilantin, and Tylenol was cut off during her time at the prison. There was no equipment to treat her lung problems, glaucoma, or muscle spasms. She needed a special diet because of a chemical imbalance, although it was unclear what kind. No special diets are allowed for mainline prisoners. Ms. Mullin's main issue is that in order to get her medication, she must attend meals. However, because of a sleep disorder, she sometimes misses meals and therefore does not get her meds. It is noted in the interview summary that this happened at least once a day.

Summary of file no. 2045: Pamela Brown

Pamela Brown was employed as a farm worker at the prison when her supervisor hit her with a truck. The truck hit her, knocked her down, ran over her foot, and dragged her several feet. She was taken to the hospital and given x-rays, but was told she had no broken bones. However, she has had continuous swelling in her foot, severe neck and back pain, numbness in her left arm, and a large knot at the top of her spine. Because of her injuries she was unable to return to work, but she received no medical care for them after the x-rays.

Summary of file no. 2047: Claire Grainger

When Claire Grainger entered the prison, her thyroid medicine and allergy medicine were taken away. It took 14 months to get her thyroid meds back. She never got her allergy meds; they only gave her over-the-counter medication that caused negative side effects.

It took the prison doctors two years to finally diagnose Ms. Grainger with rheumatoid arthritis. She suffers severe pain and limited mobility. They won't give her any pain meds stronger than Motrin and even then her prescriptions are often delayed.

Ms. Grainger was also diagnosed by the prison doctors with multiple fibroid tumors. But she had been experiencing intense symptoms such as abdominal cramping, heavy bleeding, and extreme pain for 12 years and was told that entire time that the symptoms were caused by emotional strain. When she was finally diagnosed correctly, they suggested that she get a hysterectomy, but because the condition was not cancerous the surgery was elective. She was afraid to have the hysterectomy because she felt like the level of care was inadequate.

During her time at the prison, the surgery became necessary. Her doctor examined her in July and said that the tumors had grown significantly. The weight of her abdomen had increased drastically, and she was at great risk for developing varicose veins and other vascula r problems. Her doctor recommended that she have the hysterectomy right away to avoid these complications. However, she did not receive the surgery until 6 months later.

Also, Ms. Grainger waited four months to receive any kind of medical care after an incident where her roommate beat her with a closed fist on the side of her head. The beating caused serious injury to Ms. Grainger, including memory loss.

Summary of file no. 2059: Gloria Anthony

In Gloria Anthony 's case, the prison took 23 months to complete an evaluation for her condition. In February, she was found to have a mass at the base of her neck and was referred by the yard doctor to a surgeon.

Three months later, a sonogram and x-ray of the neck were ordered. A month after that, she said the mass was causing pain and headaches. The x-ray is reported as showing muscle spasm and disc narrowing, but no mass. She wasn't seen by a surgeon until six weeks later when excision of the lump was advised.

Four and a half months later, she was again diagnosed with the mass, and an orthopedic reevaluation was ordered. Two weeks later a neuro consult was obtained, which found the lump and again advised surgery. Finally, a month later, the MAR recommended removal of the mass by surgery.

Summary of file no. 2085: Daphne Christian

Daphne Christian has hepatitis B and C, advanced cirrhosis of the liver, and end stage liver disease. She has ascites; a very swollen abdomen; difficulty eating and holding down food; pitting edema of entire lower extremities; severe, sharp pains in the area of her liver; and white or tan stools. Her liver medication was discontinued, and she was told "it won't do any good." She has been told that she's on the list for a liver transplant, but is not hopeful that she will get one. She fears dying in prison.

Dr. _____ threatened her that if she didn't go to SNF permanently, he would discontinue her meds. She didn't want to go because she didn't want to give up her job, her cell, and her good time. The doctor discontinued her potassium, Lasix, Lactulose, spironolactone, Tagamet, muscle relaxer, and pain medication, leaving her on only three varieties of psych meds. They got into an argument and she called him an asshole, so he wrote her up and she lost some good time. As her legal adviser writes, "her present punitive denial of care by the CMO puts her at risk for cirrhotic hepatic coma, peritonitis, pneumonia, renal failure, and essentially alienates her from her only source of medical care."

Her denture plate was seized by staff as contraband and thrown in the garbage. She needs her dentures to eat and cannot eat with prison issue dentures, as she has major bone loss in her jaw. She waited weeks to get treated for bronchitis and was given aspirin, even though it's contraindicated for people with end stage liver disease.

She cannot get a special diet.

Summary of file no. 2179: Flora Shaw

Flora Shaw has multiple sclerosis, is paralyzed (she can only move her head), and lives in the SNF. She has no button on her bed that she can reach to call for attendant care. The MTAs feed her, though she doesn't eat much. But they do not brush her teeth, hair, or wash her often, and there is no regular schedule for turning, sitting, or moving her. She is brought to the commode only once a day, and is sometimes left there for hours at a time. She rarely gets outside, does not get fresh air, and believes her treatment is unlawful.

This prisoner has had delayed appointments for blurred vision associated with the MS, delayed treatment for MS, frequent interruptions in medications for MS, and she has not had a pap smear in two years of incarceration.

Summary of file no. 2195: Lonita Marsh

Lonita Marsh 's primary health concerns are a broken arm and recurring grand mal seizures. In September she hurt her right arm during a seizure when it was caught between the bunk and the wall. She spoke with MTA _____ the following day, who did not allow her to see a nurse. She went to the doctor two days after the injury. During this visit her arm was x-rayed, showing that the muscles, tendons, and tissues in her arm were torn.

Ms. Marsh also had a hernia that was visible in her stomach area, as well as a herniated disk in her back. Dr. _____ gave her a hernia belt, but she could not wear it because it caused her back pain. She then saw Dr. _____ who told her that she needed an operation, but at that point nothing had been done as far as scheduling surgery.

Ms. Marsh suffered from chronic seizures and was vulnerable to heart attacks. She has never had a CAT scan or an EKG. She did not receive physical therapy after a stroke, nor was she warned that she should stop smoking and consuming caffeine. She has been wheelchair-bound since her stroke. After her stroke she attempted to call Legal Aid. The CDC stopped the phone conversation and placed her handcuffed in a stripped cell.

Ms. Marsh saw a note in her file that she had a hematoma on her brain.

> _____ told the interviewer that during one of her seizures, MTA _____ watched her and then proceeded to flick cigarette ashes into her mouth.

Harassment: When her roommate came back from school, Officer _____ did a long pat search, rubbed her breasts, and put his hands between her legs, claiming to perform a "thorough search." At one point when Ms. Marsh asked if her Bible had arrived in the mail, the CO asked her what she would do for him to get her Bible. She claims that he is also verbally abusive to pregnant women. For example, he asks, "What's your baby's name—Trick?"

Summary of file no. 2200: Moesha Cray

Moesha Cray was bitten on her lower calf by a spider while working at her job. She asked her supervisor (a civilian) for a pass to visit an MTA immediately afterwards, but her request was denied. A large area of her calf became inflamed within 24 hours. Her supervisor then allowed her to see an MTA who gave her an ice pack and ducated her to see a doctor. It took a week for her to see a doctor, during which time her leg continued to swell. The area burst a few days later, and with the help of other prisoners she was able to squeeze heavy fluid from the boil-like wound. She was accused of having a drug-induced abscess when finally seen by an MTA, but was given antibiotic cream, gauze pads, and tape.

A month later, she was taken to the doctor at the infirmary who lanced the area, gave her Motrin, an antibiotic cream, and a lay-in for seven days. The doctor said he would ducat her in a week, but two weeks passed before her supervisor sent her to the MTA and then to the doctor. The doctor then gave her pain medication for the bite, and the MTA gave her a ducat each week to visit him for follow-up. Until it started to heal, a 3/4-inch hole approximately the size of a quarter could be seen in her leg. About one month after the initial injury, new bites appeared around the original infected area and on her weekly visit to the MTA, 2200 was sent to the yard doctor and then to the infirmary where she received a tetanus shot and the bite was lanced for a second time. The yard doctor gave her oral antibiotics. She was told to come by regularly to have the dressing on her leg changed, but the MTA always claimed to be too busy.

Summary of file no. 2201: Ruby Sands

Five years ago, Ruby Sands was diagnosed with stomach cancer. Although she had been in remission, she has again begun to experience the same physical ailments she had when the cancer was first detected (exhaustion and regular vomiting). She has a long history of cancer in different places and many times (15 times to be exact). Four years ago, a knot on top of her head was measured. It was very tender to the touch, and the medical staff believed it may have been a tumor and they might do an MRI or a biopsy. Dr. _____, however, told her that the rapidly growing lump on her head is "just the way your head is growing!"

Nine months later, Ms. Sands was suffering from painful headaches (as if someone was stabbing her in the head) for two weeks straight. She wanted to know if the pain in her head and stomach as well as her vomiting after each meal were related. She had recently had two sets of head x-rays, a chest x-ray, and blood work performed.

After one appointment with a doctor, Ms. Sands was prescribed two pills, one red and one white. The medication was unfamiliar to her, and she was threatened with a 115 if she didn't take them. After two days of taking the pills, she slept and could not function at her job. She returned to the pharmacy to find out that there was another prisoner with the same name who was also taking red and white psychiatric medication.

Later that fall, Dr. _____ administered tests in an attempt to understand Ms. Sands ' chronic vomiting. He discovered that her heart valve is leaking. The blood test was borderline normal, the urine test was abnormal, and the ultrasound results were questionable. She claims that Dr. _____ later told her all the results were normal.

Although she has a chrono for "no bending," "no chemicals," and "no lifting, pushing, or pulling," she had been cleaning the windows of the administration building at the time of an interview four years ago.

Harassment: Ms. Sands says that particularly in admissions, the prisoners are treated like a "herd" and that when they enter the holding cell they must strip in front of 15 to 20 other women and a few female guards. They have to put their hands on the wall while the guard feels underneath their breasts. In addition, they must squat, cough, and spread their cheeks. If this is not done to the satisfaction of the guard, they must repeat the action. When she was admitted, there were male guards watching from a room facing the holding cell. The staff calls women "bitches" and the male guards watch when they use the toilet. She has heard about guards "getting too familiar" as well as watching the women shower, but this has not happened to her.

Summary of file no. 2202: Leticia Reyes

Leticia Reyes was diagnosed as HIV positive over 15 years ago. During her stay in the prison three years ago, medical staff started her on a protease inhibitor without giving her any information about the drug; she was not told how to take it (i.e., on a full stomach or empty stomach) or about any possible side effects. When she got the meds, she took one every eight hours as she was verbally instructed, but after two weeks into the treatment, she noticed that the label specified taking two every eight hours.

Ms. Reyes also has epileptic seizures and takes meds for these as well. Her seizure meds have often been interrupted for as long as two weeks. She was told that interruptions in her HIV meds would cause problems. She has experienced seizures when her meds are interrupted.

Ms. Reyes has had problems with HIV confidentiality status since she has been at the prison. For example, she went for a flu shot and asked who was eligible for them. She was told "You're a high priority because you have the virus." This was said in an open area in front of many other women.

She is supposed to have a viral blood test every six months, but was one month overdue at the time of her interview.

Ms. Reyes has had difficulty getting care when she has seizures. For example, she had a seizure outside in the heat (107 degrees) and was brought to a nurse by a friend to get her into the air-conditioned room. The nurse said that she could finish having her seizure outside before she could come in. When she was finally brought inside, she had another seizure and was told that she was faking.

Summary of file no. 2215: Rosamunda Morales

Rosamunda Morales suffers from intense migraines for which she takes Midrin. In March, she had been without her medication for two days. Between the pain in her head and the panic and stress of being reprimanded by a guard, she had a nervous breakdown. She only remembers blacking out and then waking up with scratches on her arms. The next day she was placed in the crisis unit, but was not seen by a psych until two days later and then only for 5-10 minutes.

The day after she saw the psych, she saw a doctor for about five minutes. He prescribed pain medication and a psychotropic drug that is used for seizures and as a mood stabilizer. (She had experienced petit mal seizures as a kid but outgrew them.) She put her name on sick call and wanted to see a psych to talk about her meds because she felt they were too strong for her.

A week after she saw the doctor, she had either a seizure or a blackout while climbing into her top bunk. She felt dizzy climbing up and fell to the ground. She broke her left wrist, hit her left cheekbone, and cut her knee.

The next day she was moved to a bottom bunk, taken to the ER in the infirmary, and told that they couldn't x-ray her arm because it was too swollen. Instead, she was given a lay-in for a day and five days of ibuprofen.

Her psych ducat was answered by an appointment with a counselor who told her that he was unable to address the psych med issue. She complained of feeling drunk all the time, and he said that it takes time to adjust, but he would put in a psych ducat for her.

The next day she was given a pass to get her arm x-rayed. She waited for four hours and was then told that the x-ray technician had left. Six days later she saw a doctor and complained of extreme pain in her wrist. The doctor ordered the x-rays and they were taken five days later.

A month after she saw the doctor, her second request to see a psych was again answered by the counselor who can't help her. He said he would again ducat her for a psych visit. Three days later, she decided to take herself off the psych meds.

Over a month later, she still had not seen a psych.

For as serious an issue as monitoring psych drugs that cause feelings of drunkenness and cause accidents, Rosamunda Morales has obviously had a very difficult time getting a very small amount of information. No one seems to want to talk to her.

Summary of file no. 2221: Audre Clifton

Audre Clifton 's leg was smashed in a severe automobile accident several years ago. Her leg and ankle were reconstructed with many pins and plates before her incarceration. While incarcerated, she began complaining of intense pain and visited sick call numerous times. Her skin began to be pierced by the hardware in her ankle, and the skin became red and filled with pus. The area became obviously infected and yet Dr. _____ continually ignored her repeated requests for surgery. She filed 602s regarding the delayed surgery. The pain was so bad and the problem so obvious that housing staff helped her request an emergency visit. After months of complaining of intense pain, she was scheduled for removal of the pin, but the outside appointment was canceled because she was not ducated (no explanation for the cancellation was given). The surgery was not actually performed until nine months later—almost a full year after she began to request help.

Summary of file no. 2223: Alma Masterson

Alma Masterson had a mammogram performed over six years ago because of a "problem in [her] right breast"; it was negative. The next year she was transferred to the prison, where she had another mammogram exam that was negative. She was then sent to a gynecologist who observed that the right nipple had opened up at the tip and was producing a foul discharge. The doctor claimed it was a "staph infection." She related that nothing changed after the exam. It is unclear whether or not the discharge continued and how much time passed until another doctor found a lump under her nipple. By this time Ms. Masterson was paroled. Without medical insurance, she sought help at a hospital. It took a few months to get an appointment and three years ago she was arrested again. That year the lump grew to a size that she could feel easily. In addition, she found another lump, this time in her left breast. She went to see a doctor and was told that the new mammogram was also negative, although the doctor admitted to feeling the lump.

Summary of file no. 2227: Marie Compton

Marie Compton suffered severe burns on over 50% of her body. When she was incarcerated, she had only one pair of custom-made pressure garments. Outside contacts attempted to send in other prescribed pressure garments, but these packages were refused and sent back. As a result, her burns began to show massive scarring. She was forced to wear the same one garment for months without washing it. This is completely unhygienic and dangerous to her condition—it is likened to wearing the same pair of underwear for months on end. 2227 was also denied physical therapy at the prison. As a result, her muscles tightened up and she was unable to walk. She spent most of her time in a wheelchair that was unsafe and difficult to maneuver on her own. When she was finally able to stand up, she could only do so on the tips of her toes because the muscles were too short. She also had extreme difficulty getting the medications she needed. Pain meds and lotions to help the burns heal were prescribed by outside doctors, but often they were never ordered. She wasn't even able to get olive oil to help loosen the skin.

Summary of file no. 2230: Linda Hurtado

Linda Hurtado suffers from a rare skin condition, which limits the amount of sun and heat she is able to endure. Her no sun or chemical exposure chrono is a constant battle to renew, as renewing often means standing in line outside in the heat, which causes further skin irritation. As one point they had her working inside, exposed to cleaning products. Apparently Dr. _____ promised to order special hypoallergenic cosmetics and sunscreen through the dermatologist but then refused to special order it, so she never got it. (She has lost good time on account of being medically unassigned.)

Ms. Hurtado also suffers from severe glaucoma, which requires close monitoring; however, she has been unable to see the ophthalmologist regularly. She has been instructed to use eye drops in both eyes (not just the right one), as her eyesight has begun to fail in both eyes. The outside specialist, based on 2230's potential blindness, has recommended a biopsy; however, prison medical staff have neglected to carry through with this order.

At this point, Ms. Hurtado 's greatest desire is to transfer to another facility, where the environment would be more conducive to her condition. The request has been denied by the prison's administration in spite of the fact that the medical staff from both facilities have recommended this transfer. Apparently even the CMO at the prison confirmed that the climate at the other facility

would be beneficial to her. The basis of the denial is that she was sent to the prison as a disciplinary measure.

Summary of file no. 2234: Assata Sherrod

Assata Sherrod has severe back problems including scoliosis, degenerative disc disease, herniated discs, and rheumatoid arthritis, as well as several blood conditions and a heart condition. She has had five back surgeries requiring 13 vertebrae to be fused. She was supposed to be on light duty, but she wasn't. Therefore, she hurt herself in the kitchen. She saw a doctor who put her on muscle relaxers and gave her a two-day lay-in. She was brought back to the prison a week later and saw another doctor. She had to walk quite a distance to the infirmary where they gave her heart meds. She breaks her pills in half on her own because they are the wrong dosage. She is also not receiving enough of a different med. She ran out of meds and Dr. _____ said she couldn't have more until she paroled (she was close to her release date at the time of the interview). For some reason she had six TB tests in one year's span.

Summary of file no. 2235: Brenda Holmes

Brenda Holmes was given a pregnancy test by her street doctor which came out positive. She was tested again at reception to county jail and again the test came out positive. When she was about 5-1/2 months pregnant she was in prison. She started bleeding and her substance abuse teacher called emergency. When she went to see a doctor, he told her to "get out." Another male doctor told her that she was "crazy," that she wasn't pregnant. Apparently one test she took came back negative, but the rest came back positive. They took her off her prenatal pills and did no further tests. After two weeks, the cramping and bleeding stopped for a few days. She eventually miscarried. After the miscarriage she experienced nine days of bleeding and then after 2-3 weeks another period. Before one of her classes she explained to the MTA _____ about the bleeding and he replied "oh fucking well."

Summary of file no. 2236: Kendra Brooks

Kendra Brooks has an extensive family history of breast cancer. Therefore, she does self-exam quite regularly. She found a lump in her right breast, and fought to get a mammogram done. Finally, three months later they agreed to give her the mammogram. However, they kept putting her off and once even told her she'd have to go to the hospital because their machine was broken. She didn't actually get the mammogram until over a year later. When she went to get the results, the x-ray tech said there was no mammogram record in her file. She was told that they would have to do another one. She waited another three weeks for the results of the second mammogram. Then she was ducated to get another mammogram. When she questioned the tech about why she needed three mammograms, he said that they didn't see anything on the first one and so they were going to do it again. Ultimately she was told that the results were fine, but considering all the difficulties she had, she has trouble trusting them. She is very concerned because she has noticed that the lump is larger and there is now another small lump in her left breast.

