The State of the Prisons

The prison medical service in England and Wales: a commentary from the director of the prison medical service

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The research and journalistic skill Dr Richard Smith put into his 18 articles on prison health care (weekly from 19 November, p 1521 to 31 March, p 995) have generated considerable interest among doctors, and the series will stand on its own as a signal contribution to published reports and knowledge on the subject. This article is less a riposte than a descriptive commentary on the same problems seen from my unique viewpoint.

Structure

The prison medical service, of which I became director on 1 October 1983, is concerned with the physical and mental health of the 45 000 inmates of the prison system currently contained in 122 separate establishments scattered across England and Wales. These establishments are divided geographically into four regions. The medical services in each region are the responsibility of a principal medical officer in the directorate of prison medical services at prison department headquarters. As head of the directorate I am responsible for clinical aspects of medical policy, recruitment and training standards, and the effectiveness and efficiency of the medical services generally. In carrying out these responsibilities I am accountable to the director-general of the prison service and ultimately to Home Office ministers.

The prison medical service consists of four main groups of professionals. The first is the hospital officer group, which at full strength would number just under 1000 with a chief hospital officer and head of nursing service. There are about 250 nursing officers almost all serving in women's establishments. There is a group of qualified pharmacists supported by technicians and by hospital officers trained as compounders.

The medical cover is supplied by medical officers for whom there are about 100 full time posts, currently about 10% under strength. There are also part time posts usually filled by NHS general practitioners who assist the full timers or provide all the cover required by 87 of the establishments which do not justify a full time officer. There are also some locum appointments providing emergency short term cover. In support of these are several hundred consultants and specialists who work regular or occasional sessional time or give specific individual consultations as required.

I estimate that about two thirds of all the actual medical work done in prison establishments is carried out by doctors whose principal employment is with the NHS. These number about 1000 in all. While many establishments have all their medical cover provided in this way, all establishments including those to which full time prison medical officers are posted have some of their cover provided by NHS medical staff.

We are immensely dependent on and grateful for this help, which in most cases we find without problem. It provides a

desirable degree of functional integration with the NHS and helps to ensure that prison medical practice equates with that of the community.

Inmates

The number of people contained within prison establishments is currently just under 45 000. They are of all ages but mainly from the younger age groups. They are predominantly male. Many are there not for the first time. While all classes and levels of intelligence are represented, the mode is from the lower levels. A higher prevalence of disease and disability is seen than in the community at large. Most research work on this has been psychiatric, and this has shown much higher rates of mental illness, subnormality or near subnormality, and psychopathic or sociopathic behaviour. The Mental Health Act of 1983 contained provisions which I hope will facilitate the transfer of those suffering from mental illness requiring treatment from prison to hospital. In addition to the relatively small number of inmates diagnosed as mentally disordered within the meaning of the 1983 Act, there is a substantially larger but not easily quantifiable group who were they at liberty would not be detainable under the Act but who would be recognised as mentally abnormal to a degree which would call for psychiatric care or support. As the general community has closed down more and more institutions which used to provide asylum for the inadequate but without making sufficient alternative care available, many of these are drifting in and out of prison. I see no quick answer to this problem, though we who know must continue to state it.

The task

The prison medical service is responsible for the physical and mental health of the inmates of the system, which has to receive all those committed to its care by the courts. The numbers currently cause overcrowding, particularly in local prisons where unconvicted or remand prisoners have increased considerably. A large prison building and rebuilding programme will go far to meet this problem during the next decade given that the current projections of inmate numbers prove to be accurate. New ideas on sentencing may also do much to reduce the numbers sent to prison and the length of time they stay there. The Parole Board's important work and the support available from the probation service are also important factors.

Overcrowding is a main cause for problems in the environmental health of the inmates, but a single room or cell for each inmate is not necessarily a desirable aim in itself. There are many prisoners who prefer a companion to solitary boredom, and there are many for whom company is a safeguard against depressive, suicidal tendencies. Naturally, however, such doubling up is medically desirable only where the space allows, and this is much in the mind of those planning the refurbishing

programme. Communal activity, work, education, and exercise are important elements in a healthy prison regimen.

