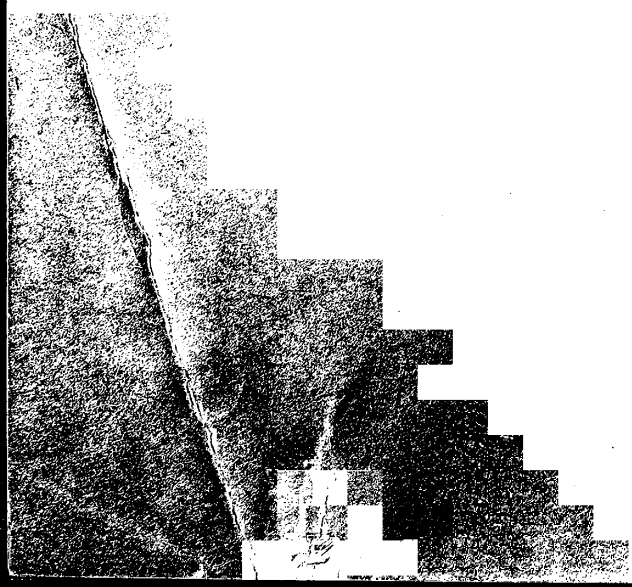
# MEDICAL SERVICES FOR PRISONERS

REPORT OF A DAY CONFERENCE
HELD BY
KING'S FUND CENTRE
AND THE
HOWARD LEAGUE FOR PENAL REFORM

LONDON
KING'S FUND CENTRE
1978



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## THE HOWARD LEAGUE FOR PENAL REFORM

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THE HOWARD LEAGUE was formed in 1921 by the amalgamation of the Howard Association (founded in 1866) and the Penal Reform League (founded in 1907). It is a charitable organisation which exists to put forward constructive proposals for the reform of penal and social policies, to consider the principles on which such policies should be based and to spread information about the way offenders are treated. Its publications include the Howard Journal and pamphlets on various aspects of the penal system.

It has consultative status with the United Nations, and is a member of the Alliance of Non-Governmental Organisations at the UN on Crime Prevention and Criminal Justice.

It receives no government grant, but is supported entirely by donations and the subscriptions of its members, many of whom also contribute to its policies from their experience in the administration of justice and the penal system. Membership is open to all individuals and organisations concerned to bring about reforms.

Details of how to become a member will be sent on request.

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## KING'S FUND CENTRE

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INTRODUCTORY NOTE

Some time ago the Council of the Howard League discussed the possibility of holding a conference on the role of the Prison Medical Service in penal reform. After discussion it was decided that a public meeting would be unproductive, and that as a first step a private meeting of some fifty participants would be more constructive. The King's Fund Centre considered that the topic was within their remit, which includes all aspects of health care, and they agreed to offer their facilities for such a meeting.

Four speakers were invited to open the discussion and it was agreed that their papers would be published. At the meeting it was agreed that the discussion would be confidential but that the views expressed might be summarised for publication. Very few preferred that their names should be omitted, but to avoid any possible breach of the undertaking it has been decided to delete all names in the report of the discussion.

In the event the meeting encountered a variety of problems. Magistrates, doctors, psychologists inside and outside the service, a prison governor and Home Office representative took part, but although five whole-time members of the Prison Medical Service were invited none were able to attend except the first speaker. The Chairman of the meeting, Dr Gray, unfortunately fell ill very soon after the meeting. Dr MacKeith delivered his paper from notes and the text printed here was contributed later.

The Kind's Fund Centre are most grateful to the Howard League for taking the initiative on this subject and to Professor T C N Gibbens for his great help in editing this report.

W G Cannon
Director
King's Fund Centre

# C O N T E N T S

# PRISON MEDICINE

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This paper presents a short account of my personal experiences of Prison Medicine - a subject about which I have no shame in admittting I am still a student.

During the years I have worked both as a part-time medical officer and a full-time medical officer I have experienced the same emotions I had in general practice many years ago - sadness and anxiety; bereavements and crises occur both inside and outside a prison - the diagnosing for the first time in a young man of 20 odd years grave conditions like teratoma testis or anklyosing spondylosis. Frustration at the inability of shaking some common sense into someone whom you know is heading for more and more trouble. Amusement at meeting regular guests who bring with them their own brand of humour, and downright hilarity at the antics of some endeavouring to convince me of their insanity.

I have been exposed to 'fool proof' methods of gaining access to buildings, the opening of car window quarter lights and short-circuiting ignition systems! I have been offered by a hospital red band facilities from a friend of his to obtain for me a refrigerator at considerable saving - the red band was due out shortly and said his friend would 'fix it for me'. Needless to say I made the appropriate noises and excuses - as well too, for he was back inside within a month for handling stolen goods - refrigerators!

This only served to remind me I was practising the same type of medicine, but in a different environment.

Prison Medicine is a unique branch of medical practice being undertaken by a number of doctors who have chosen work in penal establishments either full-time or part-time.

It embraces all branches of medicine including forensic psychiatry and with varying degrees of administration added.

Every penal establishment in England and Wales has allocated to it one or more registered medical practitioners appointed by the Home Office. The full-time doctors are members of the Medical Civil Service as are their colleagues in the DHSS, MOD and EMAS. Part-time doctors are usually local general practitioners appointed by the Home Office and whose terms of service include the provision of a locum tenens to maintain the full cover required.

The larger establishments have both full-time and part-time doctors whilst the smaller establishments have only a part-time doctor. The title of this conference is all embracing - covering as it does all aspects of medical practice in respect of offenders. It must therefore include the pre-trial period either in custody or on bail, during a custodial sentence or a period on probation, and during the after-care period whether on normal release, or release on Licence.