M. Brooks has also started having frequent dizzy spells where she sees black spots and stars. She was given a finger prick sugar test and was told that her blood sugar level is very low. They told her to eat

more fruit to get her sugar levels up to par. This is a nearly impossible solution for her, since no one at the prison gets a special diet.

Summary of file no. 2252: Roslyn Williams

Roslyn Williams 's immediate medical issue is that she cannot seem to get her refill prescriptions on time. She is on medication for a bleeding ulcer, high blood pressure, a torn rotator cuff (shoulder), and a torn ligament in her knee. Her file is full of Health Request forms and Inmate Interview requests; however, the pharmacy has managed to divert her pleas by stating that she has not followed procedure in one way or another. It seems that they are annoyed by persistence. Her bleeding ulcer condition is very real and must be treated with pills regularly.

Ms. Williams was also having chest pains and felt that she should have an x-ray done. After the x-ray, she was ducated to see the doctor about her results but was unable to discuss them as the lab had lost them.

Summary of file no. 2281: Pat Parker

The timeline of events regarding the diagnosis and treatment of Pat Parker 's lung cancer is a bit unclear, but I will try to make sense of it. First, she began to experience night sweats and a dry cough. Seen by a doctor, she was given a TB test (negative) and x-rays were done. Upon review of these x-rays, a large mass was discovered on her right lung. The following week, a biopsy was done and it was determined that 2281 suffered from large cell lung cancer. A private doctor who reviewed her chart later said that chemotherapy should have been administered no later than two weeks from the previous biopsy date, as her cancer was steadily getting worse. However, the prison doctors recommended a second biopsy and so no treatment was given.

Though her health was declining, the prison tumor board spent eight weeks deliberating over the severity of her illness, in order to verify that chemotherapy was needed and deserved. Finally, after eight weeks and no follow-up biopsy, 2281 was given her first chemotherapy treatment. Though she was extremely ill and needed a blood transfusion (red blood count at 6), she began her chemotherapy and the tumors have begun to shrink.

Ms. Parker was told by doctors that she had a 10% chance to live for another five years; however, she was unclear whether the chemo treatment changes this estimation. She is still perplexed by the absence of the second biopsy, and why it took so long for treatment to begin.

Summary of file no. 2300: Katrice Alba

Upon arrival at the prison, Katrice Alba was diagnosed with cervical cancer by the on-staff gynecologist, Dr. _____. Immediately following this diagnosis she was scheduled for a biopsy. During this routine biopsy, the speculum broke while lodged inside of her body, causing enormous amounts of pain and bleeding. In order to retrieve the broken speculum, the doctor called maintenance to bring a screwdriver and a pair of pliers. Without sanitizing these instruments, he stuck them in and pulled out the broken speculum. Though she was not bleeding prior to the exam,

she bled afterward for approximately two days. She told the interviewer she was sure they were positive of their original diagnosis of cervical cancer, although she was never shown any test results. No follow-up occurred.

Six months later, she called a friend on the outside, who then contacted the head of medical staff regarding Ms. Alba's medical results. After a couple of months, she was finally ducated to see the doctor, whereupon they again insisted that she had cancer and planned to "freeze her cervix." Because she had never seen her original tests results she refused the cone biopsy; however, she did continue to pursue the issue. After being ignored for another three months, they finally ducated her for another pap smear, where the results read normal. Had she not questioned the cancer screening, she might have had a completely unnecessary surgical procedure.

Summary of file no. 2324: Jessica Stacy

Although Jessica Stacy is a member of the Chronic Care Program, she has had great difficulty getting her Dilantin and Phenobarbital levels checked monthly, as is required. Her levels were tested in November and then not again until May. She believes that the lack of testing has led to toxic levels of the medication in her blood, causing an increased rate of seizures. In May she estimates that she had three or four seizures. During that month she went as long as six days without her meds and had two seizures during this delay. Beginning in March, her rate of seizures increased from one per months to one every two to three weeks.

Ms. Stacy was extremely concerned about a memo that was distributed informing prisoners that they would be charged $5.00 for each asthma attack or seizure. She attributes the distribution of this memo to the perception that prisoners are faking attacks or seizures. She believes that because of the delayed response time of prison officials to prisoner medical emergencies they often arrive after the attack or seizure is over and then accuse the women of faking.

Ms. Stacy also has an artificial pin in her knee that slipped out of place. It is causing a bulge that can be seen from the outside. Although she has submitted at least 10 requests, she has not been able to see an orthopedist.

Summary of file no. 2340: Alicia Alvarez

Alicia Alvarez has a history of cancer. She had Hodgkin's Disease over 20 years ago and was treated with radiation that later caused skin cancer. Now she has a history of skin cancer and while incarcerated she has had new growths that she believes should be removed. She has requested a visit with a dermatologist, but has been denied by the MAR.

She also has a lump in her throat, making it difficult for her to swallow, and has lost 30 pounds as a result. Her surgeon says it is most likely thyroid cancer and should be removed since it has grown in a period of two weeks. He suggested surgery two weeks later, but it was denied by the MAR a month after that request. She filed an appeal after the MAR denial of her surgery but has not received any response. A month after the MAR denial she was brought in for blood work and the lab was very crowded. A tech said it was because there was an upcoming Sacramento inspection. She was told that she would get surgery within a week. She doesn't know if this is true or not considering the MAR.

She has also been told by the gynecologist that she may have cervical cancer. He did a pap smear and cervical biopsy and told her they came out normal. However, he still said she should have her cervix frozen. She refused because she wasn't sure which information was correct.

Summary of file no. 2351: Rosa Prentice

Rosa Prentice has advanced sickle cell anemia. She has a lifeport that needs to be cleaned once a month. If someone does not clean it, she becomes dangerously susceptible to infections and severe illness.

At one point, her lifeport had not been cleaned for six weeks. She ended up in the hospital with a massive systemic infection and a severe case of pneumonia. These illnesses could have been avoided if greater attention were paid to her specific needs. Her life was jeopardized because no one performed a medically necessary basic task.

Ms. Prentice also has had severe complications with her eyes as a result of the sickle cell anemia. In August, she went to her CCP doctor and told him that the vision in her left eye was worsening. He didn't like the look of it, but was not an ophthalmologist, so he decided to send her to the hospital that night. At the hospital, the doctor wouldn't tell her what was wrong, only that she needed surgery immediately. The next day, as she was going under for the surgery, the doctor told her that there was no guarantee that the operation would work. When she awoke, they told her a blood clot had formed and caused severe nerve damage. She had probably lost most of the vision in her eye permanently. She immediately went into a severe depression and sickle cell crisis and was given two units of blood and released to the prison five days after the surgery.

Four months later, the doctor recommended another surgery to remove the cataract on the left eye to see if it would help her vision. However, he had never worked with a sickle cell patient before, so Ms. Prentice wanted the opinion of a specialist before getting more eye surgery.

Ms. Prentice has also suffered intense harassment and retaliation at the hands of staff for being a plaintiff in the Shumate lawsuit. One MTA asked her, "Rosa, what are you going to do in July when it's all over, and things go back to the way they were, and you're at our mercy?" She was also harassed by a sergeant and a lieutenant when she was preparing to see an outside doctor. They threatened to change her room if she was going for more than eight hours even though she had a chrono which stated that her room should remain untouched when she goes out for medical reasons. The lieutenant told her, "that chrono you have ain't worth shit." And in fact when she returned, all of her possessions were confiscated and all her roommates had been reassigned to different rooms. This unnecessary harassment was very stressful for 2351 at a time when her health was very delicate.

Summary of file no. 2362: Maryann Thompson

After a physical in R&R, Maryann Thompson was told she had an abnormal pap smear. Two months later, she had surgery to remove the abnormal cells. After this, she made many requests to see a doctor, but received no follow-up care for two years. Then she had another pap, and found she still had cancer so she had a more extensive surgery at the hospital. The outside doctor's orders, including prescribed follow-up, pain meds, and antibiotics, were never followed. She continued to have an

abnormal vaginal discharge and put in three co-pays before she was finally seen. Although she was given betadine douches and pills, the discharge still occurred along with abdominal pain.

She had also had a breast lump for two years, but after they did a mammogram in R&R, they told her not to worry about it if it didn't hurt. A year later she had a burning sensation near the lump and it hurt. She put in another request. After her attorneys wrote a letter of concern to Dr. _____, he called her into the clinic. He shouted at her, "Why did you lie to those people about having a breast lump that was not treated?" He then threw her medical chart at her across the desk and told her to find it in her chart. However, he did order an emergency mammogram. Two months later she still hadn't gotten it. So she 602ed it. Her doctor responded to her 602 promising that she would have a mammogram within six weeks and admitting that an error had been made. Then she had the mammogram, but no one ever told her the results. She finally had breast surgery and the lump was removed. Still, six months after that she had not been given notification of the results of the surgery. Again she 602ed.

She also saw another doctor, who told her that her last pap again came back abnormal and he was recommending a hysterectomy. At this point everyone agreed that it was the best thing to do because of the continuing reoccurrence of cancerous cells. However, every aspect of the care given this woman had been severely delayed.

Summary of file no. 2368: Denise Walters

Denise Walters was healthy when she entered the prison, but contracted an ear infection there that she has had for at least a year and a half. She got the ear infection first in her left ear. She was first treated with a topical liquid called Visitant. Since then she has been given a combination of topical and pill antibiotics. The infection moved from her left ear to her right, and then back to her left. It apparently settled there, and now she cannot hear out of her left ear. She has been on her latest medication, Bacterin, for four years. Whenever they try to take her off the drug, the infection returns in the right ear as well. Pus continues to drain from one or both ears, and at one point it was so backed up that it drained from her eye. Over four years ago, her doctor gave her an x-ray to show the extent of the infection. He said it had gone into her sinuses, but claimed that there was no damage. During this whole dilemma, she has had difficulty getting her meds regularly. They also never irrigate her ears as they told her should be done, and she has to clean them out herself with Q-tips.

Two months after the x-ray, Ms. Walters was referred to an ear, nose, and throat doctor in a nearby city. The doctor did a complete exam and ordered a CAT scan. He also tested her hearing and found that she had lost at least 50% in her left ear. She didn't actually get the CAT scan for three or four months. The scan showed that the ear infection had eaten into the bones around her ear.

Three months later, the ear, nose, and throat doctor told her she would definitely be approved for surgery because the problem was so bad. Dr. _____ agreed. Ms. Walters signed her medical releases and was taking a special course of antibiotics to prepare for the surgery when she found out it had been denied. She is still in severe pain with visible swelling on the left side of her face in the ear and jawbone area.

Summary of file no. 2375: Evelyn Fox

Evelyn Fox experienced an irritation from a sanitary napkin. The infected area appeared white and swollen. She was examined by a nurse and told that nothing was wrong.

Four weeks later she saw a different nurse. By this point the infected area was bleeding and more swollen. She was sent to the infirmary, and they told her she probably had herpes. She denied the possibility of herpes, but had the test done to be sure.

Three weeks later she returned because she still had not gotten her test results. The infection was now spreading. Dr. _____ told her that the herpes test had come back negative. Without telling her he prescribed herpes medication anyway. He did tell her that he was still convinced that she had the disease although he never physically examined her.

When there was no progress in her condition, she saw another doctor who looked at her file and asked why they had given her herpes medication. She was surprised. Dr. _____ then gave her a tube of antibacterial cream. He never examined her either.

As of the interview this treatment was unsuccessful as well.

Summary of file no. 2388: Lynn Record

Lynn Record relates in a letter that she was given wrong medication that resulted in "stopping her heart from beating" and putting her in a coma for two or three days.

She initially went to the doctor to request iron pills because she is anemic. She believes the medication he prescribed "overdosed [her]" because it was not the medicine she should have taken. The few times she took it, she did not pay attention to what had been given to her. She asked someone who told her that she was on Dilantin, for seizures, and some kind of psych pill.

It is suggested that Ms. Record was admitted to the hospital after a negative reaction to her medication. There she had a blood test performed as well as a screen of her head to see if she is a "seizures case." She says the doctor could not find any reason for her to have seizures. After she was released from the hospital, however, she was ordered to continue taking the same medication.

Summary of file no. 2397: Loretta Vance

Loretta Vance 's primary concern is the lack of post-operative care after the first two of her three hernia surgeries. She also suffers from migraines, may have diabetes, and is a possible TB carrier. She has "surfer's feet" and requires special boots. She 602ed the need for boots and received a pair, but when she returned from the hospital they were gone.

Ms. Vance had the first hernia removed and stayed in the infirmary overnight. When her incision became infected soon thereafter, an officer took her to the hospital for one week. One month later, her second surgery also resulted in infection, including green navel discharge with a strong foul smell. One month later, she complained about the infection. Although a doctor had seen her, no medication was administered. She suffered from the pain and odor of the infection for one year. One

year later she had the third hernia operation in which the surgeon used a laser to cauterize the area. Now she is left with a long and unsightly scar. She was not given the rest of the day off after her operation and states that the nurse attempted to remove the tube while she was still having drainage.

A month after the surgery, she continues to suffer from bad cramps and constipation. She also experiences abdominal pain if she gets up too fast. She sometimes does not have a bowel movement for days.

She suffered very bad cramps from taking wrong medication which was administered by the MTAs. She claims a particular MTA is "mean" and "rude" and verbally harassed her for complaining about the medication mix-up to another prisoner.

About SHU: A prisoner who had recently given birth asked for a sanitary napkin and was told to "flip it over." This same woman slipped on a wet floor, knocked out a tooth, and the staples from the C-section came out. She removed the rest of the staples herself.

Summary of file no. 2417: Felicia Stock

Felicia Stock entered the prison system with Hepatitis B and C. While inside, she also contracted A. She has asked her CCP doctor for interferon treatment for the Hepatitis but he responded that if he "gave interferon to every woman in the prison with Hepatitis the state would be broke." So she asked instead for him to clear her for work furlough so that she can get the treatment on the outside, but he said that she is too sick to work on the outside. However, she has not been unassigned in the prison due to medical disability. How can she be too sick to work on the outside, but well enough to work for the prison and NOT receive interferon?

She was diagnosed with a vaginal infection and prescribed Flagyl which is contraindicated for someone with liver problems. Her liver reacted severely, her face turned blue, she broke out in red splotches all over her body, and she could barely breathe. She feels that the medication almost killed her.

Her second medical concern is an extremely swollen abdomen. Her doctor told her that her bladder is "failing" and that is why she is in severe pain with a swollen abdomen. When she saw him about this problem, he asked her how much longer she expected to be in prison. When she told him she was to be released in about six months, he told her to put a Tampax in to hold her bladder up. She was completely offended by him and asked him about the concerns of toxic shock. He then replied that she used tampons for her period so what was she concerned about? He did not mention the fact that abdominal pain and swelling could be a sign of liver failure (an obvious concern for someone with all three forms of Hepatitis) and will do nothing else about the matter.

Summary of file no. 2420: Brianna Redd

During Brianna Redd 's intake, a lump was detected on her neck. She was told to submit a request to see a physician. After about three months, her husband became concerned and began to contact the

institution. Finally, she was tested. Two months later she still had not received the results. Since she has PID, she is supposed to have pap smears on a regular basis, so she told them she had a bladder infection in order to see a doctor and obtain the results of the tests done on her neck. She saw Dr. _____ who was supposed to perform the pap smear. Instead, he touched her inappropriately and made sexual comments to her. The nurse who was present became nervous and left to look for something. The doctor left her on the table for 5-10 minutes while he went to calm the nurse down. When he returned she demanded her results. He told her he "didn't do thyroids or bladders" and told her to get dressed and leave. He made a phone call and she was told that she would receive a ducat to be transported to an outside hospital. Approximately two months after she was supposed to be taken to the hospital for testing, she had surgery on her neck. She feels certain that no biopsy was done before the surgery was performed.

Summary of file no. 2432: Consuelo Rodriguez

Consuelo Rodriguez suffers from grand mal seizures. Nine months ago she showed signs of stroke or toxic medication levels. Her psych asked her why she had not seen a doctor, and she responded that the doctor was on vacation. The psych called the ER for her and told them that he was looking at a woman with a deteriorating condition. He filled out the consult and sent her to the ER. When she returned from the hospital, medical staff at the SNF removed her catheter and put her in diapers. A month later an MTA told her that they were putting the catheter back in because "you wet too much." She complained about this catheter immediately because it was painful and her family also noticed some blood in the urine on one of her visits. In June an MTA removed the catheter and said "you'll regret what you asked for." She didn't get a new catheter and was not given diapers and therefore was left to urinate on herself.

Ms. Rodriguez is not being adequately cared for in the SNF. She is bathed when her family comes to visit or she is not bathed at all. She receives almost no physical therapy for her stroke. She sees the physical therapist about three times a week but only for about five minutes each visit. She is forced to feed herself, brush her own teeth, and change her own diapers; she does so only with the greatest difficulty.

Summary of file no. 2433: Bettina Washington

Bettina Washington noticed pains in her left breast and went to Dr. _____, who did a complete exam. She was given a mammogram; her family has a history of cancer. The doctor told her she had a cancerous tumor and recommended a mastectomy. She didn't want the surgery and had a very difficult time getting the refusal papers. Finally they did an ultrasound and found out that the lump is liquid and can be treated with a needle biopsy which she wants to do. Two months later, she still had not gotten this surgery.

She also has a hernia and been told that the prison won't treat hernias.

She had a spider bite which turned green and formed a lump. She couldn't get antibiotics or any other treatment. She somehow got an antibiotic from another prisoner and finally a Benadryl pad from an MTA.

Summary of file no. 2435: Terri Stark

At the time Terri Stark arrived, she was still recovering from a very serious sunburn from three years before that damaged both her legs and left her with a staph infection and osteomyelitis. The right leg never healed. It is swollen to 1.5 its normal size and has developed an area of black skin around the festering wound. She has done as much self-care as possible such as debriding and changing dressings every day. Unfortunately, she has difficulty getting fresh bandages from medical. She put in at least 20 requests before anything was done for her. She saw Dr. _____, who took a culture and put her on antibiotics. Again, there was no improvement. The doctor finally ordered a surgical consult, but it took another three months to see the surgeon. When she saw the surgeon, he suggested that she have a skin graft and approved it right away. However, she was 30 days to the gate at the time and had seen first-hand how negligent the medical care was, so she opted out of the surgery and decided to wait and have it done on the outside.

Summary of file no. 3003: Sonia Surtado

More than any medical complaint is the overwhelming presence of sexual abuse and harassment displayed in Sonia Surtado 's file. Most of this harassment can be attributed to CO _____. In her file, Ms. Surtado describes instances where the CO can be seen watching women bathe through the door window, walking in and out of the shower, as well as patting women on the buttocks as he cruises through.
Ms. Surtado also complains that the CO is known to breathe heavily on the loud speaker and often refers to the women as the A-hoes, B-hoes, C-hoes, etc. Other verbal vulgarities include such statements "on your knees doggy style, we know you like it," and "Suck in those love muscles, babies, your men will like it when you come home nice and tight." The CO has also been known to watch certain prisoners he calls "skirts" have sex. She spoke of one particular incident when she threatened to 602 him after being touched, but nothing further was mentioned.