The care for the physical health of prisoners starts with the curative service. Each establishment has a doctor who conducts a sick parade each day rather as in the armed forces and is available for emergency calls at other times. The disposal of each patient will be according to the diagnosis, and ranges from referral to a hospital (usually the NHS hospital nearest to the establishment), to a bed in the establishment's own hospital or sick bay, to outpatient treatment in the normal prison accommodation, or to a waiting list to see a specialist on his next visit. In the prison environment for obvious reasons the administration of all drugs is personally supervised by a hospital officer in treatment rooms either in the prison medical centre or in the normal accommodation. This, incidentally, ensures prescriptive efficiency not seen elsewhere.

Most establishments can call on specialist visits within a week, and these ensure a minimum waiting list for most conditions, including dentistry and optical needs.

The mental health of prison inmates is a constant cause of concern, and the numbers of psychiatric consultations are high. Much of the work is generated by reports required by the courts and the Parole Board. This, and the make up of the population, accounts for the high proportion of qualified psychiatrists in the prison medical service and among the visiting NHS consultants.

The physical and mental health of inmates is considerably conditioned by their environment. Many of the establishments are old, and attention has to be paid (again similarly to the work of medical officers in the armed forces) to the structure, cleanliness, sanitation, warmth, and ventilation of the buildings. The many newer establishments present fewer problems, though they can provide their own difficulties. Nutrition is important, and the monitoring of a balanced choice of diet is an element of the work of the prison doctor. To the extent that the occupational health of the staff is a factor in the environmental health of the inmates, that also is of concern to the prison medical service. Medical considerations play an important part in the life and wellbeing of the inmate, and so the doctor is an important member of the local senior management.

The doctor patient relationship in clinical matters is insulated from any other considerations, and despite the tendency of outside observers to see (and sometimes magnify) a conflict of interest, the reality is that this is not an important day to day problem, which speedily emerges from discussion with the many doctors so engaged. The bulk of the medical work is carried out by those whose main work is in the NHS, and these men and women do not undergo an ethical change as they enter the prison. They represent a very important human face to the inmate. The clinical independence and freedom to treat and prescribe is jealously protected, and even the Home Secretary himself does not have or seek the power to interfere with this professional relationship.

Recruitment

It will be seen from the foregoing that there is indeed a specialty of prison medicine. The best source of recruitment is from two main groups of doctors—from mature general practitioners with a working interest in practical psychiatry and from qualified psychiatrists with a taste and aptitude for general practice. Both groups should be capable of dealing with management problems (not always an obvious ingredient of the medical curriculum), and with environmental and occupational health, and should have a grounding in epidemiology. The nature of prison medical service work requires staff with high quality motivation, and the recruiting boards, on all of which I sit, hold this high in the selection criteria. There is little difficulty, save in some very remote establishments, in recruiting suitable part timers, locums, or sessional specialists.

The recently formed Prison Medical Association, which is

open to full time and part time medical officers, is a symptom of a healthy concern among members of the service to maintain the highest professional standards. This expression of a growing wish for self organisation is much to be encouraged.

The prison medical service is sustained by a group of hospital officers, currently about 840 strong with 140 vacancies, and a growing need for more to staff the new establishments now being built or planned. Their tasks are similar to those of the medical assistants in the Royal Army Medical Corps with a proportion (currently about 10%) having nursing qualifications. All have received training as discipline officers as well as their hospital officer training. I believe the proportion with nursing qualifications is too low, and I seek to increase it by the direct recruitment of certificated nurses into the hospital officer grade. Such recruits will receive appropriate discipline training after joining. It is difficult to prescribe an appropriate proportion to be qualified as nurses, but I can justify initially a target of 30%. It will be easier to offer further training to those already in the service once adequate staffing levels are reached. The selection process is rigorous. Of 45 applicants recently called to interview, 15 were offered entry. The prison medical service has its own hospital officer training schools, which are currently under considerable pressure.

There is no shortage of qualified women nurses to work in the prison medical service, and most work in the female establishments or in the specialised surgical centres. It seems reasonable to hope that a convergence of these two services will be possible to the benefit of all concerned.

Misconceptions

There are two particular misconceptions about the prison medical service, and I want to dispose of these once and for all. The first is that prison medical officers commonly use drugs for control purposes, the so called "liquid cosh." Evidence is adduced from published statistics of a high rate of prescription of psychotropic drugs, especially when related to the average NHS prescriptions for the general public. What is usually omitted in these reports is the selectively higher proportion of the psychologically abnormal population who find their way into the prison system. This has been variously estimated as up to 10 times the proportion in the community. Those who are unconvicted or on a short sentence naturally expect to continue on the drugs which their general practitioner may have been prescribing. Add to this the fact of stress and anxiety in relatively normal people finding themselves in the unfamiliar atmosphere of a prison, and it is not surprising that the levels of prescriptions should be appreciably higher than in the world outside. Discussion with most of the prison medical officers would show that many seek to wean their patients off these drugs as quickly and as far as is practicable. It is certainly my policy to encourage this process.

