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Medical News & Perspectives

A Day in the Life: Physician Cares for HIV-Positive Patients in Jail

Rita Rubin, MA

Even after she got her first job in correctional medicine, Anne Spaulding, MD, never thought she'd spend her entire career in the field.

She grew up in Northern Virginia, earned her medical degree at the Virginia Commonwealth University School of Medicine, and completed her internal medicine residency in Rhode Island, followed by a fellowship in infectious diseases at the University of Massachusetts, Worcester. For family reasons, she wanted to stay in Rhode Island when she launched her career, but jobs in her field were scarce.

"There were very few positions available at the time for an infectious disease doctor in Rhode Island," she said. One of her mentors suggested that she apply for the job of medical director of the Rhode Island Department of Corrections. Spaulding's initial reaction: "Why would I want to go off and work in a prison?"

But a friend whose brother was incarcerated encouraged her to consider the corrections department position. "They really need to have improved medical care, and what's the harm in looking?" the friend told her.

The night before her job interview, Spaulding read most of the medical literature on correctional medicine. "There was not a lot written about the field at that time," she explained. She got the job, "and now, 20 years later, I'm still in corrections."

Spaulding spent 5½ years in the Rhode Island corrections department post, overseeing the care of an average daily census of 3500 incarcerated people. After a 2-year

stint with the Centers for Disease Control and Prevention, she served from 2003 to 2005 as the associate statewide medical director of Georgia Correctional Health Care, a collaboration between the Medical College of Georgia and the Georgia Department of Corrections. She helped supervise approximately 50 physicians who cared for the 45 000 people in the state's 70 prisons and provided HIV and hepatitis C care to women in the Georgia prisons.



In 2005, Spaulding joined the epidemiology faculty at Emory University's Rollins School of Public Health. She is also an associate professor of medicine at the Emory School of Medicine. From 2005 to 2012, she consulted for Georgia Correctional Health Care as an HIV and hepatitis C expert, and since January 2017, she has been working every Tuesday as a staff physician and infec-

tious disease consultant at the Fulton County Jail in Atlanta.

"It has turned out to be a really good fit for somebody who is interested in health disparities, infectious diseases, social justice issues, HIV, and hepatitis C," Spaulding said of corrections medicine. "It has been a very good career path."

She recently spoke with *JAMA* about her typical work day at the Fulton County Jail.

Starting the Day

Spaulding tries to rise at 5 AM so she can go to the gym and then on to Bible study at her church before heading to the jail. "That's very important for me to have a good focus on what I do," Spaulding says of Bible study. Before she leaves home, she packs her peanut butter and honey sandwich—"that's my treat on jail day"—and her fruit and vegetables in a clear plastic bag so the officer at the gate of the jail can see the contents.

Arrive and Huddle With Colleagues

Before Spaulding can be cleared by security at the jail, she must take off her white coat and stethoscope so they can be x-rayed separately from her. "I don't bring a purse. I generally keep my car keys in my white coat. I can bring in a cell phone."

Each Tuesday at 8 AM, she huddles for about an hour with her colleagues—the medical director, 3 additional physicians, and a number of physician assistants (PAs) and nurse practitioners—to get caught up on what's happened with patients during the previous week.

Jack Kease/Emory University

Spaulding never knows if she'll see the same patient more than once. On average, people remain incarcerated in the jail for a couple of weeks, but within 5 days of entering, half have been released pending trial, she notes.

Her primary responsibility is caring for the more than 800 people with HIV who enter the jail each year. "Before I started working here, a physician assistant had been seeing all of them and knows the patients well," Spaulding says. "The PA and I work together."

Working Around the Jail

She aims to see a dozen patients a day, typically between 9 AM and 4 PM. "Part of the challenge is that they are on different floors. We are guests of the jail, and although we have a legal mandate to be here, we need to coordinate the delivery of health care with its operations." For example, "the correctional officers lock the doors at every shift change and have a head count to make sure

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everyone is still there. We need to work around the count at 3 PM."

The correctional officers escort patients from their cells to the examining rooms on each floor, which are equipped with a table, an ophthalmoscope, and an otoscope. "Patients behave like patients wherever they are. You've got people who may seem very tough on the outside who are very vulnerable about their health. They will let their guard down," Spaulding says. "I've been in corrections for 20 years. I've never been assaulted or felt in danger." That's not everyone's experience in corrections, she adds.

