

Prison Deaths Spotlight How Boards Handle Impaired, Disciplined Physicians

THE DEATHS in recent years of several prison inmates under the care of physicians with records of criminal or professional misconduct has critics calling on medical licensing boards to be more vigilant in protecting patients from physicians who commit serious offenses.

Stronger safeguards are needed generally, critics argue, but prison populations are particularly vulnerable. In some cases, rehabilitating physician offenders has included licensure restrictions that led them to jobs in correctional settings, where surging inmate populations have sorely stressed medical staffing and care.

“Too many state medical boards, despite a clear duty to protect the public, still believe their first responsibility is to rehabilitate ‘impaired physicians’ and to protect them from the public’s prying eyes,” said Sidney M. Wolfe, MD, director of Public Citizen’s Health Research Group, in Washington, DC.

Dale L. Austin, deputy executive vice president of the Federation of State Medical Boards in Dallas-Fort Worth, rejected Wolfe’s complaint. The first duty of medical boards is “to protect the public,” he said, and that would include patients who happen to be incarcerated.

“When faced with an impaired physician, a medical board strives to rehabilitate that physician if the public can be protected in the process,” Austin said. “However, that should be a secondary focus to the primary reason for the medical board’s existence—to protect the public.”

Correctional health experts say many physicians providing medical services to inmates are caring and competent. Still, several inmate deaths allegedly due to physician neglect or substandard care are focusing attention on the practice of licensing restrictions that, as part of the



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rehabilitation process, could funnel impaired physicians into prison health care (see following article).

For example, the civil suits that followed the death of two inmates in Alabama’s Kilby Correctional Facility revealed that the chief psychiatrist and mental health director for Alabama’s prisons was licensed by that state after twice losing his medical license for sexual misconduct in other states.

In November 1994, Correctional Medical Services (CMS), a St Louis-based, for-profit provider of correctional health care, hired Gail R. Williams, MD, to direct mental health services in Alabama prisons, even though he no longer had a medical license. The year before, Oklahoma revoked his license for sexually battering and harassing a nurse and other female staff members. Williams lost his first medical license in 1985, after Michigan’s Board of Medicine found him guilty of engaging in sexual relations with a patient and fraudulently billing

an insurance company for the sexual encounters as therapy sessions.

In September 1990, after concluding that Williams had lied under oath when he claimed that he never engaged in sexual relations with other patients, the Michigan board denied his request for reinstatement of his license. That same month, however, Oklahoma issued Williams a medical license that restricted his practice to a supervised setting of a public agency and prohibited his treating female patients without the presence of a female chaperon. He was hired to head mental health services for Oklahoma’s Department of Corrections (DOC).

He lost that job and his Oklahoma license in November 1993 when the Oklahoma State Board of Medical Licensure and Supervision found him guilty of sexual battery and harassment. Williams, however, continues to deny the charges. He said he was a victim of a “power struggle” and a conspiracy led by the nurse. He didn’t appeal the revocation of his license, he said, because he missed the cutoff date for filing an appeal.

Restricted to Treating Prisoners

After losing his Oklahoma license, Williams applied to Kansas for licensure but was refused. Despite his troubled past, lack of a medical license, and the fact that he had worked as a physician for fewer than 3 of the previous 8 years, CMS hired Williams in November 1994 and helped persuade Alabama’s Medical Licensure Commission to give him a license restricted to practice in penal institutions.

Williams also applied to Mississippi, which granted him a similarly restricted license. However, unlike his Alabama license, his Mississippi license prohibits him from treating or seeing female patients without the presence of a woman

“Only the Tip of the Iceberg”?