The second misconception is about consent to treatment. Prison medical officers do not have the statutory authority to give treatment without consent. This can only be done in NHS psychiatric establishments, and that is a main reason why the prison medical service finds it frustrating in those several cases where after the due process of certification of need of treatment in the mentally disordered offender has been completed no suitable bed in the NHS can be found. The effect of the 1983 Mental Health Act, the greater provision of secure units in the NHS, and a wider appreciation among medical and nursing staff of the implications of non-treatment of needy individual cases and the inappropriateness of their detention in prison may at least ameliorate the problem.

The only occasions on which tranquillising treatment may be given without consent in prisons by medical officers are strictly laid down—the necessary conditions are a threat to life, or grievous harm to the individual, staff, or other inmates, or the likelihood of irreversible deterioration of the patient's condition.

The future

The prison system is necessary to the community of which it is a part, serving a mixed role of deterrence, retribution, protection of the public, and rehabilitation. The prison medical service is an essential, humane part of this containment.

A medical service can only reflect the quality and motivation of the staff available to deliver it, conditioned by the facilities in which they work, and the equipment and drugs at their disposal.

The prison refurbishing and building programme will do much to rectify and establish better environmental health. Satisfactory recruitment in quality and quantity will go far to ensuring the standards of the service and offering better opportunities for the training of all staff on and off the job.

The preservation of a therapeutic regimen under the guidance of an advisory committee in the psychiatric prison at Grendon will go far towards widening the application of medical skill to priority psychiatric problems within the prison system. I hope it will also provide a focus for much needed research, which could have useful results within the system and in its linkage to aftercare in the community.

There is already a degree of functional integration with NHS doctors and units at the working level, and this will continue and be encouraged to develop further especially in relation to training of the prison staff outside the prison system, and NHS staff (particularly registrars in forensic psychiatry) within the prison establishments, where a wealth of clinical material exists.

I look forward to the possibility of identifying groups of inmates with particular medical needs in common and to being able to provide specialty support for them.

As a member of the prisons board, as director of this service, and as chairman of the Grendon advisory group, I hope to continue to influence prison policy on the highest professional and ethical lines thus underscoring and improving the reality behind the first word in the phrase "humane containment." I believe that a better understanding of the work of the prison medical service among a wider professional group will do much to minimise the criticisms made which so often arise from ignorance. For this and his insight I am grateful to Dr Smith for his series and look to his continuing interest in the future.

Which is the correct spelling for calix (calyx), orchietomy (orchidectomy), and fetus (foetus) and why?

"FETUS" is etymologically correct. "FOETUS" has acquired the respectability of ancient usage. Introduced by the encyclopaedist and etymologist Isidore of Seville (AD 560-636), it entered the English language, according to the *Oxford English Dictionary*, in 1594. It could be argued that, on the basis of four centuries of regular usage, foetus is a well established English word. I regard both spellings as "correct." Fetus has the marginal advantage of being shorter and this spelling is gaining ground. *Partus* is the commoner Latin word for the young while still in the womb, according to Professor M M Willcock. The obscurer aspects of the etymology were discussed by Professors J D Boyd and W J Hamilton (18 February 1967, p 425) and by other participants in ensuing correspondence (4 March 1967, p 568 and 11 March 1967, p 631).

