

SICK ON THE INSIDE

Correctional HMOs and the coming prison plague
By Wil S. Hylton

When David Hannah walked into a small office on the second floor of the Moberly Correctional Facility in Moberly, Missouri, last fall, carrying his belly like a hundred-pound sack of sand, the staff knew him well enough not to worry about what he might break or steal or soil in their private offices, which were normally not accessible to inmates, so I was able to close the door behind him, and we sat together and talked about what was happening to his body. He was a pale, fifty-seven-year-old white male, serving a sentence of life plus three years for rape, and his gray hair was matted to his head. His face was as worn and gaunt as a much older man's.

Hannah was angry. "Look at it," he said, glaring at his gut. "Do you want to see it?"

I didn't want to see it, but I nodded anyway. I had come precisely to see it, to witness Hannah's disfigurement, the fruit of a long series of medical miscalculations. It had begun in the 1980s with two kinds of hepatitis, B and C, a condition that prison doctors had largely ignored for a decade, then treated with a series of botched, questionable procedures that caused David's cells to cease performing osmosis properly, so that over time his natural body fluids began to collect, trapped inside his gut with no way to evacuate, his midsection swelling to accommodate those fluids, expanding to such a size and weight that the mere act of walking around had given David, by December 2000, a pair of hernias, neither of

which the prison doctors had bothered to treat. David stood now to show me the belly and the hernias, the condition his body had arrived at through an utter lack of attention. He pulled his flannel shirt to the side of his waist and lifted his gray T-shirt, and, in spite of myself, I winced. His belly was enormous, taut and pasty, seemingly glued to his gaunt frame. At the front of it, a hot-pink hernia, about the size of a grapefruit, seemed barely attached where the belly button should have been, giving David's midsection the overall contour of a giant breast and nipple. Bracing myself, I asked him where the other hernia had emerged. He studied me, obviously not fond of baring his physique. After a moment, he shrugged and unbuttoned his pants.

To describe David's scrotum as swollen and red would be a failure of language. It was about the size of a rugby ball, so raw and irritated, shiny and crimson, that it almost seemed to be covered with blood. David hung his head. "They give me aspirin," he said.

Later, when I heard that David had died of indeterminate causes and that his body had been cremated, I realized that I had probably been the last person outside of the prison staff to see David alive, to see what his body had become from all those years of mistreatment, and I wondered: Can such a secret be kept?

It occurs to me now that prisons are designed for keeping secrets, for holding inside

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not just men but also their lives and the details of those lives. In prison, social isolation is a matter of policy, and inmates are neither expected nor encouraged to have more than a modicum of contact with the outside world. This is not necessarily, or at least not ostensibly, vindictive. In many cases, isolation is the prison's approach to rehabilitation. As Alexis de Tocqueville observed nearly two centuries ago, "Thrown into solitude [the convict] reflects. Placed alone, in view of his crime, he learns to hate it; and if his soul be not yet surfeited with crime, and thus have lost all taste for anything better, it is in solitude, where remorse will come to assail him."

Still, the social isolation of prisoners creates a host of difficulties, not least of which is that of monitoring their treatment, of ensuring that they are assailed only by their own remorse and not by anything else—by, say, other prisoners, or by those who keep the watch. Opacity, after all, runs both ways, and if the prison walls keep convicts in, they work just as effectively to keep observers out.

This problem is only made worse inside the prison infirmary. By its very nature, medicine is a private matter, and a prisoner's medical records are protected by the same confidentiality laws that protect free citizens. This means that a prisoner's medical chart is both locked inside a physical fortress and shielded by a battery of privacy restrictions, all of which leaves the field of prison medicine cloistered and nearly impossible to survey. Compounding this is the fact that prison medicine, and, indeed, the principles of medicine itself, are fundamentally at odds with all

other facets of prison life. Even the term "prison medicine" borders on oxymoron: Whereas prison is designed to alienate and punish, medicine exists to nurture and soothe. So where is the boundary between care and punishment? At what point do they meet?

Until the 1970s, which is to say for the first two centuries of American life, these were not questions that anyone felt compelled to ask, let alone answer. As a matter of law, prison medicine had always been considered a privilege, not a right, and the final authority on treatment was not a doctor or even a court but the local warden. Prisoners whose medical needs were not being met, whose broken noses and diabetes were left untreated, who were stabbed and not sewn, feverish and not medicated, prisoners who had cancer but no treatment, who had prescriptions that

wardens refused to fill, whose mental health teetered at the edge of self-destruction—those prisoners had no recourse, nor reason to expect it. In the early 1970s, a survey of jails by the American Medical Association found that fewer than 30 percent had medical facilities and only about one in five had a formal arrangement with any medical provider.

