The State of the Prisons

Prison doctors: ethics, invisibility, and quality

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Some doctors join the prison service in search of a quiet life. Some have tired of the rigours of general practice, and a few may be attracted by the "old time" world of prisons where, within the hospital at least, the doctor is boss and both staff and prisoners call him Sir. Several of the older prison doctors whom I met had started their careers in the colonial service, and when they had returned to Britain had felt unenthusiastic about the new National Health Service. For the prison is a hidden world where the doctor applying to the service may imagine that he will be able to practise in peace, uninterrupted by politics, consumer movements, the media, and ungrateful and possibly litigious patients. But prison medicine cannot be relied on to provide either a sinecure or a haven. The doctors face problems just as difficult and ticklish as any faced by doctors in the outside world, but it is true that most are resolved without interference.

Ethical problems

Ethical problems present the prison doctor with some of his most difficult decisions and most stem directly from the system in which he works. Is he there to serve the prisoner or the prison? Many of the prison doctors whom I spoke to—including the acting director, Dr Ingrey-Senn—thought that the ethical problems were exaggerated by outsiders. They were quite clear that their responsibility is to the patient, that they are bound by the same ethical codes as all doctors, and that therefore everything is straightforward. In my opinion, and in the opinion of other prison doctors¹ and of Dr Benjamin Lee, the doctor who was until recently on the staff of the Chief Inspector of Prisons,² they delude themselves. Firstly, they have a naive belief in the ability of ethical codes (whether it be the BMA's *Handbook of Medical Ethics*³ or the United Nations' *Principles of Medical Ethics*⁴) to give guidance on the huge range of subtle ethical problems that arise all the time. Secondly, they are perhaps failing to see the ethical implications inherent in so many of their problems, and this blindness may result from working full time in isolated and oppressive institutions.

Dr Kim Thorburn, a doctor who divides her time between San Quentin prison and the University of California, has discussed the many dilemmas that face "croakers" (the name that American prisoners give to doctors), and she concludes that "the dilemma of whose interest physicians are serving permeates nearly every aspect of prison medical practice."¹ Dr Lee agreed, and he was saddened that he had come across some prison doctors who had "run out of sufficient stamina to remain on the ethical qui vive which must . . . be constantly maintained if the doctor is not to function merely as a rubber stamp on behalf of management."²

One issue that always raises ethical problems is punishment.

In days gone by doctors in British prisons had to declare prisoners fit to be hanged or fit to be put on a diet of bread and water. In other countries prison doctors still have to make such declarations, and they may even be called on to pronounce prisoners fit to be tortured. Worse still, they may even administer the torture. But in Britain now doctors have to see every day those prisoners who are in the punishment block. They visit them to see that they are not being harmed by the punishment, and the doctors see this as different from declaring the prisoner fit to be punished. But is it different? Is this not like the difference between "killing" and "not striving to keep alive"—more a difference in words than actions? And when is a prisoner being harmed by his punishment? And what if the doctor is overruled by the prison governor?

There may, too, be a problem sometimes in differentiating between punishment and treatment. If a prisoner is creating great difficulties and has to be "restrained"—as 930 prisoners had to be in 1982 in England and Wales⁵—is it always possible to differentiate between those who are restrained for medical reasons and those restrained for other reasons? The prison department does so in its annual report, but is the differentiation reliable?

Forced examination is a further issue that highlights some of the ethical problems presented to prison doctors, and it gave rise to much discussion at the second world congress on prison health care in Ottawa in the summer of 1983. The problem usually arises when doctors are asked to examine prisoners suspected of trying to smuggle drugs or arms into the prison in a body cavity. Such an examination is clearly for the sake of the prison not the prisoner. So should the doctor refuse? If he refuses the examination may be undertaken by an unskilled and even brutal prison officer. Might the doctor get round the problem by asking the prisoner to consent to an examination? But even if he does consent what value can be put on his consent? Might the examination be circumvented by examining the patient with ultrasound or x rays? What about explaining the risks of these procedures to the prisoner? Might another solution be to put the prisoner in a cell and refuse to let him use the lavatory? This answer was suggested at the conference, but many delegates thought it thoroughly unsatisfactory. Yet another solution suggested was to create a group of officers who were skilled at such examinations but had no part in treating prisoners. But again delegates were doubtful that the medical procedures undertaken for the prison and those undertaken for the prisoner could be so easily separated that different workers could carry out the different categories. And who would want to have medical skills that were used only in the interest of the authorities?

Informed consent and research

The problem of informed consent, which will always present difficulties within prisons, is important when considering research in prisons. In 1976 the Department of Health, Education, and Welfare in the United States banned all prison

I am possibly the most hated official in San Quentin and I know it. Much of the animosity that is bound to develop in a caged man's mind is focused on the medical department. My position is a vulnerable one. If a prisoner doesn't get the food he likes or the treatment he feels he deserves, or if he fails to 'make pogy' [get admitted to the hospital], he blames me.