Summary of file no. 3021: Viola Bryant

Viola Bryant has heart problems and was taking heart medication to control her condition. She went without her heart meds for a month. She started having heart palpitations and despite the fact that she has letters from the outside doctor saying she needs it, the appeals coordinator wrote a nasty response about her 602. Dr. _____ also wrote a response that said "your Roboxin has been ordered." However, Roboxin is a muscle relaxant and not a heart medication.

Ms. Bryant has also experienced many severe forms of sexual harassment and abuse. One guard continually asked her about her sexual preferences and sexual practices with her husband. Another guard was rude and embarrassing to her in front of her family. He actually told her husband that she stays thin by having sex. There is a lot of name calling by the guards and rude comments made about her and other women's bodies.

Summary of file no. 3034: Nikki Thomas

Nikki Thomas has a history of mental imbalance that has caused her to attempt suicide and often gets her in trouble with the COs. At the time of her most recent interview, she was in the SHU because of a fight with four other prisoners. She was charged with participating in a riot and had been in the SHU for three months since the fight without an official sentence.

Originally, when she arrived at the prison, she was diagnosed as a manic depressive by Dr. _____ and prescribed several psychotropic meds, including Prozac. Later, the psychiatrist overruled the doctor's diagnosis and upgraded her to borderline personality disorder. Initially, she remained on her meds, but says that she was tricked by an MTA into signing a refusal which resulted in the termination of her medications. She states that the MTA was crushing her meds and told her that she would have to sign the release and then re-request the medication in order for this practice to cease. However, after she signed, her medication was never re-administered.

After her medication was discontinued, she attempted suicide. As a result, she was sent to the hospital, where she spent two and a half months. While there, she was placed back on her meds, and her condition began to improve. Upon release from the hospital she was sent back to the prison and her medications were again taken away. Obviously, this resulted in another deterioration of her condition. At the time of her latest interview, she reported feeling more and more depressed, anxious, and angry. She says that she is hearing voices, has developed insomnia, and a habit of "repetitious behavior."

The psych doctor that she had been seeing in the SHU rarely actually "saw" her. Instead, he would usually send "one of his psychiatrists." She states that sometimes she receives no medical attention at all unless "she cuts on herself." When her psych doctor in the SHU does personally attend to her, he merely asks how she is doing through the cell door. He does not offer to take her out for private consultation.

Ms. Thomas also reports that Dr. _____ sexually molested her during a pelvic exam.

Summary of file no. 3049: Jacqueline King

Jacqueline King had a tooth extracted by Dr. _____. She had a very strange feeling in her mouth after the surgery but she went to sleep. When she awoke she had no feeling in her lower lip or chin. She first thought that perhaps she had been given too much novocaine and it had not worn off. However, the numbness went all the way up to her ear.

The next morning she went back to the dentist. After checking her mouth, the dentist informed her that they must have hit a nerve in her mouth and that it might be six months before the feeling returned or it might not return at all.

The next morning she woke up in severe pain. Although she was not given a pass from the staff officer, she went back to the dentist anyway. They checked her mouth again and said it was fine. At work she was crying from the pain so she took two Motrins and asked to leave. Her boss called the dentist who said she was fine, but her boss could see she was in pain so he let her go back to her room.

The following day her roommate noticed that her mouth was swollen and bulged out slightly. They refused to give her a lay-in because she did not have a fever. Suddenly she experienced chills and then fever so she ran down the hall crying and the CO called her boss to get a lay-in.

The next day she was even more swollen. Her roommates convinced the CO to get her another lay-in. She couldn't eat or sleep. She was told that dental is not considered an emergency and that such swelling is normal.

She spoke to her mother who became concerned when an outside dentist told her that 3049 probably got an infection after the tooth was pulled and she didn't receive antibiotics. Her mother called the institution and spoke with Sgt. _____ who assured her that 3049 would see a doctor.

The following day, she was seen again by the dentist, who cut in her mouth and was pushing it around, but never told her what was going on.

The next day, the whole side of her face all the way under her chin was swollen. She was losing weight because she couldn't chew. Her lips were white, cracked, and bleeding, and she felt like her jaw was locking.

Finally she was told by Dr. _____'s boss that she had an infection in her tooth, the tooth had sealed over the infection, and that had caused the swelling. This doctor okayed a liquid diet, but her boss told her that her superior would not let her have a liquid diet nor would they give her ice.

Around this time they finally put her on antibiotics. She still has headaches and numbness and sometimes slurs when she talks. She still has a cyst on the side of her mouth that causes the teeth beside it to hurt. However, at this point she is terrified of letting another institution dentist touch her.

Summary of file no. 3064: Harriett Marcus

Harriett Marcus was one month pregnant when she arrived at prison. There she received blood tests, checked the heartbeat, got vitamins and calcium. However, she was transferred to VSPW along with other pregnant women supposedly because they would receive better care there.

There, Ms. Marcus began to have a thick brown discharge. Dr. _____ gave her Monistat for a yeast infection, but it only became more irritated.

There, Ms. Marcus felt the baby "balling up" inside her, but Nurse _____ who does all the ducats said that's normal. Dr. _____ would never look at her, would not give her a pelvic exam, and would barely touch her.

Ms. Marcus was previously a nurse's aide and therefore she knows how to read blood pressures. Hers was often 140/100, which she knew was high, but those reading it were writing it down as lower.

One night, she felt the baby continually balling up and releasing. So she went to MTA _____ who, after checking her, said that he couldn't detect a heartbeat. She went to a nurse who sent her to Dr. _____ who finally sent her to the infirmary. At the infirmary, two MTAs argued about whether or not they should send her back to her unit because the ultrasound was unavailable. They finally called a doctor who sent her to the hospital after she told him that the baby had been balling up for three days.

At the hospital, the ultrasound confirmed that there was no heartbeat. The baby was too small for a C-section, so they induced labor. Although she wanted a copy of the autopsy and pathology report, she was told they were not on file.

Summary of file no. 3069: Angela Wright

Angela Wright contacted Dr. _____ because she was pregnant and had a history of miscarrying at about the third month. She was concerned because she had some minor cramps and wanted him to take a look at her ultrasound. She was told she would indeed get an appointment but in fact never did. She put in a request to see the OB/GYN, but never received a response. The next week she started spotting. An MTA told her that she should receive a pass to go to the doctor, but she never got one. Finally, her counselor called the infirmary and she was admitted to get bed rest. They gave her medication to keep her from dilating and kept her in the infirmary overnight. Finally she was taken to the hospital, where the doctor told her it was too late to have her cervix "tied off with a piece of nylon string." She lost the baby and is convinced that she did so because of medical neglect. Had anyone listened to her original pleas for help it might have not been too late to save her baby's life.

Summary of file no. 3076: Samantha Parker

Samantha Parker was diagnosed as an insulin-dependent diabetic while in prison six years before.

When she re-entered custody, she was pregnant and was given insulin for two months, at which time Dr. _____ canceled her insulin without taking any lab tests.
Three months later she had dangerously high levels of glucose in her urine. She was rushed to the infirmary and given insulin.

Two weeks later, she was paroled to a home for pregnant women and three days after that her baby was delivered stillborn at the hospital. The doctors who delivered her said that the fetal death was due to a diabetic coma from the lack of insulin while she was in prison.

Summary of file no. 3077: Esperanza Perez

Esperanza Perez suffers from chronic asthma. Her main concern is that her medication be refilled in a timely manner. She is reliant upon pills and an inhaler, which, if not taken, severely aggravate her breathing condition. While in prison, her meds have run out twice. In an interview, she described one time in particular when missing her medication led to an unnecessary coma.

The trouble began when she complained of breathing problems. At this time, her pill medication (prednisone) and inhaler had run out, and it was very difficult for her to breathe. Two days later, she went in for a regular breathing treatment. Another two days later she was supposed to go in again for her treatment but was denied access to the procedure.

As weeks went by, she continued to experience troubles in breathing but was consistently denied treatment by the medical staff. Finally, she experienced a severe asthma attack that landed her in the hospital two weeks later. Just after arriving at the hospital, she went into a coma. Seven days later, she was released from the hospital and sent back to prison.

Ms. Perez's follow-up treatment was scheduled three days after her release from the hospital; however, the only appointment she was granted was a trip to the prison kitchen where she would begin working the following week. She was not seen by a prison doctor until the ninth day of her return from the hospital.

Concerning the medical staff at the prison, Ms. Perez mentions Nurse _____, whom she has deemed the "epitome of the inadequate medical care." She has witnessed the nurse laughing at and throwing away doctor request forms. Also, Ms. Perez asked the nurse if her cell blanket could be replaced with a non-woolen one, as it causes her to wheeze. Nurse _____ insisted that that was not the cause of her allergic reaction and refused to order a change of blankets.

Summary of file no. 3113: Mechele Miller

Mechele Miller has a lengthy set of complaints against many officers at the prison. She has had numerous run-ins with guards and write-ups for disobedience and verbal outbursts. Many people seem to think she has paranoid delusions (i.e., she thinks they are putting psych meds in her food). However, some of her fears seem valid (i.e., her fear that allowing the psych docs to document any mental illness in her charts could be used against her). In addition, being housed in the SHU, the most repressive part of an already oppressive institution, is obviously difficult for anyone to deal with. She has filed many 602s against prison officials. Many relate to strip searches, others refer to male guards who watch the women in the SHU during their showers, and some relate to the withholding of her meals when she refuses to comply with disciplinary measures such as the requirement that she wear a spit mask.

Summary of file no. 3146: Nina Simmons

Nina Simmons arrived at the prison eight months pregnant. The next month, she had a baby girl. While in the county jail, six months after conception, the doctor gave her 100 mgs. of Mysoline for seizures. According to 3146, she had never had seizures and was only fainting due to the combination of the pregnancy, the stress, and the heat. After arriving at the prison, Dr. _____ gave her 150 mgs a day of Phenobarbital for seizures. She told him that she didn't have seizures and was only fainting due to the stress and the heat. She was then threatened with a 115 if she didn't take the medication that he prescribed. After being prescribed the Phenobarbital, 3146 threw up blood every night until the baby was born. She was in the infirmary every other night for this. During this time, she was seeing Dr. _____ once a week every week and continued to do so until the baby was born.

When she went into labor, she was taken to the hospital, where they were very concerned that Dr. _____ had switched her prescription so far along in her pregnancy. They tried to call the doctor to ask him why he had made this decision, but got no response. The baby tested positive at birth for Phenobarbital and now suffers from grand mal seizures.

After she had the baby, Ms. Simmons refused the medications in writing and has been trying to get a medical clearance to be able to participate in the mother-infant care program. Dr. _____ has refused to clear her and she continues to be on restricted duty. She no longer suffers from the fainting spells.

She would like to get into mother-infant care, to file a complaint against Dr. _____, and to get a copy of her medical file.

Summary of file no. 3195: Suzanne Connery

Suzanne Connery 's baby was born in March, but was 18 days early.

Dr. _____ gave her a prenatal exam that she describes as rough. She describes Dr. _____ as jamming and twisting the speculum up inside of her; she could feel it against her uterus. She describes the baby as low at this point in gestation. He said that her warts had not changed. She describes bad cramping after the exam. There was no bleeding or bloody show. Three days later, her water broke and the baby was born.

Unfortunately, the baby had birth defects—3195 reports that the child is unable to bend at the knees and has problems with fingers on both hands. 3195 had three previous children, all of whom were born late.

She says that she took no drugs, alcohol, or any prescription medicine during the pregnancy, with the exception of prenatal vitamins. She may have used a pregnancy-contraindicated anti-wart ointment at her previous institution.

The child was delivered by C-section and 3195 says she was told the baby was breech. The staples used to close the C-section became infected and remained infected for 4-5 days before removal. They were removed late. MTA _____ first informed her that there was no paperwork ordering the removal of staples and later that the paperwork said the staples should have come out four days after the birth. MTA _____ applied Betadine to the infected staples prior to their removal.

Ms. Connery questions her follow-up care. She says there have been no medical request slips on her yard to request an appointment for postpartum abnormalities. She reports that last week she was ducated by Dr. _____ to the infirmary. He asked her if she had the baby, looked at her stomach, and said he would see her in six weeks. She is currently complaining of an abnormal discharge (yellow, dark in color, thick consistency), strong and unusual smelling (different from her previous pregnancies); her stomach wound is still open on the right side, she experiences burning and stinging around the scar and pain and cramping in the upper part of the abdomen.

She expressed an interest in filing a complaint.

Summary of file no. 3220: Norma Orozsco

Norma Orozsco has had Hepatitis C since 199X. Three years later, she filed a 602 about treatment for her Hepatitis. It wasn't until almost two years after that that she saw a liver specialist who said that her enzymes were high and recommended interferon treatment. As of the interview, eight months after she saw the specialist, she still had not yet received the interferon.

She has tumors on her left lower side back, and on her left front in the general area of her ovary. She had surgery in March, in October, and the following May to remove the tumors. She reported that she was never told the cause of these tumors and that tests were never done to determine the cause. During the October surgery, Dr. _____ removed a lymph node on the left side along with the tumor because, as he said, "they couldn't save it." When she returned from the hospital she had a drainage tube sticking out of her for three weeks. They were nine days late in taking it out because they didn't ducat her for a follow-up appointment. When she finally got an appointment, they were immediately

alarmed and explained, "what is that doing in there?! It is healing around the tube!" The doctor was called and she got ducated the next day so they would remove the tube. The tumors began to reappear in July and are growing faster than before.

Summary of file no. 3226: Gwendolyn Walker

Gwendolyn Walker has a deteriorating tissue disease. Her leg brace was taken away from her when she entered the prison. She begged for a brace and was finally given one by Dr. _____, who had it made at the prison. The brace was a shoddy combination of blue and plastic and stuck to her skin, causing blisters.

She was also given a shoddy wheelchair. At one point she was crossing a crack in the pavement, the front wheels broke, and she was nearly thrown to the ground. Although she was given another chair, she was charged $500 for it.

The seizure meds that she is currently on are not controlling her seizures. She often has several a day!! Despite being on the meds she has not been able to get a heat pass from the MTAs who tell her that she is bringing the seizures on herself.

Summary of file no. 3248: Julie Coombs

Julie Coombs was 7-1/2 months pregnant when she arrived at the prison. She was having lower abdominal cramps and wanted to be checked out. A week later she saw a doctor who discovered that her blood pressure was very high. Dr. _____ decided to admit her to the infirmary. She was in for six or seven weeks, so that she would be able to get bed rest and be closely observed, as the doctor was afraid she might develop eclampsia or toxemia.

Unfortunately, they could not get her blood pressure down and continued to switch her meds. They gave her nifedipine, Apresoline, metoprolol and enalapril, all of which she believes were dangerous for the baby.

She felt that she received severely negligent care, especially from the night watch. All the nurses were supposed to check her blood pressure every two to four hours, but they rarely did. The last day that they checked the fetal heartbeat was late November. On the night that the baby died, they hadn't checked her blood pressure or the fetal heartbeat for 12-16 hours; therefore, she is unsure how long the baby was dead inside her before they discovered that something was wrong.

The institution claims that the baby died of syphilis and even called the father of the child to tell him that he needed to get a blood test. 3248 said that although she tested positive for syphilis several years before, she was seeing a doctor regularly on the street for prenatal care, and that she was no longer positive for VD. When she arrived at the prison, her intake physical gave her negative results for VD.

Ms. Coombs had an extremely difficult time getting information about the burial of the baby. She wanted an autopsy done. She signed a paper in the hospital that she thinks was a request for an autopsy. They told her they wouldn't do it. Her counselor wasn't sure about the location of the body, although she thought it was with the coroner in Ms. Coombs' home town. First, they reported that an autopsy had been done, but then they changed and said it had not been performed. For a week, they went back and forth on the issue. She still doesn't know whether was done or not. Dr. _____ first said they had done it, then he said that they would do it. After much emotional trauma and pushing, they finally told her that she would have to pay for a burial plot or else the body would be cremated. After a month of more back and forth, they cremated the baby against her will. Soon after, they called her fiancé to tell him that because he had served in the military he had a right to a burial plot after all, but at this point it was too late. She said it was someone from the institution who called him.

Summary of file no. 3252: Tanya Phillips

Tanya Phillips has advanced sickle cell anemia. She is suffering severely, but has been told that nothing needs to be done because she is going home soon. However, she is in sickle cell crisis. Two of her toes have turned black. She did not have her blood work done for over a year. She is hyperventilating, experiences dizziness, swelling in her joints, wave-like pains in leg and lower back muscles, and severe pain in her pancreas. She has knots on her left breast and a terrible vaginal discharge which is "milky and bacterial," as well as a bladder infection. She has a blue-ish color around her irises and bloodshot eyes caused by acute oxygen deprivation for the sickle cell. Dr. _____ told her that he doesn't know anything about sickle cell and can give her no assurance that when her blood level reaches the crisis level, she will be treated appropriately. Her bladder problems are not treated nor is her asthma. Essentially, she has many medical problems and is offered few if any solutions.

Summary of file no. 3294: Bernice Gray

Bernice Gray was playing softball when she slid and hurt her knee. She experienced some swelling. When she arrived at the prison, she showed Dr. _____ the knee, but he said it would go away on its own and did nothing for her.

Two weeks later, she was scheduled to work with the yard crew, and the knee became aggravated and more swollen. She went to the MTA, who told her to come back at sick call. She saw the doctor at sick call and he rescheduled her appointment for a week later, so he could drain her knee.

At that appointment, Dr. _____ drained her knee, but the drain produced blood instead of fluid. He bandaged the knee and told her to come back the next day for a follow-up exam. During that night, her knee swelled up again.

The next day, Dr. _____ drained her knee again. She was given a lay-in for a couple of days and was given Motrin for the pain. She was told to stay off the leg, but was not given crutches to help with the pain and difficulty of moving when necessary.

The following day, she went back to the doctor and he drained her knee for the third time. Again, the drain produced blood but no fluid. Seeing this, Dr. _____ exclaimed, "Oh My!" and mentioned that she might have broken a blood vessel in her knee.

Two days later, Ms. Gray returned to Dr. _____ because the knee had swollen up yet again. He said he wouldn't drain it again. She asked for more Motrin and wanted crutches. She was told that there weren't any crutches at the prison and that she couldn't have a wheelchair.

The next day, Dr. _____ summoned her to tell her that she had edema. The bottom of her leg had swollen up by this point. Dr. _____ wanted to take her to the infirmary at another facility, but she wanted to wait until Monday so that she could put her financial matters in order. She was permitted to do so and was given crutches. She was told that she would need an x-ray taken as well.

On Monday, she inquired about her appointment for the x-ray and was told it was scheduled for two days later. On that day, she went to sick call and was told by the nurse that she should have been taken for her x-rays earlier in the day. She waited 45 minutes for transport, but it had come and gone without her being notified. Her appointment was scheduled for three days later and she was told to be ready at 8:00 a.m. that day.

On the day of her appointment she was taken to be x-rayed at 5:15 a.m. and given three x-rays. She was told that the results would be ready in 2-3 days.

Two days later, Ms. Gray went back to the MTA office to get her results and was told that they were not back. Dr. _____ attempted to locate the x-rays for 45 minutes. It turned out that they were in the warden's office. The warden's office told the doctor over the phone that 3294 had a cracked knee cap. Dr. _____ told the nurse to schedule 3294 for an appointment with the orthopedic doctor.

On the day she was scheduled to see the orthopedic doctor, she could not because he was not at the prison.

