Health Care for Youth in the Juvenile Justice System: Policy Statement from the AAP
Michelle Staples-Horne, MD, MPH, CCHP

In December 2011, the American Academy of Pediatrics (AAP) released its new policy statement on Health Care for Youth in the Juvenile Justice System. The article was published in Pediatrics 2011:128:1219-1235. The publication is also available online with updates at: http://pediatrics.aappublications.org/content/early/2011/11/22/peds.2011-1757.

This publication highlights the health needs of youth in the juvenile justice system. Those of us that are a part of the correctional world are fully aware of the unmet physical, developmental and mental health needs of this population. What is most important is that the AAP through this publication has brought this issue again to the attention of pediatricians and other health care providers in the community, who may not be familiar corrections. The article was the result of the dedicated work of the AAP Committee on Adolescence. Dr. Paula Braverman is chair of the committee and has been a champion advocating for health care in juvenile settings. She was a member of the AAP Juvenile Committee for six years and was appointed as Chair of the AAP Committee in 2011. Dr. Braverman is also a member of the NCCHC Juvenile Health Committee, which provides technical assistance to the Commission for the Juvenile Health Standards. Her position as Medical Director of the Hamilton County Juvenile Court Youth Center in Ohio for several years has given her great insight into the health care of juvenile offenders. She is also Professor of Clinical Pediatrics at Cincinnati Children’s Hospital Medical Center and Director of Community Programs, Division of Adolescent Medicine. I interviewed Dr. Braverman shortly after release of the policy statement. She expressed that there is a great need for advocacy for this population so that detained juvenile offenders receive the same level of care as in the community. She also expressed a huge concern about the ability to offer continuity of care in this population and advocated for health insurance suspension rather than termination when a juvenile offender is detained.

The article is extensive in its review of the juvenile health literature, although this area has not been widely researched. The National Commission on Correctional Health Care (NCCHC) conducted a national study of juvenile health care in 1991. This study had a national scope which included 1801 youth from 39 short-term or long-term correctional facilities in the United States. These youth had higher

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The Patient Perspective

I was recently asked by my doctor to speak before a group about the patient perspective on dealing with chronic disease and medication treatment. I opened with saying when I was diagnosed, all I wanted was my life back and I closed stating chronic disease is time consuming and when you are feeling better becomes an annoyance in getting on with your life. Why should these feelings be different for our patients? Not only might their normal look quite different from ours on the outside, but achieving it is constrained by the institutional schedule and regulations. For most prisoners, times for the gym/recreation, commissary, laundry distribution and library are assigned and personal visits frequently are made by appointment far in advance. We tell our patients especially those with diabetes, hypertension and hyperlipidemia to exercise, but get angry with them when they miss an appointment to do so. Personal visits are the patient’s connection to his or her outside life. Additionally, the visitor may have had to travel a significant distance to see your patient. What would you choose: seeing your children and spouse, going to a routine appointment or maybe even an appointment of which you had no knowledge?

When I need an appointment for either a doctor visit or testing, I can tell the scheduler days and times to avoid so that I can lead my “normal” life; however, we don’t ask our inmate-patient his or her assigned times for the above mentioned activities or if he/she has any upcoming visits (personal, legal, etc.). This is compounded by the reality that for security reasons, prisoners are not allowed to know when their off-site appointments are scheduled. Most providers become frustrated by patients who are “no shows” or refuse an appointment especially that difficult to obtain off site specialty clinic appointment or procedure, but maybe we should change the paradigm.

We know that objective data in corrections is lacking for many aspects of medical care. Consider using this paradigm shift as a research opportunity. Assess your “no show”/refusal rate. Then, start asking patients before making an appointment their assigned day/time for various activities and if they have any upcoming visits. Pass this information on to the scheduler for both on- and off-site appointments. When you explain to the patient that you cannot tell them the time and day of the off-site appointment, add an explanation that some off-site appointments are both difficult to obtain and sometimes only occur on certain days and at specific times, but you will try to take the into consideration the information that they have provided. Provide a way for them to contact you or the health service administrator if any of the information changes. Discuss this issue with security as well. Could a protocol be developed such as a patient can both go to the off-site appointment and for example, be given an opportunity to get their commissary without waiting an additional week?

After these changes are implemented, reassess your “no show”/refusal rate. You also may want to assess less tangible factors such as patient satisfaction, compliance and general attitude and well-being as well as control of their disease. Perhaps several institutions could pool their data similar to a multi-site clinical trial by connecting on the new SCP Facebook page. Share your experience with your colleagues either by writing about it for publication in CorrDocs, presenting it at an SCP meeting or both.

Lynn Sander, MD
Editor
It is with great pleasure that I can announce, on behalf of the SCP Board of Directors, that we have unanimously passed a resolution to change the bylaws of the Society and accept Nurse Practitioners and Physician Assistants as associate members of the organization.

This action has been discussed by previous boards for the past ten years. With careful deliberation viewing the benefits and negatives and with input from the membership, we decided that the overriding positive of including our non-physician colleagues was in the best interest of correctional physicians, nurse practitioners, physician assistants, our organization, and the patients we treat.

SCP’s mission is to advance excellence in the provision of medical care to incarcerated individuals. We believe including our colleagues who are nurse practitioners and physicians assistants will result in better education, networking and ultimately patient care.

Extensive surveying and discussion occurred before implementing this change. While our decision is unanimous, discussions revealed some key opposition to the idea. We actively engaged these members in dialogue and found that those who disagreed did so because of concern that it would weaken the organization politically and would stretch already scarce resources. While we recognize the risk, positive factors are numerous, including our providing an improved educational outreach, helping to organize leadership from among NP's and PA's, mentorship, increased membership, and the strength that comes from sharing common challenges. We see it as a win-win proposition that will strengthen the Society and the profession.