Dr Leo L. Stanley, chief doctor at San Quentin prison for about 40 years¹⁴

research funded by its grants, and the Food and Drug Administration has considered prohibiting drug company research in prisons.¹ Some appalling "research" has gone on in the past in American prisons: *volunteer* prisoners have been injected with malaria parasites and with leukaemic cells.¹ This sort of research is quite unacceptable even if the prisoners are "volunteers," but what about other sorts of research—for instance, the use of hormones in sex offenders? Some sex offenders are keen on this treatment, particularly if it means release from prison. What about psychological or sociological research, where the prisoner has only to answer a questionnaire or be interviewed by a researcher? High quality American studies have shown that such research can produce rich rewards like a much more relaxed prison,⁶ and it is hard to see ethical objections to such research. But the prison department in England and Wales seems unenthusiastic about all research by outsiders. When I questioned Dr Ingrey-Senn about this his immediate response was that prison research was ethically very difficult.

A final ethical problem that arises in prisons is confidentiality. Prisoners have little confidence that what they say to the prison doctor goes no further. This is partly because they see the doctors as very much "them" as opposed to "us" and partly because they cannot believe that their medical records are not available to the governor and other authorities. Another particular problem is that often the prisoner has to see the doctor not because he has a problem but because the doctor is preparing a report on him for the courts, the prison department, or the parole board. The prison doctors try to get round this problem by making it clear to the patient that a particular consultation is being undertaken so that a report can be prepared and that everything said will be passed on. Suppose, however, that the prisoner has seen the doctor the same week at his own request and has discussed in that consultation something that he would not want the courts or parole board to know? Can the two sorts of consultation be neatly divided?

Many of the sentences in the preceding paragraphs have been questions. I do not have answers to them, but I hope that I have made it clear that prison doctors are confronted all the time with difficult, and even unresolvable, ethical problems. There must also be worries that these questions are not adequately answered because of the isolation, invisibility, and lack of accountability of the prison medical services.

Isolation, invisibility, and accountability

Prison doctors do not work on their own as do some general practitioners, but they are far from the medical mainstream. The full time doctors in England and Wales, the ones who run and set the tone of the service, are employees of the Home Office, which is probably the most obscurantist of government departments, and attempts to bring the prison doctors closer to the NHS are resisted⁷ and have been unsuccessful (17 December, p 1867). Most prison doctors seem to want to remain apart, and the Home Office wants them that way.

Thus the doctors who are responsible for an underprivileged and sickly group and who must daily tackle difficult ethical

and social problems do their work unobserved by the rest of the profession. Unlike doctors in the NHS, who make their opinions on priorities, funding, and conditions heard loud and clear, the prison doctors say little or nothing. When they attempt to comment on prison conditions their remarks are suppressed,⁸ and they are virtually never seen or heard discussing the purposes of imprisonment, questioning the large numbers of people imprisoned, highlighting the large burden of physical and mental illness among prisoners, discussing their ethical problems, or planning to improve their service. The silence is deafening and unnerving. Why should not prison doctors comment on prisons in the same way that ordinary doctors comment on the NHS? One obvious reason is because they have all signed the Official Secrets Act, but why do doctors need to sign such an Act? What have they got to hide?

Sadly the invisibility goes together with a lack of accountability. All prison doctors are accountable to the director of the prison medical service, and he in turn is accountable through the director general and the permanent secretary to the Home Secretary. But this is a long internal chain of accountability before outsiders have any say. Prison doctors are also accountable to the governor of their prison, and boards of visitors have the right to inspect any part of a prison at any time. Even so, the ability of either the governors or the lay boards of visitors to assess a doctor's standards and practice must be limited.

The May inquiry into the prison services recognised these problems of accountability and introduced a prison inspectorate which includes a doctor.⁹ The inspectorate remains, however, within the Home Office, and how effective it will be has yet to be seen. Its first few years have not been happy, and the first doctor on the staff quit complaining of the difficulties of his job.² Certainly one part time medical inspector for about 120 establishments is not many. When he left the inspectorate Dr Lee wrote an article in the *Lancet* calling on the prison doctors not only to speak up in public about their problems but also to open their actions and records to independent scrutiny by their professional peers.² His advice has so far been ignored but seems eminently sensible.

Quality of the service

If prison doctors were to open up their records for peer review what would their peers find? This is a crunch question, and the one question that non-prison doctors always ask me when I talk about my visits to prisons is "How good is the prison medical service?" I ask the same question to all the outside doctors whom I meet who visit prisons regularly. Some tell me that "prison doctors are third rate doctors offering a third rate service"; others tell me of suicides that they thought could have been prevented; some tell me about medical mistakes made by prison doctors; and some tell me of their admiration for prison doctors and of the difficult work they do. It would, of course, be possible to ask hospital consultants about the quality of general practitioners, and vice versa, and get a similar range of answers.

One answer to the question of the quality of prison doctors is that, as with any group, some are good and some are not so good. The same variation is seen among general practitioners and hospital doctors, but a crucial difference is that a prisoner, unlike a free patient, cannot change his doctor: if he has a bad doctor he is stuck with him. It is this lack of choice that most upsets prisoners and prison reformers, and they hope that incorporation of the prison medical service into the NHS would mean more choice for prisoners. It might.