Patients with medical conditions that require closer monitoring, such as HIV that's not well controlled, severe mental health issues, and frailty due to old age, are placed in cells on the medical housing floor, where Spaulding spends about a third of her day. "Sometimes we don't see somebody when they're on our schedule because they're at court. Going to court so they can get out of

jail is a higher priority than a routine doctor's appointment."

If somebody is medically unstable, they can be taken to the local hospital emergency department, but that occurs only occasionally, Spaulding says. "One of the more common reasons I send someone out is for a lumbar puncture. We've had patients with fungal meningitis, which you'd see in late-stage HIV, or suspected neurosyphilis."

When Epidemics Collide

About 4% to 5% of people in the Fulton County Jail are HIV positive, roughly the same percentage as seen in New York City jails, Spaulding says. "We have basically 2 epidemics coming together: the epidemic of incarceration and the epidemic of HIV."

In the United States, about 750 of 100 000 persons are incarcerated at any given point in time, but the proportion in the South is 25% higher than the national average, Spaulding says. "In the Southeast,

we have the highest incarceration rate in the world. The average entrant goes into jail 1.4 to 1.5 times a year. Sometimes there is a new allegation

of criminal activity. Sometimes people are on probation or parole and haven't met the requirements. One of my patients had 40 separate stays in Atlanta-area jails since age 18."

A disproportionate number of people incarcerated in the United States, as well as in Georgia, are racial minorities, Spaulding says. "For the most part, I'm seeing newly arrived men. The majority (of her patients) are black men who have sex with men."

A project that ended in December 2017 offered rapid HIV testing to anyone at the jail who did not opt out of it. Between March 2013 and February 2014, 89 new cases of HIV were identified as a result of the project, Spaulding reported in 2015.

Nurses continue to do some testing in the jail, Spaulding says, but most of the HIV-positive men she sees come in knowing their HIV status. "Over the years, I have seen maybe 1 or 2 guys a month who have just learned that they're HIV-infected. We fill out the CDC form saying this is a new

diagnosis of HIV." But sometimes, it turns out that the men who say they didn't know they were infected are already in the health department's HIV registry, Spaulding says. "Often, getting an HIV diagnosis is an iterative process. Sometimes people need to hear it several times in order to have the reality set in."

Continuity of HIV Care

Some patients she sees in the jail are homeless and always keep their HIV medication with them. If they're not homeless, they might have had an opportunity to retrieve their medication before entering the jail.

Generally, though, the jail doesn't allow people to take medication brought from outside because they might have replaced the anti-HIV drugs in their capsules with heroin or OxyContin. But, Spaulding adds, "if someone comes in with their hep C medications, which currently cost several hundred dollars a dose, we are glad to have the meds from home."

"We try to provide medications from our pharmacy," she says. For those who don't bring in their anti-HIV medication, "we have wall charts so they can point to the pill that looks like the one they take."

The goal is to avoid a break in treatment because of incarceration, no matter how brief. On days she's not working in the jail, "I tell my colleagues that if somebody can tell you their credible medical regimen, continue that regimen. With HIV medications, you want to have seamless continuity of care." That doesn't necessarily happen in jails in less-populated Georgia counties, many of which don't provide HIV medications because they haven't budgeted for it, Spaulding says.

Wrapping Up

Spaulding tries to see a couple of patients after the 3 PM head count. Officially, her day at the jail ends at 4 PM, "but I might be finishing paperwork up to 6," she says. "I've never been the fastest physician seeing patients. I tend to have notes that are too detailed. That's who I am." Given that they often have complicated medical histories, "writing about our patients is sometimes challenging."

Winding Down and Looking Ahead

When Spaulding leaves the jail, she texts her husband, a physician who works for the Centers for Medicare & Medicaid Services

in Atlanta, to let him know she's on her way home and will be making dinner. "The thing that gives me a lot of joy, in addition to seeing my husband at the end of the day, is cooking. If you start with a good mix of vegetables and chicken, something good is going to come out of it. Something gets produced that is tangible."

After dinner, she might try to wind down by reading or watching "NCIS" or "Designated Survivor." But then there's always a day's worth of emails waiting for her to read and answer.

"Writing and publishing and being involved in scholarship is a really important part of what I feel like I'm called to do," says Spaulding, who recently coauthored an [article](#) about how jails represent an "unappreciated" medical home that could link incarcerated HIV-infected individuals with care in the community after their release.

