JULIA TUTWILER PRISON FOR WOMEN
ALABAMA

Introduction

This report is the result of a medical evaluation of the Julia Tutwiler Prison for Women done on June 1-3, 1994. The observations, facts, findings and analyses in this report are the result of review of policies and procedures, interviews with correctional staff, interviews with medical-dental staff, inmate interviews, review of medical grievances, review of randomly selected medical records and review of medical records that resulted from inmate interviews.

I was accompanied by Andrew Barrick, Christopher Cheng and Shanetta Brown, attorneys for the Department of Justice. Jeffrey Metzner, M.D. and I were the physician evaluators.

The population of the facility ranges between 700-740. There are all levels of custody at this facility. All health care services are the responsibility of a private contractor by the name of Quest Care (which is a division of Southeast Health Care). The clinical director is George Lyrene, M.D.

Emergency care is available at the Elmore County Hospital recently renamed Central Alabama Regional Hospital. This is a 40 bed hospital approximately 5 miles distance from the institution. It is reported to us that the hospital has an on-site contract physician to manage the emergency room. The next largest hospital is Humana East which is in Montgomery, Alabama approximately 20 miles distant from the institution. The central pharmacy that supplies pharmaceuticals to this institution is located in Birmingham, Alabama.

I. DENTAL PROGRAM REVIEW -- FACTS AND FINDINGS

1. The dental clinic is operated 32 hours per week. Dr. Wilson, the staff dentist is on site for 24 hours along with a dental assistant and a dental hygienist. Dr. Anderson is on site for eight hours per week.

2. The dental hygienist is not licensed and therefore requires the supervision of her monitor, Dr. Anderson, in order for her to provide any services. This results in dental hygiene services being provided eight hours per week.

3. The access to dental care is through the sign-up sheet for sick call. The list of inmates requesting dental services is provided to the dental clinic by the nurses who screen the daily sick call requests.

4. The turn-around-time for dental prosthesis is reported to be two to three weeks. The prosthetics are prepared by a dental laboratory in Birmingham.

5. The waiting list for extractions and restorations was reported to be approximately seven weeks.

6. An inmate "dental runner" is assigned to the dental clinic. The inmate assists the dentist at the chairside as well as making appointments and cleaning instruments.

7. Fractures of the mandible are referred to oral surgeons in Montgomery.

8. Newly received inmates are screened by the dental hygienist.

9. A dental audit dated March, 1994 was reviewed. The results were not tabulated for Tutwiler Prison alone but included the audit of the entire system. Overall in the system, over 50% of the charts were lacking dental records and/or encounters with the dental department. In hand counting the Tutwiler inmates, I found that 139 out of 325 had no entries into the dental record of any kind. This confirms my observation that the dental records were often absent from the medical jacket or that dental services were not being provided.

Analysis

1. The system is in violation of its own policy which requires a licensed dental hygienist.

2. The system is in violation of all standards of dental care by involving an inmate in direct dental services.

3. The system does not keep adequate records in terms of reflecting the need for dental services in accordance with their own stated policy.

4. For an inmate population of 700, including a reception center function, the number of dental personnel is inadequate.

5. Scheduling twelve inmates per day with about three inmates being seen as an emergency, plus evaluating new arrivals, is an inadequate and unacceptable production figure and any dentist in the free world would soon become bankrupt with this work production.

6. It is reasonable to conclude that over 50% of the inmates received at this facility do not receive dental screening based on the system's own audit study.

7. The dental office is a disgrace. Equipment is broken, the chairs are taped together, the wiring is a disaster, and smoking is allowed in the dental

operatory. On the desk in the dental operatory was an ashtray containing a cigarette butt. There is no attempt to provide a professional appearing dental office.

Recommendations

1. Implement a dental program in keeping with the dental policies.

2. Implement a system of logs that define the needs of the inmate patients at this facility.

3. Remove all inmates from providing dental services.

4. Increase the dental staff to meet the dental needs of this population.

5. Renovate the dental office and upgrade the equipment.

6. No smoking in the dental office.

II. INMATE DEATHS

In spite of a document request, and a request by myself on the first day of the inspection, the medical records of two inmates who died were not made available to me for review. The medical staff appeared very nervous about providing this information.