Things began to change in 1971, when an uprising at the Attica penitentiary in New York forced the subject of prison conditions into the national conversation. Amid a flurry of laws enacted in response to Attica, state and federal legislators began crafting measures to guarantee basic health care to prisoners. Although the laws have changed over the past thirty years, little else has. If anything, prison health care is in further decline now than ever. Most departments of correction have chosen not to invest in medical infrastructure but rather to farm out the business to subcontractors, and these days a single, private corporation controls the health care of all prisoners in ten states and manages a portion of inmate health care in another seventeen, having underbid competitors everywhere it exists. Correctional Medical Services is not merely the nation's largest provider of prison medicine; it is also the nation's cheapest provider, a perfect convergence of big business and low budgets. But unlike the traditional HMO, whose risk of a malpractice suit is real, and is felt, and is reflected to at least some degree in the quality of medical care, companies such as CMS have little or no reason to protect themselves. Most juries are reluctant to decide in favor of a convict, and those juries that do favor the convict are often reluctant to award money. Cost-benefit analysis takes on special, human overtones behind bars.

Perhaps even more significantly, private companies such as CMS feel no responsibility, and have no legal obligation, to account to the public for what goes on inside their facilities. So, while CMS receives about \$550 million of taxpayer money each year, the company chooses not to provide any accounting of how that money is spent or even how much of it is spent—and how much unspent, to be pocketed as profit. And although lawsuits over the years have revealed discredited health-care professionals working in CMS facilities, the company refuses to reveal the names of its doctors and nurses for verification or to provide any account of how many have been disciplined or had their licenses revoked in other states. With CMS responsible for so many patients nationwide, it is fair to say that the practice of medicine in prison has reached an unprecedented level of inscrutability—indeed, secrecy—and if this fact seems abstract or unlikely to affect regular folks in the gen-

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tween care and punishment? At what point do they meet?

eral population, well, just wait until the hepatitis epidemic comes flooding out of the gates.

For those of you who have never been personally acquainted with the hepatitis virus, allow me to describe it briefly. In the spring of 1995, I downed the wrong glass of frozen margarita somewhere in the Chihuahua desert and unleashed the disease on my insides. Unaware, I took a bus back to Juárez a few days later, walked across the border, drove home to Albuquerque, and, when the travel itch returned a few weeks later, set out for Glacier National Park, where I intended to spend thirty days in the backcountry, mountaineering. By the time I arrived in Montana, however, the virus had begun to set in, and I found myself overwhelmed by fatigue. Deciding to get some rest before starting out, I found an empty cabin near the boundary of the park, crawled down to the basement, settled into a bed, and, with one last glance at my backpack by the door, passed out. When I woke up several days later, I was lying on my back in a medical facility 120 miles away with an IV in my arm and a sign on the door that said, "Warning: Take Enteric Precautions Before Entering." Asking around, I learned that I had been delivered to the medical center by a friend who worked in the park. My liver-enzyme levels, upon check-in, had been gauged at more than a hundred times the normal level. The first time I looked in the mirror, I saw that my jaundiced skin was roughly the same color and texture as a dried tangerine. I spent several days lying in place, flitting in and out of consciousness, playing host to an array of curious physician's assistants, nurses, and certified nursing assistants, some of whom ran tests on my urine and blood while the rest mostly stood around marveling at how odd I looked. That was the beginning. For the next six months, I was forced to live at my parents' house, where my daily priorities became eating healthy food, sleeping at least half of each day, and wishing that my perpetual headache would relent. This was the face of hepatitis A, the least virulent strain of the virus.

The difference between the type of hepatitis I contracted and, say, hepatitis C, which is the most severe strain, is mostly a matter of intensity. My hepatitis eventually went away; hepatitis C, in most cases, does not. It keeps on attacking your liver for the rest of your natural life. That means people with acute hepatitis C can essentially forget about all the wonderful things that livers do, such as fighting infections, filtering toxins, and storing energy. To make matters worse, people with hepatitis C are contagious for the rest of their lives. Even twenty years after their initial infection, even if the virus is in remission and they feel pretty good, they still constitute a

walking weapon and had better be careful where they bleed. It is worth noting, then, that somewhere between 20 and 40 percent of American prisoners are, at this very moment, infected with hepatitis C, and therefore quite contagious. It is



also worth noting that most of them will eventually be released back into the general population, where the infection rate is, for now, only about 2 percent. The Association of State and Territorial Health Officials noted in a 2000 report that "an estimated 1.4 million HCV-infected persons pass through the correctional system each year." And although the virus is most pervasive in prison because of the high incidence of injected drugs there, it can be transmitted just as easily on the outside through sex, blood transfusion, or even a nasty fistfight.

With a scourge like this roiling on the inside, threatening to boil over to the outside, you might expect prisons to adopt some kind of screening policy for inmates and to institute a treatment offensive for the afflicted. Unfortunately, no such national program exists. Although the cost of a hepatitis test is only a couple hundred dollars, very few facilities volunteer to provide them, and there has been no federal legislation to require the measure. "It's a missed opportunity,"

says Dr. Cindy Weinbaum of the Centers for Disease Control and Prevention. "The number of prisoners with hepatitis C is incredibly high. It's unbelievable."

