Federal Probation
JOURNAL

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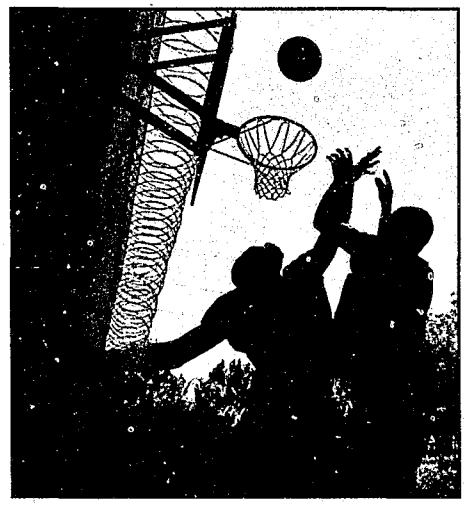

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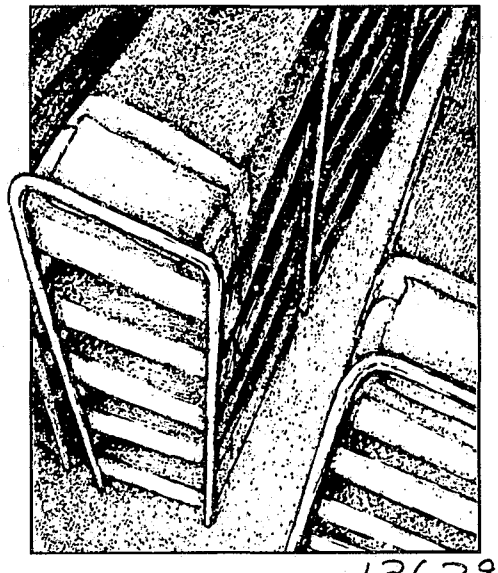

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A Working Partnership for Health Care

The Bureau of Prisons and the Public Health Service

Robert L. Brutsché, M.D.
as told to John W. Roberts, Archivist, Federal Bureau of Prisons.

Since 1930, the U.S. Public Health Service (PHS) has cooperated with the Bureau of Prisons in providing health care to Federal inmates. The Bureau's Health Services Division is responsible for medical and dental treatment, sanitation, environmental and occupational safety, food services, and farming operations throughout the Bureau. In addition to maintaining infirmaries at all Federal prisons, the Health Services Division operates six medical referral facilities for Federal prisoners. About 15 percent of the Division's staff are commissioned officers of the PHS, including physicians, psychiatrists, dentists, psychologists, nurses, and pharmacists. The Division is always headed by a senior official of the PHS.

Rear Admiral Robert L. Brutsché, M.D., an Assistant Surgeon General with the Public Health Service, was Medical Director of the Bureau of Prisons from 1969 until his retirement in 1988. He looks back over his years as Medical Director and comments on some of the primary issues in correctional medicine in this excerpt from an interview that was conducted as part of the Bureau's oral history project.

Admiral Brutsché joined the PHS in 1948; his first assignment was to serve on the medical staff of the U.S. Penitentiary at Leavenworth. In 1952 he transferred to the PHS Hospital in San Francisco, where occasionally he was called upon to treat inmates from the former U.S. Penitentiary at Alcatraz. From 1955 to 1957 he was Deputy Chief of Medicine at the Bureau of Prisons' Medical Center for Federal Prisoners in Springfield, Missouri. After serving at the PHS Hospital in New York and as Chief of Medicine at the PHS Hospital in Savannah, he moved over to another PHS operation, the Indian Health Service, where he served until returning to the Bureau of Prisons in 1969 as the seventh Medical Director in the Bureau's history.

Are there many differences between correctional medicine and medicine in a more conventional setting?

There are a lot of differences. The first thing is that the inmate must accept the physician at the institution as his physician. He has no choice. By the same token, the physician has to accept the inmate as a patient. This creates quite a different situation than you run into outside.

Also, the physician inside has to work with a rather definite set of restrictions. He or she can't prescribe medications and treatment as easily as on the outside. Many simple home remedies available on the outside, such as tub baths, massages, bed modifications, specific exercises, special foods, and over-the-counter medicines, are not readily available to the inmate. Not only does this limit the choices available to the prescribing physician, but the physician must be particularly cautious to weigh carefully any prescription, advice, or special approval that might be used by the inmate for secondary gain, such as "lay-ins," "convalescence," job change, special celling, and certain medications.

