

BY JUDITH KIRKWOOD



PRISONER Patients

Correctional medicine can be good for physicians, prisoners, and society as a whole. Is it right for you?

PHOTO/ © 2002 BRUCE FRITZ

Physicians in prisons. It sounds like a good topic for a gripping reality TV series, a combination of “ER,” HBO’s “Oz,” and “Survivor.” Actually, correctional medicine is intense and fascinating. But you don’t have to wait for it to be discovered by the masses. Now is the time to get in on the ground floor. Some physicians have found that practicing behind locked doors provides them with more freedom in their practice and lifestyle than they ever dreamed was possible.

Why work in a prison?

Dr. Steven Shelton, the president elect of the [Society of Correctional Physicians](http://www.uoworks.com), characterizes prison medicine as “a return to the prac-

tice of good medicine.” In private practice in Salem, Oregon, for 13 years before going into correctional health full time, Shelton’s reasons for changing career paths are straightforward: “I see a patient, I write a chart note. I never fill out an insurance form, never bill a patient, never have to look at accounts receivable. I see a patient, I take care of a patient. I don’t have to worry about whether the patient can afford medical care and procedures. I just treat them appropriately. It’s the practice of medicine not driven by the dollar or the insurance company—and you can live a normal life, plan days off, take vacations.”

It was not easy to leave a practice of patients he’d seen for a number of years. “It was tough to say good-bye. At the same time, a lot of patients who had been

CORRECTIONAL MEDICINE

Continued from previous page

with me for 10 years or so had to leave me when the company they worked for changed insurance plans and they were forced to go to other physicians." The business of being a primary care doctor was killing him, Shelton says. He is one of countless physicians who thought they had their life's work planned out who are tired of having their practice dictated by insurance companies.

When you get a bunch of physicians in a room, the first thing they will begin talking about, says Bob Manche, is how stressful it is working in managed health care. "The lifestyle that correctional health care offers is a big plus," says Manche, a senior administrator at [Correctional Medical Services](#), a company that contracts with states and counties to provide management of health care for medical units in correctional facilities. "Younger physicians, especially, are looking more for family-oriented hours than upward mobility." Besides regular hours—such as 7:30 to 4:30—and less call (there's generally a state-wide rotation schedule and call is often limited to phone contact only), benefits packages include health insurance, retirement contributions, and malpractice coverage.

Salaries for physicians in correctional medicine vary by state and experience. According to 1999 numbers from the [National Institute of Corrections](#), the average salary for prisons was \$110,403. The low was Minnesota at \$58,997 and the high was Ohio at \$171,600. Large urban jails paid from \$82,536 in Dallas to \$175,000 in San Bernadino County, California, with an average of \$122,784. No numbers were available from private companies that contract



David Burnett, the medical director for the Wisconsin Department of Corrections, is focusing on quality improvement in correctional medicine. "We're looking for clinical indicators for care just as if this was the private sector."

to provide physicians in correctional settings.

Professionally, there are increased opportunities to see interesting medical cases. "The pathology is fantastic," says Dr. William Haeck, a consultant to the [National Commission on Correctional Health Care](#). "In general this population has been medically underserved before their arrival in the system, and chances to see and treat unusual pathology are enormous—from untreated STDs to TB to mental illnesses. Discovering the pathology, making a diagnosis, and initiating treatment can be very gratifying." Doctors who diagnose ADHD or bipolar disorder, for instance, have a chance to change the path of a life. Manche adds that follow-up care isn't

a problem, "because the patients aren't going anywhere."

Does correctional medicine suit you?

It's one thing to list the perks of a prison medicine job on paper. It's another to walk through the doors of a correctional institution and have them lock behind you. "One thing everybody has to understand going in is that you practice behind locked doors and your movement is restricted to the health unit unless special arrangements are made," says Haeck.

Manche points out that the facilities can be very depressing. "Some of the new ones are beautiful. But some need considerable upgrading and maintenance. It can be claustrophobic."

FIND OUT MORE

The place to start researching correctional medicine is the Internet. Go to your favorite search engine and play with phrases like "correctional health care" and "prison medicine." Also check out the Department of Corrections Web site for your state and the resources listed below.