The fundamental identity and name of the Society of Correctional Physicians will not change. We are a still a physician organization. Like other medical organizations which have accepted non-physician members, we are expanding our reach but our identity remains intact. PA's and NP's are “associate” members in that they will not vote in elections, nor hold membership on the Board of Directors. These associate members will benefit from the Society in many other ways. We hope to help our non-physician colleagues to organize. They will serve on committees of the SCP that will advance the profession, and will help physician membership to better understand how best to benefit from the expertise of NP's and PA's in their medical practice.

I recently had the distinct pleasure of surveying a small jail facility in rural Mississippi for the National Commission on Correctional Health Care. The facility there was working diligently to implement the highest standards of correctional health care with limited educational and financial resources. The doc there, a family medicine physician who works (very) part time in corrections at the jail, was very open to the Society’s educational and outreach efforts. He was thoroughly in the dark about our organization—that such an organization even exists, much less thrives. Non-physician medical providers staff similar facilities, in similar professional isolation—an isolation that most of us have experienced and can fully appreciate.

It’s my opinion that reaching out to our colleagues in correctional medicine in these settings is very much a part of our mission. I believe that our accepting Nurse Practitioners and Physician Assistants is a step in the right direction.

The Board of Directors is excited about this change. We encourage ongoing dialogue on how we can best serve the correctional medical community in our outreach, educational, and political aspirations as a group. We encourage you to contact a member of Board of Directors with questions or comments. Your involvement with the SCP is essential for the vibrancy of your organization.

Michael Puerini, MD
President
president@corrdocs.org

CorrEthics

In 2010, there were a total of 46 executions in the United States; in 2011, there were 43. Given that, depending upon who counts and when they counted, there are somewhere between 2,100,000 and 2,500,000 inmates confined at any given moment, executions represent an infinitesimal portion of correctional activity. The attention given to the death penalty, however, is clearly disproportionate to the number of executions actually carried out. No correctional activity seems to generate the heat that can come from a simple discussion of the death penalty. Is it an effective deterrent? Is the retribution necessary or appropriate? Is it administered fairly? This brief column will not resolve any of these questions, but given the publication in this issue of a SCP position statement on correctional physician participation in the execution process, it seems reasonable to highlight some of these issues.

Arguments for or against the death penalty assume certain premises. For example, if human life is considered to be of no value, then the death penalty is made trivial. Conversely, if human life is highly valued, then the death penalty must either be reserved for rare circumstances or avoided altogether. There are other assumptions, too, regarding the utility of retribution or vengeance, regarding the deterrent value of the death penalty, and regarding our ability to apply without error such a unique irreversible intervention.

Our primary ethical principles make assumptions about ourselves: they assume that human life is valuable, that we have obligations to act in ways that

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Membership Application
Your name should be submitted exactly as you want it to appear on all official correspondence. Please print or type.

First Name  Middle Initial  Last Name

Educational Degrees (limit two)

Organizational/Job Title

Primary Work Affiliation/Workplace Name

Mailing Address

Mailing City  State  ZIP+4

Billing Address

Billing City  State  ZIP+4

Phone  Fax

Mobile  E-mail

Setting for the majority of your correctional health work
☐ County or city jail  ☐ Dept of health  ☐ Federal prison  ☐ Federal - INS
☐ Juvenile facility  ☐ State DOC  ☐ University  ☐ Other

Other

How did you hear about SCP?
☐ Co-worker/Employer  ☐ NCCHC  ☐ ACHSA
☐ CorrDocs  ☐ SCP Web site  ☐ Other

Other

Gender  ☐ Male  ☐ Female

Payment Information
☐ Enclosed is a check for $125 (payable to Society of Correctional Physicians).
☐ Please bill my:
☐ MasterCard  ☐ Visa  ☐ Discover  ☐ American Express

Card Number

Expiration Date  Secure code

Signature (only if paying by credit card)

I hereby certify that my Society of Correctional Physicians application as submitted is true and correct.

Signature  Date

Eligibility
Qualifications of Members: Applicants shall be doctors of medicine or osteopathy who are licensed to practice medicine by an appropriate board of licensure, and who are engaged or interested in the practice, teaching or research in some relevant aspect of correctional medicine.

Provide a list of current, active medical licenses, including number, state, and expiration date.

Have you ever lost your license?  ☐ Yes  ☐ No

If yes, explain.

Board News
The SCP Board has continued to meet monthly via conference call. A summary of the items discussed and actions taken in the meetings that occurred November through February is below.

Associate SCP Membership for Nurse Practitioners (NPs) and Physician Assistants (PAs)
The survey distributed at the annual SCP meeting gave overwhelming support for a modified membership to SCP for mid-level practitioners. The board decided that before developing such an associate membership category, all SCP members should be asked if this is an option that SCP should pursue. Subsequently, member surveys revealed over 90% approval for creation of an Associate Membership for NPs and PAs. The board proceeded in refining the details of this membership and in February, the Board of Directors approved a change in the bylaws allowing SCP Associate Membership for Nurse Practitioners and Physician Assistants. As associate members, they will share most of the privileges of SCP membership. Now, all correctional medical providers can benefit from SCP; however, SCP remains a physician run organization with only physicians constituting the Board of Directors and voting membership.

Committees
Membership: The Membership Committee needs a Chairperson and committee members to brainstorm member benefits. The Board discussed ideas for augmenting member benefits such as improving the Members’ Only section of the website and forming an expert con-
Society of Correctional Physicians (SCP) Code of Ethics Statement

Non-Participation in Executions

Statement:

The Society of Correctional Physicians has incorporated the following into its 1998 Code of Ethics statement—(members shall) “not be involved in any aspect of execution of the death penalty.” We reiterate that position in supporting the American Medical Association’s Opinion 2.06 Non-Participation in Executions’ regarding capital punishment. The AMA’s opinion emphasizes the inherent conflict between a physician’s duty to heal and participation in a person’s death, even while that participation may not be active. The AMA definition of participation, which we affirm, states, in part:

“Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.”

Physicians who work with incarcerated people are likely to be called upon to participate in executions in some fashion. The incarcerated are clearly and directly our patients and our work is to care for their medical needs. SCP members and all correctional medical providers have the strongest ethical imperative not to participate in executions in any way, including the direct or indirect supervision of other members of the health care team.

