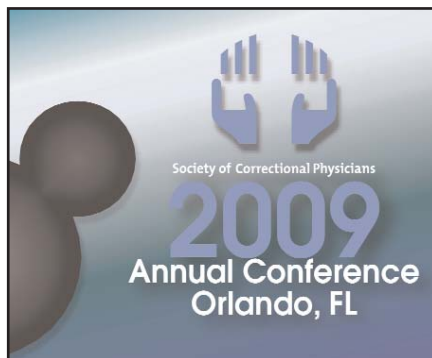


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SCP Conference on Aging Packs Them In

Lynn F. Sander, MD, MPH

The 2009 annual conference of the Society of Correctional Physicians entitled Health Promotion and Disease Prevention in the Aging Inmate was held on October 18, in Orlando, Florida. Dr. Joe Paris, DeKalb County Board of Health and DeKalb (GA) County Jail began the session with a lively case-based discussion on administrative dilemmas. The first case dealt with MRSA. The second case was about a missed cancer diagnosis due to a combination of factors including inadequate initial evaluation and poor follow up. This highlighted the fact that unexpected negative outcomes are rarely due to a single error, but occur because of a confluence of errors.



Next, a talk outlining the demographics of the aging incarcerated population was presented by William Sabol, PhD, Chief of the Corrections Statistics Unit of the Bureau of Justice Statistics.

Although still a small percentage of the total inmate population, the elderly are the fastest growing age group due to a variety of factors. In prisons, a higher percentage of these inmates tend to be incarcerated for violent crimes, primarily murder (25%) and sexual assault on a child (25%). In jails, they are held for serious offences and DUI.

The impact of the above statistics was discussed by Dr. Brie Williams, a UCSF



Nick Scharff plays the role of patient while Paula Frantz demonstrates mobility assessment.

gerontologist. Elderly inmates are a major contributor to escalating correctional health care expenses as the cost of their care is three times that of younger inmates. She also stated that the best prognosticator for morbidity in the elderly (more than any diseases a patient may have) is functional impairment, i.e., loss of one ADL or Independence ADL.

Dr. Paula Frantz, Chief Medical Officer for the Colorado Department of Corrections, followed with a talk and demonstration of objective tests to assess mobility impairment. Few appreciate the complexity of mobility which includes muscle strength, range of motion, balance, coordination of the anatomy of the skeleton, muscles, tendons and ligaments, cognition and vision. Dr. Frantz emphasized that, in addition to the objective tests presented, it is important to observe the patient upon entry into the clinic area, the exam room and while disrobing. It is also important to perform a physical exam which includes measurement of

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Letter From the Editor

It's hard to believe that another year has passed, marked by the annual SCP conference and membership meeting where the gavel of the Presidency was passed from Michelle Staples-Horne to Don Kern (hence two president's letters outlining what has been accomplished in the past as well as plans for the future.)



On the fast track is a joint effort by SCP and NCCHC to develop an examination for physician certification in correctional health. For those of you who could not join us in Orlando, I hope that the

brief summary of the meeting creates an interest in putting next year's conference date—October 10 in Las Vegas—on your calendar.

In this issue, we feature a point-counterpoint dealing with the dilemma of H1N1 Influenza. Hopefully, hearing different positions will assist you in determining how best to proceed with planning in your facility.

Once again, your opinions are important and letters to the editor telling us what you like, what you don't like and what you want in future issues are greatly appreciated.

Lynn Sander, MD
Editor

Board Report 2009 Annual Meeting

The annual business meeting of the SCP board of directors was held on October 17, 2009, in Orlando, Florida. In addition to hearing reports on the past year's activities, the board used this rare opportunity, when we meet face-to-face, to discuss strategic plans for the coming year. It is with great pleasure that I share some of these reports and plans with you.



Rebecca Lubelczyk, MD
Secretary

2009 Committee Reports

Education

This year's annual meeting saw the most preregistrations for our annual conference in our history. As many of you know, the conference was extremely well received. The speakers were timely, addressed national questions about our aging population and provided resources to use in our offices. The education committee did a fabulous job. Great work!

Policy and Practice Steering

SCP has submitted its statement on

pregnancy and restraints to NCCHC for review, as they are devising a similar statement. We hope to combine the two into a single statement that will have a substantial impact on current practice.

Membership

Encourage your colleagues to join SCP if they haven't done so already. If you work with medical students, residents or fellows, give them a brochure and encourage them to join. Membership is free to medical students and greatly reduced for residents and fellows. The membership committee is investigating membership and retention strategies to encourage new members and retention of those of you already with us.

Many of you are also members of other professional medical organizations. We encourage you to be an advocate and get the word out about SCP. Increase awareness of our organization and its goals among your noncorrectional colleagues.

Finance

Most of our revenue comes from membership dues, proceeds from conference registrations and CorrDocs advertising fees. Due to changes in the industry,

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Article Submissions

CorrDocs' purpose is to communicate the thoughts and ideas of correctional physicians, as well as to report on news that impacts their practice. We welcome all submissions. Articles should be approximately 750 words in length and submitted electronically, preferably in Word.

Letters to the Editor

Did an article, opinion, or statement in *CorrDocs* inspire you, impact your work, sound too good to be true? Express your opinions in a letter to the editor. The editor relies on your feedback to continually improve the quality of information in *CorrDocs*.

Direct All Submissions to:

Lynn Sander, Editor
editor@corrdocs.org
fax: (773) 880-2424

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Society of Correctional Physicians

1145 West Diversey Parkway
Chicago, IL 60614

www.corrdocs.org [WEB](#)
scp@corrdocs.org [E-MAIL](#)

773-883-5375 [PHONE](#)
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President's Message



This message comes to you in my final days as President of the Society of Correctional Physicians. My tenure as president has been a wonderful



experience, with tremendous support by many old and new friends and colleagues. All of your efforts make the organization what it is today. I would like to acknowledge my fellow SCP board members and Paula Hancock, since my job could not have been done without them. Thanks especially to the entire SCP membership, because you are the reason we exist.

