

# UTMB Magazine, Fall 2007

## Big House Health Care

### Why and how UTMB treats the incarcerated

by David Theis

**S**outhwest of Houston, past the burgeoning and increasingly plush suburbs of Fort Bend County, surrounded by rich alluvial farmland, and secured behind fence rows of razor-sharp concertina wire stands the Darrington Unit of the Texas Department of Criminal Justice (TDCJ).

A 1978 riot at this maximum-security lock-up, built in the 1930s, spread to other units of what was then called the Texas Department of Corrections, or TDC. That prisoner insurrection added impetus to what was to become the longest-running prisoners' lawsuit in United States history.

Styled *Ruiz v. Estelle*, this legal action was initiated in 1972 by inmate David Ruiz against then-prison system director William J. Estelle alleging dangerous and degrading living and working conditions. In essence, the lawsuit claimed that the TDC's management of its prisons amounted to "cruel and unusual punishment" in violation of the Eighth Amendment to the United States Constitution." In addition to alleging overcrowding, inadequate security, unsafe working conditions, and severe and arbitrary disciplinary procedures, Ruiz's suit complained of grossly inadequate health care—among other things, too few medical professionals for the number of prisoners, the use of uncredentialed individuals to deliver medical care, and limited therapy for psychiatric patients.

The case ultimately went to trial in 1980 before federal judge William Wayne Justice of the U.S. District Court in Tyler. After 129 days of testimony, evidence, and argument, Judge Justice issued a searing ruling in the plaintiffs' favor, ordering extensive changes in virtually every aspect of the Texas prison system challenged by Ruiz's lawyers, including, not coincidentally, how the system provided health care.



And it's prison health care that brings Owen Murray to Darrington on this bright morning. A jaunty fellow with close-cropped, sandy-blond hair and a well-toned distance-runner's physique, physician Murray is the assistant vice president for UTMB Correctional Managed Care, which is responsible for providing health-care services to nearly 80 percent of the inmates of the TDCJ (the Texas Tech Health Sciences Center at Lubbock cares for the rest). Murray has offices in Huntsville and Galveston, but he spends much of his working life driving from one prison to another, supervising UTMB's efforts. When he talks to UTMB-employed nurses and doctors inside the prisons, his questions have an enthusiastic tone, underscoring that he's genuinely excited to be behind Darrington's clanged-shut door talking about prisoner health.

I've accompanied Murray on this day's rounds, and he introduces me to members of the UTMB Darrington staff. There's nurse Sharon Cantu, a short, pleasant-looking woman who wears an olive-drab flak jacket as she dispenses prisoner medications. "Working in a prison is kind of scary," she acknowledges, noting that her jacket is "knife-proof." But she says that the stresses of the job bring the staff closer together, and that's a good thing. They cover each others' backs. "We're like family," she says.

Cantu has been working inside the prisons for only a year and a half. Tall, dark-skinned Chuma Anaduaka, Darrington's practice manager, has worked "in the system" for two decades. As he leads Murray and me through the full range of Darrington medical facilities, from dental suites to the emergency room, he favorably compares TDCJ facilities to the prisons in his native Nigeria, which he calls "true dungeons." We pass through imposing cellblocks, waiting in the wide hallways while first one, then a second massive gate opens to let us through so we can view "offender" living conditions—bleak un-air-conditioned cells that can be bitterly cold in winter and blazing hot in the summer. At one point we're about to don flak jackets

so we can enter a solitary confinement block, but a guard talks us out of it. “You don’t know what they’re going to throw at you,” he warns. “They can get very creative.”

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In the prison barbershop, Murray and I talk to a pair of trusties, convicts considered trustworthy who are accorded special privileges. Informally known as “Batman and Robin,” the pair has been in TDCJ’s custody for over twenty years and each vividly remembers prison life pre-Ruiz, and before UTMB provided health care. “Years ago, people died in the infirmary,” says Batman, a mustachioed African-American. “The doctors didn’t care. They were part of TDC. Now, they do care, and they take good care of you.”

I speak with several prisoners at Darrington, and they all praise the high quality of the health care they have received. None does so more poignantly than David Snyder, a highly tattooed, dark-haired young man who lies in an ER hospital bed with an IV tube inserted into one thoroughly illustrated arm. Perhaps it’s the painkillers he’s on, but he has a vaguely beatific look. Snyder seems older than his twenty-five years yet softer and more vulnerable than anyone ought to look after serving four years in administrative segregation (a version of solitary confinement where prisoners are kept, not in punishment for bad behavior, but because something about them—initial prison gang membership, in Snyder’s case—represents a potential threat).