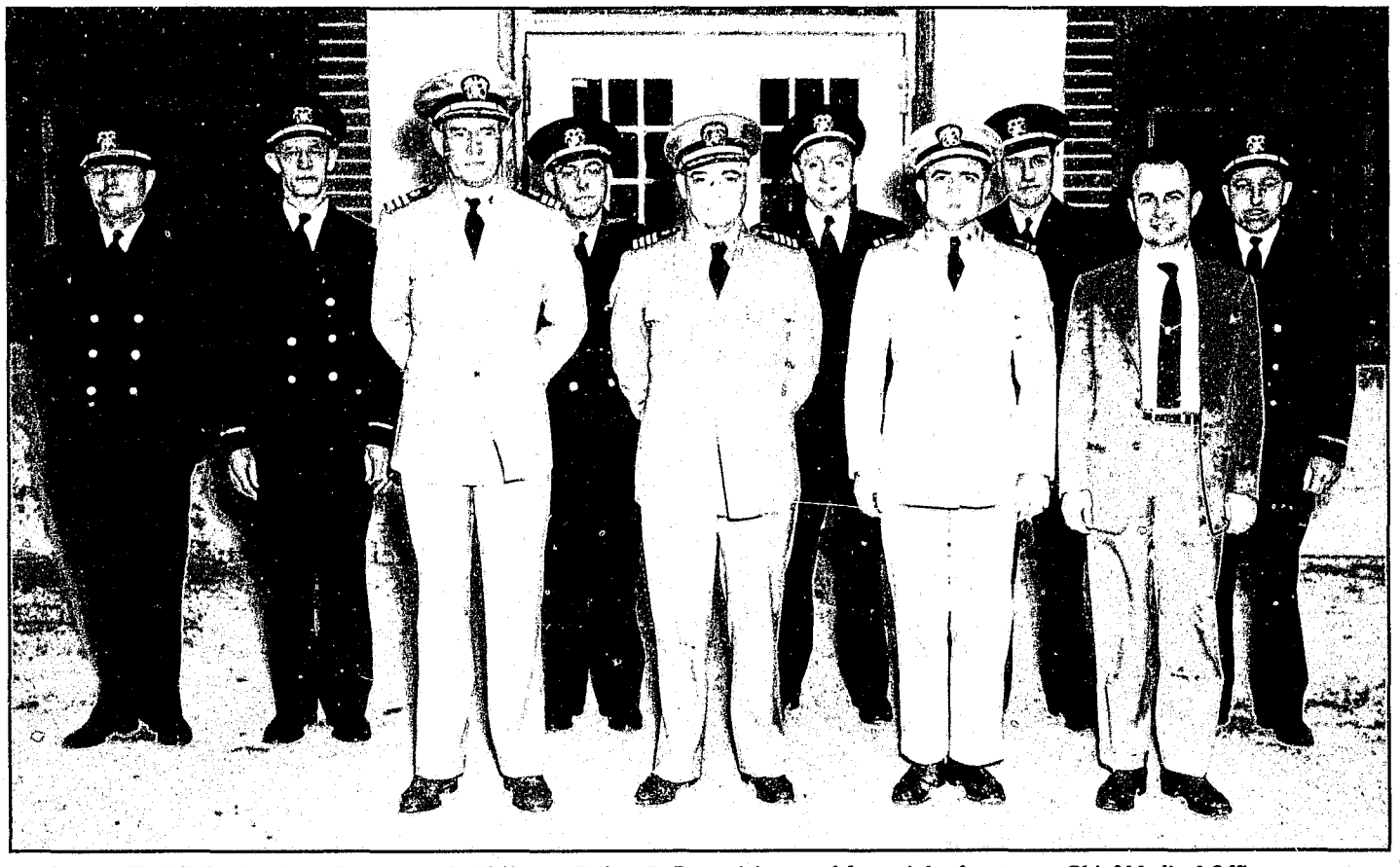
How would you say medical care available to the inmate compares with medical care available to the average citizen in the outside community?

For the most part, probably better. That's because inmates have access to a medical staff that is always there to provide the service. If you or I are sick, going to the doctor can sometimes be a problem. You have to decide whether to take the afternoon off from work, you have to choose a doctor, you have to make an appointment, and so forth. You can't just walk over to sick call nearby, see the staff, and get your treatment. Whereas inside the institution, anybody who feels they have an illness has the option of going to a group right there whose job it is to take care of them.