Four days later, she went to sick call to get medication. She requested her medical records at this time and the nurse demanded, "What the hell do you want for medical records?" She wrote to the Chief Medical Officer requesting her medical records but never received a reply.

Three days after this, she was called to sick call at 12:40 p.m. She was seen at 1:25 and asked for pain medication stronger than Motrin, requested to be medically unassigned, and demanded her medical records. She was told that she had an appointment for four days later and that she didn't need her medical records. 3294 filed a 602 against the medical staff for inadequate treatment on that day, but she did not receive a response for a month (the response was dated two weeks previous to her receiving it).

On the day she waited for the orthopedic doctor for over four hours he never arrived, but she was told that he would come again two days later.

On that day, Ms. Gray finally saw the orthopedic doctor. He made no mention of the x-ray and told her to come back the next day, so that he could re-drain her knee. He told her that she had torn the lining of her knee and gave her stronger pain meds.

Two days later, the orthopedic doctor drained her knee with an 18-gauge needle without pain killers or anesthetic. He moved the needle around in her knee, causing her to scream. The nurse thought Ms. Gray was going into shock from the pain. Dr. _____ then used a smaller needle and filled the knee with cortisone, causing her more extreme pain. Ms. Gray felt that Dr. _____ is a sadist.

Three days later, her crutches were taken away and she was told that the swelling would go down in 2-3 weeks.

A week later, she went to sick call because the pain and swelling had become unbearable. Crutches were returned to her.

Four days after that, Dr. _____ cut an incision in her knee to let it drain, using local anesthetic. The doctor allowed her to view the knee as he cut it open. Dr. _____ inserted forceps into the hole and moved them around. He then pulled out a piece of the lining to show her. She was very disturbed by this process. He finally stuffed the hole with gauze strips and told her to come back the next day so that he could change the dressing. She requested pain meds and was given Motrin. She was told that Dr. _____ would call her tomorrow.

The next day, Dr. _____ did not show up at the prison and 3294 did not receive any meds. She was running a slight fever and suffered all day and night.

The next day, Dr. _____ approached Ms. Gray at the cafeteria and told her to come see him when she was done. She told him about the extreme pain she was in and Dr. _____ offered her Tylenol or Motrin, although neither was doing anything to alleviate the pain she was in. The doctor removed the catheter from her knee without pain killers or anesthetic, and she passed out from exhaustion.

The following day, an MTA cleaned her dressing and told her that he didn't know why the doctor had removed the catheter since doctors were not allowed to perform surgical operations at the prison at that time.

The next day, Ms. Gray went to sick call at 7:30 am because she wanted to be medically unassigned and was told to come back at 9:00 am. After waiting until 10:45, she was told that Dr. _____ was the only one authorized to medically unassign her and that he was unavailable.

The next day, Dr. _____ told Ms. Gray that she did not need stitches in her knee because it was "healing from inside out." She then went to a classification meeting where she was told that her father had no right to call and complain to the prison. She was told that she needed to 602 the medical staff if she thought she wasn't receiving adequate care. She told them that she had 602ed to no avail. One of the officials at the hearing asked her if she had medical care on the outside. He said it was remarkable that so many people who "didn't have a pot to piss in" demanded care in prison.

Although she has been receiving lay-ins here and there, Ms. Gray is still not classified as medically disabled or unassigned.

Summary of file no. 3301: Yolanda Chávez

Yolanda Chávez had a boil under her armpit which Dr. _____ lanced and packed. He did not prescribe antibiotics and sent her back to her unit. About a week later, another boil appeared in the same place. She again saw Dr. _____ who had no recollection of the first boil. He put her on antibiotics and she was given an appointment to have this one lanced as well. The boil burst on its own. Then a third boil developed and six days later it was as large as a golf ball.

She was scheduled for surgery. When she arrived at the infirmary, Dr. _____ told her that he would have to make a deeper cut and that he would test the fluid this time. He cut her very deeply two or three times.

She was sent back to her unit without extra gauze because the doctor told her that she wouldn't need it and that he would see her in the morning to check on it. After an hour and a half, she noticed blood dripping from the gauze, so she took it off thinking she needed a new dressing. Fifteen minutes after she applied the fresh dressing, it was also soaked with blood. She alerted the housing staff who saw how much blood she was losing and alerted an MTA. The MTA wouldn't see her until a couple of hours later. By then she had bled through several Kotex which she was using because she had no extra dressings. Finally she saw the MTA who told her that there was nothing she could do although she had blood-soaked t-shirts, bra, towels, etc. The MTA said it wasn't that much blood and that Dr. _____ had said he would see her at 8:00 a.m. The MTA put a fresh gauze on the cut and sent her home.

By this time it was only 8:00 p.m. She continued to return to the MTA for fresh gauze every fifteen minutes until 9:00 p.m. At 9:30 p.m. the housing staff came in to check on her and saw how much blood she was losing. They again called the MTA. At 11:00 p.m. the MTA arrived with a sergeant. They saw the blood dripping from underneath her arm and saw huge spots of blood on her sheets, towels, shirts, etc. Again, they only wrapped her in gauze. She was afraid to sleep because she thought she might bleed to death.

The next morning around 7:00 a.m. she was again sent to the MTA who again told her she was scheduled to see the doctor at 8:00 a.m. Finally she saw the doctor who told her they would apply pressure to stop the bleeding. He said it was best to stop the bleeding this way because surgery would cause a scar. They tried this until 10:00 a.m., when the doctor finally called the hospital.

She arrived at the hospital at around 2:00 p.m. and was admitted for surgery around 5:00 p.m. The surgery resulted in a huge cut in her arm and over 10 stitches. She stayed at the hospital overnight and spent the next night in the infirmary to make sure the wound didn't start bleeding again. Essentially, they let her bleed from 4:00 p.m. until the next day before giving her the medical attention she needed.

Summary of file no. 3333: Cheyenne Cisneros

Cheyenne Cisneros suffers from a variety of medical problems, including a lump in her left breast (that was removed), intestinal complications, a broken foot, an ovarian cyst, and borderline multiple personality disorder. She has had trouble receiving adequate medical attention for all of these conditions; however, her worst problem is the sexual harassment she has experienced in the SHU. The target harasser is CO _____. Ms. Cisneros explained that it all began when she asked the CO to pass her a book. In reply he said that she would owe him one, and without thinking of possible repercussions she simply said "sure." Later, he approached her and requested that she lie on the floor and masturbate. When she rejected his request, CO _____ threatened that he would be back. In addition to the threats, Ms. Cisneros has witnessed him masturbating while watching her from the tower. She has complained about CO _____'s inappropriate behavior several times; however, there was no mention of him being reprimanded. Of course, he denies these claims and states that she's lying.

Summary of file no. 4001: Faith Dutton

Faith Dutton has been HIV positive for nine years and now has full-blown AIDS and chronic asthma. During our interview she stated that she is a relatively healthy woman, active in the management of her HIV, although these last four months she has dealt with an unidentifiable skin rash. She believes this rash to be a negative side effect of the pneumonia vaccine she was given; however, no clear diagnosis was ever stated.

The trouble began when Ms. Dutton passed out and was sent to the emergency room at the infirmary. She was seen by Dr. _____ who sent her to get a chest x-ray. After reading the x-ray he diagnosed her with bronchitis and advised her to drink a lot of hot water and get some rest. Later that evening Nurse _____ also read the x-ray whereupon it was decided that 4001 be sent to the hospital. Once there she was diagnosed with PCP Pneumonia. Six days later she was released from the hospital; however, she received no hospital meds or follow-up care.

Four days later Ms. Dutton began to break out into a rash that spanned from her arms and legs to her back and stomach. The rash caused her to itch terribly and made her skin red and flaky. Unable to get the proper medical attention, the rash continued for two months, until CMO _____ noticed the severity of her bruises and put her in isolation for fear she might be contagious. During this time she was seen by Dr. _____ and Dr. _____, both of whom were unable to identify the rash or the proper treatment. At this point Dr. _____ summoned a dermatologist, who took a skin sample and tested it for scabies; this test came back negative. On this date, the dermatologist also took a biopsy; however, those results were not read for a month. At this point, Ms. Dutton 's rash had begun to blister and secrete a clear fluid when submerged under hot water.

Still with no clear diagnosis, Dr. _____ suspected an allergic reaction and proceeded to stop all of Ms. Dutton 's regular HIV meds, as well as her psych meds. Naturally she experienced serious withdrawal, including nausea, vomiting, sweating, and insomnia. At this time she was being housed in the Psych ward in the infirmary. Fortunately, she was put back on her meds after a week.

When the dermatologist read the results of the biopsy he concluded that it must be eczema; however, it was clear to Ms. Dutton that the dermatologist was not sure of his prognosis. She was given a low dosage of prednisone, which did not seem to work. At some point during this time, she also saw a Dr. _____ who was also unsure about the rash and its symptoms, but ordered Diflucan from the pharmacy anyway. After a couple of days she began to notice that the redness and itching had subsided, and that the blisters were beginning to dry up and scar. A few days later she was ducated to see the HIV specialist Dr. _____, whereby her condition was discussed; however, eczema and HIV-related symptoms were ruled out. At this point her skin was looking and feeling much better; however, big bruises could be seen down the front and back of her body. Dr. _____ could not explain this.

A week later she saw Dr. _____ from C-Yard who was very difficult to understand. He took no steps to diagnose what at this point has become a mystery skin irritation.

Two days after this, she returned to the dermatologist who recommended that she be moved to the infirmary and administered a higher dosage of prednisone for 21 days. Reluctantly, she moved into

the SNF and began her treatment, whereby almost all of the symptoms of the rash subsided with the exception of the bruises.

Five days later, Dr. _____ was still unclear of the nature of the rash. Three days after this, 4001 was released from the SNF; however, the bruises/scars remain all over her body.

Two days later, she awoke feeling weak and feverish and approached MTA _____ about her condition. After taking her temperature, which revealed a 102.5 fever, she was sent to the infirmary where she was given a breathing treatment by RN _____. Later that day she was sent to the hospital. During her stay in the hospital, she was diagnosed with an inflammatory infection and given prednisone intravenously. She was also given a stool softener for her constipation. Four days later, she was discharged from the hospital and returned to the infirmary with no medication. She was put on a plan to wean herself from prednisone; however, no doctor has structured or monitored that program.

Aside from the bruising everything else seemed fine until four days after her discharge from the hospital, when she was hauled off to the hospital on a Monday morning, for a knee surgery she knew nothing about. According to 4001, she had gone to see a doctor several months before about the screws that were coming loose in her knee; however, no follow-up was done to further address the problem. Now, after several (unsuccessful) attempts to renew the short walk chrono she was given at the initial visit, she was being prepped for surgery. Upon arrival at the hospital, she went through the various procedures, initially surprised but ultimately pleased that her knee would be repaired. After a couple of hours had passed, she was notified that her surgery had been canceled whereby she was returned to the prison. At the close of our interview 4001 expressed interest in suing the CDC for medical neglect, which is something her father has already begun to investigate. She goes home in two months.

The SNF:

During our interview Ms. Dutton mentioned several times how dreadful the SNF is for sick women. Not only is medication always late by at least two hours, but women are given 115s if they disagree with or fail to take the medication they are given. She says that the nurses are lazy, and that all privileges are taken away while they are housed there. She recalls that while housed in the SNF, she received a wrist band with Dr. _____'s name as her doctor. She says she has never met or been treated by this doctor and doesn't understand why he was labeled as her doctor. Also, on the next day she was given a TB-exposed roommate, who was removed only after 4001 notified the woman of her HIV status.

Deaths:

During our visit, Ms. Dutton informed me of four deaths that have taken place in the last month. These women are: XXXXX - possible brain cancer, XXXXX - also cancer, XXXXX (?) - nature of death unknown, and XXXXX - nature of death unknown. 4001 recommended we talk to XXXXX, who was in the SNF at the time of these four deaths.

Summary of file no. 4002: Brandi Mills

Brandi Mills was diagnosed with pre-cancerous cells on her cervix, and immediate surgery was recommended. Though she tried to refuse this surgery under the suspicion of a faulty diagnosis, she was given the surgery anyway. Later, she was notified that the previous records on her "abnormal pap" had shown no signs of pre-cancerous cells and that the surgery could have been avoided.

Another upset was her removal from the HIV support group, which caused her depression and fatigue, making her everyday work responsibilities miserable. The file did not indicate why she was rejected from these meetings; it only mentioned that she would write up medical excuses to avoid attending work and was once caught forging a pass to see a visitor. These two incidents extended her sentence by three months.

In terms of Brandi Mills ' skin condition, she has made numerous attempts to see a dermatologist about the discoloration (pale spots) of her skin pigment, but to no avail. It was not mentioned whether she 602ed this. Her most recent attempt to find out information on early menopause detection has also been unsuccessful, as she has found no doctor willing to talk to her about it.

Summary of file no. 4003: Camille Sanchez

Camille Sanchez has full-blown AIDS and suffers from several opportunistic diseases including CMV (Cytomegolovirus) and AIDS-related pneumonia. Her CMV condition has advanced to the point of total blindness in both eyes. Her overall condition resulted in her compassionate release, whereby she was returned to society and her health improved. Apparently her chronic pneumonia became less chronic with the adequate medical care she received upon release, although her sight was not restored.

Summary of file no. 4004: Lisa Gordon

Lisa Gordon died of lung cancer (which began as uterine cancer) in a comatose state at a community hospital. Months before the death of 4004, her lawyer filed several times with the Board of Prison Terms to request compassionate release in light of 4004's condition, but to no avail. It was agreed by all that she would not last much longer, but no amount of paperwork would alter the Board's decision.

Summary of file no. 4005: Virginia Navarro

Virginia Navarro has cervical cancer. She had a CAT-scan and ultrasound, and Dr. _____ told her that the cancer had spread to her bladder and colon. Two months later a doctor at the hospital told her that the cancer had not spread. At this time she finally started the treatment for her cervical cancer, including radiation and chemo. She was prescribed Vicodin for the pain. A month later she went to the infirmary for a scheduled appointment, but instead of seeing her usual doctor, she was seen by Dr. _____ who told her that she wasn't going to get anything for the pain. This doctor said he didn't know why her previous doctor had given her anything since "cancer doesn't cause pain." At the same time he refused to do anything about a discharge for which she wanted a pap smear and antibiotics.

Summary of file no. 4006: Ellen Blair

Ellen Blair has waited two weeks for HIV meds. She has had very little appetite and difficulty eating. She reports that in the SNF the staff forbids prisoners from taking showers and refuses to assist in sponge baths. Often they lock her in or out of her room, limiting her mobility. She received results of a pap smear on a piece of paper tossed under her cell door. It was not in an envelope or folded and read "Infected" across the top.

Summary of file no. 4009: Christina Sosa

Before receiving compassionate release two years before her death of HIV-related pneumonia, Christina Sosa suffered immensely. She was confined to her bed and completely immobile except for slight control over her left arm. She suffered from wasting disease and neuropathy. She suffered great pain and was given methadone, which did not control this pain and only caused her to be extremely nauseous, exacerbating her wasting syndrome. She never received physical therapy in the SNF for the neuropathy.

Five months earlier, Ms. Sosa fell out of bed in the SNF, injured her right shoulder, split open her head above her right eye, and knocked out her two front teeth due to a seizure. There were no bars on the bed to prevent falls from her frequent seizures. At the hospital, she was told that her Dilantin levels were dangerously high. As a result of this fall, her mobility was reduced and her ability to eat decreased further, again contributing to wasting syndrome.

In the SNF, her call button did not always work. When it did, staff routinely took a long time to respond. The showers in the SNF often had cold or tepid water only. The drinking water was often cloudy. Some of the nurses in the SNF refused to bathe her. RN _____ said in front of her, "I'm not touching this girl; she has sores."

Often the food served in the SNF was cold, nasty, and inedible. She found bugs and dirt in it. Sometimes she had difficulty getting her ENSURE/RESOURCE because the staff told her they had run out. She never saw a dietitian, although her weight went from 130 to 79 in a 10-year period. She experienced delays of 2-3 hours in getting her meds in the SNF even though these delays caused severe muscle spasms and seizures.

Often she was housed with prisoners suffering from other contagious diseases such as hepatitis and pneumonia, putting her at great risk. She was never under the care of an HIV specialist during her time at the prison.

Summary of file no. 4016: Trina Morris

Trina Morris had an abscess in her stomach that the staff incorrectly treated as a bladder infection. During this time, she couldn't walk or urinate without intense pain. Eventually she was given a sonogram, which also revealed blood clots and excess fluid in her uterus as well as abscesses, ulcers, and tumors in her stomach. She finally received intestinal by-pass surgery.

Ms. Morris also had visibly rotting teeth which made it difficult to eat. She was told not to file 602s or else she would be placed on the bottom on the list to see the dentist. An MTA told her that unless she had an abscess the size of a golf ball she should not expect to be seen.

Summary of file no. 4018: Sheila Ward

Sheila Ward has a pacemaker. The battery of this device has not been changed for over six years.

She also had a yeast infection which was left untreated for five to six months. She had a cough/flu that was untreated for three weeks. She was continually refused appointments and told to drink water.

Summary of file no. 4019: Imani Armstrong

Imani Armstrong has a heart condition and did not receive her meds for six weeks.

She is HIV positive and has severe neuropathy. She has fought constantly to get adequate pain meds. At one point while she was in the SNF a staff member gave her meds without consulting her file to see if they contraindicated her HIV meds.

Summary of file no. 4020: Valerie Johnson

Valerie Johnson is HIV positive and is suffering from severe neuropathy. She had to steal a wheelchair in order to get back from her unit after a doctor's appointment.

Presently, she is not taking any HIV meds because her first treatment made her violently ill. Her second caused headaches, diarrhea, and stomach cramps.

Summary of file no. 4027: Patricia Baca

Patricia Baca tested positive for Hepatitis C two years previously, but as of the interview date, she did not know her viral load.

She has had rectal bleeding for a year. She saw Dr. _____ who said that she had internal severe hemorrhoids and gave her Maalox. She went to another institution two months ago on a pre-court visit regarding parental rights. While there, they sent her to the infirmary because she was lethargic, pale, and weak and ended up giving her a blood transfusion. She was returned to the prison a month later and was still experiencing rectal bleeding. Nine days later she was sent to the hospital and was given a colonoscopy and diagnosed with diverticulitis. At the time she was told that needed a follow-up in a month, but she still has not gotten one. Since then, the bleeding has gotten heavier and more frequent, and she is experiencing worse diarrhea. On a recent visit to see Dr. _____ she asked for her HCV counts and was refused the information.

Summary of file no. 4041: Rochella Waters

In September, Rochella Waters was admitted to the SNF and given sputum tests for TB. Three weeks later, the results had not come back. In the meantime, she had been directed to take a large amount of high dose TB meds by the prison staff. These meds are extremely toxic for people with Hepatitis (4041 has Hepatitis B and C). She has been exhibiting signs of inefficient liver function, such as jaundice, inability to keep food or water down, and passing dark orange urine.

Appendix 2B

Jane Doe's Testimony

I, Jane Doe, declare under penalty of perjury that the foregoing is true and correct.

