

PERSONAL NARRATIVE

Health Risks of Practicing Correctional Medicine

Dionne Hart, MD

Abstract

Correctional staff suffer high rates of posttraumatic stress disorder compared to military veterans, and the suicide rate among correctional officers is twice as high as that of both police officers and the general population and higher than that of all other professions combined. Correctional facilities' physician employees are at risk of not only burnout but also other adverse mental health effects related to working in a correctional facility. Prison reform efforts should address the needs of both inmates and clinical staff.

Burdens of Working in Correctional Health Care

How do you explain the experience of working in prison to members of the general public, whose interest in an offender ends when the flashing lights stop and the sirens are silenced? In some ways, the groupings in a prison are a visual flashback to the Civil Rights era—segregated by race, with Native Americans separated from whites, Hispanics, blacks, and Asians in dining halls, recreational units, and housing. In prisons, there are separate, self-sorted groups for various gang affiliations, white supremacists, sex offenders, and those with mental illnesses. According to the US Bureau of Justice Statistics, in 2016, there were 2 162 400 adults incarcerated in US prisons and jails.¹ As *CNN* reported, "That means for every 100 000 people residing in the United States, approximately 655 of them were behind bars."² That the United States represents about 4.4% of the world's population but houses 22% of the world's prisoners is staggering.³

When you enter a correctional facility, you are searched and your belongings are scanned. By entering, you voluntarily disconnect from the world, as you leave behind your mobile phone and almost all contact with the community. Unlike visitors, correctional staff receive a stab-proof vest, mace, a radio, and keys to internal doors. Their nasal passages are the first to recognize pungent odors from body fluids, garbage, and musty old buildings. Drawing on my 16 years of personal experience, I seek here to raise awareness of the unique health risks to correctional workers.

Correctional Staff: Demographics and Health Risks

Stereotypes abound not only about men and women who are criminally involved but also about men and women who work in these facilities. In the media, they're often depicted

as corrupt, predatory, inept, and—most recently—as political pawns.⁴ This stereotype masks the vulnerabilities of correctional staff.

Similar to the inmate population, correctional staff are predominately white men, but there are a large minority of women. According to a recent *Washington Post* article, women correctional employees represent nearly 30% of staff employed in prisons, jails, juvenile facilities, and community-based facilities.⁵ However, women correctional staff often face verbal and sexual harassment and might experience retaliation.⁵

Correctional staff—like all law enforcement officers—face constant physical risks as well as lesser-known mental health risks. For example, 34% of correctional officers suffer from posttraumatic stress disorder compared to 14% of military veterans.⁶ And the suicide rate of correctional officers is twice as high as that of police officers and the general population.^{7,8} In fact, the suicide risk for correctional officers is 39% higher than that of the general working-age population and all other professions put together.⁸⁻¹⁰ Correctional staff also have higher rates of depression and substance use.¹¹ Given these statistics, it is perhaps unsurprising that the average life expectancy of a correctional officer is 59 years compared to the national average of 75 years.¹²

Modeling Tolerance

The causes of health risks associated with correctional work are multifactorial, and every worker's story is unique. My story began more than a decade ago when I accepted a position at a prison hospital; I was young, healthy, and invested in performing my duties. Inmates were mostly appreciative. It was uncommon for a staff member or inmate to be assaulted, threatened, or harassed. That changed.

Occasionally, I would overhear black men shouting the n-word across the compound as a term of endearment to each other as they joked. I wondered why they chose to normalize a word characterized by such deep-seated pain for so many. I would hear inmates use so much profanity and slang in one sentence that it was difficult to understand even the simplest message. I would caution inmates that a judge sentenced them to prison, but the prison culture doesn't have to live in them.

Each day, I tried to model tolerance. I never withheld a greeting to an inmate covered in a swastika or confederate flag tattoos, nor considered giving special favors to someone who shared my ethnicity. I treated everyone the same. Occasionally, I would hear other staff members refer to me as an "inmate lover" when they thought I was out of hearing range, but I did not internalize their judgment. The physician workforce in the United States is only 4% black or African American,¹³ so I was well aware of my privilege to provide health care to one of the most underserved populations in the country, and I was determined to fulfill my professional duties without compromising my values.

