The State of the Prisons

Organisation of prison medical services

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Much of the discussion about prison health care in the past few years has focused on whether the prison medical service* should be incorporated into the National Health Service. Some critics have tended to see this as an answer to all the ills of the service, and the prison department has taken the threat seriously enough to devote most of the part of its 1981 annual report dealing with health and medical services to reasons why it would not be a good idea.¹ In this article I outline how the medical services are organised and then consider what might be lost and what might be gained by reorganising the service so that it was either part of the NHS or at least responsible to the Department of Health and Social Security. Interestingly, in Scotland and Northern Ireland prison health services are already organised in a different way.

Organisation of the prison medical service

The prison medical service is part of the prison department, which in its turn is part of the Home Office. The medical service has a director who is and always has been a doctor, and he sits on the Prisons Board, which is chaired by the director general of the prison service and runs the prisons in England and Wales. The director of the prison medical service thus plays a part in running the whole service. But it seems that he has a free hand with running the medical services and little to do with overall prison policy. The director is based in London and has under him a deputy director and four regional directors, all of whom are doctors and based in London.

The present director is Dr J L Kilgour, who started on 1 October and succeeded Dr Ronald Ingreby-Senn, who had been acting director since Dr James Orr resigned in July 1982. Dr Kilgour has never worked in the prison medical service, and this is the first time since the service started over 100 years ago that an "outsider" has become director. Dr Kilgour came from working with the World Health Organisation and had previously been a principal medical officer in the DHSS, making him, as it is quaintly put, an "inside outsider." His appointment has given rise to dinner table speculation as to why an outsider should be appointed: Does it mean that there is internal unhappiness with the prison medical service? And has Dr Kilgour, with his close knowledge of the DHSS, been brought in to make the prison medical service part of the NHS despite the prison department's protestations that this would be a bad idea?

Theoretically the 120 prison department establishments in England and Wales are staffed by 98 full time and 114 part time doctors. At the moment the service is short of 19 full time and 16 part time doctors. The part time doctors are all NHS general practitioners, who receive sessional payments from the Home Office. Most of them are in group practices: sometimes the members of the practice take it in turns to visit the prison, and usually whoever is on call for the practice will cover emergency calls to the prison. Most of the doctor-prisoner consultations that take place in prisons are thus between prisoners and general practitioners who work outside the prisons.

In many prisons there is no full time doctor; a full time doctor from the nearest of the larger prisons will be responsible for the prison and will visit regularly, but the day to day care and emergency cover are provided by the visiting general practitioner. This is the case, for instance, in Ford open prison in Sussex, which I visited: a local doctor comes in each morning, and then emergency cover is provided by whoever is on call for the practice. Whenever talking about prisons in general, it is worth remembering that every prison has its own character and that there are big differences between them all.

Even in prisons that have full time doctors much of the day to day care is provided by part time prison doctors. Brixton, which is London and the south east's remand prison and which has 77 000 new prisoners passing through its gates each year, has seven full time doctors, but the day's surgeries and the admission consultations are often done by part time doctors. At Long Lartin, a maximum security dispersal prison near Evesham, there is a full time prison doctor for the 400 or so inmates, but a local general practitioner comes in each morning. The full time doctors tend to be concentrated in the big local prisons, where there is a large turnover of prisoners and many court reports to be written, and in prisons like Grendon Underwood or Parkhurst, which contain hospitals and special facilities for disturbed prisoners.

Full time prison doctors are also supported by part time specialists who visit the prisons. These are most commonly psychiatrists who come in for one or two sessions each week, but physicians, venereologists, and gynaecologists (for women's prisons, obviously) also visit regularly. General surgeons and specialist surgeons also do sessions in the prisons with operating theatres, and then prison doctors can call in whatever specialists they need if they think that it is easier for the doctor to come to the prisoner rather than for the prisoner to go to him. This would tend to be the case with prisoners who are high security risks. Dentists and opticians also visit all prisons regularly, and some prisons have visiting physiotherapists, speech therapists, occupational therapists, and the like. Although prisons may have little success in turning out prisoners who are better citizens than when they went in (26 November, p 1614), most prisoners come out with their teeth in better condition and with glasses if they need them, and they don't have to pay. All of these doctors and therapists are supported in their work sometimes by nurses and more often by hospital officers, who are discipline officers who have been given a short training in nursing.

* To make these articles easier to read I use prison medical service when I mean that for England and Wales and will make it clear when talking about those for Scotland or Northern Ireland.

Joint appointments

In addition to psychiatrists who visit the prisons for a few sessions a week there are some forensic psychiatrists who hold joint appointments with the Home Office and the NHS. These chimeras were created by the 1964 Home Office working party on the organisation of the prison medical service.² The working party rejected complete integration of the prison medical service and the NHS, and seemed to see these joint appointments as some sort of compromise. The prison doctors could continue

"most interesting patients," or telling them how to run the medical side of the prison. Some of the forensic psychiatrists who adopted a low key consultant role fitted in well, but most of those who aimed higher came to grief.