My assigned housing is ____. Minerva Gonzalez, W#61287, was assigned to _____. On Tuesday, August 26, 1997, Gonzalez complained that she could not stop vomiting. She was not even able to keep water in her stomach. She vomited even though her stomach was empty. Gonzalez continued displa ying the same symptoms through Thursday, growing weaker. She found it difficult to pull herself back onto her top bunk.

Friday, August 29, she went to sick call. She told me that she saw MTA Nichols and Dr. Do. She stated that Dr. Do said she didn't have the flu as she had no fever and he gave her a two day lay-in. RN Nichols wrote the lay-in for five days. She said medicine was ordered. Friday evening the cooling system on C-Hall broke again and was giving off heat. Our room was stifling hot over the

three day weekend. Several times the temperature was taken on third watch; it was in the low 80s. Sometimes the doors were left open to admit a small amount of air.

Gonzalez continued to grow weaker. By Monday morning she had been without food or water for six days, still experiencing dry heaves. She was so weak she spent a lot of time on the floor. The inside of her lips had a white ring around them. She had to sit on a chair to take a shower. Her skin was blotchy. Although her skin felt cool, she complained it burned.

Staff would not give her any meals. I brought her dry toast and punch but she could not keep it down.

After brunch on September 1, I went to pill line and spoke to MTA F. I described Gonzalez's symptoms and that she was too weak to make it to C-clinic. She said even if she could no one was in the facility to see her and she should come Tuesday. At approximately 0900, Prisoner P. B. told Gonzalez she had meds but the MTA wouldn't give them to anyone else. She stated that MTA F. claimed there wasn't an available wheelchair. With the help of B. and another prisoner, Gonzalez tried to go to C-Clinic. Approximately 45 minutes later they brought Gonzalez back, exhausted and shaking. She had only been able to get as far as C10, the next building. B. told MTA F., who agreed to bring the medicine to Gonzalez. At approximately 1300 hours, MTA brought Gonzalez one small white pill in a paper cup and a prescription bag with 20 small royal blue capsules to be taken twice a day as needed. MTA F. said the white pill would increase her appetite. MTA F. did not touch Gonzalez and seemed unconcerned even after I reminded her that this was who I was talking about. She said come tomorrow. A few minutes later, MTA F. returned and requested that I feel Gonzalez' skin. I said it felt cool but funny, almost clammy, but could come to pill line at dinner for another white pill. Later I realized her skin felt almost waxy.

M. R. asked C/O B. if we could get a Labor Day dinner tray for Gonzalez. After claiming she wouldn't be able to eat it and might end up with a box lunch, he agreed to call Sgt. E. Sgt. E. agreed. Gonzalez was only able to eat a couple of bites of watermelon but couldn't keep it down.

Tuesday, September 2, a wheelchair was borrowed for Gonzalez to go to sick call. She said she saw MTA C. who told her she was very dehydrated. She stated he told her to come back at 1300 hours. At 1200, MTA C. called to say they were too busy and come back the next day.

Gonzalez said our housing staff, C/O A., was very angry and told her that she better "fucking" get it taken care of today or "fucking" be back to work tomorrow. Gonzalez was a porter in CO9. At approximately 1900, Gonzalez begged P. C. to get B. She said she had to get out of here. C. came back saying C/O B. would come when he finished laundry sign-up. At 2000 hours Prisoner B. reminded C/O B. C/O B. came down to our room and lectured Gonzalez saying she had all day to take care of this. He said there was nothing he could do or call because she was awake, breathing, and should just lay there. Gonzalez said he didn't understand. She felt like she was going to die. C/O B. said he'd call the MTA but not to expect anything. About 2015 C/O T. M. came requesting Gonzalez's lay-in. C/O B. came back and said the MTA "really pissed me off." The MTA wouldn't come and C/O B. got mad and called C Program Office. They called Control who called the Firehouse and told them to get her out of here ASAP.

At approximately 2040, the fire rescue team came. The woman (black, slender, free staff) was short with B., wanting to know why she was told to pick her up ASAP. She didn't think Gonzalez looked sick enough. We all, her roommates and her, explained her symptoms and that no one from medical would help her. Gonzalez stated she felt like this when something was wrong with her lung and was in 805 for a month. We gave the fire woman Gonzalez's pills. Gonzalez slowly walked to the gurney and they took her out. She did not return to our room.

I read on Thursday, September 4, Daily Movement Sheet that Minerva Gonzalez W61287 died September 3, 1997, the day after they removed her from our room.

I declare under penalty of perjury that the foregoing is true and correct and this declaration was executed at Central California Women's Facility in _____.

[Jane Doe]

Appendix 3A1

Characteristics and Quality of the Data from the Legal Files

Here we present a description of the legal interview processes, the contexts in which the interviews were conducted, and the changes in interview questions. These approaches and changing sets of questions affect the results of the data analysis, primarily because slightly different questions were asked at CCWF and CIW on the one hand and at VSPW on the other.

Throughout the pre-filing, post-settlement, and monitoring periods of the *Shumate* lawsuit, two slightly different interview questionnaires were used. The earlier version of the questionnaire was used for trial preparation and was designed as a tool for exploratory investigation. During the early period of the interview process, the goal was to identify the women's perceptions of what the major medical care delivery problems were, to allow the women to define and interpret their own issues, to draft a class-action complaint that was reflective and representative of the womens' health problems, and to guide and inform the processes necessary to address these issues. Once the preparation for trial led to the settlement agreement and to the subsequent assessment phase, the nature of the investigated issues became narrowed, as the plaintiffs' legal representatives were required to focus the data collection to the particular categories specified and confined by the settlement agreement.

The second interview questionnaire developed out of experience with using the first version. Interview categories were added and/or deleted based upon the prisoners' identification of important issues related to the delivery of medical care within the prisons, the relevance of certain categories, and the development of new issues. In addition, the reorganized form was designed to assist the interviewers in gathering information related to the specific categories of the case and the post-settlement assessment period. This second version reflects the purposes of the assessment period and the resulting narrowed scope of issues. Thus, the second interview schedule was organized by the specific categories inherent in the provisions of the settlement.

Throughout the lawsuit, interviews at CCWF and CIW were administered once a month. However, during critical periods of the trial preparation and assessment phase, visits to both CIW and CCWF were made by plaintiffs' representatives at least every other week and often once a week. Throughout these periods, extensive written and telephone contact with women prisoners were also kept. During visits to CCWF, there were usually five interviewers who interviewed between 20 and 25 women (approximately four to five women per interviewer) with each interview lasting approximately one hour. The number of times each women at CIW and CCWF was interviewed varied. Some women were interviewed only one time, and others were interviewed a dozen times. However, a direct relationship exists between the number of times a woman was interviewed and her involvement in the case, as well as the seriousness of her medical issues. In other words, more interviews were carried out with the women who were going to be deposed or who were scheduled to be witnesses at trial and with those who had very serious medical problems or a combination of these factors.

The interviewing style was qualitative, open-ended, and guided by an inductive paradigm. In other words, the legal team sought to answer questions not only related to specific information (such as the chronology of illnesses and the dates and numbers related to the woman's case) or to the issues previously identified as critical, but to questions related to the exploration of the prisoner's social systems and her environment, the complex relationships between different aspects of her life, and her own definition and attachment of meaning to her experience.[xi] As one experienced interviewer states:

> Not everybody followed the form exactly. A number of us developed an interview style that would go something like this: you would introduce yourself to the woman, ask her what her reasons for coming to see us were, try to get her story in her own words—and that could often take quite a long time. Sometimes because people hadn't talked to anybody who was an advocate for a long time and they had urgent needs that they wanted to get out and sometimes the conversation would wander in many directions, and sometimes . . . you know, it's not easy to tell your story in a clinical, outlined approach . . . a lot of times, people would come with volumes of paper work, and we'd sort through it with them. The interviewing there . . . it's a challenge and an art, because you need to try to get a

> chronology from somebody but you don't want to cut them off. It's a delicate process. It's not just about squeezing information out of them.[xii]

In addition to entering the correctional system with a greater number of pressing health problems than do men, women come with extensive histories of sexual, physical, and psychological abuse. Studies indicate that women enter the system with higher rates of illness, more recent and serious injuries, severe gynecological complications, high rates of substance addiction, have had zero or substandard health care prior to incarceration, and are often uneducated about their bodies and related health issues.[xiii] A substantial body of literature also reveals prevalent rates of mental health illness among this population.[xiv] Many women are also confronted with child custody issues. The exploration of these histories and issues greatly contribute to a better understanding of the impact of the correctional system on imprisoned women as well as the ways in which these variables shape a woman's illness experience on the inside.

Thus, although the *Shumate* interviewers were bound by time constraints during prison visits, the philosophy guiding the investigation of prisoners' medical concerns encouraged the attitude that these women are whole people and must be viewed in relationship to other aspects of their lives in order to truly understand the effects of incarceration. While this methodology allowed for the development of trust between prisoner and interviewer, it also led to a wide range in the focus in the interview material.

Attorneys working with prisoners from VSPW used a third interview format. When *Shumate v. Wilson* was filed in April 1995, Valley State Prison for Women (VSPW) had not yet opened its doors. Although the plaintiff's attorneys attempted to include VSPW under the terms of the suit, the court did not permit this since the institution was not officially open.

In May 1995, Valley State began to hold women prisoners. Many women from the Central California Women's Facility (CCWF) were transferred to Valley State. Some of them had been working with staff from Legal Services for Prisoners with Children (LSPC) on the

Shumate lawsuit and continued to stay in contact with them. Some spread the word about the suit to other women in VSPW. Almost immediately after the prison was opened, LSPC began to receive letters from women at VSPW voicing medical concerns similar to those experienced by the women at CCWF.

Other letters sent to LSPC discussed the sexual harassment and abuse that were present at VSPW and the "horrific" conditions in the Security Housing Unit (SHU). The physical structure of the SHU itself resulted in a large degree of sexual harassment as the women could be seen by male guards at all times, whether in their cells changing clothes, taking showers, or using the toilet.

The SHU also seemed to create mental health issues. Attorneys felt that many mentally unstable women tended to get locked in the SHU, because they received disciplinary reports when they were unable to deal with prison restrictions. In addition, women in the SHU suffer severe isolation that in itself can lead to mental decomposition.

In response to a deluge of letters, a staff attorney at a community legal office began meeting with VSPW prisoners. At this point she was mainly involved in follow-up on the letters received and advocacy work on behalf of the women including writing letters of concern regarding the lack of medical care. Through this continued contact with women at VSPW, the attorney noticed that the medical conditions at VSPW were similar if not worse than those at CCWF. Soon, other attorneys began to interview women at VSPW.

Initially interviewers used the *Shumate* interview form. However, after the interviews when the staff met to discuss the issues involved, they realized they were encountering slightly different conditions. Consequently, they created a new interview schedule.

In fall 1998, pro bono staff at a large law firm joined the community-based attorneys to investigate the possibility of filing a suit against Valley State Prison for Women. By this time, the Prison Legal Reform Act (PLRA) had been passed and implemented. This legislation required prisoners to exhaust all institutional grievance procedures before their complaints could

be heard in court. Thus, the potential plaintiff list was limited to the women who had "602ed," appealed to the central office of the CDC, and still been denied. Many women were discouraged and frustrated with this process since staff made it so difficult to utilize. Filing a 602 requires that the accused be present except in cases of sexual harassment. Corrections officers reportedly tore up 602s instead of returning them. The CDC central office in Sacramento, the highest level of appeal, has no time limit on its response. As a result only women with long sentences complete the internal grievance process required prior to legal intervention. (Many VSPW files contain evidence of 602 filings).

Legal staff also revised interview questions as prisoner concerns changed. When women began to complain of guard brutality, the interview schedule was supplemented with questions about these assertions. Similarly it became clear through women's letters and interviews that the conditions in the Security Housing Unit (SHU) warranted investigation. Thus, the interview form was altered to questions about the SHU. Since the isolation of the SHU seemed to cause mental instability, questions about mental illness and psychotropic drug prescriptions were also added. After considering the racial make-up of the SHU population (which is primarily African American women) and complaints from women about racism, questions about racial discrimination were also included. Because the physical layout of the SHU does not offer women any privacy, questions about sexual abuse and harassment were instituted. In general, the attorneys took their cues from the women's concerns and redrafted the interview schedule to reflect those concerns.

These additions account for some of the differences between the VSPW files and the files from CCWF and CIW. They explain why there is a greater focus on sexual harassment, racism, and mental illness in the VSPW files.

Appendix 3A2

Health Access Study Log Sheet

A. Prisoner Name_____
B. Prisoner ID # _____
C. Personal Material yes _____ no_____
D. Prison (check only one)
1. CCWF _____ 2. VSP _____ 3. CIW_____
E. Special Housing Info (check one if applies)
1. SHU__ 2. SNF __3. OPHU __4. N/A_____
F. Primary Diagnosis/Complaint (select one)

_____

G. Record Diagnostic Categories
(check as many as apply)

1. Death _____
2. HIV _____
   a. AIDS
   b. Not AIDS _____
3. Cancer
   a. Reproductive
      1. Cervix_____2. Ovary _____
      3. Uterus_____4. Vaginal ____
      5. Vulva _____6. Breast_____
      7. Other _____
   b. Nonreproductive
      1. Skin_____2. Lung
      3. Colon_____4. Thyroid ____
      5. Liver_____6. Stomach____
      7. Mouth_____8. Esophagus___
      9. Blood _____
      10. Other _____
4. Liver Disease
   a. Hepatitis B_____
   b. Hepatitis C _____
   d. Cirrhosis _____
   e. Other _____
5. Seizures
   a. Epilepsy or Fits or Convulsions _____
   b. Grand Mal _____
   c. Petit Mal _____
   d. Other _____
6. Mental Illness
   a. Depression _____
   b. Manic-Depression (Bipolar) _____
   c. Schizophrenia _____
   d. Personality Disorder _____
   e. Anxiety Disorder
   (Agoraphobia/Panic Attacks) _____
   f. Suicide Attempts _____
   g. PTSD _____
   h. Self Injury/Mutilation _____
   i. Hallucinations_____
   j. Sleep disorders_____
   k. Psych meds _____
   1. Other_____

Coder's Initials _____
Coding Date _____

7. Drug Abuse
   a. Alcoholism _____
   b. IVDU _____
   c. Cocaine_____
   d. Other_____
8. Gynecological/Reproductive
   a. Breasts
      1. Lump(s) _____2. Cyst(s) _____
      3. Mastitis _____
      4. Other _____
   b. Uterus/Ovaries
      1. Menstrual Irregularities _____
      2. Ovarian Cyst _____
      3. Dysmenorrhea_____
      4. Infertility_____
      5. Prolapse Uterus_____
      6. Fibroids _____
      7. Cervicitis (Cervical Erosion)_____
      8. Menopause_____
      9. Pregnancy_____
      10. Other_____
9. STD/Vaginitis
   a. Vaginitis (Non-Specific) _____
   b. Gonorrhea_____
   c. Syphilis_____
   d. Herpes _____
   e. Chlamydia_____
   f. Warts, HPV_____
   g. Trichomonas _____
   h. Abnormal Pap Smear_____
   i. Requests Pap Smear_____
   j. Other_____
10. Urinary
   a. Cystitis _____
   b. Pyelonephritis_____
   c. Kidney Stones_____
   d. Kidney Failure_____
   e. Other_____
11. Orthopedic
   a. Low Back Pain_____
   b. Sciatica_____
   c. Disc Disease_____
   d. Neck Pain_____
   e. Carpal Tunnel Syndrome_____
   f. Joint Pain_____
   g. Other_____

12. Injury
    a. Cause
        1. Unintentional _____
        2. Intentional _____
        3. Unclear _____
        4. Not Indicated _____
    b. Type
        1. Fracture/Broken Bone _____
        2. Sprain/Strain _____
        3. Bruises _____
        4. Gunshot_____
        5. Stab _____
        6. Other_____
13. Rheumatic Disease and Arthritis
    a. Rheumatoid Arthritis_____
    b. Osteoarthritis_____
    c. Lupus, SLE_____
    d. Other_____
14. Cardiovascular Disease
    a. Heart Disease _____
    b. Heart Murmurs/Mitral Prolapse _____
    c. Endocarditis_____
    d. Arteriosclerotic Vascular Disease_____
    e. Heart Failure_____
    f. Angina Pectoris_____
    g. Other_____
15. Hypertension/High Blood Pressure
16. Respiratory Disease
    a. Asthma_____
    b. Emphysema, COPD _____
    c. Bronchitis_____
    d. Pneumonia_____
    e. Sinusitis_____
    f. Upper Respiratory Infection_____
    g. Allergy_____
    h. Other_____
17. Hormonal but not Reproductive
    a. Hyperthyroid_____
    b. Hypothyroid_____
    c. Other_____
18. Diabetes Mellitus
    a. NIDDM (not insulin dependent) _____
    b. IDDM (insulin dependent) _____
19. Headache/Neurological
    a. Headache _____
    b. Migraines _____
    c. Paralysis/Spinal injury _____
    d. Other_____
20. Gastrointestinal

a. Ulcers _____
b. Gallbladder Disease _____
c. Constipation _____
d. Diarrhea _____
e. Colitis _____
f. Appendicitis _____
g. Other_____

21. Skin
a. Acne _____
b. Eczema_____
c. Psoriasis_____
d. Cellulitis, Infection_____
e. Ringworm_____
f. Fungus_____
g. Warts_____
h. Other_____

22. Eye
a. Infection _____
b. Glaucoma _____
c. Cataract _____
d. Refraction _____
e. Other_____

23. Ear
a. Infection _____
b. Vertigo_____
c. Deafness _____
d. Ear Wax _____
e. Other_____

24. Throat
a. Tonsillitis, Pharyngitis _____
b. Dysphagia_____
c. Canker Sores, Aphthous Stomatitis _____

25. Dental
a. Caries/Cavities _____
b. Abscess _____
c. Missing Teeth _____
d. Pain _____
e. Gum Disease, Pyorrhea _____
f. Other_____

26. Sexual Harassment
a. Verbal _____
b. Viewed _____
c. Touched _____
d. Inappropriate Paps or Pelvics _____
e. Cell Extraction (male)_____
f. Pat Searches (male)_____
g. Other_____

27. Iatrogenic Problems
a. Error in Meds_____

b. Error in Diagnosis_____
c. Missed Meds_____
d. Other_____

28. Other Diagnosis/Complaint_____
_____
_____

29. No Diagnoses/Complaints _____

Additional Comments:_____
_____
_____
_____

Appendix 3B1

Frequencies and Percentages of Diagnostic Categories/Complaints:

All Institutions

Diagnosis	Percentage	Percentage
		0.7
Death	7	
HIV/AIDS	116	10.8
Cancer	2	.2
Cervical Cancer	24	2.2
Ovarian Cancer	3	0.3
Uterine Cancer	9	0.8
Cancer of Vulva	1	0.1
Breast Cancer	17	1.6
Other Rep. Cancer	4	0.4
Skin Cancer	4	0.4
Lung Cancer	3	0.3
Colon Cancer	6	0.6
Thyroid Cancer	1	0.1
Liver Cancer	1	0.1
Stomach Cancer	2	0.2
Other Nonrep. Cancer	17	1.6
Liver Disease Unspec.	3	0.3
Hepatitis B	22	2.1
Hepatitis C	62	5.8
Cirrhosis	11	1.0
Other Liver Disease	32	3.0
Seizures	52	4.9
Epilepsy	37	3.5
Grand Mal	10	0.9
Petit Mal	2	0.2
Other Seizures	8	0.7
Depression	66	6.2
Bipolar Disorder	24	2.2
Schizophrenia	4	0.4
Personality Disorder	6	0.6
Anxiety Disorder	16	1.5
Suicide Attempt(s)	24	2.2
PTSD	7	0.7
Sleep Disorders	8	0.7
Psychiatric Meds	88	8.2
Other Mental Illness	30	2.8
Drug Abuse Unspec.	1	0.1
Alcoholism	13	1.2
IDU	14	
		1.3
Cocaine	9	0.8
Other Drug Abuse	16	1.5
Breast Lump(s)	44	4.1
Breast Cyst(s)	10	0.9