The Challenge of Remaining Neutral

I cannot pinpoint the moment or the turning point when the prison environment began to take its toll, but it has. I recall the first time I was verbally harassed—a white inmate called me the n-word so many times in one minute that I thought he was going for a world record. He rejected my professional expertise because of the color of my skin. He expressed his preference and concluded that I was an unqualified “affirmative action hire” and that he would not permit me the opportunity to assist him. The inmate was mentally ill, so I told myself when he begins to recover and his frontal lobe function improves, he will not use such language. I informed him that often when people are ill, they feel vulnerable and seek to gain control by making derogatory comments to others, particularly those in charge of their care. I reassured him that, regardless of his derogatory comments, I would not abandon him and that he would receive the best care possible. I endured more episodes with inmates who expressed their biases, preferences, and feelings by spewing hatred, particularly when acutely mentally ill.

But soon I encountered a different type of inmate, one who used offensive language in daily intercourse solely out of disdain for my ethnicity. I began to use write-ups when I encountered this kind of insolence, hoping write-ups would help deter these behaviors. However, my reports were repeatedly ignored, dismissed (“You work in a prison”), or discarded, so I taught myself a new skill. Each time I heard the n-word, I internally replaced it with a calming word. My new means of coping solved one problem, but it also generated more questions.

Does Concordance Matter?

In a liberty-restricted setting, such as a correctional facility, how much freedom should an incarcerated person have to choose a racially concordant clinician? Since 1976, prisoners have had a constitutional right to health care.¹⁴ Does this right mean they should be allowed to choose caregivers based on racial or any other preference? In prison settings, clinician shortages limit the feasibility of honoring preferences. In addition, honoring an incarcerated patient’s preference for a clinician of a specific gender or race can unjustly undermine a nonracially concordant clinician’s authority or elevate a racially concordant clinician’s authority, perhaps for the wrong reasons.

While Americans express a value for cultural and ethnic diversity, we often shy away from discussing racial discordance in patient-clinician relationships. Yet one study of 9 white therapists found that they initiated discussions of race with black patients within the first 2 sessions to help build a therapeutic patient-clinician relationship.¹⁵ While [racial concordance](#) has been associated with improved health care experiences among minority patients,¹⁶ surveyed patients’ self-reports suggest that it does not improve outcomes,¹⁶ so it would be hard to argue that denying a patient’s concordance request constitutes a violation of a prisoner’s right. In fact, prisoners in the United States do not have a constitutional right to health care beyond the walls of their facilities and do not have a right to [request a specific course of treatment](#).¹⁷

Setting aside racial concordance, what is to be done about patient bias? An educated, outspoken woman of color is perceived by some prisoners and staff members as equally or more threatening than a prisoner. Perhaps more important are negative attitudes of patients toward clinicians; efforts to address patient bias toward clinicians like me should focus on helping clinicians build therapeutic alliance with patients. As always, it is the responsibility of all clinicians to practice medicine consistent with the American Medical Association *Code of Medical Ethics*. A physician should be dedicated to providing competent medical care with compassion and respect for human dignity and rights.¹⁸

Policy and Practice

While separated from the community by obvious barriers, correctional facilities remain a reflection of American culture, including its ethical values. In a setting so clearly influenced by race and ethnicity, correctional physicians have a unique opportunity to **lead the profession**. Each time we are faced with patient bias, we can practice virtues of neutrality and tolerance, bedrocks of treating any high-risk population. This does not mean we should be required to do so without support from the organizations and the public we serve. Correctional physicians have the opportunity to increase the level of public awareness of the negative impacts of perceived and actual racial discrimination and race-based health disparities—and the positive impacts of intentional increased diversity in the workplace—on both patients and clinicians. And, given the number of women employed in correctional facilities, including in health care, we would be wise to promote efforts such as those of TIME'S UP Healthcare, whose mission is “to unify national efforts to bring equity, inclusion and safety to the healthcare industry” in all settings.¹⁹ What I've written here is a brief introduction to the challenges correctional staff face and a plea for federal, state, and organizational policy to address more effectively the needs of incarcerated patients and to improve the working environment of correctional workers.