An incident report on BB #152036 indicated that on 5-30-93, the correctional officer was notified of a medical emergency in dorm 7. The inmate was reported to have breathing difficulties. The inmate was dead on arrival at Elmore County Hospital. The report indicated that B.B. had two medications -- Nitro Spray and Proventil inhaler. The incident report indicated a history at 3:00 PM of the inmate being sick with emesis and pain. The inmate was escorted to the health care unit at 7:30 PM. The inmates claimed that she was ill but did not want to declare an emergency because it would do no good. The inmates interviewed reflected the hopelessness of receiving adequate medical attention. There was no evidence in the incident report that any sworn statements were taken from inmates by the investigators.

The autopsy findings indicated cardiomyopathy, congestive heart failure, exogenous obesity, uterine leiomyomata and renal nephrosclerosis.

An incident report on VP who died on 1-29-93 at age 30 was reviewed. The autopsy listed cause of death as hypertension, end stage renal disease, adult respiratory distress syndrome, and severe bronchial asthma by history. The incident report indicated end stage renal disease secondary to hypertensive cardiovascular disease. Kidney dialysis patient "who underwent life and death surgery today to replace a shunt and did not recover".

III. ACCESS TO HEALTH SERVICES -- FACTS AND FINDINGS

1. Initially the ability to sign up for sick call was represented to be available to the inmates in the dining room during the dining room operation. The director of nursing was confused regarding the availability of the sign up list to the inmates. Subsequent interviews indicated that the sick call list is made available in the dining room between approximately 2 PM and 4 PM. The same lists are taken to the segregation units and to the infirmary and then brought to the nursing staff.

   The sick call requests are then triaged by the nursing staff on the third shift between 11 PM and 3-3:30 AM. It is during this time that the inmates are called out of the housing units to come to the health care clinic to be screened regarding their sick call complaint.

2. As a result of the nurse triage, the inmate may be provided over-the-counter medication but the over-the-counter medication order must first be signed by the physician and later picked up in the pill line.

3. It was represented that an inmate could be seen at any time during the day that the physician was present as a result of an urgent problem. I observed an inmate JS #147100 who had caught her finger in a door the night before seeking some relief of pain at the pill window. The end of the finger gave the appearance of a typical subungal hematoma. I observed her showing the very swollen finger to the nurse in the pill window. I asked her when she would be seen for this problem and she said that she was instructed to sign up for sick call. A hematoma beneath the fingernail, while not a life threatening condition, is very painful and can be relieved by use of a hot paper clip putting a hole through the nail to relieve the pressure of the hematoma. Not only was this inmate not given anything for relief of the pulsating pain in the finger, but was not permitted to have the situation taken care of by the physician who was present on the day of the complaint.

4. All medications require an MD signature unless an F-15 form is prepared and then the inmate can be given medication by this method.

Analysis

1. Requiring inmates to report for sick call triage by LPN's between 11 PM and 3:30 AM is a significant and unwarranted deterrent to accessing health care services.

2. The LPN's conducting the sick call request triage procedure have received no training in triage and do not follow written protocols. In addition, the LPN's who work the night shift are not supervised by an RN which may violate the Nurse Practice Act in the State of Alabama.

Recommendations

1. Employ RN supervisors who are trained in medical triage.

2. Require the physician to write written protocols for the medical triage operation.

3. Hire enough staff so medical triage can be performed during either the first or second shifts.

4. Permit the nurses to give over-the-counter (OTC) medication for simple complaints like headache and musculoskeletal pain and implement a procedure that would permit basic OTC medication availability in the housing units.

IV. PHARMACY -- FACTS AND FINDINGS

1. The physician writes a prescription or renews a prescription. The order is faxed to the contract pharmacy in Birmingham and the medication is returned the next day to the facility.

2. There is no medication on person program at this facility. All medications, including over-the-counter medication, must be delivered through a pill window.

3. The inmates report that when prescription medicine is not available the nurses provide identical medication from another inmate's bottle. From simply observing the methodology, I believe this is a correct and truthful allegation.