Discussion:

1. Physicians who work in correctional medicine, although we serve the facilities in which we work, must primarily be patient advocates, promoting appropriate health care for our patients within the usual physician-patient relationship.
2. The physician-patient relationship may be quite tenuous in correctional facilities, given that health services providers can be seen as authoritarian figures who are subservient to their state employers. Participation in any aspect of implementation of the death penalty can easily damage this relationship despite the best intentions of the involved physician.
3. Participation in any aspect of implementation of the death penalty does not increase the safety or security of the institution, and it does undermine our ability to care for our patients. Such participation or supervision at any level is not appropriate to our professional role.
4. Physicians, while possessing special expertise in the use of medications and knowledge of the human body, should not utilize this skill and knowledge in assisting in the killing of human beings. The Society of Correctional Physicians agrees that correctional physicians should specifically decline to offer technical advice, procurement assistance, or physical participation in executions.
5. The Society of Correctional Physicians affirms the AMA’s opinion 2.06, and refers members and non-member correctional medical providers to the opinion for details and questions.

NEWS RELEASE: Jan. 5, 2012

H1N1 Influenza Vaccine Campaign During Pandemic Bypassed Many U.S. Jails

Contacts: Jennifer Johnson: 404-727-5696

“Overall, during the A(H1N1)pdm09 pandemic, 39% of responding facilities reported not receiving any A(H1N1)pdm09 vaccine; however, the response differed depending on facility type. Only 14% of federal prisons and 11% of state prisons reported not receiving A(H1N1)pdm09 vaccine during the pandemic period. In contrast, 55% of the sampled U.S. jails did not receive vaccine during the pandemic period.” - MMWR article

ATLANTA—Fifty-five percent of U.S. jails (facilities that house persons sentenced to one year or less) did not receive any H1N1 vaccine in the 2009-2010 pandemic and thus were excluded from the national vaccine campaign, according to a study reported in the Jan. 6 MMWR (Morbidity and Mortality Weekly Report). First shipments of vaccine - technically known as A(H1N1)pdm09 vaccine - to jails also were delayed compared to delivery of vaccine to prisons.

In contrast, the study found that only 14 percent of federal prisons and 11 percent of non-federal prisons did not receive the vaccine. U.S. institutions housing inmates sentenced to more than one year are referred to as prisons.

The findings were derived from a survey conducted between July and November 2010 using a representative sample of U.S. prisons and jails. The surveyors asked if and when the facilities received H1N1 vaccine during the 2009-2010 outbreak. The research team included epidemiologists at the Rollins School of Public Health at Emory University; the National Commission on Correctional...
Board News
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Consultants’ panel. Member discounts were also discussed. Finance: This committee is chaired by our Treasurer, Spencer Epps. He will be meeting with COO Paula Hancock to go over the numbers. The board decided to pursue options for developing advertising and grant options for financing, including hiring a sales manager. Discussions with the NCCHC are ongoing. This committee also is looking for volunteers.

Policy: Dean Rieger chairs this committee and is looking to assign one active topic to each committee member for policy development. Several interesting topics in the works including mentally Ill patients in segregation, military veterans and the correctional health care system, the Affordable Care Act and its impact on corrections, and expanding the role of correctional health care facilities in medical education. To accomplish this goal, additional members are needed.

CorrDocs Editorial Board: President Mike Puerini is working with editor Lynn Sander to create an editorial board to solicit and review articles. We hope this enables us to take our publication to the next level.

Technology/Communication: Tom Lincoln chairs this committee which is exploring ways to improve the SCP website. The SCP Facebook page is up and running, check out our pages at: https://www.facebook.com/groups/318159534900852/. Additionally, the link to the SCP blog is: http://societyofcorrectionalphysicians.wordpress.com/

See the boxed Call for Committee Members for contact information if you are interested in becoming active in your organization by becoming a committee member.

Death Penalty Code of Ethics
The Board completed our Code of Ethics statement on participation in executions in time for our January meeting. The new statement is published in this issue.

Conferences
Topics for the 2012 conferences were discussed. The Spring meeting will be held as a preconference seminar at the NCCHC Updates Conference in San Antonio, May 19-22, 2012. The SCP presentations will focus on specialty care for primary care providers as emphasizing information to assist primary care providers in treating patients on site and with the decision process for when to refer.

The annual Medical Director Boot Camp will occur July 20-21, 2012 in Chicago. This 2-day educational event was designed for new and advancing correctional medical leaders, but this essential training is valuable for all medical providers. Go to NCCHC.org for details.

The SCP Annual Educational Meeting focusing on Infectious Disease will take place October 21, 2012 in Las Vegas, NV in conjunction with the NCCHC Conference.

It is never too early to put these meetings on your schedule.

Call for Committee Members
If you have noticed changes happening at SCP (Facebook, blog, an enhanced CorrDocs, position statements, etc.), it is because of a more active Committee structure. To continue to improve our organization, more member participation is needed on the committees. See the Board minutes for more details.

Membership Committee: To increase our political clout, it is vital that we increase our membership and reach more physicians who are working in corrections, yet are unaware that there is an organization that is there for them. This committee is currently needs members, one of whom needs to serve as chair. It you are interested in helping to grow our organization, contact President Mike Puerini at President@corrdocs.org.

Finance Committee: Contact Spencer Epps at Treasurer@corrdocs.org.

Policy Committee: contact Dean Rieger at Policy@corrdocs.org.

Technology/Communication: Contact Tom Lincoln at IT@corrdocs.org.

Editorial Board: Lynn Sander at Editor@corrdocs.org.