Now, what about the level of care? Visualize a spectrum of medical problems, and at one end are the mild illnesses, the small things: athlete's foot, gastroenteritis, common colds. At the other end are strokes, heart attacks, stabbings, serious injuries, and so forth. In the middle, we have the whole series of acute and chronic diseases.

My feeling is that in the average penal institution, on the extreme ends of the medical spectrum, the inmate enjoys a higher level of care than is available on the outside. [Former Bureau of Prisons Director] Norm Carlson used to say, "By golly, when I get sick, I can't just walk into the doctor's office for every little thing." But, even for the mildest problems, the inmate *can* just walk into the doctor's office. On the other end of the spectrum, when somebody on the outside suffers a coronary, stroke, or accident, he might not be discovered and helped right away. But the average inmate is almost always under observation and is always close to medical facilities, so it is more likely that he will receive treatment within minutes.

But in the area of chronic diseases, you get into degrees of conflict between medical staff and inmates—particularly if the patient has been a malingerer in the past and now all of a sudden has a bona fide problem. There are a lot of elements that enter into this, but they all stem from a lack of trust between the inmate and the medical staff.



Medical staff, U.S. Penitentiary, Leavenworth, 1949. Dr. Robert L. Brutsché, second from right, front row. Chief Medical Officer, USP Leavenworth (later Medical Director of the Bureau of Prisons) Dr. Harold Janney, third from right.

What about medical care for nontraditional inmate populations, such as women and the disabled?

In years past, as you know, we had women in relatively few institutions. We utilized consultants to take a look at our medical program for women and to make recommendations. We had a lot of outside interest in women's programs. We involved inmate advocacy groups in our meetings and we involved some obstetricians and gynecologists and consultants from the Public Health Service, including some nurse-midwives. We attempted to make certain changes to keep the women's program in line with what we reasonably felt it should be.

I was concerned that we really had no well-developed medical center for the care of females within the system, like we had at Springfield, for example, for the males. And Alderson, our main institution for females, was so isolated that there were not too many outside hospitals or consultants available. To some extent we used Lexington as a referral center for women, but we felt more was needed. So when we developed Rochester, I insisted that we have some medical beds for females there, and Norm concurred. It just seemed to me that it would be almost unconscionable to open Rochester, with access to the Mayo Clinic, and not have medical services available there for women. Today, of course, we have excellent services for women at both Lexington and Rochester.

As for the disabled, that was handled pretty much on an individual basis. As we got a case, we would decide where that blind or otherwise handicapped individual could best be placed. We did have one institution—I believe it was Lexington—where we assigned several of the blind inmates, because we had better resources in the outside community for working with blind people.

You became Medical Director during the heyday of the "medical model" of corrections. Did changing corrections philosophies, such as rehabilitation or community corrections concepts, affect what you did, give you more responsibilities, or change the direction of what you were trying to do?

I guess I would have to say that the change in approach to corrections didn't really materially affect much of what I did. Now to the extent that I was involved in the mental health program, that changed some. But in terms of the more physical aspects of the practice of medicine and health care in general, I'd say that it didn't have too much impact.

But during the "medical model" days, weren't your people involved in the diagnosis or the establishment of the treatment program for inmates?

They were. For example when I became Medical Director in 1969, the Narcotic Addiction Rehabilitation Act [NARA] program was in full swing. The Act had come about in 1966, and my predecessor, Ernie Siegfried, had been involved, along with the Correctional Programs Division, in setting up these NARA units at designated institutions. These NARA units were staffed primarily with Public Health Service personnel—a psychiatrist, one or two psychologists, one or two psychiatric social workers, medical technical assistants, correctional officers, and a clerk. At that time, NARA was totally under the Medical Division.

How would you assess NARA and its effectiveness?

In the long run, the research studies didn't show much of a success rate. One of the deceptive problems of any of these group therapy programs is that they appear to be very effective initially,

Dr. Brutsché with Bureau Director J. Michael Quinlan in Rochester, Minnesota, in June 1989, at the dedication of a new medical building in his honor.

because the people that are coming to them seem enthusiastic and they seem to be off drugs or alcohol or whatever, and everything looks great. Individuals seem to do well while they are actually in the program. In the prison setting this becomes even more accentuated, because the inmate is more restricted in the degree to which he can "fall off the wagon," and he has little else to do except go to work, go to the programs, and go take part in recreation within the institution. Where it breaks down is a few weeks, months, or years down the road. When you go back and look at that cohort of individuals after they have been released, you find that the slippage rate is pretty high.

