Fulfilling the Mission of Academic Medicine: Training Residents in the Health Needs of Prisoners

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The single mission of academic medicine is the pursuit of health for all. This mandate serves as a reminder to focus care on vulnerable and underserved populations. The 12 million Americans who cycle through correctional facilities each year are arguably among the most vulnerable populations in this country; predominantly black, with a high burden of disease and many barriers to care after release. Medical training programs should provide exposure to the health needs of prisoners. Residents could establish care with inmates prior to release and arrange follow-up in the community. This addition to training would not only provide care to this underserved group, but also would train residents in the myriad problems prisoners face, and foster social responsibility.

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As the unequivocal leader in today's complicated world of health care, academic medicine shoulders a powerful responsibility to define the critical elements in the delivery of health. While the most commonly recognized mission of academic medicine is the three-pronged vision of clinical care, research, and teaching¹, the true mission is a single mandate: the pursuit of health for all.² This directive leaves no room for exclusion, and is a reminder for continuing to focus care on vulnerable and underserved populations.

AN EPIDEMIC OF MASS INCARCERATION

The 10–12 million people who cycle through our prisons and jails annually are arguably one of the most vulnerable, and rapidly growing, populations in this country.³ Last year 2.3 million Americans were in prison or jail and an additional 5 million were on probation or parole.⁴ Combined, this staggering statistic means that 1 in 31 adults are under some form of correctional control, a rate that jumps to 1 in 11 among black men, and often much higher in urban neighborhoods.⁴ For many in this marginalized, and often difficult to reach population, incarceration may provide their first encounter with the medical system. While health care is mandated within correctional facilities by the constitutional ban on cruel and unusual punishment, 95% of

prisoners will eventually be released, many without insurance or access to care. As a result of over three decades of increasing rates of incarceration, the number of releasees increased 46% between 1990 and 2000, and is expected to keep growing. Although drug offenders make up 33% of those reentering the community, 84% reported drug and/or alcohol use at the time of their crime.⁵

Among this sizable population the burden of disease is high, particularly for the addicted inmates who will make up the majority of those reentering communities. One-third of all hepatitis C infected Americans and one-quarter of those with HIV pass through correctional facilities each year.⁶ In addition, 40% of active tuberculosis cases in the United States occur among inmates⁶, and infections such as influenza, of particular relevance now, are routinely spread within correctional facilities.⁷ While infectious diseases are markedly higher among inmates, chronic diseases are also increasingly prevalent. It is estimated that 9% of U.S. inmates have asthma, 5% diabetes, and 18% hypertension.⁸ As a consequence of longer prison sentences and the aging of the general population, prison populations are getting older and these rates of chronic disease will likely increase. A study in a Texas prison found that 12 of the 15 most prevalent conditions were chronic illnesses, and the rates of hypertension, diabetes, and arthritis more than doubled in inmates over 50.⁹ The combination of increased disease and high rates of reentry make health care for this population of crucial importance, both for the health of the individuals and for the communities they are returning to.

THE PURSUIT OF HEALTH FOR ALL; BRINGING ACADEMIC AND CORRECTIONAL MEDICINE TOGETHER

If academic medicine is to continue to fulfill its goal of care for all, the health needs of former prisoners cannot be ignored. To achieve this goal medical training programs need to provide exposure to incarcerated populations for trainees. A survey in 2001 of 1,209 residency directors found that only 14% of programs offered lectures on care for incarcerated individuals and only 22% offered any clinical experiences for residents within correctional facilities.¹⁰ A similar survey of program directors regarding the training in the diagnosis and treatment of addiction demonstrated inconsistencies and an overall dearth of training, with lack of time cited as the most significant barrier.¹¹ The authors of the study on trainees' exposure to prisoners argue that "As many as 10 million Americans enter or leave the correctional system annually. For medical educators to not acknowledge this and not provide

clinical training amounts to not being sensitive to local communities, who will have to deal with the health care and addiction issues of these Americans.”¹⁰

INCORPORATING PRISONER HEALTH IN TO RESIDENCY TRAINING

Correctional facilities and academic medical centers can partner in a mutually beneficial and efficient manner to improve the health of incarcerated and soon-to-be-released prisoners. Correctional health care providers could identify those in greatest need of linkage to post-release medical care. Medical residents would ideally see those inmates prior to their release to establish a relationship and schedule an appointment after release, a simple step which has been shown to result in a 60% follow-up rate in this hard to reach population.¹²

While it may seem that residency programs are already overburdened with requirements, providing a correctional healthcare curriculum is not only feasible but also practical. With the new ACGME requirements for one-third of residents' time to be spent in ambulatory medicine, many programs are struggling to reshape the structure of their training. One way to address this issue is to replace inpatient elective rotations with outpatient experiences. Time spent in prison-based clinics would be an easy way to accomplish this.