Snyder suffers from Crohn’s disease, a chronic inflammation of the gastrointestinal tract characterized by diarrhea, cramping, and loss of appetite. The inflammation “ebbs and flows,” in Murray’s words, and right now it’s flowing, which is why Snyder is in the ER. He’s halfway through his eight-year sentence for aggravated assault, and he has mixed feelings about the health effects his eventual release might have.

“I’ll have more control over what I eat,” he says, which he knows is one key to effectively managing Crohn’s disease. “But money is going to be a problem.”

Indeed it will be. Murray calculates that Snyder’s treatment costs the taxpayers twenty thousand dollars, and he frets that Snyder may have trouble finding insurance to cover his pre-existing condition when he gets out.

So while Snyder would no doubt prefer the “free world,” as both medical workers and offenders refer to life beyond the prison walls, he genuinely appreciates the high quality of the health care he receives. “They [UTMB staffers] treat you real good here,” he tells me. “This is the best [health care] I’ve ever had.”

As we drive away from Darrington, Murray discusses the big picture concerning UTMB's collaboration with the state on prison health care. In 1976, four years before Judge Justice handed down his decision in *Ruiz v. Estelle*, the United States Supreme Court held—in a case styled *Estelle v. Gamble* that prisoners do have a fundamental right to health care: “Deliberate indifference to serious medical needs of prisoners” such as was alleged by Mr. Gamble, who was injured by a falling cotton bale as he unloaded a truck, amounted to cruel and unusual punishment. The state for some time resisted Judge Justice's subsequent order through a series of unsuccessful legal challenges.

Finally in 1994 the TDCJ contracted with UTMB's newly formed Correctional Managed Care (CMC) division and with Texas Tech University Health Sciences Center to provide managed health care for Texas's prison population. UTMB-CMC was given responsibility for providing the full gamut of health care, from dental to hospice, for nearly 80 percent of all Texas prisoners, who then numbered approximately fifty thousand and now total nearly one hundred and sixty thousand. In a sense, this contract was a logical extension of UTMB's historic experience; since the 1920s, prisoners had been transferred from Huntsville to John Sealy Hospital for specialized health care.

(For the past decade, UTMB also has provided medical, dental, and mental health services to inmates of the Federal Correctional Complex at Beaumont, now numbering about 5,700 male prisoners; that contract is valued at nearly twenty million dollars annually. In addition, UTMB has provided similar services to inmates of the Brazoria County Jail for the past four years. Beginning in August 2007, it will inaugurate a twenty-six-month contract to provide health care to approximately 1,000 inmates of the Galveston County Jail.)



According to physician Ben Raimer, CMC vice president and CEO, delivering this medical care has been quite a challenge, especially given the explosive growth in the prison population. Raimer, dressed in slacks and a flannel shirt on the casual Friday when we visit, notes that offenders are an unusually unhealthy population. A study from 1997–1998 found that 60 percent of all Texas inmates had at least one medical condition. According to an October 2006 report UTMB-CMC prepared for the Texas Legislature, inmates suffer from psychotic disorders three-to-four times more frequently than do members of the general public and up to 18 percent of all prisoners are severely depressed.

In a statistic that should give state lawmakers pause, Raimer notes that fully “one-third or more of all prisoners have been treated in mental health facilities,” in either prison or the free world. All these prisoners—over fifty thousand in total—are currently treated in prison for these mental health problems. Raimer questions whether “sending schizophrenics who get off their meds to jail for public lewdness” is better use of scarce tax dollars than simply getting them back on their medications would be.

Raimer points out that rates of HIV infection among offenders entering TDCJ are about double those of the general population—2.3 percent versus 1.1 percent. (Prisoners are offered voluntary HIV tests upon arrival at prison, and Raimer says “about 90 percent” of them accept. So far, there’s no telling how many prisoners contract HIV behind bars—although that will change because in 2005 the Texas Legislature mandated HIV tests for all offenders exiting the system. Raimer says “you’d have to be crazy” not to recognize that incarcerated prisoners share needles and have unprotected sex.) In any case, the cost of treating HIV-infected prisoners, who by law must have access to the most up-to-date medications, is staggering. Raimer says that “40 percent of the thirty-five million dollar pharmacy budget goes to treating HIV.”

Treatment of hepatitis C virus (HCV) also is very expensive, and it threatens to become crushingly costly in coming years. Studies show that up to 40 percent of prisoners nationally have HCV infection, as opposed to just 1.8 percent of the general population. HCV can lead to end-stage liver disease, which can be treated only by liver transplant, at a cost of almost four hundred thousand dollars each. Current estimates suggest that as many as forty thousand TDCJ prisoners may have HCV.