Other Breast Ailments	31	2.9
Menstrual Irregularities	27	2.5
Ovarian Cyst	23	2.1
Dysmenorrhea	4	0.4
Fibroids	14	1.3
Menopause	11	1.0
Pregnancy	92	8.6
Other Uterus/Ovaries	87	8.1
Vaginitis	20	1.9
Gonorrhea	1	0.1
Syphilis	2	0.2
Herpes	9	0.8
Chlamydia	3	0.3
Warts/HPV	5	0.5
Trichomonas	4	0.4
Abnormal Pap	31	2.9
Requests Pap	8	0.7
Other STD	24	2.2
Cystitis	1	0.1
Kidney Stones	4	0.4
Kidney Failure	1	0.1
Other Urinary	38	3.5
Low Back Pain	37	3.5
Sciatica	5	0.5
Disc Disease	32	3.0
Neck Pain	6	0.6
Carpal Tunnel	10	0.9
Joint Pain	16	1.5
Other Orthopedic	97	9.0
Injury (cause):		
Unintentional Injury	141	13.2
Intentional Injury	32	3.0
Injury Cause Unclear	45	4.2
Injury Cause Not Ind.	8	0.7
Injury (type):		
Fracture/Broken Bone	65	6.1
Sprain/Strain	27	2.5
Bruises	14	1.3
Gunshot	13	1.2
Stab	2	0.2
Other Injury	140	13.1
Rheum. Dis./Arthritis	26	2.4
Rheumatoid Arthritis	22	2.1

Diagnosis/Complaint	Frequency	Percentage
Osteoarthritis	18	1.7
Lupus	9	0.8
Other Rheum. Disease	5	0.5
Heart Disease	11	1.0
Heart Murmurs	17	1.6
Endocarditis	2	0.2
Arteriosclerosis	2	0.2
Heart Failure	14	1.3
Angina Pectoris	2	0.2
Other Heart Disease	80	7.5
High Blood Pressure	112	10.4
Asthma	108	10.1
Emphysema/COPD	13	1.2
Bronchitis	22	2.1
Pneumonia	14	1.3
Sinusitis	5	0.5
Upper Resp. Infection	2	0.2
Allergy	35	3.3
Other Respiratory	61	5.7
Hyperthyroid	10	0.9
Hypothyroid	5	0.5
Other Hormonal	18	1.7
Diabetes Mellitus	24	2.2
NIDDM (not ins. dep.)	7	0.7
IDDM (insulin dep.)	29	2.7
Headache	55	5.1
Migraine	24	2.2
Paralysis/Spinal Injury	9	0.8
Other Neurological	60	5.6
Ulcers	49	4.6
Gallbladder Disease	11	1.0
Constipation	12	1.1
Diarrhea	10	0.9
Colitis	2	0.2
Appendicitis	5	0.5
Other Gastrointestinal	60	5.6
Acne	1	0.1
Eczema	5	0.5
Psoriasis	6	0.6
Ringworm	2	0.2
Fungus	1	0.1
Warts	1	0.1
Other Skin	44	4.1
Eye Infection	5	0.5
Glaucoma	8	0.7
Cataract	7	0.7
Other Eye	50	4.7
Ear Infection	11	1.0
Vertigo	1	0.1
Deafness	6	0.6
Other Ear	18	1.7
Tonsillitis	2	0.2
Dysphagia	1	0.1
Canker Sores	1	0.1
Unspecified Dental	24	2.2
Caries/Cavities	1	0.1
Abscess	5	0.5
Missing Teeth	29	2.7
Dental Pain	4	0.4
Other Dental	48	4.5
Verbal Sex. Harassment	40	3.7
Inappropriate Viewing	27	2.5
Inappropriate Touching	26	2.4
Inappropriate Pap	11	1.0
Male Cell Extraction	2	0.2
Male Pat Searches	19	1.8
Other Harassment	78	7.3
Error in Meds	53	4.9
Error in Diagnosis	34	3.2
Missed Meds	232	21.6
Other Iatrogenic	54	5.0
Iatrogenic Nontreatment	20	1.9
Miscellaneous Health	278	25.9
Miscellaneous Access	206	19.2

Top 10 Diagnoses/Complaints: All Institutions

Diagnosis/Complaint	Frequency	Percentage
Miscellaneous Health	278	25.9
Missed Meds	232	21.6
Miscellaneous Access	206	19.2
Unintentional Injury	141	13.2
HIV/AIDS	116	10.8
High Blood Pressure	112	10.4
Asthma	108	10.1
Pregnancy	92	8.6
Psychiatric Meds	88	8.2
Other Uterus/Ovaries	87	8.1

Ns

Total N = 1072
CIW N = 253
CCWF N = 481
VSPW N = 338

Appendix 3B2
Frequencies and Percentages of Diagnostic Categories/Complaints: CIW

Diagnosis/Complaint	Frequency	Percentage	Diagnosis/Complaint	Frequency	Percentage
Death	2	0.8	Abnormal Pap	6	2.4
Total HIV/AIDS	31	12.3	Requests Pap	5	2.0
Cancer Unspec.	1	0.4	Other STD	8	3.2
Cervical Cancer	7	2.8	Kidney Stones	1	0.4
Ovarian Cancer	1	0.4	Other Urinary	13	5.1
Uterine Cancer	3	1.2	Low Back Pain	8	3.2
Breast Cancer	7	2.8	Sciatica	2	0.8
Other Rep. Cancer	2	0.8	Disc Disease	9	3.6
Skin Cancer	1	0.4	Neck Pain	2	0.8
Lung Cancer	0	0.0	Carpal Tunnel	3	1.2
Colon Cancer	3	1.2	Joint Pain	7	2.8
Other Nonrep. Cancer	2	0.8	Other Orthopedic	27	10.7
Hepatitis B	8	3.2	Injury (cause):		
Hepatitis C	20	7.9	Unintentional Injury	39	15.4
Cirrhosis	1	0.4	Intentional Injury	5	2.0
Other Liver Disease	10	4.0	Injury Cause Unclear	17	6.7
Seizures	14	5.5	Injury (type):		
Epilepsy	4	1.6	Fracture/Broken Bone	14	5.5
Grand Mal	1	0.4	Sprain/Strain	7	2.8
Other Seizures	2	0.8	Bruises	2	0.8
Depression	22	8.7	Gunshot	2	0.8
Bipolar Disorder	6	2.4	Stab	1	0.4
Schizophrenia	1	0.4	Other Injury	44	17.4
Personality Disorder	1	0.4	Rheum. Dis./Arthritis	11	4.3
Anxiety Disorder	3	1.2	Rheumatoid Arthritis	6	2.4
Suicide Attempt(s)	4	1.6	Osteoarthritis	4	1.6
PTSD	1	0.4	Lupus	1	0.4
Sleep Disorders	3	1.2	Heart Disease	4	1.6
Psychiatric Meds	23	9.1	Heart Murmurs	3	1.2
Other Mental Illness	7	2.8	Arteriosclerosis	1	0.4
Alcoholism	2	0.8	Heart Failure	2	0.8
IDU	1	0.4	Angina Pectoris	1	0.4
Other Drug Abuse	2	0.8	Other Heart Disease	18	7.1
Breast Lump(s)	14	5.5	High Blood Pressure	35	13.8
Breast Cyst(s)	5	2.0	Asthma	30	11.9
Other Breast Ailments	13	5.1	Emphysema/COPD	3	1.2
Menstrual Irregularities	6	2.4	Bronchitis	11	4.3
Ovarian Cyst	9	3.6	Sinusitis	1	0.4
Dysmenorrhea	1	0.4	Upper Resp. Infection	1	0.4
Fibroids	6	2.4	Allergy	13	5.1
Menopause	3	1.2	Other Respiratory	20	7.9
Pregnancy	16	6.3	Hyperthyroid	3	1.2
Other Uterus/Ovaries	16	6.3	Hypothyroid	3	1.2
Vaginitis	2	0.8	Other Hormonal	6	2.4
Gonorrhea	1	0.4	Diabetes Mellitus	9	3.6
Herpes	2	0.8	NIDDM (not ins. dep.)	3	1.2

Diagnosis/Complaint	Frequency	Percentage
IDDM (insulin dep.)	6	2.4
Headache	23	9.1
Migraine	11	4.3
Paralysis/Spinal Injury	1	0.4
Other Neurological	17	6.7
Ulcers	16	6.3
Gallbladder Disease	1	0.4
Constipation	7	2.8
Diarrhea	6	2.4
Appendicitis	3	1.2
Other Gastrointestinal	23	9.1
Eczema	1	0.4
Fungus	1	0.4
Warts	1	0.4
Other Skin	9	3.6
Eye Infection	3	1.2
Glaucoma	1	0.4
Cataract	4	1.6
Other Eye	18	7.1
Ear Infection	3	1.2
Vertigo	1	0.4
Deafness	1	0.4
Other Ear	8	3.2
Tonsillitis	0	0.0
Dysphagia	1	0.4
Canker Sores	1	0.4
Unspecified Dental	13	5.1
Abscess	2	0.8
Missing Teeth	5	2.0
Other Dental	13	5.1
Verbal Sex. Harassment	1	0.4
Inappropriate Touching	6	2.4
Inappropriate Pap	1	0.4
Other Harassment	9	3.6
Error in Meds	13	5.1
Error in Diagnosis	11	4.3
Missed Meds	82	32.4
Other Iatrogenic	20	7.9
Iatrogenic Nontreatment	11	4.3
Miscellaneous Health	80	31.6
Miscellaneous Access	68	26.9

Top 10 Diagnoses/Complaints:CIW

Diagnosis/Complaint	Frequency	Percentage
Missed Meds	82	32.4
Miscellaneous Health	80	31.6
Miscellaneous Access	68	26.9
Unintentional Injury	39	15.4
HIV/AIDS	31	12.3
High Blood Pressure	35	13.8
Asthma	30	11.9
Other Orthopedic	27	10.7
Psychiatric Meds	23	9.1
Headache	23	9.1

Ns

Total N (CIW) = 253

Appendix 3B3

Frequencies and Percentages of Diagnostic Categories/Complaints: CCWF

Diagnosis/Complaint	Frequency	Percentage
Death	5	1.0
HIV/AIDS	78	16.2
Cancer	1	0.2
Cervical Cancer	11	2.3
Ovarian Cancer	1	0.2
Uterine Cancer	5	1.0
Breast Cancer	5	1.0
Skin Cancer	3	0.6
Lung Cancer	3	0.6
Colon Cancer	2	0.4
Thyroid Cancer	1	0.2
Liver Cancer	1	0.2
Stomach Cancer	1	0.2
Other Nonrep. Cancer	10	2.1
Liver Disease Unspec.	3	0.6
Hepatitis B	10	2.1
Hepatitis C	31	6.4
Cirrhosis	6	1.2
Other Liver Disease	11	2.3
Seizures	27	5.6
Epilepsy	20	4.2
Grand Mal	8	1.7
Petit Mal	1	0.2
Other Seizures	3	0.6
Depression	25	5.2
Bipolar Disorder	10	2.1
Personality Disorder	2	0.4
Anxiety Disorder	7	1.5
Suicide Attempt(s)	9	1.9
PTSD	3	0.6
Psychiatric Meds	30	6.2
Other Mental Illness	9	1.9
Drug Abuse Unspec.	1	0.2
Alcoholism	8	1.7
IDU	9	1.9
Cocaine	6	1.2
Other Drug Abuse	7	1.5
Breast Lump(s)	20	4.2
Breast Cyst(s)	2	0.4
Other Breast Ailments	10	2.1
Menstrual Irregularities	11	2.3
Ovarian Cyst	8	1.7
Dysmenorrhea	3	0.6
Fibroids	3	0.6
Menopause	6	1.2
Pregnancy	23	4.8
Other Uterus/Ovaries	36	7.5
Vaginitis	10	2.1
Syphilis	1	0.2
Herpes	6	1.2
Warts/HPV	5	1.0
Trichomonas	4	0.8
Abnormal Pap	17	3.5
Requests Pap	3	0.6
Other STD	8	1.7
Kidney Stones	1	0.2
Kidney Failure	1	0.2
Other Urinary	17	3.5
Low Back Pain	21	4.4
Sciatica	1	0.2
Disc Disease	16	3.3
Neck Pain	4	0.8
Carpal Tunnel	4	0.8
Joint Pain	6	1.2
Other Orthopedic	42	8.7
Injury (cause):		
Unintentional Injury	52	10.8
Intentional Injury	9	1.9
Injury Cause Unclear	17	3.5
Injury Cause Not Ind.	4	0.8
Injury (type):		
Fracture/Broken Bone	31	6.4
Sprain/Strain	14	2.9
Bruises	4	0.8
Gunshot	3	0.6
Other Injury	41	8.5
Rheum. Dis./Arthritis	5	1.0
Rheumatoid Arthritis	7	1.5
Osteoarthritis	9	1.9
Lupus	7	1.5
Other Rheum. Disease	3	0.6
Heart Disease	5	1.0
Heart Murmurs	7	1.5
Endocarditis	1	0.2
Arteriosclerosis	1	0.2
Heart Failure	8	1.7
Angina Pectoris	1	0.2
Other Heart Disease	43	8.9
High Blood Pressure	52	10.8
Asthma	49	10.2
Emphysema/COPD	5	1.0
Bronchitis	6	1.2
Pneumonia	12	2.5

Diagnosis/Complaint	Frequency	Percentage
Sinusitis	3	0.6
Upper Resp. Infection	1	0.2
Allergy	12	2.5
Other Respiratory	26	5.4
Hyperthyroid	4	0.8
Other Hormonal	10	2.1
Diabetes Mellitus	13	2.7
NIDDM (not ins. dep.)	2	0.4
IDDM (insulin dep.)	16	3.3
Headache	23	4.8
Migraine	6	1.2
Paralysis/Spinal Injury	8	1.7
Other Neurological	31	6.4
Ulcers	24	5.0
Gallbladder Disease	7	1.5
Constipation	4	0.8
Diarrhea	4	0.8
Appendicitis	1	0.2
Other Gastrointestinal	23	4.8
Acne	1	0.2
Eczema	2	0.4
Psoriasis	3	0.6
Other Skin	22	4.6
Eye Infection	2	0.4
Glaucoma	2	0.4
Cataract	1	0.2
Other Eye	21	4.4
Ear Infection	4	0.8
Deafness	3	0.6
Other Ear	4	0.8
Tonsillitis	1	0.2
Unspecified Dental	8	1.7
Abscess	2	0.4
Missing Teeth	18	3.7
Dental Pain	2	0.4
Other Dental	25	5.2
Verbal Sex. Harassment	10	2.1
Inappropriate Viewing	7	1.5
Inappropriate Touching	7	1.5
Inappropriate Pap	3	0.6
Male Pat Searches	2	0.4
Other Harassment	17	3.5
Error in Meds	26	5.4
Error in Diagnosis	11	2.3
Missed Meds	92	19.1
Other Iatrogenic	22	4.6
Iatrogenic Nontreatment	5	1.0
Miscellaneous Health	118	24.5
Miscellaneous Access	71	14.8

Top 10 Diagnoses/Complaints: CCWF

Diagnosis/Complaint	Frequency	Percentage
Miscellaneous Health	118	24.5
Missed Meds	92	19.1
HIV/AIDS	78	16.2
Miscellaneous Access	71	14.8
Unintentional Injury	52	10.8
High Blood Pressure	52	10.8
Asthma	49	10.2
Other Heart Disease	43	8.9
Other Orthopedic	42	8.7
Other Uterus/Ovaries	36	7.5

Ns

Total N (CCWF) = 481

Appendix 3B4
Frequencies and Percentages of Diagnostic Categories/Complaints: VSPW

Diagnosis/Complaint	Frequency	Percentage
HIV/AIDS	7	2.1
Cervical Cancer	6	1.8
Ovarian Cancer	1	0.3
Uterine Cancer	1	0.3
Cancer of Vulva	1	0.3
Breast Cancer	5	1.5
Other Rep. Cancer	2	0.6
Colon Cancer	1	0.3
Stomach Cancer	1	0.3
Other Nonrep. Cancer	5	1.5
Hepatitis B	4	1.2
Hepatitis C	11	3.3
Cirrhosis	4	1.2
Other Liver Disease	11	3.3
Seizures	11	3.3
Epilepsy	13	3.8
Grand Mal	1	0.3
Petit Mal	1	0.3
Other Seizures	3	0.9
Depression	19	5.6
Bipolar Disorder	8	2.4
Schizophrenia	3	0.9
Personality Disorder	3	0.9
Anxiety Disorder	6	1.8
Suicide Attempt(s)	11	3.3
PTSD	3	0.9
Sleep Disorder	4	1.2
Psychiatric Meds	35	10.4
Other Mental Illness	14	4.1
Alcoholism	3	0.9
IDU	4	1.2
Cocaine	3	0.9
Other Drug Abuse	7	2.1
Breast Lump(s)	10	3.0
Breast Cyst(s)	3	0.9
Other Breast Ailments	8	2.4
Menstrual Irregularities	10	3.0
Ovarian Cyst	6	1.8
Fibroids	5	1.5
Menopause	2	0.6
Pregnancy	53	15.7
Other Uterus/Ovaries	35	10.4
Vaginitis	8	2.4
Syphilis	1	0.3
Herpes	1	0.3
Chlamydia	3	0.9
Abnormal Pap	8	2.4
Other STD	8	2.4
Cystitis	1	0.3
Kidney Stones	2	0.6
Other Urinary	8	2.4
Low Back Pain	8	2.4
Sciatica	2	0.6
Disc Disease	7	2.1
Carpal Tunnel	3	0.9
Joint Pain	3	0.9
Other Orthopedic	28	8.3
Injury (cause):		
Unintentional Injury	50	14.8
Intentional Injury	18	5.3
Injury Cause Unclear	11	3.3
Injury Cause Not Ind.	4	1.2
Injury (type):		
Fracture/Broken Bone	20	5.9
Sprain/Strain	6	1.8
Bruises	8	2.4
Gunshot	8	2.4
Stab	1	0.3
Other Injury	55	16.3
Rheum. Dis./Arthritis	10	3.0
Rheumatoid Arthritis	9	2.7
Osteoarthritis	5	1.5
Lupus	1	0.3
Other Rheum. Disease	2	0.6
Heart Disease	2	0.6
Heart Murmurs	7	2.1
Endocarditis	1	0.3
Heart Failure	4	1.2
Other Heart Disease	19	5.6
High Blood Pressure	25	7.4
Asthma	29	8.6
Emphysema/COPD	5	1.5
Bronchitis	5	1.5
Pneumonia	2	0.6
Sinusitis	1	0.3
Allergy	10	3.0
Other Respiratory	15	4.4
Hyperthyroid	3	0.9
Hypothyroid	2	0.6
Other Hormonal	2	0.6
Diabetes Mellitus	2	0.6
NIDDM (not ins. dep.)	2	0.6
IDDM (insulin dep.)	7	2.1
Headache	9	2.7