4. I observed several order sheets that were blank but contained the physician's signature. In other words the physician signed a blank sheet which I am confident violates the Medical Practice Act in the State of Alabama.

V. LABORATORY -- FACTS AND FINDINGS

1. All laboratory work is sent to a reference laboratory off site and the results are transmitted by telephone back to the institution.

2. It was represented that the physician must review the lab work and indicate such on the laboratory report before the slip is filed in the chart.

3. There is no requirement that the physician discuss the results of the laboratory test with the patient.

VI. X-RAY -- FACTS AND FINDINGS

1. There is no x-ray machine at this facility. All inmates must be transported to Kilby for x-ray services.

2. The director of nursing arranges the schedule for inmates to be transported for x-ray.

Analysis

1. For a facility of this size, an on-site x-ray would be cost effective and provide a needed basic service.

2. When x-ray services are not available on site, needed x-ray services are inappropriately delayed as illustrated by inmate MW #173435.

VII. RECEPTION PROCESS -- FACTS AND FINDINGS

1. The health history must be obtained within three days by the nurse. The physical examination must be performed by the physician within seven days. In reviewing the records there is a routine wait of at least three weeks before the physician performs a physical exam. During this time the inmates in the reception unit are not permitted to have any medications because they have not been examined by the physician.

2. The inmates receive a PPD skin test, a serology, a GC culture, a pap smear, a HIV test, a CBC, a urinalysis and a Snellen eye chart examination. They receive tetanus toxoid if they have not received any tetanus booster in the past 7-10 year period. They receive a pregnancy test if there is a possibility of pregnancy or as ordered by the physician. The system does not perform screening hearing tests.

3. The routine response to my inquiring about the delay in doing the physical examination was that the inmates were menstruating.

4. An inmate MB #176874 was admitted to the facility on 5-4-94 from Jefferson County. The inmate indicated that she was being treated for hypertension and was on INH.

   On 5-23-94 it was indicated that this inmate had a past positive PPD.
   On 5-26-94 a chest x-ray was done. A blood pressure reading on 5-7-94 was recorded as 170/100 with the inmate complaining of headaches.

   On 5-11-94 the physician evaluated this patient for hypertension. There was no evidence that the patient was examined and the blood pressure was ordered to be taken by the nurses twice weekly for two weeks starting next week. The physician also ordered a potassium in ten days. The lab reported on 5-20-94 a potassium of 3.2 with a normal range being 3.4 to 5.1. This lab slip was on the front of the chart waiting the physician's signature approximately ten days after the report was transmitted to the facility.

Analysis

1. There was no history regarding the exposure or the circumstances surrounding the past positive PPD.

2. There was no chest x-ray report on the chart and there were no liver function tests ordered in spite of the patient being on INH.

3. There was no evidence that this patient was examined by the physician.

4. There was a significant delay in recognizing a low serum potassium.

5. This patient represents a break down of the reception process and inappropriate management of a patient with hypertension and the possible mismanagement of a patient who may be a candidate for preventive INH therapy.

III. PHYSICIAN SERVICES -- FACTS AND FINDINGS

1. The physician is on site three days per week -- Monday, Wednesday, and Friday. The physician is expected to see all inmates placed on the doctor's list by the nurses as a result on the nurse triage program. He must sign all over-the-counter orders that the nurses have ordered as a result of medical triage. He must see all return appointments for follow up care. He must do a physical examination on all new arrivals, and is responsible for managing the inmates in the medical isolation unit and the infirmary.

   In addition, he must review all laboratory and x-ray reports and must complete consultation reports if a patient needs services outside of the facility.

Analysis

1. The physician does not examine patients. If the examination is done there is no evidence that the examination is recorded and one must conclude that the examination was not performed.

2. The physician does not take an appropriate history from the patient.

3. There is no diagnosis or assessment made on the patient.

4. There is no plan of management indicated in the medical record. The only plan of management is a prescription order.

5. I am convinced that the physician is not a mean spirited individual and does relate well to the patients. The physician does not have the time to perform all of the tasks that he is expected to do. A facility of this size should have a full time physician and two full time med-level practitioners (either two PA's or two nurse practitioners) to assist the physician and provide continuity of care. The only services the physician can provide is acute episodic care and the medical records reflect that practice.

