Programs for Prisoners

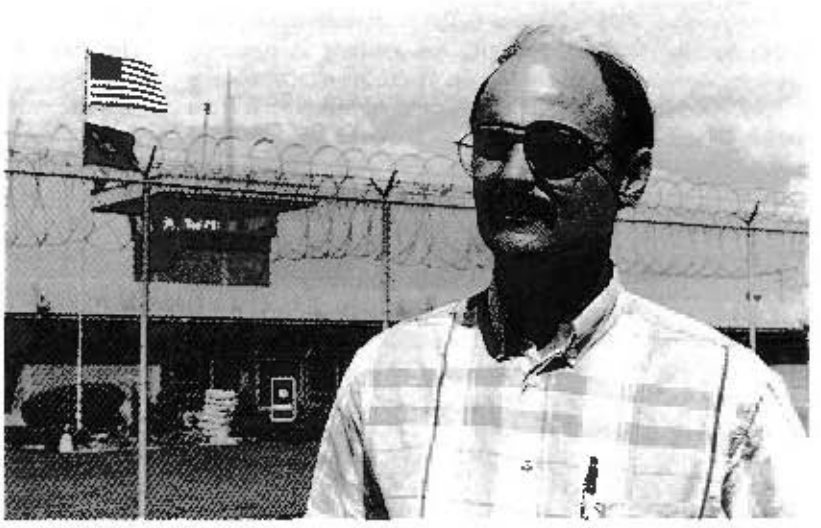
By Jeanette Germain

Mark Gornik doesn't just "talk the talk," says prison inmate Tom McPhie. "He walks the walk — he lives what he tells us."

Gornik coordinates an alcohol and drug treatment program at the Idaho State Correctional Institution. He researched and designed the program as a 1990 master's thesis in interdisciplinary studies at Boise State University.

Just two years into its implementation, the program has produced significant results at the prison. Voluntary participation in support groups such as Alcoholics Anonymous and Narcotics Anonymous has increased tenfold, from 20-30 to 150-200 per week.

As many as 75-85 percent of prisoners who take educational classes are also volunteering to enter therapy. Gornik's work has drawn the notice of the National Institute of Corrections which has invited him to share his experience with other prison staff across the United States.



MARK GORNIK: "Without significant change, criminals will continue the vicious cycle."

The program is unusual, Gornik observes, because it successfully uses inmates as facilitators. The inmate facilitators, who are carefully trained and closely supervised, present 30 hours of highly structured drug and alcohol education. While teaching, they also remain active in their own therapy.

Gornik believes the inmate facilitators gain a lot by the experience. McPhie, for example, has done so well that he became the first prison inmate to take a statewide qualifying test for Chemical Dependency Technicians. He not only passed. He got the highest score.

McPhie says he used to measure his self-worth by his skill as a shoplifter. Now he measures his self-worth by his marketable skill as a teacher. After nearly 27 years in and out of prison, he is hopeful that he can stay in recovery and make a legitimate living when he is released in March of 1994.

McPhie says that he and many other inmates have been through other treatment programs. This one is different, they feel, because of its emphasis on cognitive therapy.

Cognitive therapy, Gornik explains, concentrates on changing criminal thinking and teaching offenders new problem-solving and communication skills. The therapy helps inmates see the attitudes, values, beliefs, and emotions that have gotten them in trouble. Then they begin trying to restructure their personalities through techniques such as thought reports and journal writing. As their thinking changes, so does their behavior.

For inmates who want to change, Gornik, 42, serves not just as a program coordinator but also as a role model. He is a convicted felon and used heroin himself for 20 years.

He went through treatment and got clean 10 years ago, when his daughters were 3 and 5 years old. (Mark and wife Kelly have been married for 17 years.) In recovery, Gornik went to the Nelson Institute in Boise first as an outpatient, then as a volunteer, then as a staff person.

Gornik credits Institute founder Joan Nelson as the person who encouraged him to get an education to go with his experience. "You can't just work from your own experience," he observes, "or you end up trying to put everyone into the same box."

Gornik earned a bachelor of applied science degree from BSU in 1985. Then he designed an interdisciplinary course of study for a master's of science in alcohol and drug issues in the criminal justice system.