THE NUMBER of physicians who have been convicted of crimes or disciplined for serious misconduct who are now working in correctional health care is unknown. However, those brought to light by the preventable death of inmates are probably “only the tip of the iceberg,” said psychiatrist E. Fuller Torrey, MD, executive director of the Stanley Foundation Research Programs, Bethesda, Md. Based on his observations while visiting jails and prisons and following news accounts during the past decade, he said, these scandals are neither rare nor found in only one region of the country. An examination of medical licensing board records for physicians who were involved in inmate deaths recently reported in the news media shows he may be right. For example:

- The suicide of a 17-year-girl in the Westchester County jail in Valhalla, NY, in May 1996 brought to light the past crime of the jail psychiatrist who had ordered the teenager to stop the antidepressant medication she was taking for more than a year. According to *New York Times* news reports, jail records noted that Nancy Blumenthal was depressed and suicidal when she was incarcerated on April 17, 1996, on charges of robbery and threatening her mother with a kitchen knife. The girl had a history of psychiatric treatment going back to the fourth grade, including hospitalization for depression and suicide attempts, her mother Wendy Blumenthal said. The day after Blumenthal was jailed, Harvey N. Lothringer, MD, interviewed her for about 20 minutes and ordered her medication discontinued. She told him it made her violent and that she didn't want to take it, he said. Four weeks later, she was found dead in her cell, hanging from a bedsheet.

The Westchester County health commissioner issued a report criticizing Lothringer for stopping the girl's medication without consulting her parents, physician, or psychotherapist. In June 1997, Westchester County and EMSA Correctional Care, the Fort Lauderdale, Fla.-based private firm that provides medical care for Westchester county jail inmates, settled a wrongful death lawsuit by paying Blumenthal's family \$1.45 million. EMSA officials declined to comment.

According to the family's attorney, Jonathan Lovett, that settlement was reached quickly because the defendants feared what a jury might award after hearing the details of Lothringer's criminal past. In 1962, the physician fled the country to avoid arrest after a plumber called in to unstop the

drains of his house in Queens, NY, made a gruesome discovery. Lothringer had killed a college student in a botched illegal abortion and tried to hide the crime by cutting her body up and flushing the pieces down his toilet. Lothringer was apprehended in Europe and returned to New York where, in 1964, he pleaded guilty to second-degree manslaughter and served 4 years of an 8-year sentence. In 1973, one year after his parole ended, New York State reinstated his medical license. Lothringer did not respond to a written request for comment.

- In Utah State Prison, a psychiatrist who was twice placed on probation by the state's medical licensing board was blamed for the death of a schizophrenic inmate he ordered immobilized in a restraint chair for 16 hours. Michael Valent, a 29-year-old inmate, had stopped taking his medication, and his symptoms grew worse. When he put a pillowcase over his head and refused a nurse's order to remove it, the nurse phoned the prison psychiatrist, David L. Egli, MD. Without examining the inmate, Egli ordered him confined in the prison's special restraint chair. Guards removed the inmate from his cell, stripped him naked, and strapped his arms, legs, and torso in the restraint chair, which had a hole in the seat for defecation. A condom catheter was attached to his penis. He remained in the chair for 16 hours before he was seen by the physician and released. Moments later, he collapsed and died of a pulmonary embolism resulting from blood clots that formed during his extended immobility. The death was ruled a homicide by the medical examiner, although no criminal charges were brought.

Utah State Prison halted use of the restraint chair following the public outcry over its use on mentally ill inmates, and in July, the state agreed to pay Valent's family \$200 000 to settle their wrongful death suit. Nevertheless, attorneys for the state maintain that Valent had to be restrained because he was a danger to himself and that, while in the chair, he had received good care. “I believe that the preponderance of evidence shows that Michael's restraint was done in his best interest,” Egli said. “Our experts do not believe that the restraint caused his fatal embolism.”

At the time of the inmate's death, Egli's medical license was under probation. The psychiatrist was disciplined for having three male psychiatric patients perform what he said was a “balance test” to adjust their medication. According to Utah's

chaperon, as Oklahoma had done 4 years before.

Williams was hired “because he clearly was the most qualified physician who applied for the job,” said Larry A. Linton, regional manager for the Alabama office of CMS. “His experience in managing a statewide mental health program made him an ideal candidate. It's very rare to find someone with experience in both correctional health and in psychiatry. Dr Williams had both to offer and had done a good job previously. We believed he was the best qualified to provide mental health care for Alabama prisoners.”