And unless society decides to lock up fewer offenders, caring for prisoners is not going to get any cheaper or easier. As in other walks of life, incarcerated Baby Boomers are leading to a graying of prison life—and costlier prison health care. According to Raimer, “We spend five times more treating patients over age fifty-five as those under fifty-five,” and, because of the longer mandatory sentences that the legislature required during the 1990s, the over-fifty-five prison population is growing ten times faster than the prison population overall. “Aging is causing major funding pressure,” Raimer says. He suggests that “the legislature may want to revisit” its policies on sentencing, which are among the most draconian in the U.S. “Other states are more lenient towards the softer felonies,” such as writing hot checks and minor drug offenses, Raimer notes.

Providing prison health care is so expensive, and so daunting, that an outside observer might wonder whether it is worth the trouble. After all, Raimer notes, UTMB routinely spends twelve to fifteen million dollars more than its annual allocation and has to ask the state to retroactively make up the difference.

But there are three very good reasons why UTMB prizes its efforts to provide prison health care. For one, it is a logical extension of UTMB's historic mission to treat the indigent. Moreover, the \$343 million prison contract provides around one-third of UTMB's annual operating budget and, likewise, UTMB's more than four thousand Correctional Managed Care employees represent about a third of UTMB's workforce. Most important, perhaps, is the unique teaching opportunity that prison health care represents for medical, nursing, and allied health sciences students. TDCJ operates its own eight-story prison hospital inside UTMB, and prisoners have access to all of the health services that UTMB provides, either at in-prison clinics, or beyond the clanging door in "free world" UTMB clinics (under armed guards, of course). In return, the prisoners, who number up to 1,900 outpatients and 400 in-patients each month, provide UTMB with 25–30 percent of all its teaching cases, according to Murray.

These cases offer such rich teaching opportunities that the school actually uses them as a recruiting tool. "There's such a diverse range of pathologies" among the prisoners, marvels one resident physician. "You get to see pancreatic cancer in a twenty-year-old. It's a great asset."

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The Texas Department of Criminal Justice Hospital, located next to the Emergency Department midway on the northern boundary of UTMB's campus, represents a unique culture, or—if you prefer—clash of cultures. According to the TDCJ's head of hospital security, Major Eduardo Hernandez, the facility is the only such institution in the country, and probably in the world, located within a medical university. As such, it represents a teaching opportunity and a security challenge. An intense bulldog of a man, Major Hernandez is mostly interested in the latter.

“Security here is hard. Medical personnel see [the inmates] as patients. They [medical staff] are always asking my men to take off their restraints. But as far as I'm concerned, if they can walk, they can run. We keep the restraints on.”

Perhaps in part because they appreciate being looked at as patients rather than offenders, Raimer says prisoners repeatedly try to scam their way into UTMB. An astonishing “95 percent of all patients reporting chest pain,” Raimer reports, turn out to have no detectable heart problems. Major Hernandez says that prisoners are particularly eager to hustle their way into UTMB from other facilities during football season because “they get to watch the games with two or three other guys in the hospital rooms, instead of with seventy other guys in a prison day-room.”

The professionally suspicious Major Hernandez sees “weapons everywhere.” Recently an inmate injured himself with a pair of scissors in the emergency room. “Where did he find scissors?” Hernandez asks rhetorically. He also talks about a recent time when a pair of scissors was declared missing. “I was here until 4 a.m., until I found those scissors.” No UTMB personnel have ever been seriously hurt by an inmate, or held very long as a hostage, but relatively minor events have taken place.

Troy Sybert, UTMB’s medical director at the prison hospital, takes Hernandez’ warnings to heart. “Whenever I’m dealing with a patient, I imagine that he would slit my throat and kill me if he could. I give him the same level of medical care I would anyone else, but there’s no fluffy talk.”



The combination of healing and incarceration raises other questions as well. Sybert says that at times the faculty has to “call on the ethicists” to answer questions such as, “Why do we have to get a person well enough to go back on death row?” This is not a hypothetical question. Suicidal patients from death row have come in for psychiatric help, been treated, and then have been sent back to Huntsville for execution.

Doctors address this potential conflict by concentrating on “health issues, not social issues,” says chief resident Brad Broussard. In a group interview, he and fellow residents Michael Nguyen and Gerardo Garza say they take security concerns very seriously, but they smile ruefully when I point out that they’re all wearing neckties—a security no-no. (Ties give prisoners something handy to grab but at medical schools they are regarded as an important part of a doctor’s dress code.) “Everybody wears ties,” Nguyen protests. “It’s just normal.”

Every doctor and nurse I talked to agreed on one thing—TDCJ offenders are close to being ideal patients. Their pathologies are not only compellingly interesting, but the patients are easy to locate for follow-ups, and by and large they do exactly what the doctors tell them to, even though they can by law refuse medicine and medical

advice if they choose to do so. "They're good patients," Raimer says at the end of our interview. "They tend to want to comply."