She recognizes that individual physicians seeing patients in jails or prisons can't solve all of the problems of health care delivery in corrections. More research into best practices in corrections health is needed,

but interest—and funding—is lacking, Spaulding says.

"Some of my work has been trying to address the lack of scholarship in correctional health. If I had funding, I would like to do a project that would look at barriers for young investigators to go into correctional health as a scholarly pursuit. I believe there are ways we could train our physicians in the ethics of criminal justice research that would make it inviting." ■

Note: Source references are available through embedded hyperlinks in the article text online.

For Patients With Type 2 Diabetes, What's the Best Target Hemoglobin A_{1c}?

Jennifer Abbasi

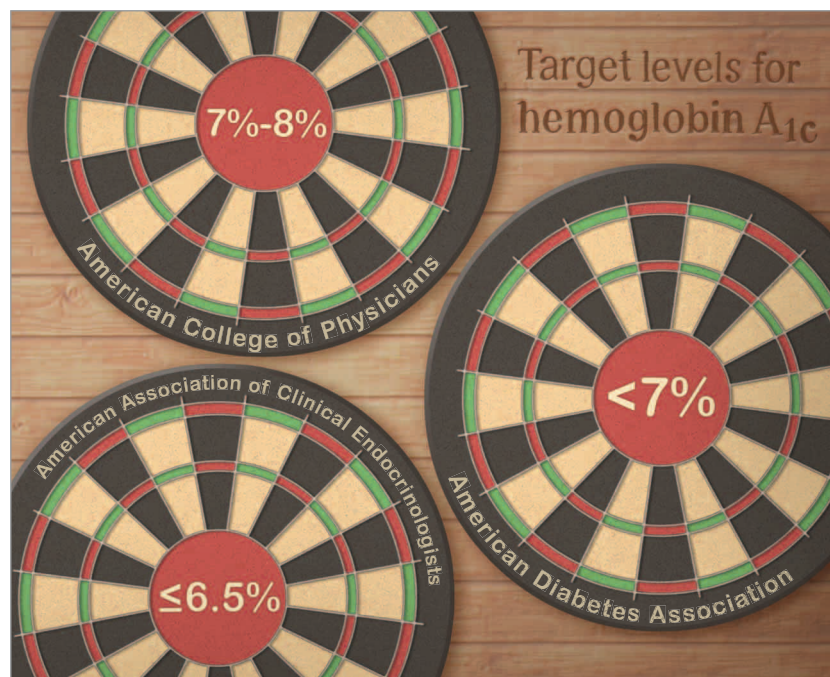
Medical organizations are at odds over new guidance that recommends easing hemoglobin A_{1c} (HbA_{1c}) targets for patients with type 2 diabetes. The [updated guidance statement](#) from the American College of Physicians (ACP), which focuses on glycemic control with medications, says clinicians should personalize goals and aim to achieve an HbA_{1c} level of between 7% and 8% for most patients with type 2 diabetes.

The ACP set its target higher than recommended by other prominent health groups. The American Diabetes Association (ADA) generally [recommends](#) an HbA_{1c} goal of less than 7%, while the American Association of Clinical Endocrinologists (AACE) [advises](#) even tighter control of 6.5% or lower if it can be achieved safely.

The HbA_{1c} test provides an estimate of the blood glucose level over the prior 2 to 3 months and is widely used in clinics. A normal HbA_{1c} level in people without diabetes is less than 5.7%.

In evaluating the clinical trial evidence for intensive HbA_{1c} targets with pharmacological therapy, the ACP committee weighed benefits of reducing the risk of microvascular and macrovascular complications against adverse effects, treatment burdens, and costs before issuing its controversial guidance.

Amir Qaseem, MD, PhD, vice president for clinical policy at the ACP, said the organization created the new guidance state-



ment to help its members sort through conflicting HbA_{1c} targets advised by different professional groups. With 152 000 members, the ACP is the largest US medical specialty organization and is composed mainly of primary care internists, who regularly see patients with diabetes.

The ACP's guidance statement, published in the *Annals of Internal Medicine*, is a quality analysis of 6 existing guidelines from other US and European health organiza-

tions and a summary of the 5 "treat to target" clinical trials and follow-up studies frequently cited in them. The statement's 6 authors each independently reviewed and scored the guidelines using an established evaluation instrument that takes into account factors including rigor of development, stakeholder involvement, and editorial independence.

The highest scoring US guideline, from the Department of Veterans Affairs and the