Diagnosis/Complaint	Frequency	Percentage
Migraine	7	2.1
Other Neurological	12	3.6
Ulcers	9	2.7
Gallbladder Disease	3	0.9
Constipation	1	0.3
Colitis	2	0.6
Appendicitis	1	0.3
Other Gastrointestinal	14	4.1
Eczema	2	0.6
Psoriasis	3	0.9
Ringworm	2	0.6
Other Skin	13	3.8
Glaucoma	5	1.5
Cataract	2	0.6
Other Eye	11	3.3
Ear Infection	4	1.2
Deafness	2	0.6
Other Ear	6	1.8
Tonsillitis	1	0.3
Unspecified Dental	3	0.9
Caries/Cavities	1	0.3
Abscess	1	0.3
Missing Teeth	6	1.8
Dental Pain	2	0.6
Other Dental	10	3.0
Verbal Sex. Harassment	29	8.6
Inappropriate Viewing	20	5.9
Inappropriate Touching	13	3.8
Inappropriate Pap	7	2.1
Male Cell Extraction	2	0.6
Male Pat Searches	17	5.0
Other Harassment	52	15.4
Error in Meds	14	4.1
Error in Diagnosis	12	3.6
Missed Meds	58	17.2
Other Iatrogenic	12	3.6
Iatrogenic Nontreatment	4	1.2
Miscellaneous Health	80	23.7
Miscellaneous Access	67	19.8

Top 10 Diagnoses/Complaints: VSPW

Diagnosis/Complaint	Frequency	Percentage
Miscellaneous Health	80	23.7
Miscellaneous Access	67	19.8
Missed Meds	58	17.2
Pregnancy	53	15.7
Unintentional Injury	50	14.8
Other Harassment	43	12.8
Other Uterus/Ovaries	35	10.4
Psychiatric Meds	35	10.4
Verbal Sex. Harassment	29	8.6
Asthma	29	8.6

Ns

Total N (VSPW): 338

Appendix 3C1

Frequencies and Percentages of Primary Diagnostic Categories/Complaints: All Institutions

Diagnosis/Complaint	Frequency	Percentage
Death	7	0.7
HIV/AIDS	108	10.1
Cancer	1	0.1
Cervical Cancer	8	0.7
Ovarian Cancer	1	0.1
Uterine Cancer	3	0.3
Cancer of Vulva	1	0.1
Breast Cancer	7	0.7
Other Rep. Cancer	1	0.1
Skin Cancer	1	0.1
Lung Cancer	2	0.2
Colon Cancer	2	0.2
Thyroid Cancer	1	0.1
Stomach Cancer	1	0.1
Other Nonrep. Cancer	7	0.7
Liver Disease Unspec.	1	0.1
Hepatitis C	15	1.4
Cirrhosis	5	0.5
Other Liver Disease	5	0.5
Seizures	19	1.8
Epilepsy	14	1.3
Grand Mal	5	0.5
Petit Mal	1	0.1
Other Seizures	2	0.2
Depression	5	0.5
Bipolar Disorder	6	0.6
Schizophrenia	1	0.1
Personality Disorder	1	0.1
Anxiety Disorder	1	0.1
Suicide Attempts	4	0.4
PTSD	2	0.2
Psychiatric Meds	4	0.4
Other Mental Illness	9	0.8
Breast Lump(s)	15	1.4
Breast Cyst(s)	3	0.3
Other Breast Ailments	10	0.9
Menstrual Irregularities	6	0.6
Ovarian Cyst	6	0.6
Fibroids	6	0.6
Menopause	1	0.1
Pregnancy	42	3.9
Other Uterus/Ovaries	35	3.3
Vaginitis	2	0.2

Diagnosis/Complaint	Frequency	Percentage
Abnormal Pap	7	0.7
Requests Pap	1	0.1
Other STD	6	0.6
Kidney Stones	1	0.1
Kidney Failure	1	0.1
Other Urinary	12	1.1
Low Back Pain	5	0.5
Sciatica	1	0.1
Disc Disease	17	1.6
Carpal Tunnel	3	0.3
Joint Pain	5	0.5
Other Orthopedic	33	3.1
Injuries:		
Unintentional Fracture	19	1.8
Unintentional Sprain	6	0.6
Unintentional Bruises	2	0.2
Unintentional Inj. (oth.)	59	5.5
Intentional Fracture	1	0.1
Intentional Sprain	2	0.2
Intentional Gunshot	1	0.1
Intentional Stabbing	1	0.1
Intentional Inj. (oth.)	9	0.8
Fracture (cause unclear)	8	0.7
Other Inj. (cause unclear)	12	1.1
Fracture (cause N/I)	2	0.2
Gunshot (cause N/I)	1	0.1
Other Inj. (cause N/I)	2	0.2
Rheum. Dis./Arthritis	6	0.6
Rheumatoid Arthritis	6	0.6
Osteoarthritis	3	0.3
Lupus	7	0.7
Other Rheum. Disease	2	0.2
Heart Disease	4	0.4
Heart Murmurs	2	0.2
Heart Failure	5	0.5
Other Heart Disease	21	2.0
High Blood Pressure	17	1.6
Asthma	14	1.3
Emphysema/COPD	2	0.2
Bronchitis	2	0.2
Sinusitis	2	0.2
Upper Resp. Infection	1	0.1
Allergy	3	0.3

Diagnosis/Complaint	Frequency	Percentage
Other Respiratory	8	0.7
Hyperthyroid	5	0.5
Other Hormonal	6	0.6
Diabetes Mellitus	2	0.2
NIDDM (not ins. dep.)	1	0.1
IDDM (insulin dep.)	18	1.7
Headache	1	0.1
Migraine	3	0.3
Paralysis/Spinal Injury	3	0.3
Other Neurological	18	1.7
Ulcers	12	1.1
Gallbladder Disease	5	0.5
Constipation	4	0.4
Appendicitis	3	0.3
Other Gastrointestinal	15	1.4
Eczema	2	0.2
Psoriasis	3	0.3
Other Skin	15	1.4
Eye Infection	3	0.3
Glaucoma	4	0.4
Cataract	2	0.2
Other Eye	7	0.7
Ear Infection	2	0.2
Deafness	2	0.2
Other Ear	6	0.6
Unspecified Dental	1	0.1
Abscess	1	0.1
Missing Teeth	4	0.4
Other Dental	4	0.4
Verbal Sex. Harassment	7	0.7
Inappropriate Viewing	3	0.3
Inappropriate Touching	1	0.1
Inappropriate Pap	2	0.2
Male Pat Searches	4	0.4
Other Harassment	29	2.7
Error in Meds	9	0.8
Error in Diagnosis	6	0.6
Missed Meds	29	2.7
Other Iatrogenic	12	1.1
Iatrogenic Nontreatment	4	0.4
Miscellaneous Health	101	9.4
Miscellaneous Access	14	1.3

Top 10 Primary Diagnoses/Complaints: All Institutions

Diagnosis/Complaint	Frequency	Percentage
HIV/AIDS	116	10.1
Miscellaneous Health	101	9.4
Unintentional Inj. (oth.)	59	5.5
Pregnancy	42	3.9
Other Uterus/Ovaries	35	3.3
Other Orthopedic	33	3.1
Other Harassment	29	2.7
Missed Meds	29	2.7
Other Heart Disease	21	2.0
Seizures	19	1.8

Ns

Total N = 1072
CIW N = 253
CCWF N = 481
VSPW N = 338

Appendix 3C2
Frequencies and Percentages of Primary Diagnostic Categories/Complaints: CIW

Diagnosis/Complaint	Frequency	Percentage
Death	2	0.8
HIV/AIDS	27	10.7
Cancer Unspecified	1	0.4
Cervical Cancer	1	0.4
Breast Cancer	3	1.2
Colon Cancer	1	0.4
Other Nonrep. Cancer	1	0.4
Hepatitis C	5	2.0
Cirrhosis	1	0.4
Other Liver Disease	2	0.8
Seizures	3	1.2
Epilepsy	2	0.8
Depression	1	0.4
Bipolar Disorder	1	0.4
Psychiatric Meds	2	0.8
Other Mental Illness	2	0.8
Breast Lump(s)	7	2.8
Breast Cyst(s)	1	0.4
Other Breast Ailments	5	2.0
Menstrual Irregularities	1	0.4
Ovarian Cyst	2	0.8
Fibroids	4	1.6
Pregnancy	5	2.0
Other Uterus/Ovaries	5	2.0
Other STD	1	0.4
Other Urinary	6	2.4
Low Back Pain	1	0.4
Disc Disease	6	2.4
Carpal Tunnel	1	0.4
Other Orthopedic	6	2.4
Injuries:		
Unintentional Fracture	4	1.6
Unintentional Sprain	2	0.8
Unintentional Bruises	1	0.4
Unintentional Inj. (oth.)	18	7.1
Fracture (cause unclear)	1	0.4
Other Inj. (cause unclear)	5	2.0
Rheum. Dis./Arthritis	2	0.8
Rheumatoid Arthritis	1	0.4
Heart Disease	2	0.8
Heart Failure	1	0.4
Other Heart Disease	4	1.6
High Blood Pressure	7	2.8
Bronchitis	1	0.4
Sinusitis	1	0.4
Allergy	2	0.8
Other Respiratory	1	0.4
Hyperthyroid	2	0.8
Other Hormonal	1	0.4
IDDM (insulin dep.)	3	1.2
Migraine	1	0.4
Other Neurological	4	1.6
Ulcers	6	2.4
Constipation	4	1.6
Appendicitis	2	0.8
Other Gastrointestinal	5	2.0
Other Skin	5	2.0
Eye Infection	2	0.8
Glaucoma	1	0.4
Other Eye	1	0.4
Other Ear	3	1.2
Inappropriate Pap	1	0.4
Other Harassment	5	2.0
Error in Meds	1	0.4
Error in Diagnosis	2	0.8
Missed Meds	10	4.0
Other Iatrogenic	3	1.2
Iatrogenic Nontreatment	1	0.4
Miscellaneous Health	22	8.7
Miscellaneous Access	9	3.6

Top 10 Primary Diagnoses/Complaints: CIW

Diagnosis/Complaint	Frequency	Percentage
HIV/AIDS	27	10.7
Miscellaneous Health	22	8.7
Unintentional Inj. (oth.)	18	7.1
Missed Meds	10	4.0
Miscellaneous Access	9	3.6
Breast Lump(s)	7	2.8
High Blood Pressure	7	2.8
Other Urinary	6	2.4
Disc Disease	6	2.4
Other Orthopedic	6	2.4

Ns

Total N = 253

Appendix 3C3
Frequencies and Percentages of Primary Diagnostic Categories/Complaints: CCWP

Diagnosis/Complaint	Frequency	Percentage
Death	5	1.0
HIV/AIDS	74	15.4
Cervical Cancer	5	1.0
Ovarian Cancer	1	0.2
Uterine Cancer	2	0.4
Breast Cancer	1	0.2
Skin Cancer	1	0.2
Lung Cancer	2	0.4
Thyroid Cancer	1	0.2
Other Nonrep. Cancer	4	0.8
Liver Disease Unspec.	1	0.2
Hepatitis C	7	1.5
Cirrhosis	2	0.4
Other Liver Disease	1	0.2
Seizures	13	2.7
Epilepsy	6	1.2
Grand Mal	5	1.0
Depression	2	0.4
Bipolar Disorder	1	0.2
Anxiety Disorder	1	0.2
Suicide Attempt(s)	2	0.4
PTSD	1	0.2
Psychiatric Meds	1	0.2
Other Mental Illness	3	0.6
Breast Lump(s)	6	1.2
Other Breast Ailments	2	0.4
Menstrual Irregularities	4	0.8
Fibroids	1	0.2
Menopause	1	0.2
Pregnancy	11	2.3
Other Uterus/Ovaries	17	3.5
Vaginitis	2	0.4
Abnormal Pap	5	1.0
Requests Pap	1	0.2
Other STD	3	0.6
Kidney Failure	1	0.2
Other Urinary	4	0.8
Low Back Pain	3	0.6
Disc Disease	7	1.5
Carpal Tunnel	1	0.2
Joint Pain	4	0.8
Other Orthopedic	15	3.1
Injuries:		
Unintentional Fracture	9	1.9
Unintentional Sprain	1	0.2
Unintentional Bruises	1	0.2
Unintentional Inj. (oth.)	15	3.1

Diagnosis/Complaint	Frequency	Percentage
Intentional Fracture	1	0.2
Intentional Sprain	1	0.2
Intentional Inj. (oth.)	3	0.6
Fracture (cause unclear)	6	1.2
Other Inj. (cause unclear)	4	0.8
Fracture (cause N/I)	2	0.4
Gunshot (cause N/I)	1	0.2
Rheum. Dis./Arthritis	3	0.6
Rheumatoid Arthritis	4	0.8
Osteoarthritis	2	0.4
Lupus	6	1.2
Heart Disease	2	0.4
Heart Murmurs	1	0.2
Heart Failure	4	0.8
Other Heart Disease	11	2.3
High Blood Pressure	7	1.5
Asthma	10	2.1
Emphysema/COPD	1	0.2
Bronchitis	1	0.2
Sinusitis	1	0.2
Upper Resp. Infection	1	0.2
Allergy	1	0.2
Other Respiratory	4	0.8
Hyperthyroid	2	0.4
Other Hormonal	4	0.8
Diabetes Mellitus	2	0.4
IDDM (insulin dep.)	13	2.7
Headache	1	0.2
Migraine	1	0.2
Paralysis/Spinal Injury	3	0.6
Other Neurological	9	1.9
Ulcers	5	1.0
Other Gastrointestinal	7	1.5
Eczema	1	0.2
Psoriasis	1	0.2
Other Skin	7	1.5
Eye Infection	1	0.2
Glaucoma	1	0.2
Other Eye	4	0.8
Ear Infection	1	0.2
Unspecifed Dental	1	0.2
Missing Teeth	4	0.8
Other Dental	3	0.6
InappropriateTouching	1	0.2
Inappropriate Pap	1	0.2
Other Harassment	4	0.8

Diagnosis/Complaint	Frequency	Percentage
Error in Meds	3	0.6
Error in Diagnosis	3	0.6
Missed Meds	5	1.0
Other Iatrogenic	4	0.8
Iatrogenic Nontreatment	2	0.4
Miscellaneous Health	48	10.0
Miscellaneous Access	3	0.6

Top 10 Primary Diagnoses/Complaints:CCWF

Diagnosis/Complaint	Frequency	Percentage
HIV/AIDS	74	15.4
Miscellaneous Health	48	10.0
Other Uterus/Ovaries	17	3.5
Other Orthopedic	15	3.1
Unintentional Inj. (oth.)	15	3.1
Seizures	13	2.7
IDDM (ins. dep. diab.)	13	2.7
Pregnancy	11	2.3
Other Heart Disease	11	2.3
Asthma	10	2.1

Ns

Total N = 481

Appendix 3C4
Frequencies and Percentages of Primary Diagnostic Categories/Complaints: VSPW

Diagnosis/Compl aint	Frequency	Percentage
HIV/AIDS	7	2.1
Cervical Cancer	2	0.6
Uterine Cancer	1	0.3
Cancer of Vulva	1	0.3
Breast Cancer	3	0.9
Other Rep. Cancer	1	0.3
Colon Cancer	1	0.3
Stomach Cancer	1	0.3
Other Nonrep. Cancer	2	0.6
Hepatitis C	3	0.9
Cirrhosis	2	0.6
Other Liver Disease	2	0.6
Seizures	3	0.9
Epilepsy	6	1.8
Petit Mal	1	0.3
Other Seizures	2	0.6
Depression	2	0.6
Bipolar Disorder	4	1.2
Schizophrenia	1	0.3
Personality Disorder	1	0.3
Suicide Attempt(s)	2	0.6
PTSD	1	0.3
Psychiatric Meds	1	0.3
Other Mental Illness	4	1.2
Breast Lump(s)	2	0.6
Breast Cyst(s)	2	0.6
Other Breast Ailments	3	0.9
Menstrual Irregularities	1	0.3
Ovarian Cyst	4	1.2
Fibroids	1	0.3
Pregnancy	26	7.7
Other Uterus/Ovaries	13	3.8
Abnormal Pap	2	0.6
Other STD	2	0.6
Kidney Stones	1	0.3
Other Urinary	2	0.6
Low Back Pain	1	0.3
Sciatica	1	0.3
Disc Disease	4	1.2
Carpal Tunnel	1	0.3
Joint Pain	1	0.3
Other Orthopedic	12	3.6
Injuries:		
Unintentional Fracture	6	1.8
Unintentional Sprain	3	0.9
Unintentional Inj. (oth.)	26	7.7

Diagnosis/Complaint	Frequency	Percentage
Intentional Sprain	1	0.3
Intentional Gunshot	1	0.3
Intentional Stabbing	1	0.3
Intentional Inj. (oth.)	6	1.8
Fracture (cause unclear)	1	0.3
Other Inj. (cause unclear)	3	0.9
Other Inj. (cause N/I)	2	0.6
Rheum. Dis./Arthritis	1	0.3
Rheumatoid Arthritis	1	0.3
Osteoarthritis	1	0.3
Lupus	1	0.3
Other Rheum. Disease	2	0.6
Heart Murmurs	1	0.3
Other Heart Disease	6	1.8
High Blood Pressure	3	0.9
Asthma	4	1.2
Emphysema/COPD	1	0.3
Other Respiratory	3	0.9
Hyperthyroid	1	0.3
Other Hormonal	1	0.3
NIDDM (not ins. dep.)	1	0.3
IDDM (insulin dep.)	2	0.6
Migraine	1	0.3
Other Neurological	5	1.5
Ulcers	1	0.3
Gallbladder Disease	2	0.6
Appendicitis	1	0.3
Other Gastrointestinal	3	0.9
Eczema	1	0.3
Psoriasis	2	0.6
Other Skin	3	0.9
Glaucoma	2	0.6
Cataract	2	0.6
Other Eye	2	0.6
Ear Infection	1	0.3
Deafness	2	0.6
Other Ear	3	0.9
Abscess	1	0.3
Other Dental	1	0.3
Verbal Sex. Harassment	7	2.1
Inappropriate Viewing	3	0.9
Male Pat Searches	4	1.2
Other Harassment	20	5.9
Error in Meds	5	1.5
Error in Diagnosis	1	0.3
Missed Meds	14	4.1
Other Iatrogenic	5	1.5

Diagnosis/Complaint	Frequency	Percentage
Iatrogenic Nontreatment	1	0.3
Miscellaneous Health	31	9.2
Miscellaneous Access	2	0.6

Top 10 Primary Diagnoses/Complaints: VSPW

Diagnosis/Complaint	Frequency	Percentage
Miscellaneous Health	31	9.2
Pregnancy	26	7.7
Unintentional Inj. (oth.)	26	7.7
Other Harassment	20	5.9