6. All outside referrals of a non-emergency nature must be approved by the clinical director.

7. The clinical director is on site approximately one time per month. The clinic director in the Alabama system travels from prison to prison reviewing consults and providing advice to the facility physician. The clinical director is a circuit rider to all twelve prisons.

8. There are no specialty services provided on site. All pregnant females and GYN problems are referred to OB/GYN physicians in Montgomery one day per week. All referrals with the exception of OB/GYN referral must be approved by the clinical director.

IX. CHRONIC DISEASE CLINICS -- FACTS AND FINDINGS

1. By order of the clinical medical director, on June 14, 1993, all facilities were to implement a chronic disease program using the chronic care forms.

2. Julia Tutwiler Prison for Women has not fully implemented the chronic disease clinics and the chronic disease forms are sporadically used in the medical records.

3. There is no evidence that any type of quality assurance review has been conducted to see if the facility is in compliance with the clinical director's instructions.

4. LPN's are charged with the responsibility of conducting chronic disease clinics. LPN nurses training does not prepare these individuals to perform this task. There is no evidence that the system provides further training to LPN's to manage chronic disease clinics.

5. It is my opinion that because of the disorganization of the medical care delivery system at Julia Tutwiler and the fact that there is a significant shortage of medical staff, the chronic care forms and the chronic disease clinics can not be implemented.

6. It is an example of callous indifference to require a medical staff to carry out functions that they are not trained to perform and to carry out functions that can not be implemented because of lack of sufficient person power.

7. The chronic disease forms are quite satisfactory and should be implemented.

X. MEDICAL GRIEVANCES -- FACTS AND FINDINGS

1. A review of twenty one medical grievances indicate that the person responding to the grievance does not usually address the issue. This is most frequently found when the grievance is filed in regard to the physician's behavior. There is no indication that the physician's behavior is investigated.

2. A common response to the inmate grievance is the assertion that the inmate is at fault because of noncompliance with medication. With a complicated pharmacy distribution system and the deficiencies in continuity of care, the system itself may be responsible for the noncompliance with medication.

3. The inmates are apparently not permitted to have on their person inhalers for treatment of asthma. This was dated 8-27-93. The inmate was instructed to obtain the inhaler at the pill line. When this was brought to the attention of the facility physician, he adamantly asserted that he does approve inhalers to be kept on person if there is no evidence of abuse. The medical records however do not support this assertion.

XI. HIV MANAGEMENT -- FACTS AND FINDINGS

1. At the time of the inspection, there were thirteen inmates housed in special segregation from the general population.

2. In March of 1994, the segregation unit was expanded to form a second unit. In the early part of 1994 there were 19 inmates on the HIV segregated unit sharing one shower, one stool and one sink.

3. There was no hot water for two weeks late in February of 1994. Hot water was carried in 40 gallon plastic garbage cans from the kitchen to the unit rolled on carts. On one occasion the cart tipped and one of the inmates was severely burned over the feet. This is an inmate by the name of TB who is not only HIV positive, but TB positive. At the present time she is on preventive therapy with INH.

4. The inmates have no access to GED programs or any other organized educational activity. TB was scheduled to take the GED examination in January of 1994 but as of the date of the inspection had not been tested. Independent study on the HIV unit was stopped one year ago and most of the activity in drug education and special tutoring is carried out by other inmates.

5. There is no meaningful recreation available other than a small outside closed yard.

XII. MEDICAL CLINIC -- FACTS AND FINDINGS

1. Nurse triage and physician encounters are all performed in one room. There are two exam tables present and on the first day of the inspection the two exam tables were located so close to each other that they obviously were not functional. On subsequent days the exam tables were separated.

2. With the congestion, crowding and large amount of traffic in the one examination room, it is obvious that examinations utilizing an exam table are not carried out by the physician. The results of physical examinations are not found in the medical record.

3. There is no ability to provide sound privacy for confidential history taking.

4. There is a four bed infirmary and two inmates were interviewed who were in the medical infirmary.

5. I suspect that the newly created second living area for the segregated AIDS patient was formerly utilized for some function of the medical clinic.