In addition to the NARA units, we developed "non-NARA" units, for addicts who needed treatment but had been sentenced under some law other than NARA. Later, this included some alcohol units. The results of these programs were pretty much like the NARA results. They looked pretty good, but only with respect to participant adjustment while they were in the units.

Ultimately, Norm Carlson became particularly concerned with the end results of the program. This was at a time when he was questioning what impact the "medical model" was really having. So he appointed a task force to look at our various drug treatment programs, including NARA, "non-NARA," alcohol treatment, and any other unit management programs that had been set up within that framework. That group pretty much found that the programs' results were not all that had been anticipated.

How did FCI Butner come into existence?

It's interesting that the proposal for Butner began with some letters in the late 1950's between Russ Settle, who at that time was Warden and Chief Medical Officer at Springfield, and Harold Janney, who was Medical Director for the Bureau. There was a lot of discussion about the need for a new psychiatric facility, but the early plans fell on hard times and nothing much happened throughout the sixties. That was during a time when some folks in Congress were not too supportive of spending a lot of money on the Bureau. So nothing much happened. Except that somewhere in the process we had obtained the land. Once in a while we dropped by there, but all it was was a piece of land with a little shed on one corner with a sign that said "B.O.P. Eastern Psychiatric Facility." And, golly, this was there for years.

Anyway, we finally submitted a proposal, got it approved, and construction began in the early seventies. And we had a terrible time. The first construction company went broke. There were cost overruns. It looked as if we weren't going to get the thing built after we'd finally gotten it approved.

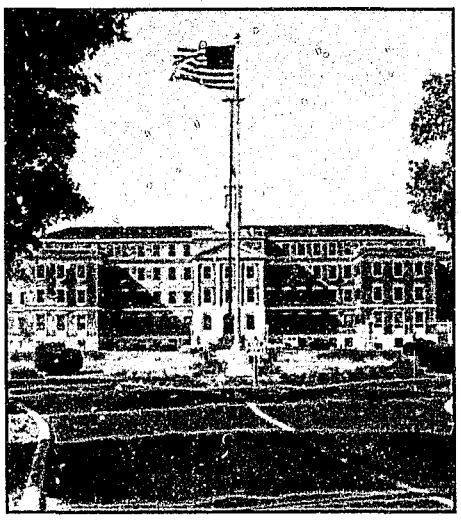
Meanwhile, of course, we had to plan what was going to be there, since the original planning was done back in 1958 to 1960. So Norm put together a blue ribbon panel, and he involved the Chairman of the Psychiatric Department at Duke, and Charlie Smith from the University of North Carolina, who was a formal Bureau Medical Director, and [Assistant Director] Roy Gerard, [medical consultant] Walt Menninger, and others.

At first I wanted to try to build into it some degree of medical-surgical capability, because of the crossovers between psychiatry and medicine and surgery. That was not done because Butner would be right there where it could use Duke and the University of North Carolina for medical services.

The first problem we had after we finally got it up and open was that we had trouble getting psychiatric staff. We were operating with some consultants from Duke, until we obtained a sufficient number of full-time psychiatrists. Over the years we were fortunate enough to have modern, aggressive, dedicated psychiatrists who were able to provide much individual attention that incorporated modern psychiatric thinking. Thus, Butner developed into a pretty doggone good psychiatric facility.

When did you first start recognizing AIDS as a problem in Federal prisons? What programs did you adopt to deal with it?

We first heard of AIDS as early as 1982, when we got a memorandum from NIH to be on the lookout for individuals who were showing signs of immune deficiency with infections or tumors.



The BOP Federal Medical Center in Springfield, Minnesota, where Dr. Brutsché served from 1955 to 1957.

Candidly, few of us really took it too seriously at first, because we presumed it was some rare disease that they were watching for. Obviously, we were taking it very seriously long before our first case appeared in the system, about 1984.