ORGANIZATIONS

THE SOCIETY OF CORRECTIONAL PHYSICIANS provides support, education, and professional development for physicians who practice in a correctional setting. One of its goals is to establish a recognized specialty in correctional medicine. 1300 West Belmont Avenue, Chicago IL 60657. 800-229-7380; www.corrdocs.org

THE NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE has developed nationally recognized standards for correctional health care and monitors accreditation according to these standards. 1300 West Belmont Avenue, Chicago, IL 60657, 773-880-1460; www.ncchc.org

PROGRAMS

THE UNIVERSITY OF TEXAS MEDICAL BRANCH in Galveston has a focus on correctional health in its general preventive medicine residency program that includes recognizing common infectious diseases encountered in prison populations; psychological diseases associated with crime and violence; diseases of fraudulent nature; problems due to the nature of incarceration; the economic and security constraints of practice in a correctional setting; and integration of public health care systems with correctional systems.

THE INSTITUTE FOR MEDICAL HUMANITIES at UTMB also offers a program on legal and ethical issues in correctional health. Visit www.utmb.edu

PUBLICATIONS

Clinical Practice in Correctional Medicine (Mosby, 1998), Michael Puisis, ed.

Correctional Health Care: Guidelines for the Management of an Adequate Delivery System (National Institute of Corrections, 2001) B. Jaye Anno. www.nicic.org/services/news/brief-chc.htm

"Correctional Medicine: A Public Policy Paper of the American College of Physicians" (American Society of Internal Medicine, 2001), John M. Robertson and Jack A. Ginsburg. www.acponline.org

Going to work is a little like passing through airport security every day. If you bring your lunch, for instance, you can't bring glass or aluminum beverage containers or metal silverware—anything that might be used as a weapon. Although certainly there are any number of medical tools that fit that description, they are kept under close watch, and stray silverware and bottles do not fit into a secure environment.

Security is uppermost in everyone's mind when they first think of practicing in a prison. How is the fear factor? "I have no fears about security," says Shelton, who describes his prison health clinic as clean, quiet, and pleasant. Although some prison wards may be chaotic and noisy, health clinics should be an oasis. "If we're not having a medical encounter," says Shelton, "it's over. The patient is taken back to their cell. There is no swearing. Inmates learn that the f-word has no function in a medical dialogue." For many inmates, a trip to the health clinic is a mini-course in learning how to function in polite society.

"You have to be able to say NO," says Manche, a requirement of any medical position. However, inmates are a particularly manipulative population, and some are very good at playing games. "Your BS meter must be on at all times. You cannot be a pushover, because that snowballs. You have to take a firm position and not waiver because word gets around if you do, and

it's difficult to recover your authority," observes Manche. You will face patients who show up with a huge array of problems and symptoms and no medical history. Or, at the opposite end of the spectrum, you'll see patients whose medical history goes back as far as being born in prison to an incarcerated female.

In addition, there are not a lot of warm fuzzies in prison practice. Unlike private practice, there are very few senior citizens who think you are wonderful and no young children to brighten the day. You won't be treating generations of families that you get to know and who invite you to their weddings and barbecues. It may often seem like your patients could care less about what you do for them—that it's never enough. "You must get your emotional satisfaction from taking care of human beings who are not the greatest contributors to society," says Shelton. But, as in any medical setting, you have opportunities to make a difference in the quality of people's lives.

What kind of medicine do you enjoy practicing? Currently, most prison physicians have a background in internal medicine, family practice, or emergency medicine. Correctional health care tends to be oriented toward chronic care because the average length of stay in prisons is years. Doctors who serve jails, however, are often oriented toward urgent care since the length of stay is generally counted in days. Jails interact far more with the local community, and there are oppor-

Dr. Steven Shelton practices correctional health in Oregon. "I see a patient, I take care of a patient. I don't have to worry about whether the patient can afford medical care and procedures. I just treat them appropriately. It's the practice of medicine not driven by the dollar or the insurance company."