As always, one wants to reflect upon the accomplishments that occurred during one's term, which I will do. But more importantly, I would like to visualize the future of the organization. In the past two years we have increased membership, developed relevant position statements,

improved our Web site, and offered exemplary educational programs including our first Medical Director Boot Camp. This publication, *CorrDocs*, has consistently been published for the membership under the direction of Lynn Sander. Our relationship with NCCHC was formalized with a Memorandum of Agreement. We have recommended a new SCP representative to the NCCHC Board, and NCCHC has appointed a representative to our Board.

In the future we hope to further expand membership, continue expanding educational programming, and improve member services. We are now developing a correctional physician certification examination and exploring the feasibility of medical specialty board recognition. Our role as the voice of correctional physicians must be further strengthened as we take positions on and develop public policy, chronic disease management, and infection control measures such as those for MRSA and H1N1 specific to the

correctional environment.

Finally, we must nurture new physicians and encourage them to enter the field of correctional medicine. This can only be accomplished through increasing the visibility of our profession to medical students and residents. Our willingness to serve as mentors to new practitioners is important, but also as important is to mentor those physicians that choose to enter correctional medicine as a later career choice. It is up to each of us to reach out to the medical community and make them aware of the challenging and rewarding field of medicine we have chosen to pursue.

It has been a great race for progress and it is with excitement and encouragement that I pass the SCP baton to Don Kern and visualize those new hurdles and finish lines that lie ahead for the organization.

Michelle Staples-Horne, MD
Immediate Past President

Plans for Presidency



Writing my first letter to the membership as President of your Society is quite a milestone in my life. The past two years as President-elect have flown by, but SCP has shown great progress under the leadership of Michelle Staples-Horne. As with sellout performers in Las Vegas, she's going to be a tough act to follow.



The good news is that there are many of you who are interested in and committed to advancing the mission and goals of the Society. The less than good news is that the current economic climate puts great pressure on correctional health care in general and our Society in particular, to maintain its quality and continue to grow. Your sustained engagement with SCP will be essential to its continuing as the foremost professional society in correctional health care.

Let me comment on five areas that I anticipate will be my priorities for my term as president.

1. Finish developing and implement an examination to test for and certify added competency of physicians in correctional health care. Part of the mission of the Society is to create a "repository of knowledge and expertise" through the knowledge, skills and attitudes of its members. SCP already confers Fellowship as an honorary title to individuals who have shown commitment to the field. However, we also want to create a mechanism for physicians to demonstrate their mastery of the art and science of correctional medicine. To this end, we have already been working with the Certified Correctional Health Professional Board of Trustees to develop a competency-based examination in correctional medicine. We anticipate having this ready to go in 2010.

2. Expand our support for developing the science of correctional medicine. The Institute of Medicine has pointed out that

current informed consent rules make research in corrections especially difficult and may prevent the conduct of important studies that might yield valuable results. SCP supports the principle that correctional health care practice should be evidence based, and I will encourage the gathering of new scientific knowledge that is more likely to be applicable to our relatively unique patient population.

3. Embrace the principles of translational medicine and apply them to correctional health care. Gathering knowledge is important; disseminating it is equally important. Correctional health care perhaps has the most to gain from the principles of translational medicine—developing evidence that becomes the basis of clinical guidelines that are then moved into practice. Despite the economic pressures affecting educational programming, SCP has expanded its offerings through collaboration to include a very successful Medical Director Boot Camp. I look

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CorrEthics The Extra Ethical Imperative

Michael T. Puerini, MD, CCHP-A, and Dean P. Rieger, MD, MPH

In the community, patients who are considered difficult by physician definitions is in excess of 15% among primary care medical practices. Medical providers in correctional facilities go with a much higher number. We encounter an assortment of difficult patient situations that our outside colleagues rarely if ever face.

Consider two examples:

Jimmy K, a young diabetic inmate, purchased and ingested an unknown medication from another inmate and was found in a coma in his cell. There was some delay in determining appropriate treatment because the initial assessment identified a blood sugar of 41 (hypoglycemia coincident with but not causal of his mental state). Jimmy eventually received the emergency treatment he required. He returned to the prison to complete a lengthy sentence, having suffered permanent hypoxic brain damage. He has an active lawsuit against health services personnel separately and individually, in the very prison where he resides, alleging inappropriate treatment delay.

Sara Y is a bipolar patient with a concurrent personality disorder who assaulted and harmed several staff members in the local community mental health center. Her violence was extreme, and she was charged with assault with intent to commit great bodily harm. Still ill, but clearly not considered ill enough to require psychiatric hospitalization, she continued to be dangerously assaultive at the jail. She

injured two correctional officers and one nurse in the course of one of her violent outbursts. Staff members are afraid of her and are uncertain how to manage her in a jail setting.

These are difficult patient case scenarios for us, and serve as examples why we consider our difficult patients to be different from those in the community.

It is our job—our ethical and legal imperative—not to neglect our patients simply because they seem ungrateful or even openly antagonistic.

In the first scenario, consider that outside of correctional settings, filing of a lawsuit against a health care professional almost universally would mark the end of the patient-provider relationship. Jimmy K, outside of prison, would need to find a new doctor. Inside the prison, the very targets of his lawsuit continue to care for him, and to provide for his daily and ongoing medical needs. There is a conflict of interest on both sides of the relationship and as such, an ethical conundrum exists.

In the second scenario, Sara Y, for reasons of mental illness and sociopathy,

is considered unmanageable in society and is remanded to the correctional system, where she is equally unmanageable. The milieu for proper medical treatment is not available elsewhere, but the correctional environment might be considered by some less adequate for appropriate treatment.

In both scenarios, correctional medical personnel must deal with difficult, seemingly unsolvable problems. So how are these cases related and what ethical principles can we apply to these and other situations that medical providers face daily?