CALIX and CALYX are not alternative spellings of one word; they are separate words. Calix is derived from the Latin for cup; in turn from the Greek κύλιξ (kylix). Calyx is from the Latin for any covering, husk, pod, shell; in turn from the Greek κάλυξ (kalyx). Because of the similarity of the spellings, pronunciations, and to a lesser extent meanings, confusion has arisen between them. The *Oxford English Dictionary* says on this: "In mediaeval Latin and in the Romanic languages, this word [calyx] has run together in form with the much commoner Latin word *calix* 'cup, goblet, drinking vessel'; and the two are to a great extent treated as one by modern scientific writers, so that the *calyx* of a flower and its derivatives are applied to many cup-like organs, which have nothing to do with the *calyx* of a flower, but are really meant to be compared to a *calix* or cup." This commentary, though written in the period 1888-93, is valid today. The earliest English use in the anatomical sense, quoted by the *OED*, is calyx in Robert Knox's translations (1831) of J H Cloquet's *System of Human Anatomy* (1798). Earlier anatomists used other terms. James Keill, in *The Anatomy of the Human Body* (7th edition), 1723, describes the calices thus: "The pelvis sends out several ramifications, which divide the urinary tubules into bundles, and which make a sort of *capsula* to the blood vessels." Laurentius Heister, in the 1721 English translation of his *Compendium anatomicum*, writes "The pelvis is a membranous cavity of the kidneys, emitting productions called *Tubuli Pelvis*, which surround the renal papillae." Before this time anatomists evidently thought that these circumpapillary extensions of the renal pelvis did not merit special description. Even Marcello Malpighi makes no mention thereof in his *De viscerum structura exercitatio anatomica (de renibus)*, pp 71-100 (1666),¹ though it is clear from his meticulous description of the kidney that he cannot have failed to notice their presence. The earliest mention in an English dictionary that I have found is in Robert Hooper's *Lexicon Medicum*, 7th edition (1839), which gives both spellings, (a) calyx, under that entry and (b) calix, under the entry "kidney." The *OED* clearly prefers calix to calyx, and in view of its cup-like

structure and function, this is etymologically right. One might add that calyx is correct botanical usage, and Malpighi adopts this spelling in his *Anatome plantarum (de floribus)* (1625).

Calix, cup, has yielded chalice, a goblet or communion cup. It is not without interest to see the muddle our Continental neighbours have got into over this. The German for chalice is Kelch; initial Cs do not occur in Germanic words. The botanical calyx, however, is *Blütenkelch* (flower-cup). The French use "calice" for everything; chalice, calix (renal) correctly, and for the botanical calyx. The Italians, as linguistic descendants of the Romans, might be expected to know better but they use "calice" for both calyx and chalice.

ORCHIECTOMY—ORCHIDECTOMY The Greek for testicle is ὄρχις (orchis); it has no -d- in any derivatives. The Latin for the plant whose tubers resemble in shape the human organ is *orchis*, derived from the Greek. In naming this botanical family Orchideae, Linnaeus (1751) wrongly assumed that the stem of the Latin *orchis* was *orchid-*. This in turn led to the adoption of "orchid" for the plant and its flower,² whence presumably "orchidectomy"³ acquired its intrusive "d." There is no etymological justification for this. On purely etymological grounds orchis/ectomy or orch/ectomy would be appropriate; compare orch/itis. Although there is precedent for orchis/ectomy,⁴ of later date than orchidectomy, it can be argued that an intrusive consonant makes for easier enunciation and perception of the spoken word by splitting what would otherwise be an awkward diphthong, much as the French insert an "l" in *si l'on*, allegedly for this reason. Furthermore, I cannot think of any other instance where -ectomy is preceded by a vowel, and the avoidance of a vowel here is probably based on euphony. Of the various -ectomies, in some the whole word is retained (pneumon-, gast(e)r-, splen-), whereas in others the last syllable is dropped (col-on, polyp-ous, neph-r-os, hyster-a), but in each case the first moiety ends in a consonant. A possible objection to orchisectomy is that of fallaciously suggesting that -sect- implies cutting. The intrusive "d" has existed in botanical terminology for 233 years, in the English language for 139 years, and in medical terminology for 114 years and might reasonably be granted naturalisation.

The origin of a word is an important but not the only consideration in word formation. Once a particular spelling has been in general use for many years it acquires a right to continued existence. Imagine the chaos that would ensue if the spelling of all English words were revised in conformation with their origins!—B J FREEDMAN, consultant, London Allergy Clinic, London.

¹ Hayman JM. Malpighi's concerning the structure of the kidneys. *Annals of Medical History* 1925;7:242-63. (An English translation of the relevant section in Malpighi's book.)

² Lindley J. *School botany; or the rudiments of botanical science*. London: Bradbury and Evans, 1846:131.

³ Hospital reports, Melbourne Hospital. Operations by D J Thomas. *Australian Medical Journal* 1870;15:277-8.

⁴ Gould GM. *An illustrated dictionary of medical, biological and allied sciences*. London: Baillière Tindall and Cox, 1894.