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Editorial

EDITORIAL
Emergency departments and the penitentiary population

The Spanish act 16/2003 on *Cohesión y Calidad del Sistema Nacional de Salud* [1] (SNS), "Act on Cohesion and Quality for the National Health System", was approved on May 28th. The law reflects on its sixth additional provision, dealing on the transfer to the Autonomous Communities of health care and institutions dependant of the prison services, that "the health care dependent of the penitentiary will be transferred to the Autonomous Communities for its full integration with its corresponding health facilities at the Autonomous Communities."

For that purpose and by means of the corresponding *Real Decreto,* Spanish Royal Decree, the penitentiary health care will be integrated to the Health National System, in accordance with the transfer system established by the different statutes of autonomy." This transfer agreement establishes that the Autonomous Community will exercise within its own territorial scope and for those prisons established within its borders. The duties of healthcare will still be performed by the state administration through the *Dirección General de Instituciones Penitenciarias,* that is, the General Directorate of Penitentiary Institutions.

The Cohesion and Quality act for the SNS, guarantees equal access to the healthcare services in different Autonomous Communities for the Spanish population among other things, given the fulfillment of transfers on zoning and administration of public health care to the Administration of the corresponding Autonomous Communities. At that moment, the need to create a different legal system for the assistance at penitentiaries appears. This triggered the creation of the *Sanidad Penitenciaria* (SP), Prison Health. It stipulates that the SP should be transferred to the different Autonomous Communities and integrated in the corresponding health care services. As an intermediate step, specialized and emergency care is provided in a reference hospital by charter.

Currently, the SP continues to be the great unknown to society and, what is even worse, to the rest of the public health. Culturally speaking, a rejection has been built towards the imprisoned population, that has extended to all levels, including the facultative one, and that does not correspond to the kind of pathology that these individuals show. Generally speaking, practitioners tend to moralize on the integral and integrated care in the health system, and on the rights of every patient, but only on a daily practice and towards some members of the society to whom we maintain some sort of rejection [2]. There is a belief that they are manipulative individuals with medical pathologies that may be only related to drugs or unsafe sexual practices.

The imprisoned population has certain characteristics that distinguish them from the rest of the population. From a demographical point of view, these features are related to the high frequency relocation of the inmates throughout different facilities (for the most diverse reasons: classification, judicial, familiar situation, etc.). This rotation, this relocation, throughout the different penitentiaries entails that their clinical monitoring will suffer frequent interruptions and, occasionally, important modifications concerning their treatment.

Furthermore, it presents some characteristics that set them apart from the rest of the population, in terms of incidence and prevalence:

- The kind of patient that goes to the hospital emergency is a young man between 31 and 45 years old.
- During imprisonment the patient frequently pursues medical consultation.
- The imprisoned population presents a high prevalence for drug abuse and during imprisonment is included in methadone maintenance programs.
- The patients present a high incidence of HIV positivity, which leads to a high consumption of antiretroviral drugs.
- The patients have a high risk of acquiring tuberculosis, which needs monitoring and direct observation during the treatment.
- In general, it is a very health controlled population given its closeness to the sources and to the healthcare staff.

The prison population represents no more than 1.5% [3] of the whole Spanish population which

could initially mean that they should not need any special attention. Nevertheless, the epidemiological characteristics and their specific health problems make them of particular relevance. The fact is that, during the imprisonment, they are the population that is provided with more health care, their health problems are thoroughly controlled (including the psychiatric ones). From these patients we obtain precise statistics of the individuals infected by the HIV and Hepatitis C, and they obtain every vaccine they need as well as all the medication required.

If we observe in detail the health activity of an inmate, we may see strong differences with the rest of the population. They have specific health staff [4] 24-hours a day: doctors, nursing staff as well as nursing auxiliaries, and partially, odontologists, a pharmacy, etc. If they need a specialized health evaluation, they are transferred to the HUCA, *Hospital Universitario Central de Asturias,* like the rest of the population. This could be for a consultation, for any special test or to the emergency department. When the transfer needs of an ambulance, the patient goes with the healthcare staff of that penitentiary, unless an intense care unit transport is required.

The prison of Villabona is in Asturias and has a prison population in which 80% of inmates are male and with 10% of foreigner population. Its reference hospital is the HUCA.

The number of inmates of the penitentiary corresponds to the population that a family doctor attends in a healthcare facility. If we do not consider the specific situation of the imprisoned population intrinsic characteristics and the specific sources needed by the prison population that differ from the sources of a traditional healthcare facility, we could make a huge planning mistake given the amount of inmates that attend a healthcare facility.

In 2010, and leaving aside the patients for pediatric reasons, 111.868 patients were attended in our SUH from whom only 148 came from the Villabona penitentiary. This represents the 0.13% of the whole scope of patients attended which, at the same time, has been a very stable percentage for the last 5 years.

From the population, the 87% of the patients was male in opposition to the 13% of the patients that were female (6 patients). Also, in relation to different ranges of age: from 31 to 45 (53.7%, 79 patients); from 16 to 30 and from 46 to 60 (20.94%, 31 patients each) and from 61 to 75 (4.72%). Only 5% is a repeated patient of the emergency department.

If we take into consideration the admissions hour frame in the emergency department, we observe that more than a half of the patients went on the afternoon shift, from 15h to 22h (54.79%, 81 patients); if we consider the frame of 8h to 15h we obtain 28.37% of the population (42 patients) and from 22h to 8h we obtain 16.89% of the population (25 patients). These patients have a more severe pathology and are more seriously ill than the rest of the patients since 29% of the patients (43 patients) needed hospital admission in opposition to a 15% of the country's population. We observe that most of the cases that need admission are for internal medicine (44.2%, 19 patients), followed by psychiatry (9.3%, 4 patients).

The percentage between men and women (88% and 12%) is maintained in the patients that are discharged (105 patients) and in 37.5% of the cases, there was a trauma cause or a minor surgery cause (suture, burn), followed by intoxication causes (6.25%) and psychiatric causes (2.5%). The rest 53.75% were for varied surgical-medical causes.

To conclude, we have a frequency of emergencies in the inmate population of Villabona of 9.25%, whom most common individuals are males, within the age ranges of 31 and 45, who usually use the afternoon shift (15h to 22h). Mostly, these patients will be discharged and, although there is a high percentage with trauma, this target population uses the emergency under surgical-medical causes that will, in principle, show no relationship with the fact of their imprisonment. Nevertheless, the fact that this population shows a chronic pathology triggers the admission under specific circumstances, like those of an internal medicine one.

The particular features of these patients make necessary to have designed or arranged areas in the SUH for prison population adequate to their healthcare needs, without undermining adequate security and protection for the patient, for the security staff and for the staff of the healthcare facility, of course. Moreover, we should not forget that, although we may confirm the preconceived idea of a high incidence of injuries among these patients, this is a population with a high health risk, with a rate of admissions much higher than the rest of the population and that most of these admissions occur under medical causes.

Mutual understanding as well as team work, have been a common practice between the security staff of the penitentiaries and the health staff working at the SUH. For many years, our healthcare facilities in Asturias have planned rotations of the penitentiary staff made by the SUH of the HUCA, taking into account, essentially, the department of psychiatry, the department of infectious diseases and of internal medicine. This place us in a position by which we

may have a low incidence of patients that require attendance in our emergency departments. This is possible thanks to the high technical qualification of the medical staff in the penitentiaries. It could be even more effective and close to the patient if the transfer of the penitentiary health to the different health departments would develop together with the different advances in telemedicine which would permit a telematic connection that aims a radiological digitalization, electrocardiograms, etc.

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