Some of this failure must be blamed on the Home Office working party, which hadn't thought through exactly what it wanted the forensic psychiatrists to do and achieve. But another factor was the refusal of the Home Office to take up the recommendations of the working party: the junior appointments were never made, and only minimal continuing education was

with their difficult job, for which being part of the NHS would not suit them, while at the same time being influenced by NHS specialists; and the young psychiatrists who took up joint appointments at registrar level might provide a good pool of potential recruits for the prison medical service. Indeed, the working party went so far as to say: "Ideally and in the long run, prison medical officers should be recruited entirely from doctors who have had previous prison experience and been trained in forensic psychiatry as registrars holding joint appointments. . . ." It said, too, that recruits to the prison medical service would need further training in both prison medicine and forensic psychiatry. This report was produced at a time when expectations about what psychiatry could achieve in the prisons were at their height. Now those expectations have declined dramatically (10 December, p 1786), and when I asked the acting director of the service what sort of doctors he wanted to recruit he answered, "Well, for a start, we don't want failed psychiatrists." He wants experienced general practitioners, and if they have some knowledge of psychiatry then so much the better but it's far from important.

The Butler Committee on Mentally Abnormal Offenders, which produced an interim report in 1974,³ favoured increasing the joint appointments in forensic psychiatry, but in practice the appointments have been a failure and are now being phased out. The main reason for the failure of the joint appointments has been, according to Professor Robert Buglass, who held one of them, that the prison doctors resented outside experts being dumped on them.⁴ They were quite willing to have experts available when they wanted them, especially if those experts had beds in the NHS and could transfer mentally disordered prisoners, but they didn't want those experts taking away their

provided to prison doctors. A final factor was a clash not only of individual personalities but also of the characters of these two parts of the profession. Doctors who join the prison medical service seem to feel happier in closed, controlled, routine, and rigidly structured conditions, while forensic psychiatrists live in a much more open, questioning, critical academic world. One moral is that future attempts at bringing the prison medical service and the NHS closer together may have more success if they bring the prison doctors out of the prisons to a greater extent as well as importing into the prisons more NHS doctors.

Organisation in Scotland and Northern Ireland

The Scottish medical service is staffed almost entirely by part time doctors. The service is run by Dr J A Morton, who is described as medical adviser to the prison service and who reports not to the controller of Scottish prisons but to the chief medical officer in the Scottish Home and Health Department. There is thus a symbolic separation between the medical service and the prison authorities, which is much easier to achieve for the Scots than for the English and Welsh because both prisons and the NHS in Scotland are run by the one department—the Scottish Home and Health Department, which is one of the five departments in the Scottish Office.

In addition to Dr Morton the Scottish prison medical service has three full time doctors—all of whom work in Barlinnie, the Glasgow prison. Twenty four visiting general practitioners provide the day to day and emergency care in the other 22 institutions, supported by visiting specialists. One reason that this system can work is because all those prisoners who are not

sufficiently sick to need admission to an NHS hospital but who are difficult to manage in limited prison conditions are transferred to Barlinnie. Another important factor is that all remand prisoners in Scotland are prisoners of the procurator fiscal, and it is up to him to arrange for medical reports to be written for the courts when necessary—it is not a job for the prison authorities.

In contrast, the service in Northern Ireland is staffed mainly by full time doctors. The prisons are run by the Northern Ireland Office, which, as well as supplying a link with the administration in Whitehall, operates like a Northern Ireland Home Office. The medical service, however, is run by a principal medical officer in the Department of Health and Social Services, and he is answerable to the Chief Medical Officer. The links between the departments are complex, but the practical result is that the line of command of the medical service is clearly separated from that of the prison service itself. This separation has been useful within the politically highly charged climate of Northern Ireland.

In 1968 there were two prisons in Northern Ireland containing 600 prisoners, who were looked after by two part time doctors. Now there are three men's prisons, one women's prison, and a young offenders centre. The women's prison in Armagh is looked after by one part time doctor, but all the other institutions have at least one full time doctor, and there are seven full time doctors altogether. Belfast prison also has one part time doctor and the Maze prison has two. The prisons contain "hospitals," but prisoners needing hospital care of any complexity are transferred to outside hospitals. One Belfast hospital has a secure ward with 18 beds in which patients are looked after by health service staff and which is guarded by the police.

Thus there are important differences of organisation among the three countries, and interestingly the services in Scotland and Northern Ireland come in for much less criticism. The Scottish system shows that a prison medical service can be run with mostly part time doctors, and both the Scottish and Northern Ireland services show that prison health services can be run by health departments with no serious problems and with probable benefits.