References

1. Bureau of Justice Statistics. Key statistic: total adult correctional population. <https://www.bjs.gov/index.cfm?ty=kfdetail&iid=487>. Accessed January 23, 2019.
2. Kann D. 5 facts behind America's high incarceration rate. *CNN*. June 29, 2018. <https://www.cnn.com/2018/06/28/us/mass-incarceration-five-key-facts/index.html>. Updated April 21, 2019. Accessed May 22, 2019.
3. Hee Lee MY. Does the United States really have 5 percent of the world's population and one quarter of the world's prisoners? *Washington Post*. April 30, 2015. https://www.washingtonpost.com/news/fact-checker/wp/2015/04/30/does-the-united-states-really-have-five-percent-of-worlds-population-and-one-quarter-of-the-worlds-prisoners/?utm_term=.6be18246ae34. Accessed March 4, 2019.
4. Magan C. As the shutdown drags on, federal workers in Minnesota say they're “pawns in somebody's game.” *Twin Cities Pioneer Press*. January 11, 2019.

- <https://www.twincities.com/2019/01/11/as-shutdown-drags-on-unpaid-federal-workers-say-theyre-pawns-in-somebodys-game/>. Accessed March 23, 2019.
5. Chandler MA. Women working in male prisons face harassment from inmates and co-workers. *Washington Post*. January 27, 2018. https://www.washingtonpost.com/local/social-issues/women-working-in-male-prisons-face-harassment-from-inmates-and-co-workers/2018/01/27/21552cee-01f1-11e8-9d31-d72cf78dbeee_story.html?utm_term=.9d524f1cf23f. Accessed March 4, 2019.
 6. Maull F. Hard time: correctional officer suicide rate rivals that of Vietnam vets. *HuffPost*. September 12, 2017. https://www.huffingtonpost.com/entry/hard-time-correctional-officer-rate-rivals_us_59b7fcc5e4b0678066213ea2.
 7. Peittaro M. Suicide among correctional officers: It's time for an open discussion. *Public Safety*. January 5, 2015. <https://inpublicsafety.com/2015/01/suicide-among-corrections-officers-its-time-for-an-open-discussion>. Accessed March 22, 2019. Accessed March 4, 2019.
 8. Stack SJ, Tsoudis O. Suicide risk among correctional officers: a logistic regression analysis. *Arch Suicide Res*. 1997;3(3):183-186.
 9. Lopez O. Prison officers need help, but they won't ask for it. *Newsweek*. May 27, 2014. <https://www.newsweek.com/2014/06/06/prison-officers-need-help-they-wont-ask-it-252439.html>. Accessed March 4, 2019.
 10. National Institute of Justice. Risky business: part 1 of 2 in a series on correctional officer wellness. April 2018. <https://www.nij.gov/topics/corrections/institutional/Pages/risky-business-correctional-officer-wellness.aspx>. Published April 2018. Accessed April 8, 2019.
 11. Mumford EA, Taylor BG, Kubu B. Law enforcement officer safety and wellness. *Police Q*. 2015;18(2):111-133.
 12. Cheek F, Miller MDS. Reducing staff and inmate stress. *Correct Today*. 1982;44(2):72-76,78.
 13. Association of American Medical Colleges. Section II: current status of the US physician workforce. <http://www.aamcdiversityfactsandfigures.org/section-ii-current-status-of-us-physician-workforce/>. Accessed March 4, 2019.
 14. *Estelle v Gamble*, 429 US 97 (1976).
 15. Fuentes JN, Mueller LN, Chauhan RV, Walker JA, Ladany N. An investigation of European Americans therapists' approach to counseling African American clients. *Couns Psychol*. 2002;30(5):763-788.
 16. Meyer OL, Zane N. The influence of race and ethnicity in clients' experiences of mental health treatment. *J Community Psychol*. 2013;41(7):884-901.
 17. *Roberts v Spalding*, 784 F2d 867 (9th Cir 1986).
 18. Moran M. AMA *Code of Medical Ethics* gets long-awaited update. *Psychiatric News*. February 27, 2017. <https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2017.3a3>. Accessed March 4, 2019.

19. Time's Up Healthcare. Mission. <https://www.timesuphealthcare.org/mission>. Accessed March 4, 2019.

Dionne Hart, MD is a Chicago native who received her MD from Rush Medical College and did her psychiatry residency at the Mayo Clinic School of Graduate Medical Education. Board certified in general psychiatry and addiction medicine, she has experience providing mental health treatment in correctional facilities, state-operated hospitals, detoxification centers, and emergency treatment units. She was previously awarded the Minnesota Psychiatric Society Psychiatrist of the Year Award and the National Alliance on Mental Illness Exemplary Psychiatrist Award.

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