The fact that most prison doctors have not seized this opportunity doesn't reflect any inherent challenge to their doing so. On the contrary, a couple of states have developed simple and effective hepatitis programs that test all prisoners upon intake, making the disease relatively easy to track and monitor. One of those states is Texas, and there, not surprisingly, prison health care is managed not by a private company like CMS but by two universities, the University of Texas and Texas Tech University. Dr. David Smith, who is the chancellor of Texas Tech and who led the battle to make hepatitis screening mandatory in Texas, assured me that the hepatitis program he created is not very special at all, or anyway that it shouldn't be. "It's just the smart thing to do," he said. "We have almost 30 percent of our prison population in Texas infected with hepatitis. That's not so different

from the numbers you see in the Dark Ages with the plague."

When I visited a handful of CMS facilities last fall, I found a very different attitude. Under CMS care, 214,000 inmates are expected to petition for any hepatitis tests they want, and even if those petitions are granted, and the tests given, and the results positive, the chances of getting any kind of treatment are only slightly better than of getting a presidential pardon. This became most obvious to me when I heard the story of Larry Fraze.

I met Larry at the Western Missouri Correctional Center in Cameron, about four hours west of St. Louis. He was a gaunt little man with a circular face surrounded by brownish-gray hair, and his thin mustache seemed to weigh on his lips when he spoke. He walked with a silent shuffle, and from the black bruises under his eyes you could see that he hadn't slept well in months, if not years. When I began reading through his medical record, it was easy to see why. Larry had first been diagnosed with hepatitis in the early 1990s, when a prison plasma center rejected him as a donor. The diagnosis had been confirmed by a prison infirmary in June 1994, but even so, between then and the end of 1997, he had managed to wrangle only a half dozen doctor's visits. It wasn't until January 2000, a full five and a half years after his diagnosis, that CMS doctors began formally monitoring his condition. Even then, treatment was not forthcoming. As Larry discovered, CMS doctors required him to meet a long checklist of conditions, known as a "protocol pathway," before he could receive any

treatment for his disease. Some of those items required off-site consultations. One of the things he needed, if he wanted treatment, was a liver biopsy. But when Larry went to the prison infirmary to ask for one, he learned that he had to have a psychological evaluation first, then enroll in a drug-abuse awareness class and sign a slew of forms releasing CMS from liability for anything that might happen during the biopsy. So Larry did those things one by one, and he signed the papers, and he went to see the biopsy specialist, who promptly sent him back to his cell because he didn't know his virus genotype. Larry couldn't find anything in the protocol pathway that required him to know his genotype, but to be a good sport he put in a request at the infirmary for a genotype test. A few weeks later, he got the test, but the laboratory somehow screwed up his results, so he had to file for a second test and wait for a second appointment and a second set of results before, in February of last year, he finally returned to see the biopsy specialist, who sent him away again, this time saying that Larry shouldn't bother getting treatment anyway, because it can be somewhat dangerous. Larry argued that it was his decision to make, and that he wanted the treatment, or at least the biopsy that he was entitled to, and maybe afterward, when he had the biopsy results and could take an informed look at them, he would be willing to discuss the risks of treatment, but the doctor just shook his head. The decision was final, he said. No biopsy. He sent Larry back to his cell, where Larry has been ever since, without a biopsy, without any treatment, feeling sick and tired and a bit like he failed himself.

But what Larry didn't realize, and what he's only now beginning to grasp, is that he never had much of a chance in the first place. As a matter of formal company policy, CMS discourages treatment for hepatitis, and the protocol pathway is just a way of making it harder for prisoners to demand it. Although a CMS spokesman insisted that CMS doctors are private contractors and that "it is the individual physician's responsibility to make sure care is given to patients," an internal memo from CMS regional medical director Gary Campbell to his fellow directors in February 1999 reveals just how much authority the doctors really have at CMS. "I am not encouraging anyone to undergo therapy," the medical director wrote. "However, if you have someone that is insistent, then this pathway is to be followed." Campbell added, "Unless I have given you specific approval to do Hep C testing, do not do so unless the patient has obvious moderate to severe liver disease or has exposure as described by the exposure policy of the DOC. Remember, all Hep C testing has to be approved by me."

And so, for the 214,000 prisoners whose health is supervised by CMS, the hepatitis epidemic continues to grow, untested and untreated, virtually unencumbered by the forces of modern medicine, while people like Larry Frazee remain right where the company wants them: stalled along the protocol pathway. Whether or not this is legal remains to be decided. In January of this year, the University of Michigan law program filed suit against CMS for failure to address the hepatitis problem in that state. If their case is successful, similar lawsuits may follow in other states. Until then, however, the policy stands: No testing, no treatment.