Should the prison medical service become part of the NHS?

Although many critics of the prison medical service see incorporating the prison medical service into the NHS as the one answer to perceived problems with the service, it is a complex issue that needs careful dissection. The 1981 annual report of the prison department marshals the argument against the proposal, cursorily dismisses arguments for, and concludes that to do so would be a terrible lot of trouble for no reward.¹

On the other side, the Royal College of Psychiatrists has neatly gathered together some of the arguments for integration: any separate system for a minority group tends to sink to a poor standard; being employed by the Home Office makes it more difficult for a doctor when there are conflicts between society's and the prisoner's interests; the Official Secrets Act can hamper clinical independence; and prison is such a total institution that to be in one all the time powerfully influences the doctor's views and behaviour.⁵ The college in its evidence to the May inquiry⁶ into the prisons also pointed out that the United Nations standard minimum rules for the treatment of prisoners state: "The medical services should be organised in close relation to the general health administration of the community or nation."

One similar argument for the integration of the two services is that it would fit with the philosophy of making prisons as much like the outside community as is consistent with security. At the moment no British prisoner can choose his doctor, and similarly a prison doctor cannot discharge a prisoner from his list. Many prison reformers would like prisoners to be able to choose their doctors. They argue that this would be the most effective way of dampening down perennial doubts about the quality of care provided by prison doctors. The quality of medical care within the community may be, and undoubtedly is, patchy, but a free

person can at least try to move to another doctor, while a prisoner who is unhappy with his doctor cannot.

The prison department simply states it as a given fact in its 1981 report that it would be impossible for a prisoner to choose his doctor, and then proceeds to use the point about quality as one of its central arguments for a prison medical service run by the Home Office. The "arrangements . . . of central control over and ministerial accountability for medical services" ensure, it says, the quality of the service, which is especially important because of the prisoner's lack of choice. But then again, as the report says, the Home Secretary is not responsible for matters of clinical judgment—and it is surely this that most worries prisoners. Cynically, I might suggest that "central control" is more important to the prison department than it is to the prisoner, because the latter is unlikely to find it more difficult to complain about an NHS doctor than about a Home Office doctor.

How practical is integration?

A crucial point is obviously whether the possibility of the prisoner choosing his doctor is utterly impracticable or not. Firstly, would general practitioners be willing to go into prisons? With some remote prisons there might not be sufficient local doctors, and more distant general practitioners might find it irritating to travel out to a prison and inevitably waste time passing through security to see a prisoner with a long list of minor complaints who primarily wants a sympathetic ear. Indeed, those with only a short distance to travel might be frustrated by the process, but in more densely populated areas it might be possible to find doctors willing to undertake this work. If there were even three or four doctors willing to visit a prison then that would provide some choice for the inmates. The Home Office might do some research to find out whether general practitioners would be willing to go into prisons.

Interestingly, in the short time that has elapsed since the first of these articles on prisons was published I have already heard from general practitioners who say that they would like to have much more to do with caring for prisoners. One important point that has been made is that it is often (if not always) impossible for a general practitioner to visit one of his own patients in prison. In an ideal world (and this happens already to a limited extent) prisoners would serve their sentences in prisons close to their homes. It might then be possible for them to remain under the care of their own general practitioners, and this would surely be a powerful way of keeping the prisoner as part of the community and would decrease the chance of him becoming a lost recidivist.

The next practical point is whether several different doctors passing in and out of a prison would constitute a security risk. They might, but, given the many prison officers, social workers, probation officers, teachers, and the like who pass in and out of prisons each day, security should not be an insuperable problem.

But if the practical difficulties could be overcome, would anything be gained? Geoff Coggan, a spokesman for the National Prisoners' Movement, is convinced that such a development would be a great benefit to prisoners: it would, he believes, remove at a stroke many of the worries about the quality and loyalties of prison doctors because prisoners would then know that they had the same doctors as people outside the prison. Thus progress might be made not because prisoners were provided with better medical care but because it removed for ever from their minds the doubts that they are being treated by second class doctors.

Isolation of prison doctors

Those doctors who did work in the prison would surely also benefit from the improved image, because not only prisoners but also members of the public and doctors are worried about the prison medical service. If prison doctors were part of the NHS

and were seen regularly in NHS hospitals and surgeries, then these worries might disappear. One practical result of such a change of image might be that recruitment became less of a problem. The other advantage of a regular interchange between prisons, hospitals, and surgeries would be that prison doctors would be less isolated and would not be in danger of practising a kind of medicine that lags behind the times.