In an earlier column we presented ethical imperatives often applied to difficult situations to make ethically sound decisions. This list included beneficence, nonmaleficence and autonomy. In some ethical schemas, justice is listed as the fourth imperative. The justice imperative refers to a “concern for an equitable distribution of benefits and burdens.” The U.S. Supreme Court provides us with the landmark case *Estelle v Gamble*, which enunciates the Deliberate Indifference Standard (DIS). In essence, the U.S. Constitution guarantees inmates the right to be free of deliberate indifference to their serious medical conditions—direct application of the justice imperative. The DIS requires correctional health care providers to include consideration for justice as part of their ethical management of

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MEDICAL DIRECTOR, CORRECTIONS HEALTH

Multnomah County Health Department, located in Portland, Oregon, is seeking a Full Time (.8 FTE) Board Certified/Board Eligible Internal Medicine Physician for our Corrections Health Division. The Health Department provides health, mental health and dental care to all detainees in Multnomah County. This position works with other provider staff to provide direct clinical care to the adults and juveniles in custody. In addition, this position provides leadership to the program for quality improvement, chronic care standards, clinical expertise and participates on the Management Team for oversight of operations, personnel, budget and service delivery of Corrections Health. This Physician/Medical Director reports to the Health Department Medical Director, as well as the Corrections Health Director.

The Health Department is seeking physicians comfortable with caring for the medically indigent, enthused about cross-cultural medicine and oriented toward preventive health. Experience with the public safety system, addicted population, multi-system health care needs and unstable chronic diseases are desired. Qualified candidates must be board certified or board eligible; this position is not a J-1 visa or HB-1 opportunity.



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HEALTH DEPARTMENT
CORRECTIONS HEALTH**

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For more information please contact Amit Shah, Medical Director, at 503-988-5140 ext. 25868 or amit.r.shah@co.multnomah.or.us

To apply, please visit our job opportunities website at: www.multcojobs.org, Job # 9490-07

Shelton Honored for Excellence in Correctional Medicine

Highest professional standards. Patient advocacy and promotion of a professional medical environment. Highest ethical standards. Dedication to research, publication and training. These are the benchmarks against which nominees for the Armond Start Award are judged.

Steven R. Shelton, MD, CCHP-A, was presented the Armond Start award on October 18, during the annual meeting of the Society of Correctional Physicians. He is the ninth member of SCP to receive the award since its inception in 1999.

Dr. Shelton, who has worked with the Oregon Department of Corrections for twenty-five years, has been medical director of the ODOC since 1993. He is a charter member of the Society of Correctional Physicians, a past board member and president of SCP, and is a current member of SCP's policy and practice steering committee.

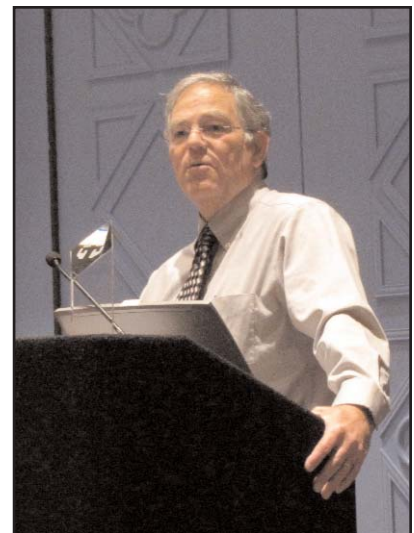
In discussing his experiences in correctional medicine as a primary care physician, Steve reflects on the advancement that he has seen in correctional

health care. "We have progressed from the days when inmates sutured one another's wounds and untrained individuals provided much of the care, to the point where quality compassionate care is the norm."

As an administrator, he pioneered and championed NCCCHC standards and accreditation for Oregon facilities. Among his many accomplishments, he supervised the establishment of one of the first prison-based hospice programs in the nation (which went on to receive NCCCHC's program of the year award), and established a patient-centered approach to medical decision making in Oregon that has been applied by other national correctional systems.

Above and beyond his professional accomplishments, Dr. Shelton is a caring, engaging man whose dynamic personality encourages others to excellence, professionally and ethically. He is a leader in our field.

But there's an important proviso. While Shelton cites colleagues such as



Steve Shelton addresses his colleagues upon receiving the Start award.

Ron Shansky and Joe Paris as his mentors, he also cites those who might claim him as a mentor. "Mentorship is mutual. We can learn from one another, and that's the beauty of SCP."

Dr. Shelton expresses gratitude, not only for the award but also for the support that we all can and do show for one another. He sees a bright future ahead for our professional organization.

Board Report

Continued from page 2

there are fewer grants available to support our conferences and, subsequently, other agenda items. Alternate fundraising strategies were discussed at length to help secure the future of SCP.

Board of Directors

The board was proud to have met its goal of convening on a monthly basis, as well as providing members with regular updates on these proceedings. The monthly meetings were highly productive and so we encourage the incoming board to continue them.

Strategic Plans

Subspecialty Recognition

Subspecialty recognition was a topic widely discussed at our meeting. In the

recent past, SCP applied to the American Board of Internal Medicine (ABIM) for subspecialty recognition, but they had advised us they were not entertaining new subspecialty recognitions at that time. However, with plans to develop a physician certification program under the auspices of the Certified Correctional Health Professional (CCHP) program, as well as interest in the issue by other organizations such as the American Osteopathic Association, the time might be right to reapply to the ABIM.

Social Media

Social networking has become more prevalent in our daily lives, especially among younger physicians. So SCP plans on developing a Facebook page as well as an entry on Wikipedia.org about correc-

tional medicine. Before you know it, SCP may be tweeting you!

Promoting Correctional Medicine

Beyond our membership recruitment efforts, the board discussed the importance of promoting correctional medicine as an exciting career opportunity to medical students and other physicians who might be considering a career change. To this end we will be reaching out to medical students via facilities who work with medical schools to provide services, as well as to physicians at correctional care units in hospitals.

Call for Volunteers

We look forward to your help in achieving these goals. Look for volunteer opportunities in the next few weeks.