"CMS is an HMO with a captive audience," says David Santacroce, the professor who is spearheading the Michigan lawsuit. "The fewer patients they treat, the more money they make."

"This is deliberate indifference," adds Michael Steinberg, legal director of the Michigan ACLU. "There is a standard for testing and treatment of hep C that the Centers for Disease Control came out with, and CMS simply is not heeding it. It's not just hepatitis, either. You talk about the tip of the iceberg! There is a systemic problem of not providing good health care to prisoners. Hepatitis is the tip of it, but there's a long list of issues below the surface that we haven't even begun to address."

Some of those issues have been addressed in other courtrooms, however, in other states, by other groups, and taken as a whole, the litany of malpractice crimes committed by CMS doctors begins to read like a horror novel. Take the inmate in Alabama who died of dehydration and starvation in a CMS infirmary after receiving care that one medical director described as "non-existent" and "a gross departure from medical community standards." Or the inmate in the same state who died when CMS staffers injected him with the wrong medicine. Or the CMS doctor in New Mexico who testified that he was required by the company to prevent off-site referrals. Or the district judge in Idaho who found that an inmate's care in the state prison "more closely resemble[s] physical torture than incarceration." Or the inmate in Nevada who died because a CMS doctor canceled her prescription for insulin. Or the federal judge in Michigan who described CMS follow-up care as "bureaucratic purgatory." Or a U.S. Justice Department inquiry in Virginia, which found that CMS medical records "failed to meet any known professional standard." Or the district court monitor in Georgia who found that CMS ran a "medical gulag" in the state prisons, giving one prisoner ibuprofen for his lung cancer and making another wait ten months to see a doctor for a broken arm.

Yet, perhaps because juries so rarely award mon-

ey to convicts, there is essentially no incentive for lawyers to bring these crimes together into a comprehensive, class-action lawsuit. Without the lure of a large settlement, most trial attorneys are unwilling to fork out millions of dollars in research and lost wages to fund such a massive endeavor. As a result, the central figure in the movement against CMS is not a major national law firm or even a renegade lawyer, but an aging, confrontational activist named Karen Russo.

I met with Karen, who runs a prisoner-advocacy group called the Wrongful Death Institute, one evening last winter at her home in the suburbs of Kansas City, and she invited me inside to sit at the small wooden table in her dining room, where we ate meat loaf and potatoes while her three dogs scurried around and her teenage kids and their friends traipsed up and down the stairs. Karen was undaunted by the chaos around her. When she had finished eating, she smoothed her dark brown hair behind her ears, sat back in her chair, and, as if she were in an office or behind a podium, she cleared her throat, blinked her heavily painted eyes, and launched into a tirade against CMS, her voice ringing through the house fervently, sometimes furiously.

"They don't want anyone to know what's going on in these facilities," she said. "Getting medical records and company documents is like going up against Fort Knox. We have to resort to all sorts of methods. We have a network of prisoners across the country who have ways of getting paperwork out to us, a couple of pages at a time. We have nuns who go in and bring documents out with them. We have nurses, doctors, whistleblowers. It's a war for information, and CMS knows it. They're just waiting to take me out. They hate me. Every Monday at noon I do a radio show on a local station, and it's like a fireside chat. The CMS headquarters is just over in St. Louis, so they have people listening. Everybody wants to know, 'Who's she going to get today?' And it could be anyone. I could go after a nurse, I could go after a doctor, I could go after the corrections staff. And I've gone after all of them. I'm putting together a file on every one of them. I call out their names on the air. 'Nurse so and so, I want you to know that I'm onto you.' And the prisoners are listening, too. This thing is growing like wildfire. A couple of years ago I was getting maybe two or three letters a week; now it's anywhere from twenty to thirty letters a day, from all over the country. Of course, some of those are from CMS decoys. That's what they're doing

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now—they get offenders to write me letters that say, 'I'm not sick, but I heard about what you're doing and I was just wondering how you got started,' and so on. You know, just dripping with it. They want to know what I've got. But I'm not naive: I can see right through that; I can smell it.



They're scared, and they should be. We've got them. I know what they're doing."