Most prison doctors, and certainly the ones responsible for running the service, resent any assertion that prison doctors are isolated. They point out that the average prison has far more specialists passing through than the average general practice. Furthermore, most of the prisons that employ full time doctors have more than one. I visited only one prison, Long Lartin, that employed only one full time doctor, and he seemed both isolated and underemployed. He had a regular contact with a local general practitioner who came in each morning to do a surgery, but he saw few other doctors. The attendance of the general practitioner also meant that his workload was greatly reduced, and as Long Lartin contains about 400 young men in the middle of long sentences there seemed little for him to do. Nevertheless, such doctors are the exception among the 90 full time doctors.

Yet the worry about isolation extends beyond just lack of contact with other doctors. Prison doctors practise a restricted form of medicine with restricted patients in restricted circumstances, which may lead to them becoming both deficient as doctors and as "institutionalised" as the prisoners they are treating. The doctor who runs the Dutch prison medical service (to be described in a future article) has no doubt that being a full time prison doctor leads to a fall in the quality of the doctor and to the doctor becoming clouded about whether he is there for the sake of the prisoners or the authorities. For this reason the prisons in Holland employ no full time doctors.

In contrast, the British prison doctors believe that being a prison doctor demands special skills and that these skills cannot be adequately learnt by a part time doctor. The present job of a full time prison doctor, with responsibilities for writing reports for courts, the parole board, and other institutions and advising the governor on all aspects of the health of the prison, goes well beyond the job of an NHS general practitioner or psychiatrist. How then, and the Home Office report implies the question, could the NHS take over responsibility for prison health care? Who would do the work?

Certainly if the NHS took over responsibility for the health care of prisons it wouldn't be just a matter of sending in general practitioners and psychiatrists to do exactly what they do outside the prison. But general practitioners working part time in the prisons could surely extend the range of their accomplishments to writing reports and advising the governor. After all, many general practitioners work part time in factories, schools, and the like doing work that is an extension of the work that they do in their ordinary surgeries. Furthermore, responsibilities for environmental health care, administration, and the like could surely be taken over by the appropriate professionals in the NHS, as recommended by the Royal College of Psychiatrists.

But the question remains whether there are special skills that a doctor can learn only by working full time in a prison. These skills are nothing to do with knowledge about esoteric diseases but more to do with understanding the limitations inherent in a prisoner not being able to choose his doctor nor his doctor him. The skills also have to do with recognising that a prisoner may have all sorts of ulterior motives for consulting the doctor, and with learning the ways of prisons. Most prison doctors that I spoke to, except in Holland, were convinced that these special skills existed and that a part time service would thus inevitably be poorer than a full time one. I remain unconvinced.

Questions of priority

In listing its reasons why the prison medical service should not become part of the NHS, the prison department doesn't

mention the probability that if the money for prison health care had to come out of NHS funds then the service in all likelihood would be trimmed back to something skeletal. If prisoners had to compete with pregnant women, babies, and patients in renal failure for limited health resources then they would probably be worse off than at the moment. Currently, in England and Wales there are 79 full time and 98 part time doctors, and 900 hospital officers (the prison equivalent of nurses) looking after 44 000 prisoners, most of whom are healthy men aged between 15 and 50—a group that in the community has low consultation rates (although prisoners undoubtedly have much higher illness rates than their equivalents in the community). In addition all prisons contain a small "hospital," and almost every prison I visited had, for instance, an x ray machine. The costs of the prison medical service cannot be disentangled from the cost of the whole prison service, but I can only assume that they are much higher than for an equivalent group in the community. My point is not that this should not be so, but rather that it would be hard to maintain the differential if prison health care were provided by the NHS.

Another formidable problem would be that the NHS is organised on a regional and district basis, while prisons are organised nationally. The Isle of Wight, for instance, contains three prisons, two of which are maximum security and one of which has a surgical hospital and special facilities for mentally disordered prisoners. For the Isle of Wight District Health Authority or even the Wessex Regional Health Authority to have the money and resources to provide for the prisons would require careful central planning.

Compromise

This analysis of the benefits and losses that would arise from incorporating the prison medical service into the NHS boils down to the conclusions that there would be considerable practical difficulties for benefits that seem only theoretical. Yet the fact that prison doctors in Scotland and Northern Ireland are much closer to the NHS does seem to have resulted in services that are much less suspect to outsiders. Maybe a compromise could be found in England and Wales in that there would continue to be a centrally organised service, but it would be part of the DHSS and not part of the Home Office. There could continue to be full time doctors, but they would do more outside the prisons, which should be easier to arrange if they were employed by the DHSS.

Professor John Gunn has suggested that there might be a special health authority under the DHSS responsible for providing health care to all secure institutions, including both prisons and special hospitals. This might well be a workable compromise, and I suspect that to take the prison medical service out of the Home Office would produce real benefit, even if to the people within the Home Office it seems to be only a matter of changing names and paymaster. Image is vitally important with such politically sensitive problems as imprisonment.

References

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