CALL FOR PAPERS
CorrDocs is seeking papers. If you have a topic that you wish to write on, have recently presented at conference and can transform your presentation into the written word or have a personal experience about practicing correctional medicine that you are willing to share (we would like this to be a regular column), please submit them to editor@corrdocs.org in Word format, Arial-12 point font. Articles can be anywhere from 750 to 2000 words (more or less dependent on subject matter). Pictures, graphs or tables which enhance the article should be submitted as well.
After 27 years in primary care medicine I decided to take on a new challenge and begin working in correctional medicine. The transition from other forms of care to correctional health care has been pretty smooth—I treat similar diseases and conditions; I apply the same evidenced-based approach as I always have; I have labs and radiographs to review; urgent calls to answer; and an electronic health record. The greatest difference for me has been the character, the personality of my patients.

I work in a maximum-security environment with some of the nation’s most aggressive and difficult-to-manage individuals. Most of my patients have either been incarcerated for decades or anticipate a very long incarceration. Many are members of highly organized, racially exclusive gangs. Many grew up in difficult circumstances characterized by extreme poverty, poor nutrition, and limited education. Most have abused drugs, including some I’ve never heard of before (e.g. “Sherm”) or alcohol to excess. Many are from fractured families.

Despite all of that, I find many of them extraordinarily sympathetic. I can imagine how some of them might have turned out if given the right opportunities early in life, or if they had the right guiding hand.

But I also have a significant number of patients who are not easy to work with. Difficult patients can be found in any practice—but in my work environment, they make up a significant proportion of the men for whom I provide care. They can be unusually suspicious—they seem to think I am out to “bamboozle” them. Some enter my exam room angry, take no comfort when I try to console them, and leave angry. Some refuse to answer questions about their health history; instead, they mount filibusters (usually about my incompetence) that would earn the admiration of a Senator. Many explain to me why a cost-effective approach to health care or a stepped-approach to care won’t be satisfactory for them. I either arrange the MRI, the potentially hazardous surgery, and the subspecialty consultation now, or they will sue me for violating their Eighth Amendment rights.

One patient explained to me the other day that his chronic back pain had been mismanaged by a spate of indifferent providers for the last 15 years. He had tried acetaminophen, nsaid, physical therapy, muscle relaxers, tricyclics, seizure medications, narcotics, TENS units, etc. He then dictated to me the medications and the approach I should prescribe for him, all the while looking at me as if I had never treated a patient with back pain before in my career. I obtained his old charts (literally thousands of pages, and nearly a dozen volumes of paper and electronic records) and found the same complaints, with minimal objective findings, and tellingly, no adverse consequences over the years. His examinations were benign and non-progressive, and his radiographic studies, unremarkable. He had filed frequent legal actions against each new provider who had cared for him. His quoted comments in the medical record, repeated over and again, spoke of an incurable condition, not inhabiting his back, rather his personality. As I pored over his records I thought, “Some people have red hair. Some people have six toes. This man has back pain and a propensity to blame others for it.”

I like to think that my approach to health care has always been based on a few core principles: Patient-centeredness; shared decision-making; a commitment to social and distributive justice; diagnostic precision; and the careful use of the tools of my craft. I tried to apply my principles to the back pain patient. He didn’t appear to have medical or biomechanical back pain. He wasn’t interested in my professional examination or in my recommendations. It was as if I weren’t even in the room with him. He seemed to me to have a different sort of illness, one that his incarceration and his monomaniacal focus had converted into an angry obsession.

“How do I reach him?” I wondered.

Another patient came to me complaining of difficulty urinating. I found a hard, suspicious nodule in his prostate. I checked labs; they too were concerning. I referred him to see a Urologist. He refused to go.

He said, “I saw that urologist once. He ripped my rectum with his hands; I think he was trying to rape him. I bled for months.” His stated concerns seemed to me embellished or simply false. [I knew the Urologist with whom he consulted in the past, and he is a consummate professional.]

I asked him to reconsider—to see the Urologist and establish a course of care. My patient wouldn’t. I brought him back to see me several times. At each visit, he launched into a more wildly slanderous and vehement tale of mistreatment. After several visits he relented to my recommendation. A prostate biopsy was performed. Unfortunately, it revealed cancer.

I came in early to work the next day to tell my patient. I wanted him to have time to process the diagnosis, without the usual hustle of the daily line. I explained what we had found. I asked him what he thought, what he was feeling. His response surprised me.

“You made me lose a day’s pay to tell me that!” he fulminated. His face was red and his eyes very sharp. “That doctor raped me. I’ve never stopped bleeding. … [expletive, expletive, expletive…]

When he collected himself, I told him I understood. I explained that I knew how hard the diagnosis of cancer must be to hear. I said he would face challenges ahead, as we moved through his cancer treatment together.

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An 81-year-old male with cavitating chest wall lesion

Male breast cancer shares many features of its female counterpart diagnosis except for the lower incidence. It accounts for approximately one percent of all breast cancer reported. Most male patients present late with symptoms of metastatic disease and/or local invasion and ulceration. In this clinical vignette, an 81-year-old male presented to the local Emergency Department (ED) for symptoms of weakness and syncope. During his initial stay and work up he was found to have advanced stage breast cancer. Accompanying the clinical case report, a review of the current literature and recommendations will be presented.

An 81-year-old male was admitted to medicine service after he was found unconscious in the driveway of his home. His neighbor stated that the patient was living alone and rarely communicated any needs to others. He had no immediate family in the vicinity and was admitted for work up and investigation of his progressive weakness and new syncope. Patient interview provided limited information, minimally helpful for the management of his condition. In the ED, the patient’s blood work analysis did not provide any immediate concerns or clues to the etiology of his symptoms, chest radiograph showed bilateral effusions, electrocardiogram was read normal. On physical examination, he was a thin, cachectic male, unkempt in appearance with a cavitating lesion measuring 9 cm x 12 cm (Fig. 1) on his right chest wall. Additional evaluations including Computerized Tomography of head, chest, abdomen and pelvis showed large bilateral effusions, atelectasis, retroperitoneal lymphadenopathy, right upper chest soft tissue mass (Fig. 2) and no acute intracranial pathology.