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			Organizational Title					
Facility Name								
Business Address								
City		State		ZIP+4				
Home Address								
City		State		ZIP+4				
Business Phone			Home Phone					
Fax Number			E-mail Address					

Preferred mailing to Business Home

Preferred listing for published directory

Business Home Do not wish to be listed

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

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.

Provide a list of all other certifications or licensure.

Have you ever lost your license? Yes No

If yes, explain.

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

Signature

Date

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

Signature (only if paying by credit card)

Please mail this form and your check to

Society of Correctional Physicians

P.O. Box 11846 • Chicago, IL • 60611-0846

Phone 800.229.7380 • Fax 773.880.2424

www.corrdocs.org

Plans for the Presidency

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forward to developing new collaborations in order to expand the educational outreach of our Society.

4. Increase our involvement in policy discussions for a civil society. Highly motivated and dedicated members of SCP have honed an iterative process to help SCP develop policy statements on important matters in correctional health care practice. As the preeminent professional membership organization representing correctional physicians, SCP should make its perspective available to inform public

debate. I will encourage the Society to continue to be a strong and reasoned voice in the public sphere.

5. Promote our colleagues. As I have already mentioned, the members of the Society collectively have vast experience and knowledge of correctional health care. I will encourage the application of survey research methods to tap into this reservoir of information. Gathering and summarizing data from our membership will help us advance our mission as well as support the quality care our members

strive to deliver to their patients.

Again, I am honored to have been elected to this position as your president and thank you all for this amazing opportunity. I look forward to serving you to the best of my ability.

Donald Kern, MD, MPH, CCHP
President

Pandemic Planning: Point, Counterpoint

One Size Does Not Fit All

Rachel D. Schwartz, MA, MS, PhD

Current pandemic influenza preparedness and response plans for corrections are largely based upon the Avian Influenza A (H5N1) outbreak, which has not materialized as a pandemic at this time. Many believe the response to the ongoing pandemic of Novel Influenza A (H1N1) has been a relatively successful dry run for these plans. But for others, including the corrections community, the current response should raise a number of red flags regarding the actual state of preparedness in the corrections system.

The one-size-fits-all approach to pandemic planning, which applies the same measures to very different types of outbreak, has already led to worldwide calls for more precise application of severity measures in determining the disease response levels of the WHO and CDC. In the case of the corrections response, specific difficulties have arisen as a result of implementing or trying to implement checklists and guidelines that were not prepared to deal specifically with a low-lethality disease like H1N1, and these recommendations are leaving corrections authorities with confusing and sometimes contradictory information.

Planning Assumptions

CDC checklists used or referred to by virtually all corrections pandemic planners are based on assumptions that don't necessarily hold in the case of a disease like H1N1. For example:

- The disease is lethal, requiring an all out response on all levels.
- There will be a grace period between an outbreak and its appearance in the U.S. (the assumption with H5N1 was that it would come from Asia), which will allow for containment and tiered triggering opportunities.
- Because of its high lethality, the disease will likely lead to absentee rates from 40% to 50% among corrections personnel.

Even when applied strictly to a highly lethal virus, these basic assumptions are

problematic and raise serious questions, such as: Where would the resources for an all out response come from? How would they be paid for? How would they be distributed? How effective would containment efforts be, especially in light of the ease of transmission through global transportation and travel? And how would facilities operate with such severe absenteeism, especially given the new responsibilities pandemic plans require of them?

When applied to the low-lethality H1N1 outbreak, these assumptions are not only problematic, they are inappropriate. Thus, unlike H5N1, H1N1 does not call for significant levels of isolation, quarantine and PPE usage. Yet correctional institutions operate using plans that require such measures be taken, or at least seriously considered. Facilities with only a few mild cases like Rikers Island in New York even weighed the possibility of partial or full closure as demanded by Norman Seabrook, president of the Correction Officers' Benevolent Association. As a result of complaints by Seabrook, the correction officers' union and others, new precautions have been implemented, including sanitizing areas where sick prisoners were held, screening all inmates who leave the island for court appearances, and deployment of medical workers at the jail complex to consult with staff and screen prisoners. The additional cost and personnel involved is stressful and costly for corrections personnel as well as the system itself.

Moreover, flu plans written for H5N1 assumed a window of time to prepare and to limit or contain spread, but were inapplicable to H1N1, as seen in the Rikers outbreak and elsewhere. Indeed, the disease was already well established in the U.S. by the time it was recognized, making border closures and other efforts at containment virtually useless, and leaving corrections institutions to deal directly with a *fait accompli*.

Finally, despite anger and anxiety

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An Appropriate Response?

Anne Spaulding, MD, MPH, CCHP, and Madhura Adiga

The article by Dr. Schwartz merits a strong response when she asks whether current CDC guidelines for the novel H1N1 influenza virus trigger an unnecessarily "panicked pandemic response." Dr. Schwartz makes several points:

- The current CDC checklists for pandemic influenza require an "all out response on all levels" which is inappropriate for the current outbreak of mild influenza. (See www.flu.gov/professional/business/correctionchecklist.html)
- Local public health authorities may not be able to help correctional facilities in the face of a true emergency.
- Containment strategies are not feasible given the current overcrowding and lack of personnel and resources in most facilities.

In fact, the interagency U.S. government website for influenza (www.flu.gov) tailors recommendations based on the severity of illness. The World Health Organization (WHO) has assigned the current situation as Phase 6, the highest pandemic phase, meaning that there are human-to-human outbreaks in more than one WHO region. Having a high phase designation does not mean that international health leaders are misgauging the severity of illness. The phase designations can refer to any influenza outbreak regardless of its origin or severity; it only reflects the outbreak's geography. As health care leaders, we can recommend a level of response fitting for the severity of disease, in order to keep inmates and our coworkers safe.

While most cases of H1N1 influenza are mild, the virus still can kill. As this commentary goes to press, five thousand persons have died worldwide. The toll has been great in persons in their 30's and younger. For health care leaders in correctional institutions where the mean age

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One Size Does Not Fit All

Continued from page 7

among corrections personnel working where H1N1 has occurred, the disease has not caused significant absenteeism. Perhaps this is because it is becoming clear that the disease is not as lethal as they had been led to expect by their training for the H5N1 response. Indeed, the strongest reactions to the outbreak were in the first weeks of its appearance, when it was unclear just how serious a disease it was. If an alternative to the high-lethality response plan had existed (as well as a better understanding of the range of influenza severity), much of the fear and tension could have been avoided.