Karen's invective seemed over the top, but she was the genuine article: a nearly obsessive crusader who had long ago discarded any semblance of a normal life in favor of late-night phone calls with sick inmates and interminable afternoons poring over their medical records. The dust on her antique piano had become so thick and sticky that it made my eyes itch after only a few bars, and the ceiling in her bathroom was crumbling to the floor. Yet Karen's memory was immaculate; she had converted herself into a database of detail, packed with accounts of prisoners met, their medical histories, life stories, and extraneous personal minutiae. To reinforce this glut of information, the back rooms of her house were stuffed with thousands of papers, most of which she could locate and produce within a few frenzied moments. When pressed, she could also furnish names and numbers for a whole range of sources, including guards and activists and prisoners' fam-

ily members (though she was more reluctant to reveal others, such as the nuns and nurses she claims to consult). In her utter submersion into the topic, Karen had even developed a personal bond with one of the prisoners, a man named Raymond Young, who was locked up nearby on drug charges and whose persistent back problems and hernias kept him in a wheelchair, but who gave off an almost eerie radiance on the day I met him, with a great, black, bald head that shone like an eclipsed sun and a grin full of golden teeth inscribed with the numbers 3, 3, and 1/3. ("Thirty-three and a third," he said in a gravelly whisper. "I'm a traveler. A lone traveler.")

On the night I visited Karen, however, she took me to meet a different friend, Leland Hunley, who had only recently been released from the prison where Raymond is housed. When I saw Leland's apartment, it was hard for me to imagine that he was any more comfortable than he had been on the inside. His building, an indistinct brick high-rise, was in the kind of neighborhood that most middle-class people choose not to know about. There were crack dealers selling openly and loudly on the corner and drunks fighting in the street. The Plexiglas front doors were smeared with random grub and old graffiti, and the spun-polymer carpeting of the lobby seemed almost melted across the floor. Up the clattering elevator a few floors, down the narrow, echoing hallway, Leland's door opened into a single shabby room where he sat in a wheelchair watching a fuzzy television set that was on top of a little table above a small collection of right-footed shoes. Leland's left leg was missing.

"Come on in," he mumbled to us, pointing toward a couple of chairs and wheeling himself around beside them. I sat down, and we made small talk for a minute, then Leland cut to the story. "Basically, what happened was, I was living on the bay," he said. "That's the common area. It wasn't meant to be a living quarters, but the rooms were all full, so they had to put about thirty or forty cots in the bay, and I lived on one of them. I was there for about a year. The whole time, they never turned out the lights. But anyway, I was getting up for breakfast one morning and I reached over and put my sock on, and I felt a sting. So I pulled the sock back off and a spider run out of it. Well, I stomped it. I knew it was a brown recluse, pretty good size, so I scooped it up on a piece of paper to bring to the infirmary."

Leland shook his head at the memory and ran a bony hand over his short white hair. "But see, you can't just walk into the infirmary. You've got to fill out a whole deal called a Medical Service Request, and then they'll call you whenever they get to you. By the time I got up there, it was a couple hours later. The bite was swelled up to the size of a quarter. I

showed it to the nurse, and she put a salve on it and sent me back. I mean, you could just look at it and see that it was going to get infected. It was swollen, throbbing, hurting like crazy. So a couple days later, I put in to go back, and she soaked my foot in a solution. It got to where she was doing that every three or four days. I would put up an MSR and she'd soak it and wrap it up again. I could tell it wasn't getting better, but I wasn't allowed to look at it or anything. I could get a conduct violation if I took the bandage off. Every time she unwrapped it, though, it looked worse. It was a big black welt on top of my foot, with a red hole in the middle. After a while, you could see my bone through the hole. It kept opening up more. At one point they had a doctor to lance it and drain out the pus. It looked like it might get better after that, but it didn't. It just swelled up more. Eventually, my whole foot got black. It was just a big black scab. That's when they started giving me antibiotics, but it was already too late. I couldn't even walk. Finally, the nurse took off the bandage one time and just ran out of the room. She was really upset. I don't know what she told the doctor, but it wasn't a matter of a day before they was taking me to the hospital. The doctor said, 'I'm gonna have to take it off.' There was nothing I could say at that point. He told me, 'If you refuse, it'll kill you.' So I said, 'Okay, take it off.'

At fifty-eight, Leland couldn't have weighed more than 120 pounds, with knobby shoulders and elbows and a thin wisp of a neck. He rubbed his knees while he spoke, hunched over in his wheelchair, weak and almost emaciated. Toward the end of the interview, Karen, who had been struggling to remain silent, broke in to ask if he was okay. "You look like you're losing weight," she said.

He shrugged. "Well," he said. "You know, I can't get to the store by myself."

To someone on the outside, what happened to Leland's leg might sound, at the most fundamental, instinctive level, like a blatant case of malpractice. The notion of losing a leg to a spider bite has no place in the modern sensibility, and the suggestion that a person wait several weeks to receive antibiotics for an infection is almost unthinkable (though Leland's medical records confirm it). But like so many other things in prison, the term "malpractice" is inscrutable. On the outside, if a doctor does not conform to certain standards of care, then he is guilty of negligence, plain and simple, and finding a trial attorney to sue him is no challenge. By contrast, in prison, mere negligence is not necessarily enough for a lawsuit. Most prison malpractice cases are filed under the Eighth Amendment, which guarantees protection from cruel and unusual pun-

ishment. Unfortunately, in order to convict a prison doctor under these terms, the inmate must prove not only that the doctor provided sub-standard care but also that he did so intentionally. This rather elusive criterion is called "deliberate indifference," and under its protective banner a prison doctor is free to be as negligent and irresponsible and incompetent as he wants, just as long as he is not intentionally causing patients to suffer. Needless to say, this makes the practice of prison medicine significantly harder to regulate, and the care of patients harder to ensure. What could be more difficult to prove—or more secret—than a man's unstated intentions?