But apart from individual variation in the quality of prison doctors it is possible to gather some circumstantial evidence on the overall quality. Firstly, the high flyers among doctors do not join the prison medical service. Secondly, once doctors are in the service they receive little further training. Despite prison doctors arguing that prison medicine is a specialty, those who join the service are not given much specialist training, and the

little training that does exist is not inspected by any of the medical royal colleges.

In addition, there are theoretical grounds for doubting the quality of the service. Dr Denis Pereira Gray has shown how social administration theory accurately predicts that the independent contractor status of general practitioners means that they will be more interested in their patients than in pleasing higher authorities but that the quality of the service will be patchy.^{10 11} In contrast, hospital doctors are in a hierarchy that pressurises them to maintain their technical competence but diverts them from the personal needs of their patients. To apply this analysis to prison doctors suggests that they may have the worst of both worlds. The rigid Home Office hierarchy will discourage them from putting their patients' interests first but will not exert much pressure to maintain medical competence. Rather the hierarchy will encourage them to pursue its primary aims, which are to keep prisoners inside the prisons and run them with minimum "fuss" and as cheaply as possible.

As well as theoretical evidence on the quality of the service more tangible evidence is to hand. The case made against the prison medical service by penal reformers is usually built around the high suicide rate in prisons (21 January, p 208) and around individual cases in which care appears to have been inadequate.^{12 13} None of this evidence is completely convincing because the suicide rate tends to be high in prisons all round the world; not surprisingly, suicide is common in prison. But, against this, the suicide rate has been lowered in some prison systems—in Michigan, for example (21 January, p 208)—and it is much lower in some prisons than others. The evidence from individual cases is always hard to assess—partly because the full facts are rarely known—but many of them worry doctors who are interested in prisons.

Quality can also be gauged by looking at what the prison doctors do rather than at the results they achieve. As the prison medical service wants doctors who are general practitioners rather than psychiatrists it seems fair to compare what the prison doctors do with what the best general practitioners do. This comparison makes the prison medical service look deficient. The best general practitioners in Britain are concerning themselves increasingly with prevention and audit, raising the standards of their records (perhaps using computers), improving their organisation, and bettering their communication with patients. I found little evidence that any of these things were happening in our prisons. This is partly presumably because prison doctors are stretched to their limits dealing with more prisoners than ever with less staff than they are supposed to have.

Prison medicine is a rewarding practice despite its frustrating conflicts. There are many reasons for striving toward high quality health care in prisons besides legal and humanitarian rights of prisoners. Crowded, often unsanitary, living conditions can be public health hazards. Preventive care and management of chronic illnesses may save costly catastrophic disease. The physician's role as an educator in describing and carrying out medical treatments can be rehabilitative by improving prisoners' self-awareness and self-image. Suffering by prisoners can be immense, with prolonged separation from family and friends in degrading living conditions. Physicians and others in the medical department can be benevolent contacts with the outside world as they work to deliver health care. These accomplishments in the course of routine health care delivery provide a sense of fulfillment.

Dr Kim Thorburn, staff physician at
San Quentin prison

A final piece of evidence on quality appears in a study conducted by Dr Pamela Taylor and Professor John Gunn in Brixton prison (personal communication). As part of their study they interviewed in depth 203 prisoners and then compared the information they gathered with the information recorded in the prison medical records. The demographic data and the data on most diagnoses agreed well, but there were large discrepancies when it came to information on suicidal behaviour and on alcohol and drug use. Seventy one of the men had made suicidal attempts and yet in 33 this was not recorded in the prison notes. Quite possibly, of course, the prison doctors had gathered the information yet not written it down (although surely such information should be written down), and, furthermore, the prisoners may have chosen not to tell the prison doctors about previous suicide attempts to avoid the stigma that is attached to the potentially suicidal in prison. But the shortfall in the recording of histories of suicide attempts is most worrying when we remember that Brixton prison has more deaths from suicide than any other prison in Britain.

Conclusion

No simple answer can be given to questions about the quality of the prison medical service, but there is some evidence that it is deficient. Because of its organisation, invisibility, and lack of accountability it may be difficult for dedicated doctors within the service to do their best by their patients. Prison doctors have to grapple with many difficult problems, and closer cooperation and better communication with doctors outside the prisons could only benefit prisoners.

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A 2 year old boy walks on his toes. He can put his heels on the ground and there is no valgus or varus deformity. What action, if any, is advised?

Many young children walk on their toes at first. This may persist as a habit and run in families but disappears at the age of 4 or 5 years. Although there is no valgus or varus deformity, it is important to exclude cerebral palsy, lesions of the spinal cord, and muscular dystrophy. Congenital short tendo Achillis may also present in this manner. The child may be able to put both heels on the ground but is more comfortable on tip toe. Examination will show a fixed equinus contracture of the calf, and if there is no spontaneous improvement after a period of observation of six months bilateral elongation of the tendo Achillis may be necessary.—L. KLENERMAN, consultant orthopaedic surgeon, London.

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