The really big issue didn't break until the testing came along in March of 1985. That's when we were faced with a very difficult decision: who were we going to test? If we found someone with a positive test, there was not one thing we could do for that patient medically. And isolating someone who tested positive was apt to get us into legal troubles, to say nothing of the practical problems involved. And we weren't absolutely certain, particularly when the test first came out, how accurate it was. So we decided to test only those people for whom it was clinically indicated, where we had someone who was actually sick.

Were you worried at all that asymptomatic carriers might have been spreading the disease?

By that time the Centers for Disease Control [CDC] had established pretty clearly that AIDS was not spread very easily. So we felt comfortable that the biggest thing we had to do was to attack it from the educational side, explaining the lack of contagiousness, except for sexual activities and common needle use. And we put out a videotape, in Spanish and English, for inmates and staff, along with booklets and other data. We also appointed a Coordinator of Infectious Diseases for each institution, and met with them in Atlanta, and with the involvement of the CDC, gave them a series of presentations. All this activity was taking place in '85 and '86.

We did isolate those with symptoms—males in a special unit at Springfield and females at a special unit at Lexington. But many who had been symptomatic when we first sent them there lost their symptoms, as often happens in the ARC [AIDS-Related Complex] phase. Initially, we kept them isolated, but CDC continually maintained that this was not necessary, so we finally abandoned that policy and put it strictly on the basis of the degree of illness.

The Medical Division had a number of nonmedical responsibilities, including the farm program. Why was the farm program cut back so much during your tenure?

When I picked up farms in my Division during a reorganization in 1974, we were down to nine farms. This represented a gradual reduction from at least twice that number.

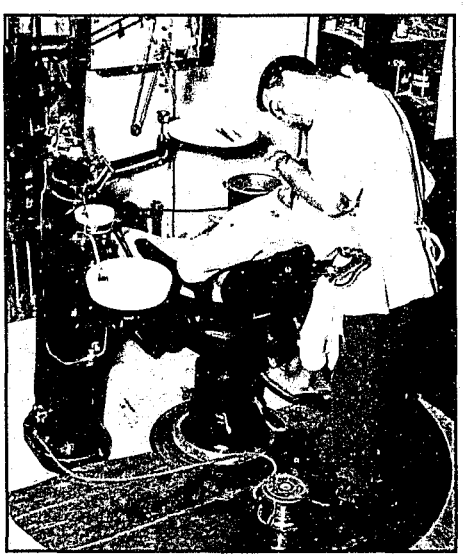
It's important that the farm program and related problems be put into proper perspective. The benefits of the farm operations were not only to put food on the table at the institution, but also to provide work and vocational training for the inmates. A "by-product" benefit of the farm was that in most cases it created a

buffer zone for isolation of the institution from neighboring activities in order to promote better security.

The farm had always been considered just another mandatory operating department at an institution, and therefore only rudimentary cost-benefit data had been regularly collected and reported. This data reflected only a few of the direct operating costs and none of the indirect costs related to the farms. Farm "profit" was expressed largely in figures representing estimated value of total production.

In the 1970's, Norm asked that we do a cost-benefit review of farm operations, so that this could be weighed with other farm benefits in determining the future of each farm. Specific analysis proved to be a complex, elusive, and frustrating undertaking, but, in seven of the nine farms, it became clear that the cost of farm operations exceeded the value of the food put on the table. The Director decided that for a farm to be retained, it must come close to a break-even cost-benefit ratio. This did not include the spin-off benefits; they would be considered separately. Early in the analysis, it became clear that the least cost-effective farm program was swine production, so the piggeries were all closed fairly soon after the evaluation began. Furthermore, the Director was anxious to remove pork from the menu, because of problems with the religious diet and the fact that dietary concern with cholesterol and saturated fat focused in part on pork.

The bottom line was that the only way an institution farm could approach a break-even to "profitable" level was to increase the market, and therefore the production, by supplying multiple institutions within the prison system. Our farms at Lompoc and El Reno were able to do this. The



A Public Health Service dentist at work during the 1950's.

other seven could not, and, much like other small farms in this country, were ultimately closed.

The Medical Division also had charge of safety and sanitation. Have safety and sanitation in the Bureau improved over the years? I guess what I'm asking is, how safe are institutions?

I think the institutions are pretty safe, and I think institution safety and sanitation have improved in geometric proportions over the years. Today we have wardens who appreciate the importance of safety and sanitation. There was a time, years ago, when some institutions felt that the safety and sanitation officer was not important, and consequently they didn't always take his recommendations very seriously. But as society in general became more sensitive to the importance of safety issues, so did the Bureau.

