The State of the Prisons

The work of prison doctors

RICHARD SMITH

"The years that I spent as a prison doctor were the most rewarding of my professional life." This statement was made to me by Lady Megan Bull, who after several years as an ordinary doctor spent four years as a prison doctor in Holloway before becoming governor of that prison. Dr Ronald Ingrey-Senn, who was until recently acting director of the prison medical service, also found life as a prison doctor rewarding and fascinating, and he was keen that I should try to bring out in these articles that prison medicine can offer a great deal of both satisfaction and amusement.

The most interesting aspect of prison medicine is the prisoners themselves, and, even if modern prisons do not quite have all the colour and pizzazz of *The Beggars' Opera*, they do contain some extraordinary people. But prison doctors also have an opportunity to concentrate on the parts of medicine that interest them most—for instance, some have become skilful at removing tattoos. These are sometimes a sure sign of somebody having been a borstal boy or a prisoner, and their removal can be seen as a contribution to rehabilitation. But the routine work must be done first.

A full day

The work of full time prison doctors varies considerably from prison to prison. Those, for instance, who work at Grendon Underwood, the psychiatric prison, are concerned mostly with psychotherapy, and the full time doctors who work in dispersal prisons have different timetables from most full time doctors, who work in local prisons. For part time prison doctors, in contrast, the work is much the same at all prisons, and that work is similar to their normal work as general practitioners: they are not much concerned in the more esoteric parts of prison medicine.

Table I shows the medical work that has to be done in Leeds prison, the second largest of the 17 local prisons in England and Wales. It should contain about 600 prisoners but usually has about 800 to 1000. Almost half of the full time medical officer's time is taken up with writing reports and investigating prisoners in order to write those reports. In Brixton, which is primarily a remand prison, even more of the time is spent writing reports, and it is all that the seven full time doctors can do to keep up.

Most of the reports are written for the courts, but these also have to be prepared for the Parole Board, the Home Office, the governor, and sometimes for other doctors, solicitors, probation officers, and relatives. The main focus of these reports, particularly the court reports, is the prisoner's mental state, and, although the prison medical service currently wants to recruit experienced general practitioners rather than psychiatrists, for

this part of the full time doctor's work experience of psychiatry is more useful than experience of general practice.

The next task to take up the full time prison doctor's time is providing medical care for the prisoners. All prisoners are seen on reception, and this consultation is a key one: here the physically ill, the mentally disturbed, and the suicidal must be sorted out and sent to the appropriate part of the prison. These examinations are usually done at great speed and under considerable pressure. The idea that this might be an ideal opportunity for practising a little preventive medicine or getting to know the prisoner was quite laughable to many of the prison doctors to whom I spoke. They were doing well, they thought,

TABLE I—Average time spent each day by doctors in Leeds prison on various aspects of their work

Job	Time spent by doctors (h)	
	Full time	Part time
Reception procedure	1	1½
General medical care	2	1
Investigation:		
Suspected physical or mental abnormality	1½	20½
Nature of offence	1½	
Request from court	6	
Request from Home Office	1	
Request from Parole Board	1	
Request from prison staff	1	
Preparation and submission of reports	10	
Making arrangements for reports to be acted on	2	
Advising about:		
Food		1½
Hygiene		
Working conditions		
Fitness of candidates		
Suitability of hospital staff		
Fitness of serving members of staff		
Accidents to inmates and staff		
Violent inmates and assaults		
Fitness of inmates for adjudication		
Fitness of segregated inmates		
Self injury		
Food refusal		
Suitability of inmates for prerelease schemes		
Suitability of inmates for transfer		
Petitions	1	
Discharge procedure	1	
Clinical meetings, management meetings, etc	1½	
Research and general administration	1½	
Staff instruction	1½	
Attendance at court, etc	3	
Total	33	2½

if they could sort out the suicidal from the non-suicidal or those who were going to develop delirium tremens from those who would sober up peacefully, and in the circumstances they were.

Similar logistic problems apply to the daily sick parades. A doctor might have to see 40 prisoners in a morning surgery, and the prisoners come for many other reasons than that they are so sick that they need the attention of the doctor: to break the boredom of prison life and also to communicate with each

other in the waiting room. They come with the most minor ailments because they have no access to simple remedies, and they come because they want to get a message through to the prison authorities or their families.

In many prisons both the receptions and the sick parades are done by part time doctors, and they have an opportunity to weed out the prisoners about whom they are worried and refer them to the full time medical officer. Some of these prisoners may even be admitted to the prison hospital, where they can be closely watched. The prison hospital also provides a refuge for those prisoners who find it hard to get by in the jungle of the main prison. Many of the latter who come into more prolonged contact with the prison doctors do so primarily because of mental problems, and in this part of his work as well a full time prison doctor may find psychiatric experience most useful.