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While I was visiting Karen and Leland in Kansas City, I placed a call to CMS headquarters in St. Louis, hoping to interview someone there. I did not have high expectations. I had already called several times from my home in New Mexico (another CMS state) trying to arrange interviews with hospital administrators and doctors and nurses, but I had mostly been ignored. On those occasions when my calls were returned, the CMS spokesperson had, in an exasperated tone, made it clear that virtually every member of his medical staff was far too busy to spend time with reporters, and that furthermore this would remain the case indefinitely, no matter how flexible my schedule was, no matter when I offered to visit. The timing, he explained, was simply awful, and it was not likely to get any better, ever.

Still, I held out some hope. Calling from within the state, I figured, would seem more real and immediate to them; and besides, I was no longer planning to ask for interviews with medical staff, or even company higher-ups, but to settle for a sit-down with the spokesperson, which seemed

like a modest request, to say the least. I had even begun looking forward to that interview, wondering how the spokesperson might respond to the accusations I was hearing. I could imagine that some of his points might be reasonable. Certainly, prison medicine must be difficult to administer, and I assumed that the spokesperson would be eager to point out just how difficult, and to illuminate the challenges of working with convicts, of sorting through faked illnesses and phony requests for medicine, ornery personalities and violent outbursts.

But when Ken Fields, the spokesperson, called me back, and I mentioned my desire to visit, he didn't sound nearly as eager as I had hoped.

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"What do you want to talk about?" he asked. "How were your interviews with inmates?"

I explained that most of them were angry at CMS, which was why I wanted to get his point of view. "I think we're going to have to handle this on the phone," he said. I suggested that it would be preferable to meet in person, since I had met the inmates in person and didn't want them to have an advantage, but he replied, "We've had bad experiences with the media." I assured him that I knew this, yet I felt that, as a member of the com-

pany's communications team, he needed to communicate the company's message, but he insisted, "I can't do it this week. I'm too busy." I offered to return the following week, but he repeated that

he preferred to speak on the phone. So I repeated my preference to meet in person, and he repeated that he was too busy. Then I repeated my offer to return, and he repeated his preference to speak on the phone. So it went, until finally, perhaps just to stop the routine, he barked, "Well, I don't want you to come back here. Why don't you just stop by tomorrow?" I agreed and we hung up, but a couple of hours later, I found a message on my voice mail from Fields, saying that he had decided not to meet with me in person.

"It's a situation where we have been misquoted at times in the past," he said, "and we're gonna respond to your questions in writing. So I wanted to give you notice of that. Thanks, bye."

But even in response to written questions, Fields was hardly forthcoming: of the fourteen questions posed, he offered only eight complete answers. For example, he was willing to provide rudimentary statistics about the company, such as the total number of patients under CMS care, but would not describe any company protocols or reveal how much money the company actually spends on patients, except to insist that, of the more than half a billion dollars that CMS receives in taxpayer money each year, a "very, very significant portion goes to patient care." Although he was quick to claim that all CMS doctors and nurses are licensed in the states where they work, he dodged the question of how many have been suspended or had their licenses revoked in the past or in other states, insisting that the company is "not obligated" to reveal those statistics. Nor would he answer the question of whether or not the company has any plans to begin screening for hepatitis, claiming that CMS leaves those decisions to state legislatures and individual doctors, a claim contradicted not only by the company's detail-heavy and

restrictive hepatitis pathway but also by the internal communications of its regional medical director.

Since CMS officials were declining the chance to meet with me, or to set up interviews, or even to talk on the phone anymore, I decided to contact some of their employees directly. This turned out to be easier than I expected. Nurses tend to know one another, and after speaking with a few nurses who didn't work for CMS, I was able to reach a few nurses who had once worked for CMS and, finally, nurses who still do. At the very least, I hoped they would take the time to reassure me that the gritty standard of "deliberate indifference" was not being met; that nurses and doctors were not intentionally ignoring their patients. But what I heard from CMS nurses was, in many ways, more upsetting than what I had heard from inmates. One conversation in particular stands out.

I had reached Christy through a series of referrals by other nurses and their friends. At first, she was anything but eager to speak with me. Her relationship with CMS was still good, and she didn't want that to change. Although she was no longer working in the jail in the northern United States where she had been a CMS supervisory nurse for half a decade (she had left to manage a hospital facility), she was considering a return to the company and didn't want to jeopardize her ability to do that. The money was good at CMS, she explained, and besides, she didn't need them as enemies. But after thinking about it and talking with her friends, Christy decided to speak with me anyway, mostly because, as she put it, she needed to tell somebody what she had seen and done, especially what she'd done.

