Prison medicine: a patient's perspective

Mark Leech

The nurse officer took a step back and punched the prisoner in the face while he was still sitting in the chair." These are not the words of a do-gooding penal reformer or the claims of an embittered relative. They were spoken under oath from the witness box of Alloa Sheriff Court in August 1992 by Dr James MacGregor. He is a local general practitioner, who with his three colleagues has been contracted by the Scottish Home and Health Department to deliver health care to the 600 prisoners in Glenochil Prison near Stirling, from where I write.

As someone who has experienced the penal system north and south of Hadrian's Wall, I found the actions of Dr MacGregor to be as unique as they are refreshingly different. I have little hesitation in believing that had the assault described by Dr MacGregor, for which the nurse officer was convicted, taken place in the presence of a doctor employed by the Prison Medical Service (PMS) in England the opening paragraph of this article would have been worded differently.

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I recall how it took me 10 minutes to crawl from the centre of the strip cell in an English prison to the corner furthest away from the cell door. I was naked, my top lip was bleeding where my front tooth had come through, my right eye was closed with swelling, and I was unable to move either my wrists or my thumbs. Four weeks later, when finally I had an x ray examination, fractures of the scaphoid bones were diagnosed. I do not know how long I lay in that corner before I heard the three doors which led into the cell open and I was confronted by six uniformed prison officers and a man in civilian dress, who nodded just once. Three seconds later the doors were closed without a word having been spoken; I had been "examined" by a doctor employed by the PMS.

Standards of medical care in some prisons are so low they border on the negligent. In his 1990 annual report Judge Stephen Tumim devoted a chapter to the work of the PMS. It was a scathing catalogue of practices which Her Majesty's Chief Inspector of Prisons said must not be allowed to continue.

At Wandsworth Prison Judge Tumim found it impossible to discover who had taken x ray films or determine the electrical

current rating or exposed times. At Featherstone the x ray machine was held together with Sellotape, which caused a radiation leak, while at Gartree a pile of 28 films had been awaiting report for four months "and most were of no diagnostic value whatever." Drugs prescribed were expensive and frequently out of date, medical checks on admission did not include blood or urine samples, and misprescription was on the increase. One jaundiced alcoholic was wrongly given the tranquilliser chlorpromazine, three prisoners were given twice the prescribed dose of dihydrocodeine, and another 20 times the prescribed dose of insulin.

In May 1990 the 110 doctors employed at establishment level were helped by 1069 uniformed prison hospital officers, only 171 (16%) of whom had even basic nursing qualifications. The Royal College of Nursing has described the hospital officer's 24 week internal training course—raised from 13 weeks in 1983—as "grossly inadequate" and even the Prison Officers Association has condemned it as "nothing more than an extended first aid course."

In a recent efficiency scrutiny of the PMS by the Home Office the role of the hospital officer in England and Wales came in for particular attention. The report concluded that the current cost of £22m a year for hospital officers did not represent value for money. The report argued that a saving of £2.5m a year and a better service to prisoners could be obtained if qualified civilian nurses were brought in from district health authorities, "particularly where specific skills are needed such as community psychiatric nurses for receptions." The report also pressed for nationally recognised nursing qualifications to be made a prerequisite for all hospital officers, a practice which has been the norm in Scotland for a long time.

There are some doctors employed by the Scottish Home Office who are seconded to the Scottish prison service, but they mostly work in a supervisory capacity. Local general practices are contracted to deliver health care to prisons in their locality and the standards are comparatively high. Dr MacGregor and his colleagues are contracted to attend for four hours each weekday and one and a half hours each Saturday and Sunday though they are on call at all other times. All receptions into the prison are first seen by a qualified nurse officer and, usually the following morning, by the local practice doctor. Medical checks on reception are given more attention, suicide screening is given a higher priority, and all prisoners are shown a video—at which attendance is mandatory—of the dangers of drug abuse and unsafe sex. The video is extremely explicit, made for prisoners by prisoners, and one prison, Saughton in Edinburgh, recently won a Butler Trust Award for its campaigning work. As a prisoner who is HIV positive, I found it to be most welcome and a change from the head in the sand approach in England.

In July 1991 at Winchester Prison, just a few weeks after being poleaxed with the news that I was HIV positive, I vividly recall how I spent three days summoning up the courage to see the prison doctor to discuss my condition. But I was effectively prevented from doing so by a hospital officer who insisted that I must first shout my reasons to him through a perspex screen while standing in a line of 20 prisoners. In Scotland the situation could not have been more different. As in the PMS there are trained counsellors in HIV and AIDS, senior members of staff who have elected to be trained for such tasks. But, whereas south of the border I had to spend three weeks trying to find out the name of one of these counsellors and was then transferred to another prison just two days before I was due to see him, in Scotland the names are well known. All nurse officers are qualified to at least enrolled nurse level and a growing number are registered in either general or psychiatric nursing or both. As a result they are far more enlightened about the medications which they are dispensing than the English hospital officers, they acquire good diagnostic skills, and, on the whole, enjoy a far better relationship with prisoners than is ever likely to be the case in England.

The more professional attitude in the medical service in Scotland has to some extent rubbed off on to the prisoners. South

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of the border there remains a great deal of ignorance about the HIV and AIDS work in prisons. It was this which decided me against accepting the offer of a transfer to England where I would be closer to my family. Prisoners in Scotland are much more enlightened about HIV and AIDS.

Had a prison doctor in England spoken out about the assault on the prisoner in his presence as Dr MacGregor found the courage to do, he would have found it difficult to continue to work in the prison, particularly if he broke the code and gave evidence from the witness box which as in this case led to conviction. In Scotland the doctors are not linked to the prison service, they do not have to remain within its precincts for the whole of their professional life, and do not depend on the political pat on the head for promotion. This contrasts with the insular and enclosed environment of prison medicine in England.

As the conviction of the nurse officer Grant McLaughlin shows, the Scottish system of prison health care is not perfect. But there are the necessary procedures, practices, and professionalism to root out the bad apples. — MARK LEECH is an inmate in Glenochil Prison, Scotland