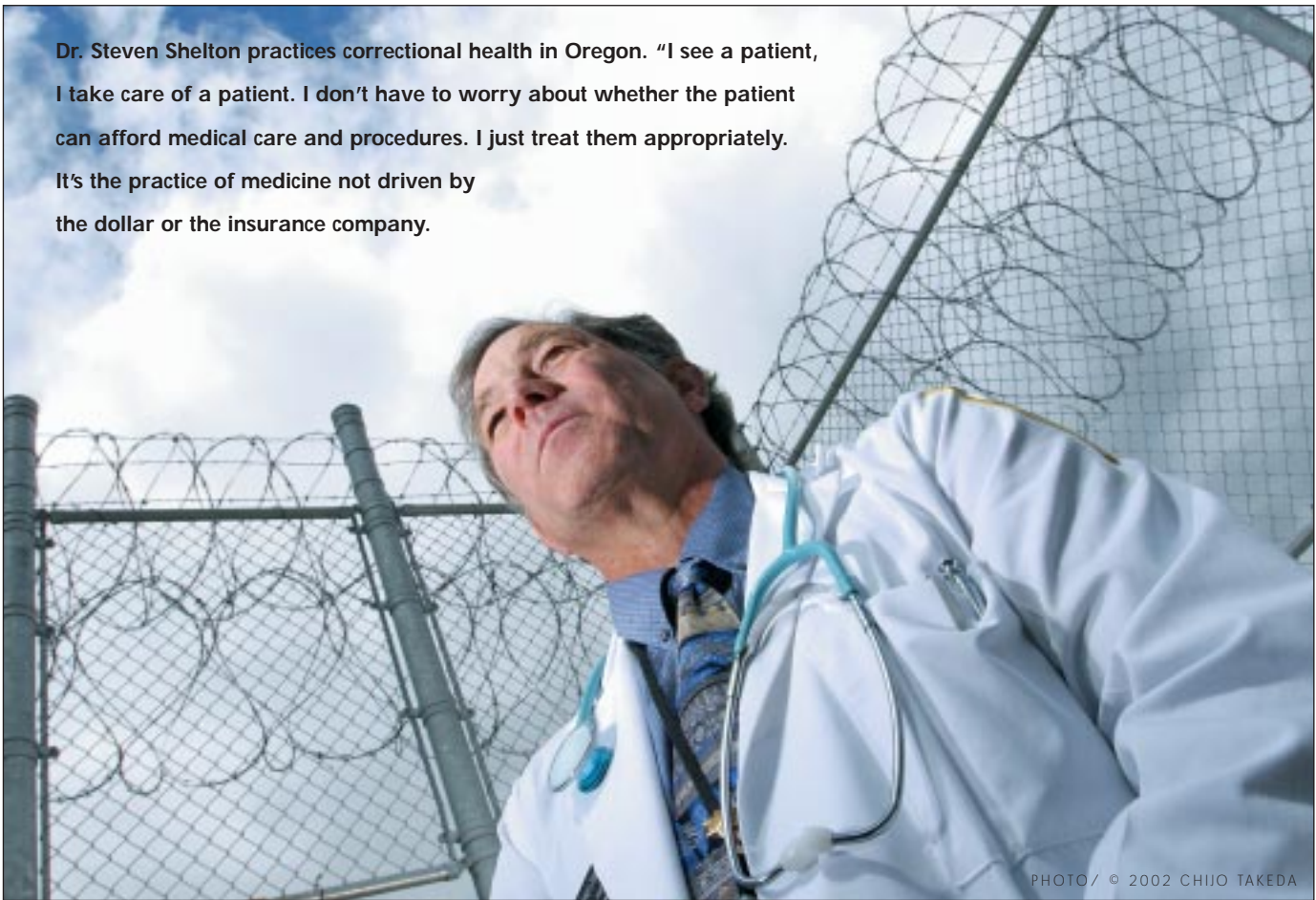


PHOTO / © 2002 CHIJO TAKEDA

tunities for a fair amount of interaction with the public health sector. Most of the patients in jails are going to return right back to the community. Women's prisons offer opportunities to practice gynecology and obstetrics and to develop programs that involve parenting. Working in juvenile detention facilities presents all the challenges of troubled adolescents on top of medical treatment.