Boise State's interdisciplinary studies program was perfect for what Gornik wanted to do. The program, which began in 1988, is designed for students whose career goals do not match fully with a single identifiable academic unit or department at the university. He had to be prepared to work with people from criminal justice, law enforcement, social services, health services and psychological services. "My hope was to bring the disciplines together to solve the problem together," he says.

He has done that at the Idaho State Correctional Institution, where Warden Joe Klauser emphasizes a team approach. Everyone, from inmates to officers to therapists to administrators, is involved in the alcohol and drug treatment program.

Gornik enjoys working in the prison with inmates. "It's a hard population to work with, but it's real rewarding, too." Most programs are set up for victims of crimes, he notes. "But the victimizers also need treatment. Without significant change, criminals will continue the vicious cycle. If the treatment is effective, both the prisons and community will be safer." □

JEANETTE GERMAIN PHOTO

Transplants and T-cells

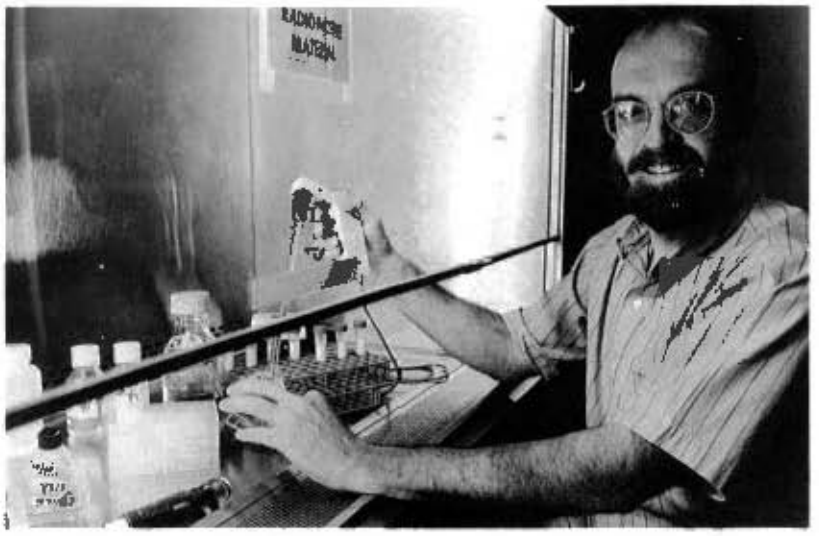
By Jeanette Germain

Keith Bishop sees the body's immune response as a beautifully regulated complex system.

But it doesn't always work the way we want it to.

"Sometimes there is a mix-up," says the cellular immunologist, "and the immune system turns against the body itself," as in rheumatoid arthritis or multiple sclerosis. Other times the immune system fails to reject dangerous intrusions such as cancerous tumors. When organs are transplanted to save a patient's life, the immune system attacks the transplanted organ as a foreign invader.

Bishop, who graduated with a bachelor's degree in biology from Boise State in 1982, is director of basic immunology research at the University of Utah Cardiac Transplant Program in Salt Lake City. He studies the underlying principles that regulate the immune system.



KEITH BISHOP: "You're basically walking a tightrope between infection and rejection."

He is most interested in T-cells because "they are the most important players in the immune response." They recognize when something foreign has entered the body and they tell other cells when it is time to produce infection-fighting antibodies.

Bishop strives to understand that system in a way that will help organ transplant patients survive. Transplant patients must take immune system-suppressing drugs to keep the body from rejecting the foreign organ. The drugs are expensive and potentially dangerous.

"You're basically walking a tightrope," Bishop explains. "If you fall off on one side, you're going to reject your graft. If you fall off on the other, you are prey to infectious diseases. Heart transplant patients may die of either infection or rejection."

Bishop hopes his research will help find new drugs, or better yet, will discover ways to influence the immune response without drugs. The body has its own system for turning the immune response on and off, he points out. He wants to learn how to keep the immune system operating to resist infection while reducing damaging reactions to transplanted organs.

Researchers in Bishop's lab have already found a way to improve the follow-up care of transplant patients. They have learned how to monitor heart rejection by looking for certain T-cells in the blood. "We can detect these as much as a week in advance of the actual rejection," he says. The current method for detecting this damage is to run a catheter through the jugular vein into the heart to take tissue samples.

This invasive procedure costs $1,500 and must be done an average of 20 times a year. Thanks to Bishop's research, physicians should soon be able to detect rejection sooner, with fewer biopsies.