The lack of such an alternative plan (really a somewhat stepped down version of the high-lethality plan) has been the cause of much confusion and, in some cases, overreaction; has led to calls for closing international borders and limiting travel, locking down or closing unaffected schools and other institutions; and resulted in so many influenza tests that labs are overwhelmed with unnecessary tests for which neither personnel nor funding is available. Even though these steps have not been taken (at least not broadly), uncertainty and insufficient guidance have left responders in a difficult position.

New CDC Guidelines

Aware of the gaps between the reality of the H1N1 situation and the H5N1 plans, the CDC issued new guidelines on May 24, 2009, aimed at tailoring a response to the H1N1 outbreak for correctional and detention facilities. But while some of these guidelines offer solid clinical advice, many are impractical, contradictory, or still appear to be based on the assumptions of H5N1 plans.

Thus, for example, the new guidelines recommend that during an H1N1 outbreak, corrections facilities implement social distancing strategies that are clearly not feasible given the current overcrowding and lack of personnel and resources in most facilities. Consider the staffing implications of the recommendation for dividing facilities into two areas: one with

sick or exposed inmates, the other with well inmates. This would require two entirely separate sets of staff and many more resources at a time when, according to the guidelines themselves, there would be less staff and fewer resources. Moreover, it's questionable if social distancing is so crucial with a virus described by interim CDC head Besser, as "not much worse than a bad case of the flu."

Furthermore, while guidelines urging cooperation with local public health agencies (LPHAs) make excellent sense, they do not take into account the fact that LPHAs usually lack resources to provide antivirals to corrections personnel either for treatment or prophylaxis, as the guidelines suggest. Indeed, with H1N1 in its current form, these are probably not needed.

Finally, as Dean Rieger, MD, MPH, notes, by changing the definition of what a suspect case is from someone with fever and two of these three symptoms—cough, runny or stuffy nose, and sore throat—to someone with "symptoms of influenza-like-illness"—fever and either cough or sore throat—the new CDC guidelines overly broaden the pool of possible flu victims to the point that nearly anyone with a fever could trigger a panicked pandemic response, including social distancing, segregation of inmates, separation of staff, etc. Thus an attempt to improve sensitivity to disease would lead to a huge number of false positives that would strain an already strained system.

The Second Wave

When H5N1 failed to materialize as a serious threat because of its inability to move easily between humans, it was viewed as a dodged bullet. H1N1 is currently also being seen by many in the same light. However, given that H5N1 continues to spread, especially in Indonesia and Egypt, it is too early to write it off, especially as it now exists: side by side with the highly contagious, though low-lethality H1N1, in situations that might be conducive to reassortment.

Even if H5N1 is out of the picture next flu season, it is likely that H1N1 will return, perhaps having mutated to a more lethal disease as occurred with the 1918-1919 Spanish Influenza. Therefore, we cannot afford to congratulate ourselves on a successful escape from serious pandemic effects. Indeed, it is crucial that corrections facilities train and prepare for measures that deal with the range of mild to severe disease, possibly employing a tiered response system. Moreover, the plans must be improved according to realistic, appropriate and operational guidelines.

Such planning can only occur if, as the CDC notes, there is good collaboration between stakeholders. In this case, it is crucial that planning be carried out not only by planning professionals, but also by those who understand what can be operationalized and what cannot, what is realistic, and what fails to take into account the facts on the ground in correctional facilities. Clinical and custodial personnel, as well as local and federal public health personnel and experts in the field of pandemic response, must work together to develop plans that are appropriate and specific to different disasters and to the unique needs of the corrections community.

Dr. Schwartz is an Assistant Professor at the Institute for Biosecurity and Disaster Preparedness, Saint Louis University School of Public Health.

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Legal and Legislative Updates *Seven Things to Know About Your Malpractice Insurance*

Deana Johnson, JD

Insurance is like your health: You purposely don't think about it until a crisis occurs. But as dull and complex as insurance can be, you likely know how much auto coverage you have and who to call if you have an accident.

When it comes to professional liability (PL) insurance, however, most don't know more than the fact that they have it. Below is a quick primer on things you need to understand about the insurance that protects your livelihood.

1. What Insurance Do You Have?

The time to find out if and what insurance you have is not when you are served with a lawsuit. Plus, you do not have to read a 48-page insurance policy to get the answers you need. Just look at the declarations (DEC) page.

The DEC page will list the name of the insurance company, the name(s) of the insured, the limits of liability and the amount of the deductible. If you bought the policy for yourself, you are likely named as the insured.

However, most correctional health care providers are employed by either a government entity or private company. If that is the case for you, don't be surprised to see your employer listed as the named insured. Then look under the section entitled "Additional Insureds" on the DEC page. It should either list you individually or, more likely, state something to the effect of "all providers employed by the named insured."

If you have questions about the coverage, ask the human resource staff. If you are not getting information, contact the insurance company. Keep asking until you get the answers you need.

2. The All Important Consent Clause

Many providers fear having to report a settlement/judgment to the board governing their license. Such an event can negatively impact licensure, future employment, insurance terms, etc. Even if the estimated cost of defense of a lawsuit

dwarfs a settlement demand from the plaintiff, the provider will not want to settle for fear of the reporting repercussions.

Of course, this choice places you at odds with your insurer, whose interest is to save money. If the carrier can settle a suit for less than it will cost to defend, it makes business sense to do so.

So can your carrier settle your malpractice suit out from under you? That all depends whether your PL policy contains a consent clause, which requires written agreement from the insured in order to settle a claim. If you are purchasing the policy, be sure to demand the inclusion of a consent clause. If your employer is providing the insurance, ask about the consent clause. You do not want to find out about your ability, or lack thereof, to control the course of a malpractice suit only after it is filed against you.