6. In my opinion, the physical plant is unsatisfactory and inadequate for carrying out needed health care services for a population of 700 women.

XIII. INFIRMARY

MW #173455 -- Facts and Findings

1. The inmate was interviewed in the infirmary being referred to the Tutwiler facility from the Birmingham Work Release Center. The patient was being treated for a kidney infection and was receiving intravenous antibiotics. She was referred for infirmary care after a short period of hospitalization.

2. A hospital discharge summary was in the medical record.

3. Torn mattresses were noted on the infirmary beds.

Analysis

1. There was no admitting note or history and physical examination by the physician. In other words the IVP which showed a duplicated ureter on the right was not even noted by the physician.

2. There was no written plan of management by the physician.

3. On discharge from the hospital the hospital recommended that Gentomycin blood levels be followed carefully. At the time of inspection the Gentomycin blood level had not been ordered by the facility physician.

TL #176902 -- Facts and Findings

1. This patient was in the infirmary because of a positive PPD skin test. The patient was admitted on 5-4-94 and the TB skin test was read on 5-19-94. The patient was three months pregnant.

2. On 5-26-94 Dr. Dupree was notified regarding the positive PPD. There was a note in the record that Dr. Dupree "was unaware of what could be done; would call back with orders". On that same day orders were written "sputum - 3 samples test AFB and cultured, shielded chest x-ray, place in isolation".

3. Sputums were collected on 5-30, 5-31 and 6-1, 1994.

Analysis

1. There was no TB history taken or recorded. I asked the patient and determined that the patient was asymptomatic and no history of exposure.

2. It is inconceivable that any one would place this patient in isolation without first taking a history and obtaining a chest x-ray. The fact that chest x-rays are obtained off site, is probably the reason why the chest x-ray was not performed in a more timely fashion.

3. While in the infirmary, the patient was not receiving the prenatal vitamins normally prescribed during pregnancy.

4. It is obvious that the management of tuberculosis in this facility is unsatisfactory and inadequate. It is my opinion that the TB control program at this facility does not meet the guidelines of the Communicable Disease Center (CDC).

5. At the time of the inspection it was one month from reception and no OB evaluation by a physician had been performed.

6. The admission history form was not dated or signed.

7. No physician assessment, plan or progress notes were found in this infirmary record.

XIV. MEDICAL RECORD REVIEW

LF #167143

1. A GYN referral recommended a D&C for this patient on 12-12-93. Apparently on 1-25-94 a D&C was performed and the finding was a 10x10 uterine fibroid. On 2-8-94 a consultant recommended six months of medical management with a decision in six months regarding further surgery.

2. A letter to the warden from the director of nurses dated 5-12-94 brought charges against this inmate for excessive sick call requests.

3. On 5-11-94 the patient requested electrolytes because she was on antihypertensive drugs and a potassium supplement. On 5-11-94 - not getting medication; 5-16-94 - complaint not getting medicine; 5-22-94 - not getting medicine; 5-24-94 - not getting meds. The last electrolyte determination on this patient was on 10-31-93 where the potassium was 3.4 - the lower end of normal. On 10-28-93, three days earlier, the potassium recorded was 3.1.

4. On 10-18-93 and again on 10-19-93, the blood pressure was recorded in the range of 180/120.

5. Two EKG's on the chart dated 2-19-94 and 1-13-94 have not received a professional interpretation.

Analysis

1. There is no evidence that the system investigated the complaints of not receiving medication.

2. Apparently there is a system for reporting to the warden for some sort of discipline when an inmate is perceived to abuse sick call request privileges.

3. There is clear mismanagement of this patient's hypertension and a failure to follow their own procedures in terms of periodically checking serum potassium.

4. There is no evidence in this record that the physician examined this patient in reference to the patient's significant hypertension.