A critical factor in correctional medicine is the ability to work well with nursing staff. "The nurses in correctional facilities are usually very strong and function independently. They may have an enormous amount of expertise about dealing with prisoners whereas a physician new to the facility does not. You have to be able to listen to the nurses," says Manche. "They are a valuable part of the health team and don't take kindly to a doctor who tries

to dominate the clinic environment."

Perceptions of correctional medicine

It has to be said that there is a perception that being a prison physician is a job of last resort. Controversy swirled around the revelation a few years ago that some jails and prisons had dealt with the shortage of correctional health professionals by staffing facilities with substandard physicians. A *St. Louis Post-Dispatch* report on health care behind bars (September 27, 1998) revealed that some states and counties were hiring physicians who had been convicted of crimes or were disciplined for professional misconduct. In addition, some states had granted restricted medical licenses for working in prisons to doctors who had lost their license in other states.

While specific instances of this kind

of unethical hiring cannot be disputed, you don't have to be an investigative journalist to evaluate a correctional setting and its standards of care. State departments of corrections are very aware of the need to upgrade both the perception and reality of medical care in prisons and jails. Negative publicity, as well as the positive efforts of the [National Commission on Correctional Health Care](#) (NCHC) and the [Society of Correctional Physicians](#), have both contributed to an increase in the professionalization of the field.

"Correctional Medical Services has a credentialing process that is just as stringent as any hospital," says Manche of the private company he works for that provides physicians for correctional settings. "We use a national practitioners data base, see copies of licenses, check with the DEA, and set up

A new specialty in the making?

Dr. William Haeck knows about building a specialty from the ground up. Currently a consultant who surveys jails, prisons, and juvenile facilities that have applied for accreditation from the National Commission on Correctional Health Care (NCCHC), Haeck helped found the field of emergency medicine. "Correctional medicine is where emergency medicine was about 35 years ago," observes Haeck, who left emergency medicine in 1994 to become medical director of a large urban jail in Broward County, Florida.

Like in the early years of emergency medicine, "virtually the entire field of correctional medicine is filled with people who have chosen it as a second career," says Haeck. But he believes that as more individuals elect it as their primary career, and as the medical profession acknowledges the special skills and unique capabilities that prison physicians need, it will become a

board-certified specialty.

Haeck notes that the field has come a long way since the early 1970s, when the AMA began looking at conditions of health care in prisons, jails, and juvenile facilities. There were no consistent standards from state to state and medical care of inmates was generally quite poor. In 1983, the NCCHC was formed to create written standards that are regularly revised and a voluntary certification program began based on an inspection by a team from NCCHC. Currently there are close to 600 facilities that are accredited. How many are not accredited? "A lot," says Haeck, "for reasons that are often political."

The rapid growth in prison building that took place in the "get tough on crime" 1980s and "three strikes, you're out" 1990s appears to be over. Incarceration rates have more than tripled since the 1980s. But since 1995 there has only been

an increase of about 4 percent a year. "Texas, which has over 100 facilities and in excess of 100,000 inmates, spent billions of dollars to build facilities and currently has no new ones in the planning stages," says Haeck. Florida, too, has stabilized in the last five years.

Figures from the Department of Justice show about two million prisoners under state or federal jurisdiction as of June 30, 2001 (an increase of 1.6 percent from mid-year 2000). But cities like Las Vegas and Fort Lauderdale that are seeing rapid growth are still building new jail space and plenty of facilities need upgrading. It's unlikely there will be a shortage of prisoners with health problems for the next few generations, however. And staffing of prison health clinics (often driven by state budget decisions) hasn't caught up with the prison population, even if it stabilizes.

Correctional medicine is wide open right now. But the buzz is

growing. "The fall NCCHC conference has grown from 500 to 1500 attendees," notes Haeck. "The opportunities for professional advancement, particularly in state systems, are good. Practitioners can use their administrative skills to organize systems of care.