CMS was fully aware of Williams' past mistakes and discussed them with the board of examiners, said Susan B. Adams, CMS' director of marketing and communications. “We are confident that

we have measures in place to prevent him from repeating his past mistakes,” she said. CMS supervises and provides quarterly reports on Williams to the medical licensing board. “There hasn't been a single incident reported that even suggests Dr Williams is anything less than what he needs to be, and that is a professional,” Linton said.

Explaining the decision to license Williams, Larry D. Dixon, executive director of the Alabama Board of Medical Examiners in Montgomery, which gathers information for the licensure commission, said the board had thoroughly reviewed his application and conducted appropriate interviews. The board was advised repeatedly that psychiatric services were “desperately” needed in the state prisons. The board was assured by

the DOC and CMS that Williams would not see or treat women without a female chaperon. The board restricted his license to practice in state penal institutions, and his license specifically requires his supervisors to provide the board with quarterly reports. “I think that the board has placed sufficient safeguards to protect the patient population—and for 4 years it appears that quality medical services have been provided without incident,” Dixon said. “We have gotten nothing but exemplary quarterly reports from the other physicians he works with as well as the DOC and CMS. I don't know what else is demanded of us.”

Defendants in Lawsuits

Williams first came under public scrutiny following the 1995 death of Billy

Physicians Licensing Board, he regularly required these patients to stand in front of him while he sat in a chair. He told them to close their eyes and stand on one leg while stepping down on the physician's scrotum with their other foot as hard as they could for up to 30 minutes at a time. After Egli acknowledged that his conduct was "professionally inappropriate and was abusive to his patients," the board placed him on 5-year probation, which expired April 1997.

Some of that abuse occurred while Egli was still on probation for a previous offense. In 1986, he received a 5-year probation after being found guilty of providing controlled substances to an addicted friend and writing fraudulent prescriptions.

Egli declined to comment about his past misconduct. However, some of his medical colleagues, including his former boss, Robert E. Jones, MD, now with the Montana Department of Corrections, speak highly of Egli's compassionate care of inmates. Carol Gnade, executive director of the American Civil Liberties Union of Utah, Salt Lake City—which worked to halt the prison's use of the restraint chair—said that inmates she interviewed generally spoke well of the care they received from Egli. "It wasn't Egli who introduced the use of that chair," she added.

- In Nevada, while still on probation for previous professional misconduct, Warren S. Gilbert, MD, medical director of the Washoe County Detention Center, ordered nurses to remove a diabetic inmate from the jail's diabetic protocol. Two days later, the woman died of diabetic ketoacidosis.

According to the Nevada State Board of Medical Examiners' findings, when Jacqueline Reich was booked into the jail on October 16, 1994, her intake form noted that she was a diabetic who took 30 units of insulin every morning along with medication for hypertension and that she wore a diabetic alert bracelet. A nurse placed her on the jail's diabetic protocol, including blood pressure checks and fasting blood sugar checks. The next day, without examining or talking with the inmate, Gilbert wrote an order on the inmate's treatment sheet to discontinue the diabetes protocol and to put her on a general diet. The nurses stopped giving her insulin and monitoring her blood glucose level.

When she began to exhibit the classic signs of uncontrolled diabetes, she was taken to the jail infirmary on October 18 and given an over-the-counter cold remedy. No blood glucose testing was done. She fell into a diabetic coma and died on the following day. According to the Nevada board's findings,

Gilbert testified that he had "intended only to cancel the order for a diabetic diet and the regular insulin dosages. He did not intend to cancel the order for glucose and blood pressure tests to be performed 3 times a day for 3 days. However, it is clear from the records that the nurses construed respondent's [Gilbert's] order to mean a discontinuance of the entire diabetic protocol, including the glucose tests. Respondent was aware that no glucose tests had been performed for over 20 hours because on October 18, 1994, he signed off on the treatment sheet, which indicated that no glucose tests had been performed."