I was immediately drawn to Christy's story, even before I had heard the details. As a supervisory nurse, she had been the highest-ranking member of the medical staff on duty, so she had been privy to many of the political and economic machinations behind company policy. I was also interested to hear about jailhouse medicine in general. People in prison, after all, have been convicted of a crime and have forfeited some of their rights (the right to vote, the right to own handguns, etc.), but most people in jail are still awaiting trial, and they haven't necessarily been convicted of anything. Not only have those awaiting trial not forfeited their rights; they are still officially innocent. Our legal system takes great pains to insist on this, so I was curious to know whether or not it made any difference to CMS.

The short answer, according to Christy, was no. "The way we treated inmates was a horror," she said. "Whenever a new inmate came in, they would have to see me, and I would assess their

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medical condition. If it looked like they were going to require any kind of serious treatment, I would go to the lieutenant and explain what I felt the cost of the treatment would be. I would say, 'We have this person here, and the treatment is going to be horrendously expensive. We need to get them out of here.' If they were a real serious criminal, like a murderer, the liability was high, so they would keep them under arrest and we would incur the cost of treatment. But if the lieutenant thought the person was not a serious risk to the community, he would proceed to get hold of judges and other people to try to release the inmate, or make arrangements to get the bail lowered. The lieutenants would often call judges late at night and on holidays to tell them the situation, then we would release the inmate and take them to the hospital, so CMS wouldn't incur the cost of treatment. The lieutenants went along with it because they didn't want to incur the cost of a deputy to stay with the inmate in the hospital. So we would let them know, and they would make a call and release the inmate, then they would take them to the hospital. After the inmate got their medical treatment, we would immediately rearrest them.

"We did this frequently also with pregnant inmates. If they went into labor, we would release them or give them a signature bond, then rearrest them and the child was put into the custody of child services. I did that for years. You just ignore what you're doing. The whole atmosphere of the jail was, these criminals, these convicts, these scumbags, they get what they deserve."

"Appointments were made for weeks or months down the road, knowing that the inmate would not be there anymore. Or we would make appointments for days that we knew the inmate was going to be in court. They don't keep the trial dates in the medical file, but you just call the booking desk up front and ask them when the trial date is. Then you make their next appointment for that date. We were told to tell them, there was a canned phrase, 'Don't worry, you have an appointment. We just can't tell you when it is because of security reasons.' So you would be consoling someone, knowing full well that they weren't going to get to see anybody. You just put them right back at the bottom of the list again.*

"It was absolutely appalling, to the point that I can't even tell you. You knew that as long as you worked there, you did not challenge any of it. But your disgust builds as the horrible cases build. Even though a good majority of these people

ended up being guilty, I just felt from a moral standpoint that it was wrong. They always play up, 'Well, look what they did to this other person,' so a lot of people say, 'Okay, justice is served.' But the way I feel is, we've all taken an oath and we have a license, and just because one person has died, that doesn't mean that a second person dying or being denied care . . . one doesn't justify the other. As far as I'm concerned, if you're sick and you get into one of these places, you might as well be signing your death certificate. Even if you don't have a death sentence."

The more I spoke with nurses like Christy, and looked at inmate medical files, and studied infectious-disease statistics, the clearer it became that, no matter where you looked or to whom you spoke, this was a medical system run amok, one that not only ignored sick patients but was actually skirting the limits of the law and, in the process, helping to unleash an epidemic on society. As one nurse put it bluntly, "We have no accountability. If I deny care, that's it. You have no recourse." Yet the clearer this reality became, the more baffling it seemed. Wasn't anyone keeping track? Where had the media been?

In the course of nearly a decade, only two newspapers had undertaken major investigations of CMS, and both were located in Missouri, which has become a kind of ground zero in the debate over prison medicine, largely because CMS is headquartered there. Even more discouraging, the reporters who wrote those stories had, in the aftermath of their work, become just as tortured and frustrated as everyone else who confronts the company. Not long ago, one of them agreed to meet with me in the basement of his office, but within the first two minutes of our conversation he insisted that I keep his name out of my story. In the weeks after his articles appeared in the *Columbia Daily Tribune*, he said, he had been under attack by CMS lawyers and publicists, who deluged his editors with denunciations, and he didn't want to be perceived as settling the score. He sat nervously with me, fidgeting, smiling, and trying to be as helpful as possible without getting further involved.