3. Claims Made v. Occurrence Based Coverage

These two little words make all the difference with regard to insurance coverage. A claims made policy is triggered at the time the claim is made. An occurrence based policy triggers at the time of the event that is the subject of the eventual suit. Occurrence based is far better coverage, and the easiest way to understand why is to use a real life example.

You graduate from school and go to work at a local jail through ABC Staffing. You leave after two years and go to work directly for the state, providing care at a local prison. In 2009, you are sued by a patient you treated while working for ABC. He developed neuroleptic malignant syndrome (NMS) from medication you prescribed.

Question: Do you have coverage for the suit? (This scenario assumes that the incident was not reported until the suit was filed, and the insurance company does not disclaim coverage due to failure to report or some other breach of the insurance contract.)

Answer: Yes if ABC had an occur-

rence based policy; no if ABC had a claims made policy.

Question: Does it matter what type of PL insurance the subsequent employer has?

Answer:

No, because the subsequent employer's insurance is not going to cover you for care you rendered while working for the prior employer.

Question: Why doesn't a claims made policy cover the suit?

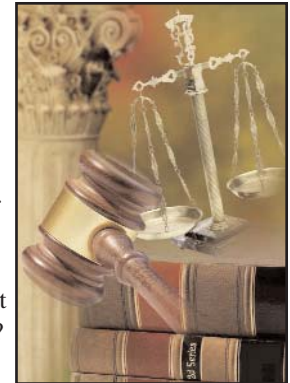
Answer: At the time the claim was made through the filing of the lawsuit, you no longer worked for ABC and were not an additional insured under its PL policy. On the other hand, if ABC had spent the extra money to buy occurrence based insurance, the trigger date would be the date you rendered the allegedly negligent care to the patient. You would have been an employee of ABC and an insured under the policy on that date.

Question: So what could I do to avoid this situation?

Answer: Read on to Nos. 4 and 5 below.

4. What is Tail Coverage Anyway?

Related to the above analysis, if you move from a job that has claims made insurance, you need to explore whether to purchase "tail coverage," an industry term used to describe insurance that covers you past the date of termination of a claims made policy. The tail continues that coverage through the date a claim could be made. That length of time differs depending upon what jurisdiction you practice in. Tail coverage is notoriously expensive. It often comes with numerous exclusions that narrow its applicability. It is very



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important to understand the risks and benefits of purchasing such coverage. In addition, you will want to explore whether your new employer will bear all or part of the cost for the purchase of a tail.

5. When Exactly is a Claim Made?

In the example above, the claim was made at the time the suit was filed because no one had ever put the insurer on notice prior to that time. While you cannot control what type of PL insurance your employer buys or which private health care vendor the government opts to use, you can take important steps to ensure coverage for yourself. Report adverse events to the insurance carrier and “make the claim.”

If a patient has a serious reaction to medication you prescribe, report it. If a patient attempts suicide and has to be hospitalized, protect yourself and report it. If a lawyer sends you a letter stating she is investigating care given to a patient, report it.

You need to understand the mechanism your employer uses for reporting incidents to its PL carrier. Use that system: it will protect not only your employer but you.

In our example above, while you were young, naïve and working for ABC, you did not know to report the NMS patient’s outcome the minute he was diagnosed. Instead, you thought since he recovered, you were safe. You did not report the adverse outcome so the claim was not “made” until suit was filed against you. By that time, you had no coverage.

Now that you know better, you would report the claim when the hospital specialist diagnosed your patient with NMS. The insurance company would set up a file and mark the claims made date as the day you gave notice. Fast forward two years when you are served with the suit. The insurer is obligated to defend you because the claim was made during the time you still worked for ABC. Another advantage to timely reporting is the carrier cannot disclaim coverage due to failure

to put it on notice. When in doubt, report.

The best security is information, so remain intimately involved from the time you start providing care to patients. And share your newfound insurance knowledge with your colleagues.

6. The Effect of Changing Employers

In the correctional field, providers can be forced to change employers in many situations: the government entity decides to privatize, the private healthcare vendor loses the contract or merges with another company, etc. Other times, you simply may decide that your employment situation would benefit from a job change.

Whatever the reason, you need to plan ahead to make sure that no gaps in insurance coverage occur. Understand the type of coverage you have with the original employer. Determine if you need tail coverage. Inquire about the type of coverage with the new employer. If there will be a coverage gap, negotiate for the new employer to buy the insurance needed to cover this risk. Companies are always going to have more room to negotiate price and coverage terms with an insurance company than an individual will.

Include all agreements about insurance in your new employment contract. For instance, if the new employer agrees to buy the tail coverage, specify that fact, the name of the carrier, the limits and all other relevant details in your written contract. Who will pay the deductible if a claim is made? Will you be compensated for time spent defending a case while working for your current employer?

7. I Have Coverage So I am Set, Right?

Not so fast. Now that you know and understand the coverage you have, you need to appreciate the risks that still exist even with good insurance.

PL policies almost always have a deductible, ranging from low ones in the \$25,000 range to high ones in the \$250,000 range. Only after the deductible is met does the insurance company have to contribute money.

Compounding this issue is the fact that medical malpractice cases are very expensive to defend. Not only do they involve significant work on the part of your attorneys, they involve the use of expert witnesses who can charge up to \$2,500/hour for their services. The cost of taking such a case through trial can average around \$250,000 depending upon the area of the country where you practice. As you can see, that easily consumes the entire insurance deductible with just defense costs.

By the time your case is in the hands of the jury, the sole protection left is the remaining insurance limits. By way of example, if your insurance policy is \$1 million per occurrence with a \$50,000 deductible and the cost to get to trial was \$250,000, you have \$800,000 left in coverage.

If that sounds like a lot, what happens if the jury returns a \$2 million verdict against you? The insurance carrier is only obligated to pay its \$800,000, and the plaintiff is going to look to you for the rest if it is a judgment solely against you.