I think we have an unusually good group of safety managers. Over the last decade we have gotten far better trained individuals. Before they become safety managers, they are in training assignments in which they are required to take a significant number of prescribed courses in various areas of safety and sanitation: all the way from sound and light exposure to the many issues involving toxic waste—both present toxic waste as well as waste that may have been dumped many years ago; all of the OSHA requirements; simple kinds of maintenance safety, such as electrical systems and steam pressure. Sanitation, or course, is a whole field in itself—everything from checking temperatures in refrigerators, freezers, and washing machines to much more complicated types of sanitation.

And when we had the farms, and we still have two of them, there's a lot of safety and sanitation, particularly in the milking operation and the handling of beef. So safety managers must be jacks-of-all-trades, monitoring safety and sanitation across the board. And not only does that require a lot of time but it requires a lot of expertise and a lot of cooperation on the part of staff. The safety manager is the only person in the institution whose sole job is to look over everybody else's shoulder and report on their deficiencies.

In our factories, obviously, there is going to be a definite incidence of injuries and illnesses. But our figures would suggest that the incidence there may be lower than on the outside. This is attributable to the intense dedication of the former UNICOR Associate Commissioners, Jerry Farkas, and Dave Jelinek before him, in initiating an outstanding safety program and giving the safety manager at an institution free rein to go in and make necessary changes; under extreme circumstances he even has authority to override a factory superintendent and close down an operation. So the concern for safety is quite explicit.

Let's discuss some administrative-type questions. What was your experience in recruiting medical personnel?

Terrible. Recruiting most health personnel, except dentists, was difficult. Prior to the mid-1940's, the PHS was a buyer's market. Doctors and other health professionals wanted to get into the PHS. But after the war, the world of specialization boomed. Doctors wanted to get additional training and go into the lucrative fields of specialty practice. So we didn't have all these general practitioners who found the PHS attractive, and the PHS didn't really have the need for all these unique specialities.

If in 1950 you looked at physicians in key positions with the PHS, you found that virtually all of them had done a tour in the Bureau of Prisons. Young officers would join PHS and spend some time in the Bureau. They might remain as PHS careerists, and perhaps rotate back through the Bureau. Some of them remained in the Bureau of Prisons, giving us a career cadre of senior PHS officers in the Bureau. With the advent of specialization, these sources began to disappear. We had largely 2-year staff coming through, and there were very few that we retained in the PHS. And after the physician draft went off in the early 1970's, we had to begin recruiting Civil Service physicians. This changed somewhat in the late 1980's, but that's another story.

PA's, nurses, and nurse practitioners became even harder to recruit and retain. The supply of these very important health professionals continued to trail the market. PA's were needed in all facilities and nurses, while serving principally at our medical centers, could also have been used in key positions elsewhere, had they been available. But the overall

Dr. Brutsché at his retirement dinner with former Surgeon General C. Everett Koop, in 1988.

shortages made it difficult for us to offer competitive salaries and to fill all positions we needed.

You faced a number of issues in the area of training, including training for a new type of position, the physician assistant [PA].

The PA concept really broke into the forefront in 1966 at Duke University. My predecessor, Ernie Siegfried, and his Executive Officer, Bud Grossman, set up a PA training school at our Medical Center in Springfield in 1968—one of only nine in the country at that time. It was a 2-year program; the first year was one-half didactic and one-half practical, and the second year was practical at a regular Bureau of Prisons institution. And it got started off pretty well. We were charter members of the Association of Physician Assistant Programs.

When the American Medical Association [AMA] examined our program, they noted several flaws. We had no pediatrics and we lacked sufficient practical training in primary and emergency care, and AMA did not allow for PA training that was designed to be specific for prison programs. Also, the school was costing us plenty of money, since trainees were full-salaried staff. So we closed it down about 1978, and we felt we could rely on recruiting people who were already trained because by then the number of formal PA training programs nationwide had increased from 9 to 50.

Developing the PA concept was important. When I started at Leavenworth in 1948, Medical Technical Assistants provided PA-type services and supervised inmate workers, who performed various medical and technical clinical activities, including pharmacy, optometry, and medical recordkeeping. This became unacceptable for a variety of obvious reasons, and the program was changed rapidly throughout the seventies.

Didn't you have to revise the medical auditing process?