Clinicians can have nice, collegial experiences with the full range of health-care practitioners—nursing, dental, mental health, pharmacy."

All indications are that the trend toward improving health care behind bars will continue. A good health-care delivery system for prisoners is important for the protection of public health from infectious diseases like STDs, tuberculosis, hepatitis C, and HIV/AIDS (most prisoners will be released back into the general population at some point) as well as for humanitarian reasons. ■

interviews between the candidate and site administrator and regional medical director before we place a physician. We check to make sure they have an unrestricted license and won't touch physicians who have had their licenses revoked for clinical issues." That doesn't mean, however, that the company would not consider a physician who has had a drug dependency problem in the past. "If a physician has been through treatment and their

dependency is in the past, we would have no problem." Manche is quick to point out that there is a difference between an impaired physician and a physician who has full functional capacity after dealing with drug or alcohol dependency. In fact, the structure of a correctional facility can provide a good match for physicians in recovery. It is a sobering experience to work with people every day who are in prison due to acts they committed be-

cause of addiction.

Another perception is that quality of care is suspect because there are so many foreign doctors practicing in prison settings. "We have no problem with employing foreign physicians," says Manche, "if their English is good. Some of our best doctors are from Pakistan, Vietnam, the Philippines." Different cultural backgrounds bring an interesting mix to both the other health-care providers

CORRECTIONAL MEDICINE

Continued from previous page

and the prisoners.

Some of the negative perceptions have nothing to do with physicians at all.

They have to do with how criminals in our society are viewed. "Many people feel prisoners don't deserve good medical care," says Shelton. "My view is that all human beings deserve good health care. The vast majority of those currently incarcerated will leave prison and go out into society, where if someone was sick you would normally say 'this poor person has a disease and needs treatment.' They are no less a human being because they are incarcerated." To critics of the quality of physicians in the correctional setting, Shelton replies "I would stack my doctors' diagnostic skills against anybody's."

The Future

Medical Director David Burnett is the new guy on the (cell) block, although his office is in the Department of Corrections administrative building near downtown Madison, Wisconsin rather than in one of the almost two dozen adult and juvenile facilities in the state. Stepping in last year to fill the shoes of a medical director who had actively worked in the prisons, Burnett had never worked in a corrections setting. A family physician by training, he got into medical management quality improvement 10 or 12 years ago in the private sector. He is part of the movement to professionalize prison medicine.

"The whole medical field has been evolving more toward a quality improvement focus," says Burnett. "It's very difficult to manage a system unless you can measure the things you are doing." Some of the things Burnett measures are the number of inmates

getting access to health care through sick call, the number of diabetics who are having retinal eye exams and hemoglobin A1c levels checked. "We're looking for clinical indicators for care just as if this was the private sector. I'm an advocate for both the people who work within the health-care system and for the inmates who receive care."

Wisconsin prisons do not yet have accreditation, which is part of Burnett's mission. "At this point, the system is understaffed with health-care personnel given the population of over 20,000 inmates in the 18 adult facilities." In fact, 3,000 of Wisconsin's inmates are incarcerated out of state, primarily with private vendors in Tennessee, Minnesota, and Oklahoma.

Nearly a third of state inmates and a quarter of federal inmates reported having some physical impairment or mental condition according to Department of Justice statistics released in 1997. A new report on the health status of soon-to-be-released inmates based on research by NCCHC will be published with the goal of generating policy recommendations for improving screening and treatment programs in jails and prisons, thus reducing the health and economic impact of serious conditions after offenders are released. Tens of thousands of prisoners are released every year with undiagnosed or untreated communicable diseases, chronic diseases, and mental illnesses.

"There is a significant burden of illness in the prison population that most people outside of correctional medicine don't understand," says Burnett. "There are a lot of unmet needs. This is an untapped area for opportunities to practice medicine with a defined population. It's a great place to apply public health measures that will increase the

health of the general public as inmates are released." Rather than seeing correctional health as a step down in status for a physician, Dr. Burnett confesses "Frankly, it's been a breath of fresh air for me." ■

Judith Kirkwood is free-lance writer based in Madison, Wisconsin.