The prison system in New York State has become an incubator for tuberculosis, and as such has become a hazard to the public health in New York, and ultimately to the whole United States.

An important aspect of this problem is the lack of health care within the prison system. The Department of Corrections (DOC) maintains a policy of providing most health care to inmates through civilian hospitals in communities adjacent to the prisons on the grounds that prisoners are indigent, and, therefore, hospitals and physicians are obligated to care for them. Personnel and patients in these hospitals are thereby exposed to the prisoners and their infections.

If the Department of Corrections is allowed to continue its current practices, the ultimate potential is for an epidemic of tuberculosis resistant to current drug therapies.

Already, in New York City and Syracuse, health care workers have converted to positive skin tests, and some have clinical tuberculosis. In Syracuse, over 60 staff members at the State University of New York Health Sciences Center have converted. Patients at the hospital have developed clinical tuberculosis. Prison guards have also converted, and one, already immunosuppressed because of Hodgkin's disease, has died.

Prisons are incubators of drug resistant tuberculosis because inmates include a significant number susceptible as a result of immunosuppression by human immunodeficiency virus. Many inmates are drawn from and return to the derelict populations of major cities. Tuberculosis has continued to exist in these populations, in spite of its disappearance elsewhere, and has even begun to increase. Because of the difficulty of ensuring that derelicts comply with therapeutic regimens, drug resistance develops as a result of uncompleted therapy. Prisoners live under conditions of overcrowding, related to the three-fold increase in the number of inmates in the past ten years.

According to the *Syracuse Herald-Journal* (Oct. 15, 1992), about 15,000 prisoners in New York State have positive tuberculin skin tests, as do six percent of the staff. In 1991, 111 cases of active tuberculosis were reported, with 62 by mid-July in 1992. It is believed that reporting of cases identified by the Department of Corrections is incomplete. Furthermore, the Department of Corrections has not been successful in identifying all inmates with tuberculosis.

Tuberculosis is transmitted through the air by patients with active disease, especially through coughing. Disease is sometimes not discovered until the late stages. There is an anecdotal story of an emaciated prisoner carrying a can to cough into for six months before being recognized as having tuberculosis.

The problem is exacerbated by the Department of Correction's practice of transferring prisoners from location to location within the system, increasing the number of inmates and personnel exposed to each infected prisoner.

The response of the Department of Corrections to the problem of tuberculosis in its institutions has been tepid. Theoretically, a program has been in place since 1988 to skin test all inmates and personnel on entry to the system and annually thereafter. Sputum smears are to be done on those with positive skin tests; X-rays are not done. It appears, according to those who have questioned
both guards and prisoners, that the skin testing has been more on paper than in fact.

It is customary for staff from the Department of Corrections to deny the tuberculosis problem despite the events at New York and Syracuse hospitals. Physicians at the DOC claim to have seen only a few cases. Prison guards are told there is not a problem. Prisoners are casual about their behavior, and it is not unusual to see prisoners with masks displaced, uncorrected by their guards.

The problem is made worse because prisoners are sent to area hospitals for even minor care. Physically, good clinic and infirmary facilities are available at the prisons, but they are poorly staffed and equipped. In fact, prisoners are frequently sent to area hospitals without prior evaluation by physicians and without medical records, in violation of the DOC’s own rules. The DOC is terrified at the prospects for suits of breach of confidentiality and does not release information on the prisoners’ HIV status. Yet, a prisoner with HIV and a fever has about a 50 percent chance of having tuberculosis. (HIV status may be important information even in caring for unrelated illness. Such knowledge might, for example, influence a decision on treating a fracture by open or closed reduction.)

Prisons fail to provide the most elementary care for inmates, not only because facilities and personnel are lacking. Prison physicians appear reluctant to attend the inmates. Prison officials regard prisoners as litigious patients. Evidently, they would rather expose community physicians to risk of a suit than expose the DOC.