The year before, the Nevada Board of Medical Examiners had placed Gilbert on probation for 2 years for violating medical practice regulations by prescribing synthetic thyroid medication for weight control and for overprescribing and inappropriately prescribing excessive amounts of controlled substances. He was charged with 33 counts involving 32 patients and 20 individual acts of malpractice.

Following the inmate's death, the board of medical examiners charged Gilbert with gross malpractice. On January 5, 1996, the board concluded that, although Gilbert's actions were "below the applicable standard of care," they were "not done willfully or with conscious disregard [and therefore were not] gross malpractice." However, the board did find Gilbert guilty of violating regulations that protect the exclusive right of physicians to practice medicine. By allowing nurses to diagnose and treat medical conditions, the board said, Gilbert was guilty of "aiding, assisting, employing, or advising, directly or indirectly, unlicensed persons to engage in the practice of medicine."

"In the interest of improving the health care of inmates in Nevada who are under the care of the Respondent as a physician or a medical director, it is hereby ordered that Respondent's license to practice medicine in the State of Nevada is revoked; however, the revocation is stayed and respondent is placed on probation for a period of 4 years," the board wrote.

Gilbert, who is now working for Nevada Occupational Health Center in Sparks, Nev, blames the nurses for the "foul up" that resulted in the death of the diabetic inmate. He also accuses the Nevada Board of Medical Examiners of being grossly unfair and unjust and of denying him due process. "I did nothing wrong either time I was disciplined by the board," he said.—A. A. S.

Roberts, a psychotic inmate who committed suicide after his antipsychotic medication was discontinued. When Williams took charge of mental health services in Alabama's prisons, he ordered the medical staff to greatly reduce the number of inmates who receive psychotropic medications. He also discontinued the policy of sending the most severely mentally ill inmates to Taylor Hardin, the state's secure medical facility. Instead, they had to be treated within their prison, despite the shortage or absence of acute psychiatric beds and psychiatric staff in the state's 12 correctional facilities that house approximately 20 000 inmates—an estimated 1500 to 2000 of whom have a serious psychiatric illness.

A wrongful death suit brought by Billy Roberts' family, in which the plaintiff was

not allowed to present evidence of Williams' past professional misconduct, was unsuccessful, said Gayle H. Gear, a Birmingham attorney who has represented inmates or their families in two wrongful death and one class action lawsuits against CMS, Williams, and other CMS health care providers. In the class action suit, US magistrate judge John L. Carroll ruled in April 1997 that the system Williams instituted when he took charge of mental health services in Alabama prisons was "woefully inadequate" in meeting the constitutionally mandated medical needs of mentally ill inmates. A federal district judge is now considering whether to issue an order that would mandate changes recommended by the magistrate judge. Because litigation is still pending, CMS declined to comment

other than to say that CMS and the DOC dispute the magistrate judge's ruling and that mentally ill inmates' needs are being adequately met.

Gear's other wrongful death suit against CMS, Williams, and other CMS health care providers was settled without an admission of wrongdoing on August 31 for an undisclosed amount. That suit was brought by the family of Calvin Moore, a 19-year-old inmate who died in Kilby Correctional Facility after serving only 7 weeks of a 2-year sentence for burglary. According to the affidavit of an authoritative forensic pathologist with Boston-based Physicians for Human Rights, Moore's death was a negligent homicide.

Prison records show that, shortly after being admitted to Kilby on January

3, 1996, the inmate began to display severe psychiatric symptoms. He stopped eating and, although he lost about a third of his body weight, he received no medical treatment other than one injection of haloperidol. He spent the last several days of his life in an isolation cell sitting or lying in his own urine, most of the time in a catatonic state. For more than a week, until a few hours before his death on February 21, 1996, no one took his vital signs. Although the state medical examiner concluded that Moore died a "natural" death "possibly related to an unidentifiable heart lesion," Robert H. Kirschner, MD, senior forensic consultant to Physicians for Human Rights, who served as an expert witness in the case, said that postmortem findings clearly show Moore's death was the result of dehydration and extreme hypernatremia.