The doctors will see each day the prisoners who are in the hospital, but this rarely entails much work. The prison hospitals contain no patients who are seriously ill physically (apart from those for whom nothing can be done), and the doctors' rounds are often a matter of haggling with diabetics who use their disease to manipulate the authorities, epileptics who will not take their drugs, prisoners scared to return to the main prison, and prisoners who want to be transferred. The hospitals in the prisons that undertake surgery (Walton, Wormwood Scrubs, and Parkhurst) demand more work, but even in them major surgery is rarely undertaken.

The doctors also see all prisoners on the day before they are discharged. The purpose of this consultation is to ensure that the prisoner is fit to fend for himself, that he has no continuing health problems, and, if he has, that continuing treatment is arranged. This is all a bit "pie in the sky" because many alcoholic, opiate addicted, and mentally disordered prisoners are discharged with the prison doctor and authorities knowing that they are unlikely to cope in the community and are likely to be back in prison before long. Indeed, it is impossible not to release a prisoner if his sentence is served. On the whole, prison doctors have little or nothing to do with prisoners after they are released, and this, too, might be a deficiency that could be put right by integration of the prison medical service into the NHS. Many prison doctors, particularly some of those at Grendon Underwood, would like to maintain contact with their patients.

The doctor as part of the prison

The duties of full time prison doctors extend well beyond the medical care of individual prisoners and the writing of reports.

TABLE II—Problems on which prison doctors advise the prison authorities

Problem	Comment
Food	Inspected daily, and menu book signed
Hygiene	Sanitary report prepared every four months covering incidence of infectious disease, heating, lighting, ventilation, etc. Drains inspected regularly
Working conditions	Temperature of workshops, occupational hazards
Fitness of staff	Sickness absence, retirement
Accidents	Compensation
Fitness for adjudication	(See text)
Fitness of segregated inmates	(See text)
Petitions	(See text)
Suitability for parole	
Suitability for transfer	

They are concerned with many other aspects of prison life, and in days gone by the prison doctor was often the next most important person in the prison after the governor. Table II illustrates the many aspects of prison life on which the doctor has to advise the governor. Long ago the prison doctors looked after the prison staff as well as the prisoners, but they now have only very limited responsibility for them.

As table I shows, prison doctors, particularly the senior ones, have to spend a fair bit of time dealing with petitions. Prisoners have the right to petition the governor, their members of parliament, or even the Home Secretary about their problems, and many of them take full advantage of this right. If the complaints are about the medical service, and they often are, then the doctors will have to comment, but they may also have to comment if these are about food, hygiene, working conditions, or any other aspect of prison life that has medical overtones. The prison doctors resent much of this work for they think that many of the petitions are frivolous and a waste of time. But there is much public concern about the accountability of prisons and prison staff (3 December, p 1705), and in such total institutions the channels for complaining must be kept as open as possible—even if they are abused.

A prison hospital.

Doctors are also involved in punishment within the prisons. This aspect of their work is extremely sensitive, and the individual doctor must be clear where his responsibility lies. Doctors will often be called when a prisoner becomes violent and aggressive. The discipline officers will want the doctor's opinion on whether the prisoner is mentally ill, and they may also want the doctor to give the prisoner "something to quieten him down." Often the doctor will not have seen the prisoner before, and sometimes with a violent uncooperative patient struggling with several officers it will be impossible for him to decide what is wrong. The doctor can thus find himself in difficult circumstances—unsure quite what is wrong with the prisoner but confronted with the necessity of doing something.

Many of the prison doctors to whom I spoke agreed that they would often give an injection to quieten the prisoner. The alternative would be for the prisoner to be put into a strip cell or into a straitjacket. Many doctors took the view that more harm was likely to come from physical than from chemical restraint. But clearly this is a delicate issue, and doctors who do use drugs to quieten patients lay themselves open to charges of acting for the authorities rather than the patient-prisoner and of using drugs to treat non-medical problems. The issue of sedating the violent patient is different from the issue of using psychoactive drugs routinely on a large scale to drug prisoners, but my impression was that prison doctors were wary of using drugs to sedate violent and aggressive patients and perhaps tended more towards underuse than overuse. That said, every doctor is free to act as he thinks right, and certainly in the middle of the night in some far flung prison there is nobody to tell him what to do.

In June 1982 Lord Avebury asked the minister responsible for prisons, Lord Elton, whether prisoners could be treated

compulsorily and if so under what conditions. Lord Elton replied: "Doctors working in prisons have no statutory authority to administer treatment against the wishes of their patients. It would thus be defensible to treat a prisoner against his wishes only if otherwise his life would be endangered, serious harm to him or others would be likely or there would be an irreversible deterioration in his condition. Such emergencies are in practice very rare."¹

Doctors also have to see any prisoner who is being punished. Any prisoner who is put into a strip cell or a segregation unit has to be seen as soon as possible by the doctor, who has to be sure that he can withstand the restraint or the punishment. The doctor may also have to produce a report on a prisoner who is to appear on a charge before the governor or the board of visitors: the doctor has to state that the prisoner will be able to understand the "trial." Then if the prisoner is to be segregated for a spell the doctor will have to see him every day and be sure that the punishment is not harming him.