Surgical consultation was obtained for pleural cavity drainage and chest lesion biopsy. Upon insertion of a 16 gauge French chest tube, 1.5 liters of serosanguineous fluid was drained from the right side and sent for cytology, microbiology and cell count examination. Under local anesthesia, a bedside biopsy of right chest wall cavitating lesion was performed. This revealed invasive ductal carcinoma (Fig. 3). The patient’s pleural fluid cytology tested positive for malignant cells signifying metastatic disease and spread to adjacent organs. Upon notification of the biopsy report, the patient and his remote family declined further intervention preferring comfort care rather than invasive surgical intervention and adjuvant chemotherapy.

Breast cancer in men accounts for

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Starting Out in Correctional Medicine

“...taking a lot of courage, “I said.

“Expletive” he said. And then he left.

Many of my patients sport tattoos on their scalps or foreheads, announcing their neighborhood or gang affiliation, or warning that they are “shaved for battle.” Some have eyelids tattooed with the words “Game Over.” Some have tattooed “toe tags,” as if they were already dead and in the morgue. Many have purpled their faces with swastikas, cryptographic codes, expletives, and tear drops, in patterns so dense it is difficult to see any unmarked skin.

I take in the facial markings as a part of prison art—the cultural expressions of the bunkered. The markings don’t faze me. I can’t say the same about the personalities of many of my men: their narcissism, their self-centeredness, their hatred of the community at large, and their obvious psychopathy.

As a newbie in prison health, I am looking forward to learning more about how to work with my patients effectively, realistically, and with compassion. I am gaining experience in turning the other cheek. In its own peculiar and sometimes bizarre way, the experience has been enriching and ennobling.
Providers as Professional Witnesses

The Benefits to the Lawyer and yourself if you do get called to testify.

Sensible reasons why this trend is developing include:

- In a variety of matters. Some examples are being called to offer testimony to try and strip the inmate of his rights as a parent.
- In a child deprivation hearing it filed instead, the State was calling her as a witness with her provision of care to the inmate:
- In a prisoner lawsuit or two. However, when the case involving one of her inmate patients, a man with several significant mental health issues who has been on her caseload for months.
- Dr. Jones knew when she went to work in the correctional environment she might have to go to court to defend a prisoner lawsuit or two. However, when she reviewed this subpoena, she was shocked to discover it had nothing to do with her provision of care to the inmate: instead, the State was calling her as a witness in a child deprivation hearing it filed to try and strip the inmate of his rights as a parent.

Increasingly, correctional providers are being called to offer testimony in a variety of matters. Some examples include:

- Inmate challenges to criminal sentences
- Inmate challenges to civil commitment decisions
- Domestic matters
- Civil rights claims against other providers or correctional staff

Set forth below is an analysis of possible reasons why this trend is developing and advice on what to do to best protect yourself if you do get called to testify.

The Benefits to the Lawyer and Litigant in Calling Correctional Providers as Professional Witnesses

In many types of court proceedings, testimony from expert witnesses is necessary to prove a claim or defense. For instance, if you are sued for malpractice, the plaintiff must present testimony of someone holding licensure similar to yours to testify that your treatment fell below the standard of care and caused the alleged damage. Such experts charge a hefty price for their services.

1. Cost

In criminal matters particularly, the prosecutors and public defenders do not have sizable budgets for their cases. They can hire a forensic evaluator, for instance, to do an independent psychiatric exam of the criminal defendant, but those funds deplete their limited resources. If, instead, they can get the defendant’s correctional psychiatrist to testify as to diagnosis, treatment, progress, etc., it is cheaper.

Plus, most criminal defense attorneys hope a treating doctor is more apt to side with their patient, the defendant, and provide helpful support for their theory of the case. Once the lawyer has you under oath on the stand, he hopes to press you to give opinions as to the likely state of mind at the time of the crime, mitigation or the like.

Now that so many states have comprehensive civil commitment laws governing crimes such as sex offenses, public defenders’ offices are even more strapped for resources. After their clients have been convicted in the criminal arena, sentenced and served their time, they now have to fight off the potential for a long-term civil commitment for the same offense. The best way to fight this result is to offer evidence that the inmate’s state of mind has changed and they are no longer a danger to society. What better way to accomplish this goal then by having the treating mental health providers testify in the inmate’s defense?

2. Credibility

In the purely civil arena, while cost is still a factor, credibility is a bigger concern. The attorneys who issue the subpoenas in civil cases have the same goal as those in the criminal cases: get the treating provider to give favorable testimony about the medical or mental health condition at issue. In the civil case, however, the greatest reward is the ability to argue to the fact finder that the treating provider is more reliable and credible than the paid experts of the other side (the “hired guns”).

The argument goes like this:

Ladies and gentleman of the jury, you have heard from John’s treating doctor at the prison. That doctor has a difficult job and took time off from his very busy schedule to come and speak to you today. He wasn’t paid $2,000/hour like the “doctors” that the defendants hired. In fact, he wasn’t paid anything over and above his normal wages. Unlike the defendants’ so-called expert, this prison provider sees John on a regular basis and is in charge of his healthcare.

He is far more credible than those witnesses who have never even met John and render their so-called expert opinions based only upon review of a select portion of his volumes of prison medical records.

The power in that argument is so strong, it is hard to resist. Unless you want to become a participant in the legal proceeding, it is important to know your rights as a witness and the risks inherent in your potential testimony.

What Rights Do You Have in Response to a Subpoena?

Many people incorrectly presume that once they receive a subpoena, they have to obey it no matter how inconvenient or objectionable. While the court rules do demand that legal orders be obeyed, they do not render you powerless. Subpoenas for medical records, for instance, do not entitle the issuing lawyer to speak to you about your treatment of the patient.

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Legal and Legislative Updates

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only cover production of the requested records.

Subpoenas for attendance at a trial or hearing require personal service to be effective. Therefore, Dr. Jones from our storyline above has a legitimate challenge to the trial subpoena that she received because it was served on the warden’s secretary, not the doctor.

Next, subpoenas must provide at least 24 notice of a personal appearance. They should be accompanied by the statutory witness fee.