Excessive use of outside health care facilities not only increases the exposure of community health care personnel and other civilians to prisoners with tuberculosis but it also floods the community health care systems with patients that overload available facilities. Many family practitioners have closed practices because they can take no more patients. Orthopedic surgeons are in particularly short supply because of the malpractice climate in New York, and even those whose practices are overburdened are obliged to take care of prisoners when they appear. Adding several thousand prisoners to a community becomes an insupportable burden to its health care system.

The prisons also send severely ill patients to facilities that are not equipped to handle them. Patients with late stage AIDS are sent to hospitals without regular infectious disease consultants. In one recent case, a patient with creatinine in the 20’s was sent to a hospital without dialysis. It is an example of prison care that the prisoner had reached this condition without anyone knowing he had renal disease. There are no laboratory facilities at the prison’s dispensary.

Prisoners are sent to hospitals without adequate security and are left in the care of a single guard. It is not permitted to shackle prisoners to the bed. Visitors are not searched when entering the prisoner’s room. Conceivably, a patient with tuberculosis could escape. Escaped prisoners, one should note, are lost to therapeutic follow up!

What can be done about the situation? Some solutions to the problem can be achieved only through changes in the practices and policies of the Department of Corrections. Some may be achieved through cooperation between prisons and other elements of the health care community. Others may have to be achieved through confrontation.

Within the DOC, improved medical care facilities are the most important need. Without question, in the long term the DOC must be able to provide care for its inmates within its own walls.
On a short term basis, much improvement is needed in communication by the prison medical services to community physicians and hospitals. The prisoners must be accompanied by proper medical records. Their HIV status must be stated. Prisoners must be effectively evaluated by prison physicians before being sent to community emergency rooms. There should be immediate improvement of the health care facilities within the prisons. Means must be found to identify tuberculosis on admission to the system and to minimize relocation of prisoners with the disease.

The standard hygienic principles used with tuberculosis in the days before antibiotic therapy should be instituted for all patients with known or suspected tuberculosis. Indeed, the Occupational Health and Safety Administration could be asked to ensure that the guards have a hygienically safe working environment.

The DOC must provide legal mechanisms to hold physicians harmless in the event of suits by prisoners, either for malpractice or for violation of civil rights—the latter a common basis of suits by prisoners.

It has been suggested that the New York State Department of Health either take over the care of patients within the prisons or supervise the care. Prison physicians should be subject to the same types of oversight by professional review mechanisms as are physicians in the civilian community. If inadequate care is demonstrated, appropriate disciplinary procedures should be invoked.

The community hospitals can support and cooperate with the DOC. For example, some hospitals could contract voluntarily with the prisons to have prison wards. The prisons could contract with community physicians to provide care at the prisons. Hospitals and the prisons could cooperate in recruiting new physicians to an area. This suggestion is timely, given recent interpretations from the Inspector General’s office that limit the types of guarantees that hospitals have traditionally provided to new physicians in the past.

Should cooperative methods fail, more confrontational methods may be necessary. Law suits of various types might be considered. These include suits for damages. A nurse at Faxton Hospital in Utica who developed HIV infection after being stuck with a needle from the arm of a prisoner has obtained a multimillion dollar judgment. Only a few such suits might discourage the DOC from using community hospitals.

At a meeting held by area medical societies to discuss the problems of care for prisoners in Central New York, one physician commented that it is as though the prison system were designed to facilitate the spread of drug resistant tuberculosis in the State of New York. What affects New York can potentially affect also the rest of the country. It is essential that the Governor, the Department of Health, and the Department of Corrections take the actions necessary to prevent transmission of this disease. It is essential also that medical systems in other states review the practices for tuberculosis control within their prisons, and outside them.

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Addendum

The New York Times on December 6, 1992 featured an article on tuberculosis in rural New York State. It noted marked increases in tuberculosis cases in Cayuga, Essex, Franklin, and West Chester Counties between 1987 and 1991. Although it was not mentioned in the New York Times article, it is noteworthy that each of these counties has at least one major prison.