In the days when prisoners were punished with bread and water diets this medical certification of fitness for punishment was perhaps both more important and more onerous. But segregation is still a formidable punishment, and the worry is that doctors may be seen as participating in and condoning the punishment rather than caring for their patients. Many doctors are keen that it should be clear that they are stating that the punishment is not harming the prisoner medically rather than that the patient is "fit for punishment."

It is with matters like these, where the line between what is for the benefit of the authorities and what is for the benefit of the prisoner is so vague, that the worries about the institutionalisation of prison doctors become most acute. What seems dreadful to the raw recruit can seem routine and unimportant to the veteran.

Recruitment and training

Who are the recruits to the prison medical service? At the moment there are 79 full time prison doctors in England and Wales and there should be 98. In Northern Ireland and Scotland recruitment is not such a problem—indeed, in Scotland the service is mainly part time (17 December, p 1867). Recruitment has been a problem for many years in England and Wales, and it is a problem, too, in other prison systems around the world. It would perhaps be surprising if it were not so: a full time career in prison is unlikely to be at the top of any young doctor's list of career options. (Part time work is quite different, and many doctors are interested in this option. This is another argument for more integration with the NHS and a greater use of part time doctors.)

Many of the doctors working full time in the prison medical service worked previously in the colonial service or the armed forces; some were juniors in psychiatry and some were general practitioners. Dr Ian Pickering, who was director for many years and who recruited many of the present doctors, believed in the importance of psychiatry in prisons and wanted more psychiatrically trained doctors in the service. In July 1982 six of the full time doctors were fellows of the Royal College of Psychiatrists and 14 were members; 45% altogether had some postgraduate psychiatric qualification.²

Dr Jim Orr, who followed Dr Pickering as director, and Dr Ingrey-Senn, who followed Dr Orr as acting director, preferred their recruits to have experience of general practice. They wanted mature, fully trained general practitioners, but they could not find enough. There has been no shortage of applicants for posts, but few are suitable. Dr Ingrey-Senn was confident that things were improving and that more suitable applicants were coming forward. This may be because of the increasing difficulty that doctors experience in finding jobs in general practice. But Dr Ingrey-Senn thought that the main problem is that an ordinary prison doctor cannot expect to earn as much as a principal in general practice.

Most outsiders see the problem of recruitment as having much more to do with the poor image of the prison medical service and the unwillingness of most doctors to commit themselves to a full time job in prisons. One of the main arguments for integrating the prison medical service with the National Health Service is that it might help improve recruitment.

Something else that might deter doctors from joining the prison medical service is that little further training is offered once the doctor is in the service. Increasingly within the profession, and particularly among general practitioners, continuing education is thought to be vitally important, but this does not seem to apply to the prison medical service. Those who join the service are given an introduction to the prison service when they first join, and some thereafter are seconded to special hospitals or do some postgraduate training in psychiatry, but there is no comprehensive, organised programme of training or continuing education. Dr Ingrey-Senn would have liked more educational opportunities to be available, but he did not think that the lack was a serious problem because all the doctors joining the service are "fully trained." I think that there should be more opportunities for prison doctors to get further training both within and without the prisons, and I suspect that many prison doctors would welcome such opportunities.

Medical facilities in prisons

Another factor that might deter doctors from joining the prison service might be their expectation that they will find themselves working in thoroughly substandard conditions. Most British prisons are old, dilapidated, and overcrowded (3 December, p 1705), but in all the prisons that I visited the prison hospital was usually of a higher standard than the rest of the prison. Even at Brixton, which was the most sordid prison I visited, the hospital was of a reasonable standard. The "psychiatric wing" was, however, quite disgusting—being nothing more than a run down cell block, and all the doctors at Brixton would like to see much better accommodation for the unfortunates who end up there.

All prisons, even small open prisons, contain "hospitals," but in many these are more like sick bays than hospitals. They usually contain a few beds in an open ward, some special cells for prisoners who for medical or security reasons need to be nursed alone, a treatment room, and a pharmacy. The pharmacies tend to be busy because the prisoners are not given drugs to take away—they have to come to the pharmacy for every dose, and usually drugs are prescribed as liquids to stop any hoarding and trading. Most hospitals also contain a room for a dentist and an optician, consultation rooms, and a room in which to take radiographs. The radiographs are taken by the hospital officers, which has caused some arguments with the Society of Radiographers, which says that they are not properly trained.

All of the hospitals that I visited were clean and most of them were spacious and well equipped. (Prisons usually are clean because there is no shortage of labour; in Barlinnie prison in Glasgow the governor follows army principles and has everything repainted as often as possible as something for the prisoners to do.) On the whole, the hospitals compared very well with general practice surgeries and with NHS hospitals. The prison medical service has much bigger problems than the quality of its facilities.

References

- 1 Lord Elton. Prisoner: compulsory medical treatment. Written answers. *House of Lords Official Report (Hansard)*. 1982 June 15; 431:col 625. (No 105.)
- 2 Mayhew P. Prison medical service (psychiatrists). Written answers. *House of Commons Official Report (Hansard)*. 1982 July 5; 27:cols 3-4. (No 146.)