That brings up the issue of compensation for your lost time from work. Statutory witness fees run about $25/day, not nearly what most people earn. Many states, however, have statutes requiring that when professional persons are called as witnesses, they are entitled to compensation for lost time from work rather than the standard witness fee. Insisting upon proper compensation is not only your right, it may encourage counsel to release you from the subpoena rather than incurring the cost of your appearance.

Next, trial subpoenas usually mandate that the witness appear on the first day of the case at the hour it is set to begin. The result is that the witness sits around for hours or even days waiting to be called to testify. As a professional, you should be granted the courtesy of being provided a specific date and time to appear by the lawyer issuing the subpoena. Make sure to get that change of date and/or time in writing so you can prove that you were complying with instructions given subsequent to issuance of the subpoena.

So, now that you have ensured proper service of the subpoena, insisted upon adequate compensation and narrowed down the time to appear, you take the stand. Do you have any further rights? The answer is yes. While you are obviously obligated to testify truthfully, you are not required to provide the free expert opinions that the lawyer is seeking.

1. Example in a criminal case

If the lawyer asks you the inmate’s state of mind at the time of the crime, it is perfectly legitimate to state you do not know and cannot to a reasonable degree of medical certainty offer such an opinion. You did not begin treating the inmate until sometime after his arrest or conviction. Also, point out you have not been

Liability insurance is designed to cover claims arising out of your provision of care to patients, not claims stemming from your testimony in criminal or civil cases.

asked to and have not conducted a forensic mental health exam.

2. Example in a civil case

If you are asked whether you believe another provider committed malpractice, you are allowed to state that you have no opinion. You should not be forced to provide expert opinions if you legitimately have not formed them. Do not comment on what you might have done if you were treating the inmate for that condition at that time.

If you are unclear whether or not you are required to give an opinion (rather than answer a factual question such as the last time you saw the patient), ask the judge for clarification. Listen carefully to the response as that answer gives you direction for future questions of a similar nature.

What Risks Accompany Your Testimony?

1. Does Your Employer or Professional Liability Insurance Protect You if You Testify?

If you work directly for a government agency, you may enjoy some immunity from routine civil claims, such as allegations of medical malpractice. If, instead, you work for a private company providing services in corrections, while you don’t get those same protections, your employer likely provides you with professional liability insurance.

Be careful, however. These protections do not apply once you leave the realm of provider and enter the world of witness. Liability insurance is designed to cover claims arising out of your provision of care to patients, not claims stemming from your testimony in criminal or civil cases. Thus, if you are sued regarding the testimony you provided, you may well be on your own in defending the claim.

While you may rightly be thinking that it is hard to win a case against a provider based on testimony in a court case, the cost of defending the matter can be staggering.

2. If You Give Them Everything They Want, They Will Likely Call You Again

If the risk of liability is not enough reason to be careful about what you say on the stand, revisit the major theme of this article: attorneys are increasingly calling correctional providers as witnesses to give them a benefit they would not otherwise have: i.e. inexpensive and/or very persuasive expert testimony. If you willingly provide those expert opinions and do not limit your testimony to simple facts of which you have personal knowledge, the attorney issuing the subpoena got just what he wanted.

Word spreads fast. Soon everyone in the public defender or prosecutors’ office is going to be calling you to court. If, on the other hand, all you did was discuss your chart notes and refuse to be led into giving expert opinions, that lawyer is going to realize there is no real benefit to calling you as a witness.

Of course, if instructed to answer specific questions by the court, you are obligated to do so. That, however, is rarely the issue when it comes to rendering expert opinions. It is usually an overly zealous witness who, when the spotlight is placed upon them on the witness stand, cannot resist educating the courtroom about anything and everything. Think twice before doing so and remember your rights as the witness.
If you step in front of an automatic sink and it doesn’t turn on, do you really exist? In public restrooms all over the country, one’s actual being as a viable entity is regularly challenged by automated plumbing.

Not long ago, another form of affirmation became apparent to me. If you’re in the hospital and your attending forgets to round on you, do you exist? A recent admission for pneumonia raised that question from existential pondering to an actual concern. Towards the end of hospital day 3, it was clear no one was coming to see me. I hadn’t been difficult. All I wanted was oxygen and sleep. For a physician-patient, I’d been quite low maintenance. No demands to read my own x-rays or analyze my labs. Yet, I was forgotten. Neglected. Unworthy of a physician visit. It stings a bit more because of the professional connection that one might have assumed. To be an internist, forgotten by my own internist… I will probably never be able to start a sink again.

Sometimes people ask why I’m so “nice” to the patients. However, I don’t feel particularly nice. I’ve done this long enough to be able to laugh with a patient while still being wary of what’s actually being requested. I don’t discuss personal matters with patients and I can say no. It’s crucial, however, to always be aware of both the physical and spiritual makeup of the person who’s come to you for care. Most of our patients are foolish and have made really bad choices. A few are actually evil. Others fall somewhere in between. As their caregiver, however, I am free from having to sort this out. The punishment has been decided, the state is carrying it out, and I am here to provide medical care.

A wise physician once told me you should believe your patient- otherwise, why are you even there? However, she phrased it as, “Trust and verify.” Not “but” – that would get things off on the wrong foot. Rather, assume the truth and verify it with objective evidence, whether it’s getting old records or calling for the canteen list. Taking a thorough history, doing a good exam and collecting appropriate data solidifies the doctor-patient relationship and gives you an invaluable base from which to go forward. A patient who trusts you will accept it better when you explain why an MRI won’t be helpful. They’ll also accept it better when you can’t find a cause for their symptoms. They believe you when you say, “Well, I don’t know what you have but I know what you don’t have [insert patient fear: cancer, infection, heart disease, etc.]”

When a patient leaves our medical unit, I want her to have a little better understanding of her condition, her medications, her responsibility in follow up and what to expect. I want her to know there are no stupid questions, and that we have a plan even if it’s simply to see her through this. When a patient leaves our unit, I expect her to have been treated in a way that allows her to turn on an automated sink.

Now I have a follow up appointment to get to—with my new doctor.