The other reporter I spoke with was less reserved, but only because he had less to lose. He had already lost it all. In 1998, Andrew Skolnick had been an editor at the *Journal of the American Medical Association*, a recent recipient of the Harry Chapin Media Award, and an inaugural fellow of the Rosalynn Carter Fellowship in Mental Health Journalism, which is a \$10,000 grant. Using these lofty connections, he had managed to get himself and two journalists from the *St. Louis Post-Dispatch* into CMS facilities, where they spoke with several inmates and doctors before

* In response to these claims, CMS wrote, "Correctional health care staff make every effort to work with corrections agencies to coordinate such offsite trips in ways that do not create conflicts with scheduled court appearances."

publishing articles in both *JAMA* and the *Post-Dispatch*, revealing a national pattern of abuse and neglect by CMS. As the organizing force behind both projects, Andrew had helped expose several CMS doctors with checkered histories and had revealed more than a dozen cases of egregious mistreatment, some of which resulted in death. One story revealed a memo from the medical director of the New Mexico corrections department explaining that several prison doctors had quit because CMS administrative officials were "changing physicians' orders and adding orders without seeing the patient or consulting the physicians directly." Another story exposed a CMS doctor in Alabama who had been convicted of having sex with a sixteen-year-old "mentally defective" patient in Tennessee. Another described the chief of mental-health services for CMS in Alabama, whose license had been revoked in both Michigan and Oklahoma after he was found guilty of sleeping with patients, harassing female staff members, and defrauding insurance companies. The newspaper series had won awards from both Amnesty International and the American Medical Writers Association in the late 1990s, but even still, looking back, Andrew said that he wasn't always certain it had been a good idea to publish it. After the articles appeared, he told me, CMS had sent a letter to *JAMA*, accusing him of hiding his involvement with the *Post-Dispatch*, which they called "fraud," and threatening to sue the journal. Within a week, *JAMA* had fired Andrew and, although CMS later paid him to settle a defamation lawsuit,* his professional life never quite recovered. Even today, the editors of *JAMA* refuse to comment on "the conditions surrounding his termination" or to defend his award-winning exposé, which has never been refuted or retracted.

"I had an exploding career," Andrew told me, "and it crashed. We may have won some awards, but the horrible fact is we lost. CMS won. After the articles appeared, they went to the state legislature in Missouri and protected themselves. They got a law passed expunging the records of physicians who are accused of malpractice in correctional facilities. So now, anytime the medical board doesn't take action on an allegation they disappear it. This means no pattern can emerge against a doctor. That is our legacy. That's our achievement. We actually made it worse."

But Andrew's investigation had a resonance far beyond that. It was his work that started CMS down the path of information lockdown, building barricades to public scrutiny, hiding numbers and statistics and the names of em-

ployees, refusing even to sit for a formal interview, and stifling the efforts of journalists to cover the field at all. Andrew's series had put pressure on CMS, but that pressure had only deepened the company's aversion to publicity. CMS officials were happy to continue operating with public funds, but they were no longer willing to provide any serious accounting of them.

Like almost any wound, the weakness of an institution festers without proper attention, and as CMS has retreated into its shell, its facilities have only grown worse. Outside of anecdotal evidence, however, it is difficult to assess exactly how much worse—it is nearly impossible, for example, to know how many doctors and nurses it employs, or how adequate its facilities are, or even what pathways and protocols it adheres to. Few lawsuits have managed to expose details of the company's inner mechanisms, and aside from the Michigan hepatitis suit there is no major legal action pending against the company at the moment, only scattered individual lawsuits—the great majority of them, it is safe to say, doomed. In Massachusetts a small network of attorneys has been threatening to file a comprehensive class-action suit, but nothing has gained much traction so far. And although the U.S. Justice Department has reportedly kept an open file on CMS since the mid-1990s, collecting evidence and reviewing cases, no formal charges have been leveled against the company, and sources say it is not a high priority in the post-9/11 climate. Even Karen Russo has her doubts that CMS will change. "It's not going to happen," she says. "They don't want to be rehabilitated. They probably can't be rehabilitated. So the only solution is to get rid of them, and they're going to fight that in every state, at every step. They're going to use all their money and power, and they have a lot."

But if the battle over prison health care is beginning to seem lost, littered with the bodies of the wounded, the sick and sickened alike, with inmates and nurses and journalists by the wayside, if the whole field seems deathly unwell and bordering on hopeless, it may, in the end, have more to do with the way we look at prisons in general than with anything CMS has done. This is not to obscure or to apologize for the company's failures and crimes. It is simply to suggest that the secrecy afforded to prisons would be easy enough to strip away. When we, as a culture, choose to see our prisoners as a part of our society (which they are, of course, and an ever growing part), when we remove the wall of secrecy that surrounds the prison itself, when we are willing to face and bear witness to the punishments we disburse, there will be no more need to wonder what is being done on the inside, in our names. ■

* According to CMS, "Company attorneys determined that a small settlement of Mr. Skolnick's baseless claim was less expensive than the cost of ongoing litigation."