Missed Meds	14	4.1
Other Uterus/Ovaries	13	3.8
Other Orthopedic	12	3.6
HIV/AIDS	7	2.1
Verbal Sex. Harassment	7	2.1
Epilepsy	6	1.8

Ns

Total N: 338

Appendix 3D

Miscellaneous Treatment Complaints and Access Problems

Abuse / Brutality

Beaten by fellow prisoner
Guard brutality
"Forced to squat and cough after stitches put in during surgery"
"Horrible treatment"
Run over by supervisor farm truck
Shot by guard three times for fight w/ other prisoner
Witnessed prisoner death

Administrative Refusals

Unable to get lower bunk chrono or light work duty
Told she must have C-section, wants to have child naturally

Communication problems

No Spanish-speaking doctors available

HIV Confidentiality Breach

In pill line – x18

Medication issues

Meds not being monitored
Adverse reaction to meds
Dilantin levels not checked often
Difficulty getting meds
Taken off meds prescribed on the street
Meds taken away-accused of selling diabetic meds
Not receiving meds
Inadequate pain relief: (not receiving meds for back injury)
Nose bleeds caused by sinus meds
Overmedication
Stomach convulsions from wrong meds
Switched AIDS meds despite patient's wishes
Taken off psych meds while in SHU-severe deterioration

Mistreatment, medical

Colostomy bag removed
Given wrong size prison boots -cause of untreated pain and swelling
Given wrong size crutches
Mistreatment of eczema
Prescribed vaginal infection meds w/o pelvic exam
Prescribed herpes meds even though tested negative
Prescribed Dilantin for seizures while pregnant
Prescribed glaucoma meds while pregnant

Needs / Requests

Medical:
Requests explanation of medical file
Needs new arch support
Needs bone marrow transplant
Needs catheterization-uses colostomy bag
Needs surgery on back
- On shoulder
- On neck
- For bladder problem

Requests treatment:
Mammogram
Visit with neurologist
Follow up treatment after hysterectomy
Disabled classification
Requests M-I-C-program
Wants to be unassigned medically
Missing teeth-can't eat

Requests, non-medical:
Wants to see records
Wants custody of daughter
"Has light mustache that needs to be waxed"

Non-treatment complaints

Of Liver problems
Cervical cancer left untreated
Denied testing:
- EKG
- X-rays (to check for TB)
- Biopsy
- Ultrasound
- Tests to monitor hepatitis C
- Pap

Not given test results: (took 4 years), (for X-rays)
Denied attention at sick call
Not seen by a physician, only given Motrin
Delayed blood-work
Delayed surgery: (lay bleeding for 1.5 hrs before being transported to hospital for stitches)
Delayed X-rays
Denied surgery: (for thumb –gave splint instead), (for knee even though recommended by 2 other doctors)
Denied surgical removal of kidney tumor
Denied regular check ups for grave's disease while in CCP
Denied treatment after assaulted by guard
Denied treatment for multiple illnesses b/c release pending
Denied follow-up treatment
- For HBP
- For lumbar discogenic disease

For asthma
For abnormal pap
After C-section incision
After stroke/semi-coma
After hysterectomy
On diagnosed cervix problems
After surgery-removed dressing herself
For diabetes, menopause
For bleeding in the brain

Unable to see Specialist: (for HIV), (for glaucoma), (for hip), (for knee)
No follow up treatment after test results
No follow up treatment for swollen face after cavity filling
No follow up after hysterectomy for cervical cancer
Needs follow up treatment for broken ankle
Delayed treatment: (pap and subsequent treatment), (of head injury)
Denied treatment of eczema
For crushed elbow
For ringing and blood in ears
Missed appointments due to neglect
Had baby alone in cell
Helped deliver other prisoner's baby
Unsanitary delivery
Untreated rash after TB test
Untreated ear infection
Broken bone ignored
Not received partial in 2 years of waiting
Inefficient preventative care
Conflicting diagnoses
Staff doesn't believe seriousness of illness
Burn Untreated
Denied preferred meds
Feels mental illness not being addressed
Second hand smoke (non smoker housed in smoking cell)
Disability access problems

Not receiving special diet

Can't get iron supplements for anemia
Requests vitamins
For thyroid condition
For diabetes (and heart problems)
For religious restrictions

Racial discrimination

Retaliation

For compliance in lawsuit
Put in infirmary in response to a 602 against the doctors
Personal property confiscated for wrongful accusation of gang membership
SHU for "improper relations" with C/O

Work Related Complaints

Work conditions dangerous
Forced to work despite disability
Forced to work despite broken coccyx
Unable to get 1/2 time off work to recover from appendectomy

Appendix 3E

Operationalization of Key Terms

Diagnoses/Complaints

Most of the categories on the log sheet refer to health diagnoses in the strictest sense. A few, however, refer to health care access issues and institutional problems (thus the log sheet refers to its categories as "diagnoses/complaints"). For example, six specific types of sexual harassment are listed on the log sheet, as well as an "other harassment" option, designed to capture types of sexual harassment not listed on the log sheet as well as all varieties of non-sexual harassment of prisoners by prison officials. Similarly, the "miscellaneous access" option and "treatment errors" options (operationalized below) are designed to capture various types of impediments to accessing basic health care services.

Treatment Errors

Excluding the option for "missed medications," options in the major category "iatrogenic" are meant to refer *only* to cases in which medical errors in treatment—e.g., medical nontreatment or errors in medication or diagnosis—were clearly documented in the file to have caused further health problems. It became evident early in the coding that missed medications was a highly preponderant complaint of prisoners in the sample. To avoid backtracking—revision of the research instrument to create a new "missed medications/noniatrogenic" variable, and recoding of the first files—we opted to use the iatrogenic/missed medications category for all cases of missed medications, whether or not these had documented adverse health effects. The iatrogenic/nontreatment variable was added only after the coding had taken place and it was noted that many of the iatrogenic/other complaints referred to cases in which medical nontreatment had significant and documented deleterious effects on prisoners' health. These cases were recoded and entered into the database as cases of iatrogenic/nontreatment.

Other

A basic methodological rule of survey and other social science instrument design is that categories be exhaustive. To adhere to this rule and ensure that the log sheet could accommodate all possible diagnoses or complaints, "other" options were provided at the end of lists of subcategories throughout the log sheet. A final "other diagnosis/complaint" option was placed at the end of the log sheet. When files contained a complaint not listed on the sheet, or when information in the file was incomplete or referred to symptoms rather that a diagnosis, an "other" option was used, and a brief description of the problem or complaint was given in the space provided.

Primary Complaints

After reviewing each file and recording all applicable medical diagnoses and complaints on a log sheet, coders selected a "primary diagnosis/complaint." This is the single problem that emerged from the file as the prisoner's most serious or troublesome

condition or complaint. While each log sheet may indicate multiple diagnoses and complaints, only one primary complaint was recorded on each sheet.

Injuries

The injury options on the log sheet allow for recording both the cause and type of a given injury. While both of these were entered into the database together when an injury was listed as the primary complaint, this was not so when an injury was not listed as the primary complaint. Rather, the cause and type of a given injury were entered into two separate cells in the database. Therefore, in the results section we discuss specific injuries in terms of both their cause and type only when these were primary complaints. Otherwise, we identify and analyze injuries by cause.

The Both Option

Not only should survey instrument categories be exhaustive, according to the rules of social science methodology; they should also be mutually exclusive. Early in the coding phase of the present research it became evident that the "both" option in the major category "liver disease" violated this basic rule. Coders were instructed to ignore the category and simply check both the hepatitis B and C options, when these presented themselves in a given file. With the removal of this option, and the provision of "other" options, the log sheet categories were both mutually exclusive and exhaustive.

No Diagnoses/Complaints

The "no diagnoses/complaints" option was used when a file was lacking information on the prisoner to whom it referred. For example, many files contained only a release of information or interview request form, or both, but no letters, medical records, or interviews.

Coding

Coders were carefully instructed on these idiosyncrasies of the log sheet. They were also provided standardized training sessions on the medical terms contained therein, lasting roughly an hour. Numerous trial file reviews were made to test the usefulness of the instrument and assist coders in gaining familiarity with coding procedures. The principal investigator was often on site to answer coders' questions as they arose. When the principal investigator was not on site, coders were instructed to set aside files about which they had questions or uncertainty of any sort. These were subsequently reviewed by the principle investigator, and in some instances the research assistant; coders' questions were answered and the files in question coded properly. Additionally, a medical terminology reference book and medical dictionary were provided on site, to assist coders in deciphering medical records, medical chart reviews, and other materials in the files.

Coders were instructed to review the file material closely, checking all applicable categories on the log sheet, and providing qualifying information and additional comments briefly where these might be useful. They were instructed to select a primary diagnostic category—that which emerged from the file as the women's most salient problem. In questionable cases, e.g., when a prisoner had multiple diagnoses, many or all of which were serious in nature, coders were instructed to seek to determine what the

prisoner seemed most concerned about in her letters and interview material. If this was at all hard to assess, coders were instructed to set files aside for the principal investigator or research assistant for review and determination of a primary diagnostic category/complaint.
Six coders reviewed and coded 1269 files. A preponderance of the files were reviewed and coded by two legal interns at LSPC, a smaller number by the project's research assistant, an undergraduate student volunteer, the principal investigator, and the litigation coordinator of the *Shumate* case.

Data Entry
A database was created by the research assistant and programmed into SPSS, a statistical software program. After discussions with the project's statistical consultant, data entry commenced. An undergraduate research assistant entered most of the data gleaned from the files and provided on the log sheets, with help from the project research assistant. The undergraduate assistant underwent an hour long training session with the research assistant, who also provided her with a clearly written data entry instruction sheet. Additionally, the research assistant was almost always on site to answer questions as they arose in entering the data.

Data Quality Assurance Procedures
Steps were taken to assure the quality of the data presented here. During the coding process, the research assistant carefully re-reviewed every twentieth file coded, checking it against its corresponding log sheet. The few errors identified by this procedure had to do with coders missing diagnostic categories buried deeply in files. Occasional oversights were brought to the attention of coders in an effort to engender even more meticulous file review practices. Such oversight, infrequent as it was, diminished over the course of the coding phase. Additionally, the log sheets were reviewed once for standardization before commencing with data entry.
Similarly, the research assistant regularly checked the accuracy of data entry performed by the undergraduate assistant. When the data entry phase was complete, many days were devoted to painstaking review of the data set, including the identification and correction of occasional inconsistencies and errors in data entry.

Final Changes to the Data Set
Unusable Cases
One hundred ninety seven of the 1269 log sheets were unusable and were expunged from the data set.[1] Their exclusion leaves 1072 cases for the present analysis.

Added Variables
As previously mentioned, the "miscellaneous health," "miscellaneous access," and "iatrogenic/nontreatment" variables were added subsequent to the coding phase of the research.[1] The final variable added to the data set identifies the number of complaints each prisoner's log sheet contained. The database allowed for counting each option on the log sheet only once for each case, so that if a prisoner had multiple "miscellaneous

access" complaints or multiple injuries of the same type, for example, these could only be counted once. The project research assistant, with help from an undergraduate assistant, poured through the log sheets one final time to count the number of complaints on each. This allows for precise analysis of the numbers of health complaints extant in the sample.

Collapsing the HIV/AIDS variables

While the log sheet lists several options for various stages of HIV/AIDS disease, these specifications are omitted from the present analysis; the three original HIV and AIDS variables have been collapsed into one variable: "HI

Appendix 4

Institution Population Tables

Institution Population — December 31, 1996

Institution	Total Population	Hispanic	Black	White	Other
CCWF	3,147	815	1,118	1,011	248
CIW	1,736	392	614	636	94
VSP	2,960	698	1,039	1,000	223

Institution Population — December 31, 1997

Institution	Total Population	Hispanic	Black	White	Other
CCWF	3,344	879	1,142	1,156	167
CIW	1,846	410	602	726	108
VSP	3,302	805	1,110	1,158	229

Institution Population — December 31, 1998

Institution	Total Population	Hispanic	Black	White	Other
CCWF	3,619	975	1,265	1,202	177
CIW	1,777	386	626	678	87
VSP	3,742	838	1,234	1,448	222

Institution Population — December 31, 1999

Institution	Total Population	Hispanic	Black	White	Other
CCWF	3,402	916	1,242	1,070	174
CIW	1,882	415	647	736	84
VSP	3,544	799	1,149	1,431	165

Institution Population by Age Group — June 30, 1999

Institution	Total	Mean Age	Under 18	18-19	20-29	30-39	40-49	50-59	60-69	Over 69
CCWF	3,577	36.0	0	32	777	1,650	905	182	23	8
CIW	1,927	36.8	0	6	347	939	485	124	23	3
VSP	3,669	35.3	1	17	875	1,753	857	142	22	2

Central California Women's Facility — CCWF

Population by Ethnicity and Percent

	Total	Total Percent	Hispanic	Black	White	Other
1998	3,656	100.0	27.1	34.9	32.9	5.2
1999	3,577	100.0	26.6	37.2	31.9	4.3

California Institution for Women —CIW

Population by Ethnicity and Percent

	Total	Total Percent	Hispanic	Black	White	Other
1998	1,825	100.0	22.4	35.9	37.0	4.6
1999	1,927	100.0	21.3	34.2	39.3	5.2

Valley State Prison for Women — VSP
Population by Ethnicity and Percent

	Total	Total Percent	Hispanic	Black	White	Other
1998	3,318	100.0	22.8	32.5	36.4	8.2
1999	3,669	100.0	22.7	33.2	39.1	4.9

Appendix 5

CMA Board Composition

State of Florida Correctional Medical Authority

(1) There is created in the Department of Corrections the State of Florida Correctional Medical Authority. The governing board of the authority shall be composed of nine persons

appointed by the Governor subject to confirmation by the Senate. One member must be a member of the Florida Hospital Association; one member must be a member of the Florida League of Hospitals; one member must be a member of the Association of Voluntary Hospitals; and one member must be a member of the Florida Medical Association.

The Department of Corrections shall provide administrative support and service to the authority. The authority shall not be subject to control, supervision, or direction by the department. The authority shall annually elect one member to serve as chairman. Members shall be appointed for terms of 4 years each. Each member is authorized to continue to serve upon the expiration of his term until his successor is duly appointed as provided in this section. Before entering upon his duties, each member of the authority shall take and subscribe to the oath or affirmation required by the State Constitution.

(2) A member of the authority may not be a current employee of the department. Not more than one member of the authority may be a former employee of the department and such member, if appointed, may not be appointed to a term of office which begins within 5 years after the date of his last employment by the department.

(3) At least two members of the authority must be physicians licensed under chapter 458, and at least two other members of the authority must have had at least 5 years' experience in health care administration.

(4) At least one member of the authority must have had at least 5 years' experience in the identification and treatment of mental disorders.

(5) At least one member of the authority must be a dentist licensed under chapter 466 and have at least 5 years' experience in the practice of dentistry.

(6) At least one member of the authority must be a nurse licensed under chapter 464 and have at least 5 years' experience in the practice of nursing.

(7)(a) Five members of the authority shall constitute a quorum, and the affirmative vote of a majority of the members present at a meeting of the authority shall be necessary for any action taken by the authority. No vacancy in the membership of the authority shall impair the right of a quorum to exercise all the rights and perform all the duties of the authority. Any action taken by the authority under this act may be authorized by resolution at any regular or special meeting, and each such resolution shall take effect immediately and need not be published or posted. All meetings of the authority shall be open to the public in accordance with s.286.011.(b) Neither the provisions of this section nor those of chapter 119, or of s. 154.207(7), shall apply to any health care provider under contract with the department except to the extent such provisions would apply to any similar entity not under contract with the department.(c) Notwithstanding any general or special law, rule, regulation, or ordinance of any local agency to the contrary, service as a member of an authority by a trustee, director, officer, or employee of a health facility shall not in and of itself constitute a conflict of interest. However, any member of the authority who is employed by, or has received income from, a health facility under consideration by the authority or the department shall not vote on any matter related to such facility.

(8) Members of the authority shall receive no compensation for the performance of their duties under this act, but each member shall be paid expenses incurred while engaged in the performance of such duties pursuant to s. 112.061.

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Notes

[i] See L Acoca and J Austin, *The Hidden Crisis: Women in Prison*, National Council on Crime and Delinquency, San Francisco, 1996.

[ii] C.W. Harlow, *Profile of Jail Prisoners 1996,* Bureau of Justice Statistics, U.S. Dept. of Justice, Washington, DC. 37% of female inmates and 11% of male inmates said they had been physically abused; 37% of female inmates and 6% of male inmates reported that they had been sexually abused; 27% of female inmates and 3% of male inmates reported that they had been raped; see also B. Owen and B. Bloom, *Profiling the Needs of California's Female Prisoners - A Needs Assessment*, National Institute of Corrections, U.S. Department of Justice, Washington, DC, 1995.

[iii] In March, 1999 there were 11,240 women in California prisons or 7.1% of the total inmate population. California Department of Corrections.

[iv] Tracy L. Snell, "Women in Prison," BJS Special Report, U.S Department of Justice, Washington, DC, 1994.

[v] "Reports from the New England Regional Symposium: HIV Infection Among Incarcerated Women," Special Issue of *Journal of the National Commission on Correctional Health Care* 5:2 (Fall 1998): 121-254.

[vi] Bob Egelko, "Health Care in Prisons Is Called Bad," *Daily Journal* (5 April 1995): 3; Marc Lifsher, "Suit Targets Women's Prison Health Care," *Orange County Register* (5 April 1995).

[vii] Legal Services for Prisoners with Children, "Moving Forward on All Fronts: Litigation," Winter 1998-1999 Newsletter, 1.

[viii] Experts on the evaluation team were B. Jaye Anno, Ph.D., Joseph P. Fowlkes, M.D., Steven S. Spencer, M.D., and Kim Thorburn, M.D.

[ix] Included in "Memorandum in support of motion for partial restoration to the trial docket, reopening of discovery and other relief," *Charisse Shumate et al. V. Pete Wilson,* No. CIV-S-95-619 WBS JFM, August 2000.

[x] California State Auditor, "California Department of Corrections: Poor Management Practices

[xi] Jerome C. Wakefield, "When an Irresistible Epistemology Meets an Immovable Ontology," *Social Work Research* 19.1 (1995): 11.

[xii] Donna Willmott, personal communication, December 16, 1999.

[xiii] Elaine Lord, "A Prison Superintendent's Perspective on Women in Prison," *Prison Journal* 5.2 (1993): 258; Beth E. Richie and Christine Johnsen, "Abuse Histories among Newly Incarcerated Women in a New York City Jail," *Journal of the American Medical Women's Association* 51.3 (1996): 111-114.

[xiv] Kathleen B. Jordan, William E. Schlenger, John A. Fairbank, and Juesta M. Caddell, "Prevalence of Psychiatric Disorders among Incarcerated Women: Convicted Felons Entering Prison," *Archives of General Psychiatry* 53 (1996): 513-519; E. C. Pomeroy, R. Kiam, and E. Abel, "Meeting the Mental Health Needs of Incarcerated Women," *Health & Social Work* 23.1 (1998): 71-75; Linda A. Teplin, Karen M. Abram, and Gary M. McClelland, "Prevalence of Psychiatric Disorders among Incarcerated Women: Pretrial Jail Detainees," *Archives of General Psychiatry* 53 (1996): 505-512.