Dr. O’Brien is the Associate Medical Director for the Wisconsin Department of Corrections. Readers may contact her at Kellym.obrien@wisconsin.gov.

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**Letter to the Editor regarding Winter Ethics Column**

What did they do? In my facility eventually somebody probably would have given in and let him have what he wanted. I would have tried to dig my heels in, but I know staff gets very uncomfortable with dwindling inmates.

Liz Rantz, MD

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**Dean Rieger’s Response**

A small number of readers wondered by email what happened with the patient discussed in the last CorrDocs ethics column. First to briefly refresh the readers’ memories: We were faced with a patient who declined offered treatment in favor of a different more costly treatment for inflammatory bowel disease. Although all involved clearly understood that the treatments were equivalent and that the jurisdiction had the authority to pick one regardless of the reasoning, the patient’s refusal had repeatedly resulted in clinical deterioration that required interventions that were far more dangerous and invasive.

First, we made sure that all involved were fully informed. This included the treating professionals (on-site and off-site), the jurisdiction responsible both for providing care and for funding the care, and legal services representing both the jurisdiction and the health care providers. Then, we searched for a differentiator that we could use to avoid the slippery slope associated with inmates demanding specific treatments, and settled on the immediacy of the harm associated with this refusal. Unlike, for example, refusal of one medication for treatment of hyperlipidemia in favor of another which might have effects over many years, if ever; this refusal reliably resulted in deterioration in a matter of weeks. We discussed similar clinical challenges, and representatives of the jurisdiction agreed that they did not want to put inmates at immediate risk for harm even if it cost them a bit more in the short run. We agreed to revisit this position should we come across other equally determined inmates who were putting themselves needlessly at risk, but to provide this particular inmate with the medication he demanded. In short, we followed the path of non-maleficence and beneficence for this individual patient. Should costs have been more dominating, we would have had to consider the effects on other patients of acceding to the inmate’s demand. Then the impact of non-maleficence and beneficence might have led to a different conclusion.
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roughly one percent of all breast cancers and 0.1 percent of all male cancers. The estimated incidence is 1 case per 100,000 men and has a unimodal distribution with peak incidence at 71 years old. Among the histologic types, invasive ductal carcinoma is the most common. Family history, advancing age, chest radiation and exogenous estrogens are some of the risk factors associated with breast cancer in men. Gynecomastia is noted to be present in 6 to 38 percent of all male breast cancers; therefore, this diagnosis should be considered in men presenting with this complaint.

Typical presentation begins with discovery of breast lump or nipple retraction on self-examination and mammography is an important initial screening tool. Axillary node involvement is noted in 50 to 60 percent of cases and estrogen and progesterone receptors are positive in 75 to 92% and 54-77% of cases respectively. Fine needle aspiration and surgical biopsy will provide further information about the suspected diagnosis and allow histological confirmation. A family history of breast cancer should prompt analysis for BRCA 1 and 2 gene mutations which may be found in some cases. Furthermore, in search for comorbidities one French study of 19 men with diagnosis of Breast Cancer found all patients to have diabetes, hyperlipidemia, hypertension and excess weight. All patients with a confirmed diagnosis of breast cancer should have evaluation for hormonal receptors and expression of proto-oncogene HER 2. As with women earlier detection provides a more favorable prognosis for cure and treatment.

The approach to treatment is similar to that of female breast cancer patients: mastectomy, radiation and chemotherapy. Because most male breast cancers have hormone positive receptors, hormonal manipulation plays an important role in the treatment algorithm. Tamoxifen is the drug of choice for men with hormone positive receptors with the response rate ranging from 25 to 80 percent with variation related to whether the male patient had orchiectomy. Tumor size and, more particularly, histopathological axillary involvement are the strongest predictive factors for both locoregional recurrence and metastasis.

In correctional healthcare setting where the majority of patients are male and the growing population of aging prisoners presents daily challenges, male breast cancer should be in the differential for any patient presenting with gynecomastia, retroareolar lump and cavitation. While male breast cancer is still a rare diagnosis and its incidence remains well below that in women, the diagnosis should be considered in any male over 65 with history of gynecomastia or breast lump. Male breast cancer is a treatable and curable condition that carries good prognosis if detected early. Work up for metastatic disease and lymph node staging remains the standard initial step in a patient with new diagnosis. Education of providers and patients alike will result in greater awareness about this rare, but potentially fatal disease.

CorrEthics

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Clearly returning Mr. McVeigh to society would have been unacceptable, but life without parole, could have accomplished the protection society required at far less cost than the approximately $15 million society spent to kill him. At the other extreme, the Innocence Project has been instrumental in the release from death row of approximately 17 convicted inmates. Who can be comfortable with the idea of executing them? And how many other innocents were executed or remain on death row?

I cannot use ethical principles to tell you how to feel about capital punishment, but I can hope that you will think about your beliefs and consider whether they are consistent with your understanding of ethical principles.

Clinical Vignette

Continued from page 9

enhance that value, and that we must sometimes weigh acting in a manner that benefits one or many humans to the detriment of others. The shorthand terms for these principles tell you much about the underlying assumptions, although these do little to convince us to believe one way or another about the death penalty. Benificence, non-maleficence, and patient autonomy seasoned by the justice principle. These are now broadly accepted in our clinical world and probably will be for the foreseeable future, but our agreement with these principles does not stop us from holding disparate views regarding the appropriateness of the death penalty in the most extreme of crimes.