According to Adams, the CMS staff at Kilby provided Moore with appropriate and compassionate care. "The settlement was for the compromise of a doubtful and disputed claim," she said. "A consideration in CMS' decision to settle this case was the anticipated high cost of trial and the healthcare providers' time and attention which would be diverted from their duties."

Crime Against Nature

Another physician named in the Moore wrongful death suit was Walter F. Mauney, MD, who was medical director at Kilby when the inmate died. According to CMS records, Mauney was hired in 1995 shortly after being released from a drug addiction treatment center, where he said he was treated for an addiction to pain medication resulting from complications following knee surgery.

On his job application to CMS, Mauney wrote, "In 1978 while on vacation, I got drunk and had sex with an 18-year-old. The age of consent was 19. I pleaded guilty to sexual misconduct and received probation."

However, criminal court records in Monroe County, Tennessee, show that in 1979 a Tennessee grand jury charged Mauney with three counts of having oral sex with and "sexually penetrating" a 16-year-old "mentally defective" boy. Mauney, who was 40 years old at the time, pleaded guilty to one count of "crime against nature" and was sentenced to 10 years in the state penitentiary, but the sentence was suspended.

In explaining his false statement to CMS, Mauney told *JAMA* that he thought the boy was 18 years old. He blamed his behavior on alcohol. He

stopped drinking in 1990, he said, and pointed out that his mistakes never involved a patient. "I've taken care of a lot of people over the years," Mauney said. "I've tried to be a good, caring doctor."

Mauney's crime occurred almost 19 years ago, said Louis Tripoli, MD, CMS's chief medical officer. "Dr Mauney underwent 10 years of probationary supervision and has paid his debt to society," he added. "Given Dr Mauney's remorse, his desire to make amends, and based upon a review of his professional credentials and record available to us at the time, CMS believed that Dr. Mauney was a satisfactory candidate to provide inmate healthcare services."

Mauney's criminal conviction led to misconduct charges being filed against him in 1980 by the medical licensing boards in Tennessee and in North Carolina, where he lived and practiced. The Tennessee board revoked his license in April 1980, but reinstated it in November 1981 after Mauney sued the board.

In February 1982, the Alabama Medical Licensing Commission gave Mauney a medical license. According to Dixon, the commission's decision was influenced by letters from physicians, patients, a judge, and other supporters urging that Mauney be licensed.

In a letter dated December 20, 1982, North Carolina's licensing board informed Mauney that it would indefinitely postpone its investigation and told him to give the board 90 days' notice should he ever return to North Carolina to practice medicine.

When CMS contacted the Tennessee Board of Medical Examiners to inquire about Mauney's discipline record, it received a letter dated May 5, 1995, stating that "there is no derogatory information in our files concerning this medical doctor."

Easier to Refuse Than Revoke

These events show how willing some medical licensing boards are to forgive and forget the crimes and misconduct of physicians, said Wolfe. "North Carolina said to a doctor who sexually abused a mentally defective 16-year-old boy, 'Stay out of our state and we'll let you keep your license,' and Alabama said, 'Come to ours, we'll give you one.' This is outrageous."

However, according to Austin of the Federation of State Medical Boards, "medical licensing boards in each jurisdiction have the prerogative to review and reconsider the facts in each case. Their interpretations of the facts don't

always agree. Being composed of humans, each board makes good decisions and, from time to time, may make bad decisions."

In a recent article on physicians disciplined for sexual crimes or misconduct (*JAMA*.1998;279:1883-1888), Wolfe and Christine E. Dehlendorf reported that, despite the seriousness of these offenses, discipline was no more severe than probation or license restriction for more than 25% of physicians found guilty. "Physicians disciplined for sex-related offenses apparently are being allowed to continue to practice with, at most, safeguards, such as having a chaperon present during examinations and having another physician monitor patient records," they wrote. "This finding is problematic considering that there are difficulties in properly assessing the potential for successful and sustained rehabilitation of these professionals. Furthermore, safeguards such as monitoring are often inadequately overseen by medical boards."