Thus, you can see that higher insurance limits offer more protection in such a situation. The best security is information, so remain intimately involved from the time you start providing care to patients. And share your newfound insurance knowledge with your colleagues.

Ms. Johnson is an attorney with Insley and Race, LLC, in Atlanta, Georgia. Readers may contact her at djohnson@insleyrace.com

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An Appropriate Response

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is in the 30's, we should be concerned, especially since inmates live in such close proximity to one another. Ninety percent of persons hospitalized are less than 65 years old. The average age of persons admitted to an ICU is 29 years of age. Equally striking is that the average age of the persons who died was 26 years of age. Thirty-five to forty-five percent of persons who have been hospitalized had no underlying chronic medical condition.

Influenza is the leading cause of death from a vaccine preventable infection. Let's get in line to procure H1N1 vaccine for our patients who need it, especially pregnant inmates and those with severe cardiac, pulmonary, immunodeficiency or neurodegenerative disease. All persons in the recommended target groups should receive the vaccine unless they have had infection proven to be H1N1 by real time reverse transcriptase PCR. As correctional health care workers, we also will need to roll up our own sleeves for the vaccine.

Dr. Schwartz says that local public health agencies often lack resources in time of need. The corrections checklist stresses forming relationships before cri-

sis occurs. Such an approach worked when influenza struck the Cumberland (ME) County Jail. In their presentation at this year's National Conference on Correctional Health Care, "From the Shuffle to the Tango When H1N1 Waltzed In," presenters Meyer, North and Walsh described how they were able to handle H1N1 adequately, precisely because they had a strong relationship with their health department. Appropriate antiviral medications were obtained. Infected inmate-patients were sequestered in an empty housing unit. They were preparing for the "tango (H5N1), but were able to respond to the "waltz,"(H1N1) because relationships were in place.

Adequate planning saves lives by preparing us for a variety of crises. Use the present headlines as a catalyst to call together a pandemic planning group if your institution has yet to form an outbreak plan. Establish a working relationship with your local health department so that when an outbreak of influenza-like illness appears, you might receive adequate support to determine whether infections are from oseltamivir susceptible

H1N1 or a resistant strain of another influenza virus-rapid antigen tests have lacked sensitivity. Also, go to the Federal Bureau of Prison Web site and read recently updated guidance on Surveillance:

www.bop.gov/news/PDFs/pan_flu_module_1.pdf

Treatment:

www.bop.gov/news/PDFs/pan_flu_module_2.pdf

Health Care Delivery:

www.bop.gov/news/PDFs/pan_flu_module_3.pdf

Yes, an ounce of prevention is worth a pound of cure.

Dr. Spaulding is an SCP member and assistant professor of both epidemiology and medicine at Emory University in Atlanta, Georgia. She is lead author of: How Public Health Can Partner with Prisons for Pandemic Influenza Preparedness—Report from Georgia published in the Journal of Correctional Health Care (2009 Apr;15(2):118-28.)

Ms. Adiga is a fourth year medical student at Emory University.

CorrEthics

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inmates. In the medical model, justice fits poorly, but we must add it to our more basic concerns for beneficence, nonmaleficence and autonomy.

Jimmy K, as an insulin-dependent diabetic, has a well-documented and serious medical condition. The fact that he is suing us should and does make us feel uncomfortable, but it does not relieve us of our ethical obligations. The fact that the patient is suing us is immaterial in an ethical sense. While it may go against the grain, it is our job—our ethical and legal imperative—not to neglect our patients simply because they seem ungrateful or even openly antagonistic. We must somehow find a way past our emotions, past the personal injustice that we might feel, to a treatment plan that is objectively and thoughtfully administered. We don't have

to like it, but we simply must do it.

Sara Y also has a serious medical condition, her bipolar disorder, complicated by a condition that is not usually considered serious, her personality disorder. Similarly, under the DIS, the danger posed by her violence does not relieve us of our obligation to provide her treatment, although considerations for justice do require us not to place her need for treatment above our coworkers' need for safety.

As correctional professionals we must be familiar with what the DIS does and does not require of us, in much the same way that those of us bound by the Hippocratic Oath must understand it. How else can we properly respond to inmate requests and demands? Understood as an additional ethical

imperative, the DIS not only serves to protect the worst off among us, it also helps us to perform responsibly as physicians.

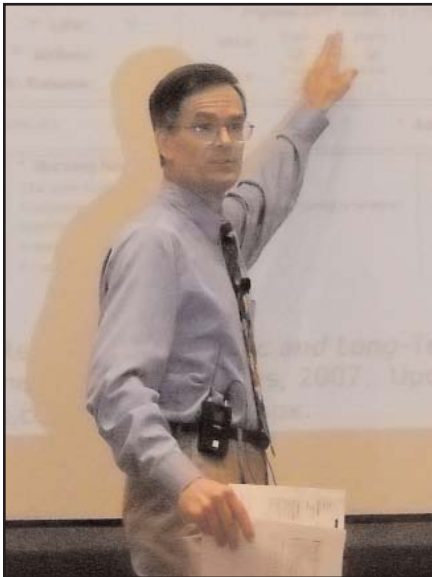
Dr. Puerini is the Chief Medical Officer for the Oregon State Correctional Institution in Salem, Oregon. Dr. Rieger is the Corporate Medical Director for Correct Care Solutions in Nashville, Tennessee. Readers may contact the authors at mike.t.puerini@doc.state.or and drieger@correctcaresolutions.com.

Annual Conference

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muscle strength, range of motion, knee ligaments, skin integrity, joint and muscle tenderness, effusions and edema, and vascular integrity.

Next, Dr. Terry Hill discussed the need to appropriately assess inmates for infirmary placement since these beds are a limited resource. Many infirmary beds are filled with younger patients and for reasons other than medical management, e.g., CPAP, inability to store clean nephrostomy supplies, indwelling catheters. To be efficient and appropriately allocate these limited resources, systems should find other ways to manage these nonmedical needs. Dr. Hill also noted that in corrections level of care depends on more than clinical



Terry Hill points out important aspects of the inmate needs summary.

characteristics.

