Old Doc, New Challenges: Correctional Medicine

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It seems no one goes to medical school with a dream of caring for patients in a prison, yet late in my academic career, I was encouraged to consider becoming the medical director of our state’s prison system. After some discussion with the director of public safety and his staff, I applied for and was accepted into the position. The medical director of the Department of Public Safety in Hawaii is responsible for the medical care of approximately 5,900 jail and prison inmates located in nine facilities on four islands in Hawaii and in three private prisons on the mainland. To my surprise, I have found this position enjoyable, incredibly challenging, and a nice mix of my public health and clinical medicine backgrounds, coupled with the administrative skills I’ve built over the years. In most of my clinical experiences, I have worked with medically underserved populations, and this position continues that commitment.

What I Have Learned

I needed to learn a whole new language and culture to work in corrections. I am still learning about pretrial, misdemeanor, felon, probation, parole, high versus medium versus minimum security, parole boards and their function, security requirements, special holding, sex offender treatment, shanks, swipe, and more. It has captivated me such that my personal reading now includes books on corrections, including those on famous trials, escape attempts, political discussions, and history. It has brought about a whole new range of emotions for me as a physician, such as seeing and examining a special-holding patient who is in handcuffs and shackles. It challenges my decision making on that same patient as to whether it is more important to do a complete exam out of restraints but thus with a corrections officer present, forgoing confidentiality, or to do an abbreviated exam with the patient still in restraints but with confidentiality intact. I am inherently a “touching” physician, a habit I have had to curtail in this environment.

I have learned that the security side of corrections ranks higher in importance than my need to deliver community-standard medical care, but that these two can in fact achieve a balance. The men and women in uniform were almost threatening at first, but now I welcome the “Mornin’, Doc” greeting when I come to each facility. For some reason I was not threatened by the five or six locked doors between my arrival location and the medical units in the various facilities and the subsequent loss of my own freedom once in the facility, but many new health care workers are. In some cases, new health care staff last only a couple hours as their fear outweighs their wish to serve the prison population.

The value of teamwork is not at all new to any of us, but in prison and jail facilities, the nurses are there all the time and thus basically “run the system.” The physicians are there less frequently, since they usually have responsibilities at more than one facility. I have always enjoyed the challenge of learning to work with a staff that I did not hire and yet having to serve as their administrator. It takes considerable time to build up rapport, integrity, and respect as a competent physician and leader. My inherent nature of educator has been important in teaching health care staff the “why” of the standards of care I am putting in place for diseases such as diabetes or hypertension. I am only beginning to use these educator skills in inmate education on topics such as hepatitis B and C and look forward to some day teaching at the training academy for our corrections officers.

I also learned that the correctional system is political. The director of public safety changes with the party of the governor, and thus my boss has already changed once in my nearly 2 years on the job. Political savvy has never been my best skill, yet it is important in every aspect of my position. In corrections, I need to advocate for our medical budget. Health care priorities may have input from the political leadership who have worried about the two cases of chicken pox at one of our facilities, from the

From the Department of Public Safety, Honolulu.
wardens who are worried about iso-
lating inmates with methacinin-resistant Staph. aureus, and from me as I worry about keeping hepatitis C treatment guidelines current. Money has always been a political topic for family physicians whether it is reimbursement for practicing physicians, malpractice fees, or educational and research funding for academic physicians. That need to educate others to gain one’s budget is similar in the prison environment. It is interesting that people do not like to spend their tax dollars on prisons and that they are surprised at the level of health care that inmates receive (well beyond that received by the uninsured), yet they want criminals in jail so they will have safe communities. In out-of-workplace discussions, I end up defending a system I did not create.

Challenges

In corrections, physicians often have a bad reputation to overcome. The stereotype is that only borderline-performing doctors work in prisons. I have found the stereotype not to be accurate, and I have met, both locally and nationally, excellent clinicians and leaders, many of whom are family physicians. The stereotype is not only rampant in the medical field but also among the inmates themselves and their families! They likely wonder what competent physician would choose to work in a prison and thus assume that prison medical care is not meeting the standard of the community.

Some inmates are litigious, and there are always several lawsuits pending. These suits are the greatest stress for physicians in the prison system. The nature of our population is that they know the law, they are guaranteed a law library, and they know that even an out-of-court settlement of a few thousand dollars is worth the effort when there is nothing else to do. Inmates rarely win the suits, but it is a time-consuming pursuit for physicians to defend themselves against inmates’ medical problems that are usually the result of years of inattention by prisoners to their health and then trying to blame a system for not correcting the problems caused by those years of neglect.

Chronic pain management is a particular challenge in a system where most of the patients have a history of drug abuse. Many patients have old injuries or arthritis that cause discomfort, which they are used to solving with illicit drugs.

Infectious disease challenges, such as high rates of hepatitis C and an extremely high rate of methacinin-resistant Staph aureus in our population, have made me almost an instant expert in those diseases. The responsibility of writing the system-wide treatment guidelines for hepatitis C that meet continually changing national standards is enjoyable, but dealing with inmates who want to be treated but don’t meet the guidelines is less rewarding.

What’s the Same

Taking care of individual patients is the same in corrections as in a community-based office practice. The individual patient appreciates questions about his or her family, previous job, area in which he or she grew up, etc, just as much as any other patient. On the other hand, the provider can almost assume that each patient has drug problems, anger management problems, and loss of relationships with partner and children. Each patient needs support in health endeavors such as weight loss or success in substance abuse treatment programs. Patient education is just as important in corrections as anywhere: people need to understand their diabetes and its consequences if they are to pay attention to diet and exercise, quit smoking, or accept a flu or pneumococcal immunization.

Friends and colleagues continue to ask me what it is like to care for a murderer or a rapist. Usually I don’t know the crime for which an inmate has been incarcerated. In the case of the elderly (and there are many), I assume it has been a serious, even heinous, crime but am able to go about my business of being a physician without holding a grudge against the patient.

Humor is a wonderful medicine in corrections as it is in any practice. In the past, office staff have wondered how patients that come in very ill, depressed, or upset can often be heard laughing with me through office doors. With inmates, it is the same: there is so much stress in life behind bars that humor is often a successful tool to uplift patient and physician.

Would I Do It Again?

Would I do it again? Yes! I enjoy my new position and find that the continued challenges keep me excited and alive as a physician. No, I didn’t go to medical school to practice in a prison system, but I did want to work with medically underserved. I continue to think like an academic physician and have many ideas for research and educational programs. I continue to practice medicine. The administration of a correctional system is as challenging as any I have undertaken.

I hope my learning curve levels a bit as the years of experience go on, but, meanwhile, I will tackle new challenges with excitement, my problem-solving abilities, and a smile.

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