In the old days, we had very few staff and travel was a big problem, so there wasn't much auditing. When I was at Springfield in the fifties, the Medical Director probably visited us only once or twice in 2 years. The visits were more supportive than audit-related; the Medical Director would ask about general operational problems, but the issue of auditing what we were doing just wasn't in the cards. It wasn't possible and it wasn't expected, under accepted medical practices of that era. But that was the only kind of visit we got from the Central Office at all, on the medical side. That pretty well was the way things were up until Ernie Siegfried came along as Medical Director. By that time, the medical community was becoming increasingly aware of the value of quality assurance, and Ernie responded to that by setting up several audit teams. He

established that first medical manual. It didn't deal with a lot of how-to-do medical things, but it dealt with medical administrative matters. He was able to squeeze together about four teams of two people, who would go out and do audits. It was not really quality assurance, but it was a step in the right direction.

Well, I finally settled on what we called the Quality Assurance Program. We would take a group of physicians from within the system —a chairman and at least two other doctors, plus the appropriate Regional Medical Administrator—and they would spend a week at an institution performing a real medical audit. This worked pretty well. There's just one problem, and that is that there just wasn't the money or the manpower to get around to enough places. So we had to trouble-shoot; that is, go principally to those places where we suspected problems.

Was there once a plan to phase out PHS operations in the Bureau?

The Office of Management and Budget had been dissatisfied with the Commissioned Corps of PHS as a personnel system for a long time and tried to get PHS out of any role they could, such as PHS hospitals and the Coast Guard and BOP medical programs. When the President's 1976 budget came out, all PHS Commissioned Corps positions for the Bureau were to be eliminated. We had 112 positions, and I had to draft a phase-out plan that would eliminate them all within 3 years. But after the change of administration, the whole thing gradually blew over. This is obviously an oversimplification of a very complex issue.

It happened again in '81, but this time we were able to get some Congressional supporters who said they did not want PHS taken out and did not want the ceiling reduced. This was quite effective, since there was no way we could violate this Congressional mandate, and again the issue seemed to fade. And in 1987, when the Surgeon General got the revitalization of the corps approved, the whole thing dropped.

Throughout your tenure, courts took an increasing interest in prison matters and day-to-day prison administration. What impact did this increasing court interest have on your division?

Over time, I think it had a lot, indirectly. Not so much by suits that we had in the Bureau—there were some—but the impact that courts were having on correctional medicine nationwide.

If you go back to the early sixties, there was no court involvement at all. But after Attica, the court decisions began to come down in a number of States. These cases made it clear that the standards of care were going to be improved, and if they weren't you were going to be in trouble with the courts. There were pressures from Congress that helped mold certain things that took place. And a lot of this congressional interest and pressure arose from court cases and outside advocacy groups.

Any other observations you would care to add?

Yes. I would like to pay a special tribute to the Medical Technical Assistants—the MTA's—a gone but not forgotten group. I suppose there may be a few still on duty, and there are others who have advanced up the administrative ladder, but the position is no longer being filled. These individuals were a critical cog in the machinery of health care delivery in the Bureau of Prisons for over 50 years. They performed a spectrum of duties ranging from the simplest medical tasks to serving as a physician assistant. They rotated through all clinical areas in the hospital and covered all duties during "non-working" hours. Many moved up to Assistant Chief MTA, then on to Chief MTA/Hospital Administrative Officer, Regional Medical Administrators, and some to Camp Administrator, Associate Warden, Warden, and Regional Director. This group has been the backbone of the Bureau's health care delivery system. Today the PA's are carrying on that tradition of service.

As you look back over nearly 20 years as Medical Director, what would you say were your main accomplishments?

It's difficult for me to claim credit for many accomplishments, because usually they were the product of so many people.

We gradually improved the structure and caliber of the delivery of medical care in several ways: by organizational change, in which we brought more continuity to the program by establishing the position of Hospital Administrative Officer as the codirector of the medical section at each institution; by the addition of the PA concept; by the improvement of female medical care; by the marked improvement, though I don't take a lot of credit for this, of the safety program; by the increase in referral centers and the use of outside medical care; and by increased staffing, including the development of program supervisory staff in Regional Offices. I feel we also significantly improved the effectiveness of evaluation and followup of medical cases. The pharmacy program is vastly improved throughout the system by the addition of full-time pharmacists, and the expansion of the dental laboratory capability provided both increased service and training. ■