Next was a talk on special accommodations for inmates with disabilities ranging from modest physical impairment to behavioral impairment, including both mental illness and dementia, by Dr. Nick Scharff, Chief of Clinical Services, Pennsylvania DOC. He also discussed hospice care and the special management units that Pennsylvania has created and the criteria and procedures for transfer into these units.

After a much-needed lunch break, Dr.

Mike Puerini, Chief Medical Officer, Oregon State Correctional Institution, moderated a discussion about use of restraints during pregnancy. The topic was timely as SCP and NCCHC are finalizing a position statement on the subject.

Dr. Richard Kosierowski, Director of Oncology Services for Prison Health Services (PA), followed with a discussion on prostate cancer, the most common malignancy in the aging prison population. Although using PSA for screening is still recommended through age 75, studies have shown malignancy can be present in those with a low PSA. And those with a high PSA may be cancer free. Additionally one should take into account racial differences as the normal PSA in African-American men is higher than that of Caucasians, whereas Chinese men have a lower average PSA. According to Dr. Kosierowski, the best predictor of poor outcomes is the Gleason grade on biopsy: those with grade six or less generally die of other causes. Recent studies have shown that in these low-risk patients, there is no difference in mortality from prostate cancer amongst the treatment options of watchful waiting, radiation and surgery.

Next, Drs. Natalie Needham, Ob-Gyn Consultant, and Don Kern, Chief Medical Officer, NaphCare, discussed care of the aging female inmate. Recommended screenings include yearly breast exams and mammograms until age 75, and pap smears every one to three years until age 70, as long as there is a cervix. It is also important to check for osteoporosis in postmenopausal women and those with myriad other risk factors.

The final talk on psychiatric treatment of elderly inmates was delivered by Dr. Daniel Comiskey of MHM Services. Psychiatric medication management in this population becomes more complex because of various physiological changes associated with aging. These include delayed absorption of oral medications, such that next day side effects are common;



Mike Puerini leads a lively discussion on use of restraints on pregnant inmates.

lower muscle and higher body fat composition, creating a smaller volume distribution which increases the risk of toxicity of hydrophilic medications like lithium; decreased amounts of circulating proteins, so there may be increased circulating levels of protein-bound medications such as Depakote and Tegretol; and decreased function of the liver and kidneys, delaying clearance of many medications. Because of these factors it is important to carefully monitor these patients, decreasing doses and obtaining blood levels. Another factor that complicates treatment is interaction with other medications, as the elderly tend to be on more medications than younger patients.

At the end of the day, all participants headed out to an informal networking dinner which provided a good time for all who attended.



Anne Spaulding, Michelle Staples-Horne and David Kenney enjoy dinner among friends and colleagues.

A Day in the Life

Kelly O'Brien, MD, FACP, CCHP

Score! Rural County has sentenced another chef. It's a small jail nestled in the base of the Rocky Mountains along Interstate 70, which leads to such popular destinations as Vail and Aspen. When a chef becomes a guest of the county, he's promptly assigned to cooking duties. There's an immediate lifting of spirits. Mac and Cheese becomes Three Cheese Pasta. Eggs have both texture and taste. Diabetics are no longer well controlled. Everyone, including staff, complains about the weight gain and then goes by the kitchen in case anything's left over.

It's beautiful when someone can bring special talents to any situation. Take Mr. H, an IV heroin user with osteomyelitis. MRSA, of course, IV vancomycin is the drug of choice. His jail doesn't do IVs, so he's now staying with us in the hospital correctional care ward for 6 weeks of therapy. The judge is unmoved by the sheriff's pleas for financial mercy. His case will be heard in 7 weeks.

Due to MRSA, which according to the evening news will kill you instantly if it jumps on you at school or in the gym, all of Mr. H's disposables are put into a trash can inside his room. Recently, he had a low grade fever, tachycardia and a mild hypoxemia. CT-PE was negative, CXR was unremarkable, repeat blood cultures were negative, and there was no change in his inflammatory markers. He must have gotten just plain tired of all the tests, because he confessed he'd gotten a syringe out of the trash, crushed his pain pills and injected them into his Hohn catheter, just out of sight of the room camera. Such planning! Such cunning! Why he confessed so readily I'll never understand, because it wasn't something I was figuring out. The whole thing could have gone on quite a bit longer.

We changed our MRSA disposable policy, and started cheek checks with him. As a staff we learned a lot about trust—such that now we have less of it.

Mr. G was another patient whose ingenuity was a source of awe. As a child, he'd been burned by his father. He had bilateral BKAs and scarred skin up to his

chest. Amazingly, his face and his hands had been spared. He's been active, working and getting around well on bilateral prosthesis. So well in fact, that when he didn't believe he needed an ambulance transport, he solved the dilemma by leaving... with the ambulance. He pushed the surprised paramedic out the door and drove right off. This had to be dealt with on the legal front, of course, but I hope that if I ever lose two legs I'll still have the balls to steal an ambulance. And you have to feel a little bit sorry for the para-

medic. "Aren't you the one whose rig got taken by a guy with no legs? Maybe you better let me drive."

Cooking for crowds. Pharmaceuticals. Vehicle procurement. Just a short list of the talent we've seen this year. And people ask why I work in corrections.

Dr. O'Brien is an SCP member and Acting Chief, Division of Correctional Care at the Denver Health Medical Center. Readers may contact her at kelly.obrien@dhha.org.

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Production Schedules & Deadlines

Issue:	IO due	Art due	Distribution
Winter 2010	January 11	January 22	February 10
Spring 2010	May 3	May 14	June 2
Summer 2010	July 12	July 23	August 11
Fall 2010	October 18	October 29	November 17

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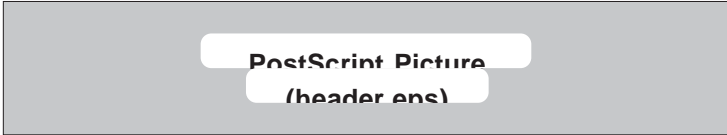
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