But can this research be considered cost effective? Do we as a society want to continue spending money on major organ transplants when we might be looking for an AIDS vaccine, for example?

Bishop notes that funding for non-AIDS immunology research has already dropped significantly. The National Institute of Health funds only a small percentage of non-AIDS proposals submitted, he says.

Even in this time of spiraling health costs, Bishop sees significant benefits from transplant immunology research. For example, he points out that Medicare now pays for kidney dialysis.

The price of a successful transplant operation with follow-up care is more cost effective than long-term dialysis. More importantly the patient is freed to be a productive person in society. "A kidney transplant serves the patient and the taxpayer better," Bishop comments.

Bishop takes satisfaction in knowing that his scientific work will be used in medicine. Those dual interests first blended when he was an undergraduate student at Boise State. He had been a medic in the Navy and thought he was going to be a medical technician. But then he took classes from BSU biology professors Harry K. Fritchman, Russ Centanni and Gene Fuller. "They were incredibly inspirational," he says.

After graduating from BSU, Bishop went on to earn a Ph.D. in immunology at Washington State University. He was a post-doctoral fellow at Ohio State University.

He loves the science but always wanted to see it applied in the context of medical clinics. "Science for the sake of doing science is great. It's fun," he remarks. "But it's really nice to do something that will benefit us all." □

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The Healer

By Glenn Oakley

A medicine man's vision convinced David Baines to stay in medical school and reconcile the conflicts between his Native American philosophy and the strictures of Western medical practice.

Today, his successful merging of those two philosophies has brought Dr. Baines national acclaim. For the past eight years at the St. Joe Valley Clinic in St. Maries, Baines has patched up busted up loggers, delivered babies and treated residents of the nearby Coeur d'Alene Indian reservation with technical skills learned at the Mayo Clinic and with spiritual healing skills learned in medicine lodges on reservations throughout the western United States.

DAVID BAINES: "Western medicine has a tendency to think there's only one way to heal."

A member of the Tlingit/Tsimpsian tribes of southeast Alaska, Baines decided to go to medical school while recovering from injuries sustained in a saw mill explosion.

On a whim Baines took a career aptitude test and "seven out of 10 came up medical so I figured somebody was trying to tell me something," he says. Baines cut his hair and entered medical school. Despite good grades, however, Baines was thinking about quitting school because, "I thought I had to lose my Indianness to get educated. And I was unwilling to do it. I'm much more proud of being an Indian than being a physician."

Baines went to a sweat ceremony in South Dakota conducted by a local medicine man. "I don't even know the guy's name. I only met him that one time. But he is one of the key people in getting me through. He didn't know me, but he found out in the ceremony I was struggling with [medical school]. And then he gave me a vision about having my hair long and working on a reservation and helping people. And it's come true."

Western medicine, says Baines, "has a tendency to think there's only way, there's only one religion, there's only the American way, there's only one way to heal. That's not true. I send people to chiropractors, to acupuncture people, to medicine people. I'll just tell my patients, this is just something we don't do very well."

In his own practice, Baines seeks to meld the physical aspect of Western medicine with the spiritual approach of Native American healing. "I still give people antibiotics, I still set their fractures, I still sew them up," says Baines. "But I utilize from our traditional belief system a more spiritual approach to not just treating them, but diagnosing. As far as being able to ascertain whether the person is having emotional or other problems, I'm more attuned to that. Western medicine pretty well ignores that, although they are readdressing that in the training process."

Baines trusts intuition as well as X-rays and MRIs. "There have been many times I've made diagnoses with very little if any physical signs. Something will come to me. That's something that traditional healers I've worked with have tried to help me with. One time I had a guy come in and I was sure he had heart disease. ... The cardiologist didn't want to do him because he had a normal cardiogram. But I said, 'Hey, my nose is itching on this one; you've got to do it.' So they did it and sure enough he had a 90 percent blockage and was about to have the big one."

Traditional Indian healers from the Arapahoe, Shoshone, Sioux, Navajo, Kalispell and Coeur d'Alene tribes have helped him develop his intuitive skills. "The traditional people have taught me so I can use other methods," he explains. "People have an energy around them. And you can see that energy, but not with your eyes."

Baines tells the story of a Coeur d'Alene Indian healer who was injured in a car crash. "One night a year ago from January she had a major wreck. The night that she had the wreck — and it took three hours to extract her and it was 10 degrees out — she came to me in a vision in my sleep. My wife woke up and I was singing Indian songs. And what it was is I knew Lucy was in trouble so I was trying to help her in my dreams."