KG #166686 -- Facts and Findings

1. On 5-3-94 it was recommended that a CT or MRI of the head be obtained to rule out a pituitary lesion.

2. The inmate was seen on 5-17-94 - need to check meds and again on 5-31-94 - bad ear ache.

Analysis

1. There was no evidence as of 6-2-94 that the CT or MRI had been ordered or scheduled.

2. This is an example of the failure to provide continuity of care and adequate follow up.

AG #175573 -- Facts and Findings

1. GYN consultation on 5-31-94 indicated a diagnosis of possible diverticulitis secondary to rectal tenderness. The plan was to schedule a barium enema prescription for Anaprox DS, Rocephrin, Doxycycline x 14 days; follow up in six weeks and discontinue Motrin.

2. As of 6-2-94 a request was submitted for the nonformulary drug Anaprox DS. There was no signature on this request and no date. In addition, there was no order for Doxycycline.

3. The Rocephrin was given intramuscularly on 5-31-94.

Analysis

1. This is another example of failure to provide continuity of care. The facility physician had not reviewed, implemented or modified the consultant's recommendations.

2. There appears no rationale for the use of antibiotics on this patient. Is this an example of the quality of consultations provided to these patients?

TW #176522 -- Facts and Findings

1. Patient was admitted on 4-7-94. The history form on this patient was not dated and not signed. On 4-8-94 the patient was started on Bactrim DS for 10 days.

2. On 4-10-94 the patient was seen claiming she was cramping and having a miscarriage. Last menstrual period in the first week of January. She had not seen a physician. The plan: return to the dormitory.

3. On 4-14-94 two notes regarding treatment of a positive sexually transmitted disease. The Alabama Department of Health indicated that the patient does not need treatment. On 4-18-94 the patient was started on Lithium and Phenergan without a diagnosis and without an order for blood levels. On 4-20-94 patient stated that she missed period for two months and then bled for ten days. On this same date 4-20-94, a physical examination by the facility physician described only a deformity on the left forearm. There was no mention on the physical exam form of the abortion which supposedly occurred 10 days earlier.

4. On 4-27-94 a hemoglobin A1C was drawn.

5. On 5-4-94 2.4 million units of Bicillin IM was ordered and a repeat serology in two months. At 3:15 p.m. on the same day: change the above order to Doxycycline x 14 days, a verbal order by the facility physician.

6. On 6-1-94 the Phenergan and Lithium were reordered without explanation or blood levels ordered.

Analysis -- This case will be analyzed by asking a series of questions:

1. Why doesn't the physical examination on 4-20 by the physician make mention of the probable abortion on 4-10-94?

2. Why the Bactrim DS order of 4-8-94?

3. Why the treatment of Doxycycline and cancelling the order of Bicillin when no treatment was recommended by the state health department in a note dated 4-14-94?

4. Why was this patient started on Lithium and Phenergan without diagnosis and blood levels being ordered?

5. Why was this patient not examined by a physician at the time of the miscarriage but simply returned to the dorm?

6. Why the draw of a hemoglobin A1C reported on 4-3-94 as 5.4?

7. The above questions are illustrative of the poor quality of care provided the patients at this facility.

VS #174936 -- Facts and Findings

1. This patient was admitted on 12-7-93 with no history of peptic ulcer disease.

2. This patient was seen each month in the medical clinic beginning in January, 1994 and continuing into May with severe heartburn as a constant complaint.

3. The patient was treated by the nurses and the physician with antacid and H2 blockers. On 3-25 and again on 5-27-94, this patient with severe dyspepsia was treated with nonsteroidal anti-inflammatory drugs. On 4-6-94 there is a physician order for institute Tagamet twice a day for 30 days and to DC Zantac. This order is written without explanation or without examination.

Analysis

1. There is 5 months of constant complaints of dyspepsia which the patient describes as severe heartburn. No diagnosis and no physical examination by the physician.

2. There is no relief to medications ordered by the physician.

3. This case was called to the attention of the physician regarding exploring the cause of the constant five months of significant symptomatology, not responding to treatment.

4. Non-steroidal anti-inflammary drugs are contraindicated in treating peptic ulcer disease.

5. The physician order of 4-6-94 is not explained.

KA #175902 -- Facts and Findings

1. This patient was admitted on 2-23-94 and had her physical examination done on 3-7-94. The patient was 14 weeks pregnant and was seen in the OB clinic on 3-8, 3-28, 4-25, and 5-23.