An accompanying Editorial (*JAMA*.1998;279:1915-1916) discussed the reasons licensing boards must be more discerning when considering the application of a physician whose license was revoked in another state. Because of the need for due process and the likelihood of litigation, "it is more difficult for a board to remove a medical license than to issue one," wrote F. Douglas Scutchfield, MD, of the Center for Health Services Management and Research, University of Kentucky Medical Center, Lexington, and Regina Benjamin, MD, MBA, a fellow of the Federation of Medical Licensing Boards, a member of the Alabama State Board of Medical Examiners, and former member of the American Medical Association's Board of Trustees. "Accordingly, it should be the goal of each licensing board to ensure that their processes at the front end, before they issue a license, as well as their processes for license renewal, are such that, in an ideal world, the board should never have to remove a license from a physician for misconduct. The responsibility is to guard the profession and safeguard the public from the relatively small proportion of problem physicians, and to prevent these physicians from practicing not only in the state taking the disciplinary action, but also in other jurisdictions."

—by Andrew A. Skolnick

Research for this article was supported in part by a Rosalynn Carter Fellowship in Mental Health Journalism.

Critics Denounce Staffing Jails and Prisons With Physicians Convicted of Misconduct

IN AN EFFORT to provide health care in their burgeoning jails and prisons, some states are hiring physicians who have been convicted of crimes or have lost their medical license because of professional misconduct. Some states are even issuing medical licenses that restrict the disciplined physician's practice to prisoners. That policy is not just bad for the incarcerated, say correctional health leaders and other critics, it is bad for correctional medicine and it's bad for society.

In one case, a psychiatrist who twice lost his medical license for sexual misconduct, first in Michigan and then Oklahoma, was issued licenses in Alabama and Mississippi. "Although sufficient grounds exist to deny [the psychiatrist] licensure," the Mississippi State Board of Medical Licensure wrote in its order, "the evidence presented, along with Applicant's testimony and demeanor, indicate that Applicant could serve a useful purpose as a practitioner in the State of Mississippi limited to the correctional system." That physician now heads mental health services for Alabama's state prisons (see preceding article).

Another example is Robert A. Komer, DO, whose medical licenses were revoked in six of seven states after he pleaded no contest to 59 counts of sexually abusing patients and other offenses from about 1982 through 1988. In June 1990, Michigan's Board of Osteopathic Medicine and Surgery found him guilty of sexually abusing six psychiatric patients, four of whom he first drugged with amyltal sodium. One of the patients was so upset following treatment that she slashed her wrists in a suicide attempt. Another became dependent on the physician's attention and attempted suicide several times "in order to be hospitalized and have more contact with Komer," the board found.

After Michigan revoked Komer's license, Arkansas, California, Florida, Iowa, Missouri, and Ohio did the same. Texas, however, did not. In January 1991, the Texas Board of Medical Examiners placed Komer on probation for 3 years, during which he had to undergo psychiatric treatment and to notify the board in the event he left employment with the Texas Department of Mental Health and Mental Retardation, where he was assigned to the Department of Corrections.

Komer, who now works part time at the Ferguson Unit of the Texas Depart-



Renée Roberts

ment of Corrections in Midway, declined to comment.

"No Lesser Standards"

"It is unethical and inhumane to say that a physician isn't trustworthy or good enough to treat people in the community, but that he or she is good enough to care for inmates of correctional facilities or mental hospitals," said Sidney M. Wolfe, MD, director of Public Citizen's Health Research Group, Washington, DC. The practice is "reckless and dangerous," he said.

