bles," an approach that cannot be justified on the basis that "these are the data available."

The data presented may, nonetheless, suggest some policy considerations for the corrections agencies. The authors point out that full-time prison physicians are older and have had less academic medical training than have most part-time prison physicians. Agencies might consider whether this difference in training affects the quality of care or is compensated for by greater clinical experience and whether supplementary training programs may be advantageous for this group. Further, they should consider whether their source of future medical practitioners in the prison system can be expected to come from the current cohort of part-time prison physicians or whether they in time will be replaced by subsequent waves of still younger physicians with different training experiences.

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Age Difference Was Key to Conclusions

We described the characteristics of the population of physicians who worked in prisons in the fall of 1979 (*1*). We also compared the subset of physicians who worked in prisons on a full-time basis with those who worked part-time in terms of their demographic and professional characteristics.

Since we had no measures of the actual quality of care provided by these physicians, we stated: "In the absence of data about the technical quality of care . . . inferences about quality . . . may be based on [the physicians'] professional attributes." We cited several studies which found a significant relationship between physicians' characteristics (age, years of training, specialty status, scope of practice and, in certain cases, graduation from a foreign medical sch⁻ol) and the quality of care they render (*2–9*). We then noted our concern about the quality of care "full-time prison physicians were likely to provide since their profile indicated that a disproportionate number had characteristics associated with lower quality care." Namely, we found the population of full-time physicians to be older, less likely to be board-certified or eligible, and more likely to be foreign medical school graduates (FMG), to declare no specialty, and to hold a restricted license. It was not the physicians' full-time employment status that led to our concern; rather, it was the characteristics of the physicians themselves. Our conclusion was based solely on inferences derived from the known association between these physician characteristics and quality.

In his letter, Dr. Lamm points out that full-time prison physicians are much older than their part-time colleagues. This was evident in the age distributions we presented, and Dr. Lamm's assertion concerning median ages is correct: the median age of full-time and part-time practitioners was 52 years and 45 years, respectively. However, Dr. Lamm's argument that we did not give adequate attention to these age differences is inaccurate. The age difference was, in fact, one of the key bases of our conclusion. We expressed concern about the quality of care rendered by full-time rather than part-time practitioners because, along with their other characteristics, they were markedly older.

Dr. Lamm's point about duration of employment and quality of care is an interesting one. However, our data reveal that part-time physicians maintained their relationship to correctional programs for a *longer* period than full-time physicians (an average of 78 months and 52 months, respectively). This does not support Dr. Lamm's hypothesis.

Finally, a note on our conclusion. Given our findings, and our assumption that the "fiscal and 'environmental' conditions that make full-time prison practice unattractive to mainstream providers are not likely to change soon," we recommended that, based on considerations of quality alone, administrators of prison health programs rely more heavily on part-time physicians. Of course, this recommendation would not apply where the set of physicians or individual practitioners working full-time in a given institution or prison system do not resemble the typical full-time provider found in our study. Likewise, if a future cohort of full-time prison physicians were, indeed, younger and more well-trained than the current cohort, our recommendation would also not apply to them.

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Investigative Reporting of Genetic Testing in the Workplace

In February 1980, a series of front-page articles appeared in the New York Times on the subject of genetic testing in the workplace (*1–4*). The Times series did an excellent job of identifying selected technological and social issues possibly associated with a vastly underreported subject. On the basis of the information presented in the Times series, it is obvious that this subject requires further, extensive public policy analysis.

The Times series was a major impetus to subsequent congressional hearings on this subject (*5–7*). To the great surprise of the congressional subcommittee investigating occupational genetic testing, it was learned through a survey of major American companies that many companies have used either biochemical genetic testing or cytogenetic testing in the past, some are using these tests presently, and many companies expressed an interest in using such testing in the future. The consensus at the congressional hearings was that the technology associated with genetic testing was in the embryonic stage. Major scientific and feasibility issues must further be resolved before possible practical applications of genetic testing for occupational screening or monitoring may be pursued. A large number of unresolved ethical and legal issues were also raised at the hearings.

Legislation may come out of the congressional hearings. Congressman Albert Gore, Jr., who chaired the investigating subcommittee, has reportedly asked the National Institute for Occupational Safety and Health to begin work on guidelines pertaining to what constitutes a valid genetic screening test (*8*). The subcommittee hearings have further led him to call for the Equal Employment Opportunity Commission to design guidelines affecting workers possibly at risk in the workplace environment (*9*). Another proposed action was for Congress to amend existing occupational safety and health laws to protect workers from possible discrimination in employment and job placement (*9*).

Before the publishing of the Times series, relatively little attention was directed in the scientific literature towards identification and analysis of the many technologic and public policy issues possibly associated with occupational genetic testing. Since the publishing of the Times series, however, a growing body of editorials, commentaries, and articles have appeared in the literature, addressing selected issues possibly raised by this subject. Legislation pertaining to occupational genetic testing has similarly been enacted in several States since the publishing of this series of articles.

Much remains to be learned about occupational genetic testing. On the basis of the prompt, strong reaction of the scientific and public health community to the publishing of the Times series, it appears that continued investigative reporting in close alliance with ongoing scientific investigation is an important factor associated with efficacious public policy development in the area of genetic testing in the workplace.

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Letters to the Editor Encouraged

Readers are invited to join in the dialog in our "Letters to the Editor" section. Responsible comments on the journal's contents and on current concerns in public health are welcome. We ask that future comments be limited to 500 words and 10 references—conciseness is appreciated.