2. On 3-1-94 there is an order in the record for Bactrim DS for 10 days.

3. On 3-24-94 there is an order for Amoxil for 10 days with a note that the urine dip stick showed 2+ leukocytes.

Analysis

1. Two antibiotics were ordered presumably for urinary tract infection. In neither instance was there evidence of a history taken, a diagnosis made, or a microscopic urinalysis or culture done.

2. There was no follow up to determine the effectiveness of the treatment in a pregnant patient.

SB #168369 -- Facts and Findings

This patient record was reviewed and illustrates the inadequate system of continuity of care at this facility.

1. The patient began with a problem of coughing on 12-28-93. She was seen in the medical clinic on 3-15, 4-1, 4-4, 4-11 and 4-12 for continuous complaint of coughing with production of yellow mucous and was treated with symptomatic medication such as Robitussin and Mucobid.

2. On 4-16-94 a review of the medical jacket indicated serious coughing accompanied by nausea and vomiting with green yellow material. A TB skin test was given but there is no indication in the record that the TB skin test was read. The patient was again seen on 4-25-94 coughing and again Mucobid was ordered along with Sudafed.

3. On 5-2-94 the patient was again seen in the medical clinic because of coughing and asthma. The coughing was so severe that it created vomiting and involuntary urination. The patient complaint of chest pain when coughing.

4. On 5-4-94 the patient was examined by a physician who on physical examination described "mild wheeze throughout" and ordered Erythromycin and a Metaprel inhaler 2 puffs qid along with Tylenol with codeine and Mucobid for seven days.

5. The patient was again seen on 5-13-94 and on 5-17 for constipation and again on 5-23 when medications were renewed including Erythromycin for 7 days. On 5-30-94 the Metaprel inhaler was renewed for 90 days on a verbal order of the facility physician.

Analysis

1. There is no reason to apply a tuberculin skin test unless one has a system that indicates that it would be read. The fact that someone applied a tuberculin skin test means that someone was thinking TB and that issue was never addressed in the entire four month period of coughing.

2. During this entire four month period the physician apparently examined this patient only one time and did not see the patient in follow-up.

3. Four months of continuous coughing with medication being prescribed by a nursing staff is unacceptable. This demonstrates that the nursing staff is inadequately trained and not qualified to evaluate significant symptomatology.

4. This is inadequate clinical management. There has been no follow up to the physician M.D. visit, there has been no diagnosis and no chest x-ray. Is the failure to obtain a chest x-ray the result of the off-site x-ray machine?

5. This case clearly is adversive to the contemporary practice of medicine.

6. The clinical note of 5-4-94 by a physician should be reviewed by the Board of Medical Examiners.

BM #174218 -- Facts and Findings

1. On 12-20-93 there was a consultation which indicated that this patient had uterine fibroids and was to be treated with estrogen.

2. A second consultation dated 1-21-94 indicated that the birth control pills were to be continued and a follow up visit in four months. On 2-22-94 there is a note that the patient went to the East Montgomery Medical Center to see Dr. Walker-Dupree by ambulance. There is a note dated 2-24-94 post-op D&C.

There is a note on 2-22-94 - an ER record that indicated heavy vaginal bleeding with clots.

3. On 3-23-94 there were discharge orders which indicated that the patient should receive clearance for a hysterectomy. 18 weeks size uterine fibroid symptomatic.

Analysis

1. There has been a failure to provide continuity of care in terms of the recommendation for a hysterectomy.

2. There is no medical record of the consultation and the D&C performed in February of 1994.

3. There is no clinical management plan in this record by the facility physician.

JB #137136 -- Facts and Findings

1. The problem list is blank.

2. On the chronic care clinic forms diabetic is checked, asthma is checked, nothing else is completed.

3. Report of the annual health assessment - 9-14-93, not completed by the physician but signed. On 9-20-93 the annual physical examination and pap smear was the last clinical entry in the record.