Timothy McVeigh killed 168 people and injured countless others in a cold-bloodedly planned murderous attack. And he was unrepentant; he would do it again.
Academic Conference in Atlanta Highlights Research and Collaboration

The 5th Academic and Health Policy Conference on Correctional Health Care in Atlanta, GA, took place this past March and offered the participants a comprehensive curriculum of ongoing research, developed policies, academic partnerships, and outstanding plenary speakers. Course directors, Dr.’s Anne Spaulding and Warren Ferguson along with their National Advisory Board flush with SCP members, created a 4-track schedule addressing mental health, juvenile justice, infectious disease, women’s health, research methods, policy, workforce topics, as well as chronic illnesses and substance abuse. Familiar faces were at every table and conference room since so many SCP members were presenters. Dr.’s Dave Thomas, Newton Kendig, Stephen Martin, and Arthur Brewer expounded on incorporating academics into correctional health care, either as a research opportunity, a training experience for students and residents, or as a collaboration with an education institution. Dr. John May presented his work during the outbreak of cholera in the Haitian prisons after the earthquake. Dr. Robert Greifinger discussed the aging correctional population and the specific challenges they bring to the correctional system. Dr. Jennifer Clarke presented her work on eliminating outside smoking from the inside as well as on post-incarceration contraceptive empowerment. Dr.’s Jeffrey Metzner, Robert Trestman, along with Dr. Kenneth Appelbaum, tried to optimize delivery of mental health care, while Dr. Joseph Penn underscored the risk of re-incarceration in those with dual-diagnosis. Dr. Thomas Groblewski and his cohort presented the Massachusetts success with telemedicine/teleconferencing. Dr. Michelle Staples-Horne reviewed the trends and treatment of juvenile obesity. Please note this list is not complete nor exhaustive but applauds all the hard work of our current SCP members and their exceptional associates. Rounding out the conference were plenary speakers, Dr. Jeremy Travis who challenged us to address health care in this time of mass incarceration, and Dr. Sheila Bird who presented her research on Naloxone-on-release as a way to curb opiate overdose deaths. Seventeen posters completed the current research trends and SCP was fortunate to be one of the six exhibitors. Past-President Dr. Donald Kern and President-Elect Dr. Rebecca Lubelczyk were some of the SCP members that were on-hand to answer questions about our national organization and to support the great work presented at this important conference. The 6th annual Academic and Health Policy Conference on Correctional Health will be held in Chicago, IL, March 21-22, 2013. www.correctionalhealthconference.com.

Health Care for Youth

Continued from page 1

The majority of the article expounded on the extent of the physical and mental health issues and needs of this population. General physical health was discussed including dental health, injuries, tuberculosis, and reproductive health. The mental health section included a general overview as well as the prevalence of psychiatric and substance abuse disorders and treatment. The importance of screening and assessment was identified as well as references made to the NCCHC Juvenile Health Care Standards. Continuity of care and community based interventions for incarcerated youth, to include the issues of meeting educational needs and health care financing was also discussed in the article. Specific recommendations were made in the policy statement regarding delivery of care; developmentally appropriate confinement facilities; integration of available systems of care; treatment and intervention; and advocacy. The abstract below fully captures the content and intent of the article.

“Youth in the juvenile correctional system are a high-risk population who, in many cases, have unmet physical, developmental, and mental health needs. Multiple studies have found that some of these health issues occur at higher rates than in the general adolescent population. Although some youth in the juvenile justice system have interfaced with health care providers in their community on a regular basis, others have had inconsistent or nonexistent care. The health needs of these youth are commonly identified when they are admitted to a juvenile custodial facility. On-site correctional health care providers must not only try to identify these health issues but also determine if there has been active medical management in the community. Pediatricians and other health care providers play an important role in the care of these youth, and continuity between the community and the correctional facility is crucial.”

As correctional physicians we all have a role in being at the forefront for demanding excellent health care for our patients. I feel this is even more critical for juvenile populations. After all, adequate health services received as a juvenile may result in improvements in behavior and reduced recidivism, ultimately reducing the number of youth to be incarcerated as adults. But it takes more than those of us in correctional health to accomplish this goal. We must solicit our community health providers to become more involved, and stand up for legislative and policy changes that will improve access and continuity of care for this very special population of children.
Clinical Vignette

Continued from page 8

roughly one percent of all breast cancers and 0.1 percent of all male cancers. The estimated incidence is 1 case per 100,000 men and has a unimodal distribution with peak incidence at 71 years old. Among the histologic types, invasive ductal carcinoma is the most common. Family history, advancing age, chest radiation and exogenous estrogens are some of the risk factor associated with breast cancer in men. Gynecomastia is noted to be present in 6 to 38 percent of all male breast cancers; therefore, this diagnosis should be considered in men presenting with this complaint.

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News Release

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Health Care in Chicago, Illinois; and Correctional Medical Services in Saint Louis, Missouri.

Jail and prison inmates are at increased risk for exposure to infectious agents, and lack of vaccination affects not only inmate populations and correctional workers, but also potentially the health of nearby communities, the authors state.

Including jail and prison inmates in emergency preparedness efforts, especially vaccination campaigns, is important for the health of communities overall, notes corresponding author Anne C. Spaulding, MD, assistant professor of epidemiology at Emory University’s Rollins School of Public Health.

“Inmate populations can include those in the highest risk categories for influenza, such as pregnant women. Access to healthcare may have been poor before incarceration. The typical jail detainee is released within a couple of days and returns to mix with the general community,” explains Spaulding.

“Future pandemics may be more severe than the 2009 H1N1 outbreak, and vaccination of incarcerated adults should be an important part of the preparedness effort.”

Approximately 2.3 million inmates were confined in U.S. prisons and jails on any given day in 2009, and over the course of the year approximately 10 million people spend some time in these facilities, according to prior research by Spaulding.

“Higher priority may need to be placed on provisions for high risk populations such as jail inmates,” the report states. “Public health needs to protect persons in jails who might otherwise be missed during vaccination efforts and pandemic influenza planning,” says Spaulding.

In addition to Anne Spaulding, the authors were Alice S. Lee, MPH, David M. Berendes, MPH, Katherine G. Seib, MSPH, Ellen A.S. Whitney, MPH, Ruth L. Berkelman, MD, and Saad B. Omer, PhD, from Emory University; R. Scott Chavez, PhD, National Commission on Correctional Health Care; and Patricia Lynn Meyer, Correctional Medical Services.

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Healthcare for Youth in the Juvenile Justice System  *Starting Out in Correctional Medicine*
Another Subpoena, Another Day