For residents with limited interest in prisoner health, a two to four-week ambulatory elective could be offered that would be a mix of didactic teaching, assigned readings, and several days a week working alongside physicians within jails and prisons. Similar ambulatory electives focused on specific populations such as geriatrics or homeless healthcare already exist in many residency programs. Prison health curricula could include an overview of addiction medicine, with training on how to screen, briefly intervene and refer to treatment (SBIRT), which has a positive effect on provider confidence and the frequency of interventions, as well as patient outcome.¹³ Additionally, pharmacologic treatment of opiate addiction with buprenorphine or methadone within corrections and at the point of release could be discussed. Other relevant topics include the management of psychiatric illness in the often detrimental environment of corrections; HIV and hepatitis C therapy within prisons; chronic disease management among an aging incarcerated population; addressing the discrepancies in health outcomes among minority groups; the complex needs for successful transitioning back into communities; and the ethical issues and dual loyalty of providing healthcare within a system that was designed for punitive measures.

Residents with a greater interest could elect to have their clinic site split between a community site and a site within a correctional facility. With this arrangement, these residents could alternate weeks between seeing inmates and seeing patients in the community, providing them with a mix of medical issues and also allowing them to arrange good follow-up care for inmates being released.

A MUTUALLY BENEFICIAL PARTNERSHIP

The benefit of training residents in treating current and former prisoners goes beyond providing much-needed medical care to

a population in need. Increased exposure to correctional health would offer excellent opportunities for physicians in training to learn about the myriad problems facing this population. A pilot program in Ohio which offered medical students a rotation in correctional medicine, demonstrated these advantages with students reporting the experience offered them unique exposure to extensive pathology and the opportunity to practice medicine in a nontraditional environment.¹⁴ Integrating residents into correctional medicine would also address the massive issue of racial discrepancies in health seen in this country, where American Blacks experienced 4.3 to 4.5 million more premature deaths relative to whites between 1940 and 1999.¹⁵ Given that 60% of inmates are minorities¹⁶, and 9% of black adults are under correctional control¹⁴, addressing the needs of this population might begin to offset existing racial health disparities in the community.

The disproportionate concentration of HIV among incarcerated populations increases the risk in the communities that lose large numbers of men to incarceration, resulting in massive social disruption.¹⁷ Not coincidentally, minority communities are the most affected by both HIV and incarceration. As incarceration rates skyrocket and sentencing guidelines grow harsher, “those who enter and leave [the correctional] system are increasingly Black or Latino, poorly educated, lacking vocational skills, struggling with drugs and alcohol, and disabled.”¹⁸ Additionally, black Americans are at the highest risk for HIV infection. This disparity has resulted in the Center for Disease Control launching a new campaign, “The Heightened National Response to Address the HIV/AIDS Crisis Among African Americans.”¹⁹ President Obama has also acknowledged the importance of addressing racial disparities in HIV through developing a National HIV/AIDS Strategy to reduce HIV incidence and health disparities particularly among Blacks.¹⁹ Given that prisoners are disproportionately both HIV-infected and minority, providing access to healthcare within prisons and as inmates transition back into communities is a key step towards addressing these disparities. Integrating academic medical centers and physicians-in-training into corrections exposes residents, provides much needed care, and trains the next generation of physicians in these crucial public health issues.

FOSTERING SOCIAL RESPONSIBILITY IN ACADEMIC MEDICINE

Teaching social responsibility to physicians-in-training has been recognized as a critical, and often under-recognized, component of medical education.²⁰ Early exposure to care for the underserved, whether domestically or abroad, may help foster social responsiveness, compassion, and interest in working with the underserved, and awareness of the social determinants of health.^{21,22} To this end, early exposure to care for incarcerated and formerly incarcerated populations could help lay the foundation for social responsibility, and further what is thought to be the first recorded mission of an academic medical center, the “pursuit of health in the service of society.”²

Academic medicine has the opportunity to be a leader in modeling excellence in health care for prisoners, the most marginalized population in our society.²³ Providing training and exposure for residents fosters social responsibility among the next

generation of physicians, and provides a much needed service.²⁴ Not only is this "ethically and legally the right thing to do, but most prisoners (often very quickly), return to their communities, where their illnesses become the illnesses of the community."²⁵

CONCLUSION

Linking academic medical centers and correctional facilities is a feasible and mutually beneficial partnership, providing much needed care to the disproportionately minority, addicted, and HIV-infected incarcerated population, and exposing residents to important medical and public health issues. With new ACGME requirements calling for greater ambulatory clinical time in residency training, an outpatient correctional medicine curriculum is a practical way to meet these guidelines. Additionally, teaching residents to care for marginalized prisoners fosters social responsibility and fulfills the ultimate goal of academic medicine to pursue health for all and reduce health disparities.

"I will remember that I remain a member of society, with special obligations to all my fellow human beings," Modified Hippocratic Oath written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University.

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