"If physicians who have been disciplined for past misconduct are congregating in correctional settings, it should be a concern to the medical regulatory community," said Dale L. Austin, deputy executive vice president for the Federation of State Medical Boards, in Dallas-Fort Worth. "However, it may be appropriate on certain occasions for a medical board to limit a physician's practice to a specific setting to prevent a repeat of past misconduct and to assure that the public is protected," Austin said. For example, it may be appropriate for a board to limit the practice of a physician who was disciplined for sexual misconduct involving female patients to an all-male inmate population. "Such restrictions, however must be used very cautiously," he said. "I would hope that no board views health care in correctional settings as requiring lesser standards than is required for the general public."

However, inmates, especially those with serious mental illness, are vulner-

able to exploitation, Wolfe said. Because prisoners are widely perceived as manipulative, complaining, and dishonest, their complaints of mistreatment are often discounted. In addition, inmates may reasonably fear that complaining about sexual or other abuse from a member of the correctional health care staff could mean that they won't get timely medical care when needed, he added.

"While errant physicians as well as inmates can reform, the recidivism rate for sexual offenders is too high to risk the health and welfare of patients by recycling physicians who may offend again," Wolfe said. "Because prisoners are powerless and vulnerable to exploitation, we need to be careful not to place them under the care of health professionals who have a history of victimizing patients."

In justifying the practice of providing correctional health care jobs for physicians who were found guilty of crimes or professional misconduct, some licensing boards and departments of corrections point to the difficulty in meeting the rapidly increasing demand for correctional health care providers.

According to the US Justice Department's Bureau of Justice Statistics, the nation's jail and prison population has more than tripled since 1980. In 1997, an estimated 1.7 million men and women were behind bars on any given day. Each week the nation has to add 1000 more prison beds to keep up with the exploding prisoner population. That this population has pressing health care needs is well documented—the prevalence of HIV infection, hepatitis, tuberculosis, and other communicable diseases, serious psychiatric illnesses, and tobacco, alcohol, and other drug addictions is much higher in jails and prisons than in the general population. As the mounting number of federal and state lawsuits suggests, inadequate medical staffing in many correctional facilities is compromising the health and safety of inmates and leads to expensive litigation that's paid for by the public.

Difficulty Recruiting Physicians

While it's true that correctional facilities nationwide are having difficulty recruiting physicians, this doesn't justify hiring those who are not qualified to practice in the community, said Edward Harrison, president of the National Commission on Correctional Health Care (NCCHC), Chicago, the nation's

leading correctional health services accrediting agency.

"There have been vast improvements in correctional health in recent years, in both professionalism and the quality of care delivered in correctional facilities," he said. "This sounds like a step backwards. The commission has a standard that requires state licensing for physicians and other medical professionals. The commission strongly believes that the community's standard for professional conduct and competency should apply equally to the correctional setting."

Roderic Gottula, MD, president of the Society of Correctional Physicians and assistant professor in the Department of Family Medicine, University of Colorado Health Sciences Center, Denver, said the society's board "is unanimously opposed to the practice of granting medical licenses restricted to practice in corrections. Doing so is detrimental to the welfare of inmates and the practice of correctional medicine."

The American Medical Association's Council on Ethical and Judicial Affairs does not have a policy on this issue.

A recent editorial in *Lancet* summarized the case against holding physicians in correctional settings to anything other than general community standards: "The principle that prisoners are entitled to the same level of health care

as that provided in the wider community is accepted in enlightened societies and prison systems. Failure to achieve such equity could not only damage the patient but also put society at risk" (*Lancet*. 1998;351:1371).

Any disproportionate staffing of jails and prisons with physicians who have trouble getting work elsewhere also makes it more difficult to recruit qualified candidates, said Ron Honberg, JD, director of legal affairs for the National Association for the Mentally Ill, Arlington, Va. "Creating separate standards for prisoners sends a terrible message," he said. "How can you recruit more good people in a field that many look down upon as full of misfits, reprobates, and otherwise unhireables?"

Most Return to Society

According to E. Fuller Torrey, MD, executive director of the Stanley Foundation Research Programs, Bethesda, Md, and an expert on the treatment of severe mental illness, the quality of physicians providing health care in the correctional setting is "biphasic."