4. A clinical note on 7-30-92 indicated medicine renewal for chronic care screening Diabinese 250 every day for 60 days and Theodur 300mg tid. On 8-27-92 medication renewal -- the plan is a discontinue treatments and remove from the chronic care list. Signed by a physician whose signature can not be recognized.

Analysis

1. It is unbelievable why this person was removed from the chronic care list when the patient apparently has non-insulin dependent diabetes and asthma. In any case, the reason for removal from the list is not stated and is unacceptable and inadequate in terms of physician performance.

2. There is a high hematocrit of 50 listed in the record on 9-18-93 which has not been addressed.

3. There is no theophylline blood level in this clinical record in spite of the fact that the patient was on theophylline medication in 1992.

4. This inmate was brought to our attention by other inmates who expressed concern about a chronic cough which had been present for months. Analysis of the clinic record indicated that there was a past positive PPD skin test in 1986.

   This case was called to the attention of the facility physician regarding the evaluation of a patient with a chronic cough that had a past positive tuberculin skin test. I was also concerned that the last clinical entry in this patient's record was 9-20-93.

5. The fact that a chronic cough of many months duration in a patient with a past positive tuberculin skin test, indicates that the system of health care at this facility has not implemented a satisfactory TB control program in compliance with the recommendations of the Communicable Disease Center in Atlanta.

PM #174289 -- Facts and Findings

1. This patient was admitted to the facility on 2-15-94. The history and physical examination indicated no mention of a seizure disorder.

2. On 3-3-94 Dilantin and Phenobarbital was ordered by the physician. There was no justification, no seizure history, no order for blood levels.

3. The medication administration record indicated that the patient was on Dilantin and Phenobarbital 3-4-94 to 6-4-94.
4. In approximately 20 health care encounters, mostly with mental health, the seizure disorder was not addressed.

5. The problem list was blank and the chronic care forms were not present.

Analysis

1. Inadequate management of a seizure disorder.

2. Failure of this system to adequately implement a chronic disease program.

AC #133945 -- Facts and Findings

1. This patient with a seizure disorder on Dilantin was found to have sub-therapeutic blood levels of Dilantin on 10-27-93 and again on 11-10-93.

2. This patient with a history of "mitral valve prolapse with multiple risk factors need to maximize treatment and maybe repeat cardiac assessment." This note was recorded in the record on 1-27-94.

3. In spite of complaints of the heart beating funny and having shortness of breath, there were two EKG's on 5-30-94 and 6-2-94 in the record that had not been read. An EKG on 1-13-94 had been read by a handwritten interpretation and the signature was not discernable.

4. On 6-2-94 at 7:30 p.m. health care staff was called to the dormitory for chest pain. The complaint was "worse than I have ever had" according to the patient. Objective findings were diaphoresis, blood pressure 140/100, and a pulse of 98. The plan was to refer to the M.D. There was no M.D. evaluation on this patient on 6-2-94 or 6-3-94.

Analysis

1. Inadequate chronic disease management of a seizure disorder.

2. Inadequate and unexplainable neglect of a patient with significant heart disease who developed chest pain and diaphoresis and not examined by a physician.

3. No cardiac consultation had ever been ordered on this patient. In addition, it is unexcusable for EKG's not to be read or interpreted.

CD #174915 -- Facts and Findings

1. This patient with bilateral optic nerve atrophy, with blindness of the left eye, and losing sight in the right eye, has been under evaluation for this problem since February 1994. There is no adequate plan of management in the record. There is evidence that consultations are needed but not obtained. There is no record of a neurological consultation in the record. There is a record of an MRI of the orbits and of the brain which were considered normal. One MRI indicated a left maxillary sinusitis which was not addressed by the facility physician.

2. The dental record on 5-16-94 indicated number 13 on the right complain of pain and swelling associated with the extraction site. Incision and drainage, treated with Darvocet and Erythromycin. The significant deficiency is that there is nothing in the dental record regarding the original extraction.

XV. PATIENTS DISCUSSED WITH THE FACILITY PHYSICIAN

Patients JB #137136, VS #174936, and SB #168369 were discussed with the facility physician because I felt that the symptomatology expressed by these three patients required a physician's immediate attention.

Armond H. Start M.D.
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7/5/94