Two days later Baines learned Lucy was at a Spokane hospital. "When I walk in there, Lucy looks up at me — and she's about 80 years old and pretty banged up — and she says, 'Oh, it's good to see you. I've been calling for you.' I said, 'I know but you forgot to tell me where you were at.' She said, 'You're supposed to know those things.'"

Such abilities are gifts, says Baines. "My gift is I communicate well with my patients both ways. I can read them well and I can educate them so they understand why we're doing what we're doing and if we can't fix them why we can't fix them." □

GLENN OAKLEY PHOTO

Helping the Homeless

By Amy Stahl

Seated in her cramped office at the Boise Clinic, nurse practitioner Betty Weatherby takes a sip of coffee and thinks about the kind of person it takes to provide health-care services for the hundreds of homeless people in Boise. Finally, she says: "I guess you've got to believe in people."

The Boise Clinic, which is operated through Terry Reilly Health Services, is Idaho's primary health-care facility for the homeless. Clean and orderly, it is nonetheless jammed with supplies, filing cabinets and patients standing quietly in a tiny airless waiting room.

With assistance from a small office staff, Weatherby sees 350 to 410 patients per month. She provides initial diagnoses, performs common procedures like Pap smears and treats ills from colds, headaches and cuts to diabetes, seizures, coronary artery disease and pneumonia. Volunteer physicians and a doctor who rotates in once a week from Nampa advise Weatherby and handle more complicated ailments.

BETTY WEATHERBY: "You've got to be able to accept people as they are."

A compassionate woman with a soothing voice and an upbeat attitude, Weatherby says she's wanted to be a nurse for almost as long as she can remember. As a child in Grangeville, she came to admire nurses at the hospital after she was injured in an accidental shooting. She still bears scars from shrapnel wounds to her head.

As a high school student Weatherby worked as a nurse's aide, and then earned an associate's degree in nursing from Lewis Clark State College in 1972. She received a family nurse practitioner certificate from the University of Utah in 1976, and in 1992, a baccalaureate degree in nursing from Boise State University. She joined the Boise Clinic full time nearly six years ago after working as a temporary fill-in.

Weatherby says her goal at the clinic is to get her patients "back on their feet to whatever living style they want to live in." The clinic team, which includes social workers, also guides them to programs available in the community such as housing, food and other services. After all, she says, "it's hard to treat somebody medically if they don't have a place to live or food to eat."

Day-to-day existence is difficult enough for most homeless people, but life becomes even more tenuous when complicated by a major illness such as HIV/AIDS. Weatherby currently sees about 40 such clients, but the number fluctuates because of the rootlessness of the homeless population. Weatherby provides as much care for the HIV patients as she is able and then refers them to other agencies in the community. Sadly, eight have died.

Preventive care, however, is well within her scope as a nurse practitioner and Weatherby devotes a lot of energy to educating her clients. She tries to prevent the spread of the HIV virus by providing condoms and talking to intravenous drug users about not sharing needles and the availability of treatment.

Weatherby is frustrated by society's short-sighted attitudes toward the homeless. After all, she asks, "How long can any of us live on our savings or whatever without finding another job? Think about what these people are going through."

Given encouragement and assistance, many homeless individuals return to lives as fully functional members of society, she says. "From homelessness to becoming productive citizens — the difference is having support," says Weather-by. As a result, Weatherby and her staff try to build relationships with the patients that extend beyond just physical ailments.

Despite prevailing myths, she says, "A lot of people don't want to be supported by agencies. They don't want somebody taking care of them for the rest of their life." Some, however, face uncertain futures. Many illnesses are caused by stress, poor living conditions, inadequate nutrition and other sometimes uncontrollable factors.

Homeless parents have an especially difficult time keeping their children healthy. Weatherby asks: "If you're looking at children living in cars on the street or in a shelter, how do you prevent them from getting sick or prevent the others from catching it?" It's nearly impossible for these parents to get ahead under these conditions. "Some aren't looking at their child's college education because they're looking at what's going to be on the table for supper tonight."

The work is rewarding for Weatherby, but she says providing health care for homeless patients isn't for everybody. "You've got to enjoy it. You've got to be able to accept people as they are," says Weatherby. "You can't push your values off onto other people." □

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