Based on conversations with wardens and others on his many visits to jails and prisons in 15 states during the last decade, said Torrey, along with reading about those cases of incompetence that make the news, he concludes that, "There

are many dedicated and caring men and women working in correctional health, but there is also a strongly disproportionate percentage of incompetent physicians for whom correctional facilities are the place of last resort to practice.

"The use of special licensing arrangements that allow physicians who cannot be licensed to treat the public to treat sick and mentally ill inmates in prisons or jails is a scandal," he said. "It is a scandal that is being tolerated because we don't care what happens to these people. And we don't seem to care that much what happens after they're released."

According to Torrey, approximately 10% of inmates have a serious mental illness, yet there are few links between the correctional system and the health and psychiatric care systems in the community. The vast majority of men and women in jails and prisons do not remain behind bars. Last year, 12 million incarcerated men and women were returned to society. There is a great national commitment to punish offenders, he said, but very little commitment to make sure that offenders don't leave prison in worse shape than when they enter.

—by Andrew A. Skolnick

Research for this article was supported in part by a Rosalynn Carter Fellowship in Mental Health Journalism.

Miscellanea Medica

Eugene A. Oliveri, DO, Michigan State University College of Osteopathic Medicine, East Lansing, has been named president-elect of the American Osteopathic Association.

Joseph A. Fontana, MD, PhD, has joined the Karmanos Cancer Institute, Detroit, Mich, as director of Veterans Administration Research Programs and the John D. Dingell VA Medical Center as chief of hematology and oncology. **William M. Hryniuk, MD**, has joined the institute's Center for Cancer Economics, Technology Assessment, Innovation and Development as director of technology assessment.

Peter J. O'Dwyer, MD, has been named to direct the Experimental Therapeutics Program and has been appointed professor of medicine at the University of Pennsylvania Cancer Center, Philadelphia, Pa.

Three new directors elected to the American Board of Family Practice are **Jack M. Colwill, MD**, University of Missouri-Columbia School of Medicine;

Richard F. LeBlond, MD, University of Iowa College of Medicine, Iowa City; and **L. Thomas Wolff, MD**, State University of New York Health Science Center at Syracuse.

Kenneth I. Kaitin, PhD, has become director of the Tufts Center for the Study of Drug Development in Boston. He replaces **Louis Lasagna, MD**, who will continue as dean of the Sackler School of Graduate Biomedical Sciences at Tufts University and academic dean of Tufts University School of Medicine.

Frederick F. Becker, MD, University of Texas M. D. Anderson Cancer Center, Houston, has been honored with the establishment of the Frederick F. Becker Distinguished Chair for Cancer Research. He has also received the M. D. Anderson Presidents' Award for his contributions to the institution.

Paul A. Kettl, MD, Elizabethtown, Pa, has been appointed to the Joyce D. Kales, MD, Chair in Community Psychiatry at Pennsylvania State University College of Medicine in Hershey.

Alfred O. Berg, MD, MPH, University of Washington School of Medicine, Seattle, has been appointed chair of the US Preventive Services Task Force, which has been reconvened at the Agency for Health Care Policy and Research.

Ronald G. Evens, MD, director of the Mallinckrodt Institute of Radiology, St Louis, Mo, has been named president of the American College of Radiology. **Ruth G. Ramsey, MD**, University of Chicago Pritzker School of Medicine, is vice president; and **Abner M. Landry, Jr, MD**, Memorial Medical Center, New Orleans, La, is secretary-treasurer.

Stephen J. Nelson, MD, chief medical examiner for the 10th Judicial Circuit of Florida (Polk, Hardee, and Highlands counties), has been appointed to the state's Medical Examiners Commission.

Editor's Note: Miscellanea Medica normally appears in the Medical News & Perspectives section several times each month. Items submitted for consideration should be sent to Marsha F. Goldsmith, editor, Medical News & Perspectives.