As a brief introduction it should be remembered that each medical officer has a statutory obligation to attend to the physical and mental needs of all prisoners in that establishment, and in order to secure a comprehensive medical service he must maintain a close liaison with his colleagues in other fields of practice, NHS hospitals from whom he obtains his specialist

and consultant advice, and depending upon the needs of the establishment, the benefit of assistance from a number of sessionally employed consultants, specialists and ancilliaries. Some establishments have Consultant Forensic Psychiatrists appointed jointly by the Home Office and the Regional Health Authority, and about which we shall be hearing later. Visiting dental surgeons, venereologists, psychologists, opticians and physiotherapists complete the therapeutic team.

For the purpose of this paper, I will confine myself to the services during a period in custody whether on remand or convicted and sentenced. The senior doctor is responsible for organising this team of specialists in his own establishment, and for supervising the medical services of the satellite establishments coming under his medical jurisdiction where it may be necessary for services to be shared.

Since prison medicine not only involves a substantial clinical element but organisational ability, it both adds to his responsibility and exposes him to a broad spectrum of sickness and human behaviour.

The duties, numbers and qualifications of medical officers appointed to an establishment are clearly determined by its role and size which can vary considerably from a small detention centre with a group of fit young persons, to a top security establishment with a large medical and surgical unit being used as a regional resource.

It should be remembered that the population about which we are directing our thoughts today, is a rather special group of people who may not be altogether truthful, tolerant or understanding. They may be litigious,

manipulative, and sometimes difficult as well! Doctors, therefore, gain a considerable expertise in handling and managing offenders which is not easily learned.

The main areas of medical work within a penal establishment can be summarised as follows:

1 Reception Procedures

2 Provision of general medical care

3 Investigation of certain inmates

4 Preparation and submission of reports

5 Advice to the Home Office, Governor and his staff

RECEPTION DUTIES

Here the newly admitted prisoner will be seen and examined by a doctor as soon after his arrival as is convenient - certainly within 24 hours. At this examination attention is paid to his or her general physical health and mental state and an assessment made regarding the appropriate labour grading and location in the prison. It will be be quite clear to everyone here today that in certain establishments the sheer numbers of prisoners being received during short periods of the day and sometimes very late evening, means that the examination may be brief, but it is not perfunctory. Particular attention is directed to evidence of recent injury, infestation, communicable diseases and conditions such as mental abnormality, epilepsy, diabetes and so on. This may often be difficult when a prisoner for various reasons prefers to remain silent for a day or so, or expects you as the ostensible expert, to 'find out for yourself'. Despite problems in this area, if the examining doctor has any doubts about a prisoner, he can admit him to the prison hospital for observation, or arrange to see him

again the following day, or in the case of a part-time doctor, refer him to a full-time medical officer the following day. Many doctors prefer to see the prisoners themselves so that they can follow him through the system. These options ease the pressures of reception duties.

PROVISION OF GENERAL MEDICAL CARE

In the majority of establishments, general practitioners engaged as part-time medical officers undertake the morning surgeries. No restrictions are placed on prescribing. Part-time medical officers become highly skilled in determining the genuine sick from those who choose to use the surgeries for other purposes. The number asking to see the doctor is large because:

a) prisoners use the surgeries as a means of communicating with one another

b) they are not allowed their own supply of simple remedies, i.e. aspirin, laxatives, antacids etc., nor facilities for purchasing same

c) they have requests to make regarding their conditions of confinement - (Governor may be seen as a father-figure, and the doctor as a mother-figure)

d) some wish to relieve the monotony of the day or avoid work.

Only a small proportion of those who ask to see the doctor are actually in need of medical attention. However, having said that, doctors are aware of the need to be on guard for regular visitors presenting with a variety of symptoms as possibly having an underlying mental illness. Furthermore, even when ill many recidivists are unable to resist overstating their symptoms and embellishing genuine complaints. There are those also who have a very high threshold to pain and can genuinely suffer for days before complaining. A prisoner is in a community, and everyone a patient of the doctor. What he does for one, he may have to consider for others. Similarly he cannot put another prisoner's health at risk because of the behaviour of one - for example, a prisoner found to be suffering from a

communicable disease, say tuberculosis and both refusing treatment and leaving his workshop. He would have to be isolated for the sake of everyone, staff and inmates alike. On the whole the prison population is a healthy one, and those individuals who are in poor health on arrival, are almost invariably improved when they leave. Prisoners requiring special treatment or investigations in a NHS hospital are transferred without delay or conveyed there as an out-patient.

INVESTIGATION AND OBSERVATION OF CERTAIN INMATES

Information reaches the medical staff from a variety of sources concerning the behaviour of prisoners. Letters are noted which contain reference to threats of self-injury or alleged illnesses; relatives may write in to the Governor about the health of an inmate. These are investigated always bearing in mind the ethical considerations involved.

A particularly rich source of information reaches the medical staff from the prison officers who observe odd or bizarre behaviour, report food refusal or episodes of unexpected violence, note quietness in an otherwise alert inmate or that someone is withdrawn. Usually this type of report warrants the inmate being admitted to the prison hospital for observation.

PREPARATION AND SUBMISSION OF REPORTS

Local and Remand Centres have to provide a continuous supply of medical reports to both Magistrates' and Crown Courts. Medical Officers will also be engaged in the making of arrangements for the supplementation of recommendations made to the Courts, either for a bed in an NHS hospital, or a Special Hospital under the provisions of Section 60 of the Mental Health Act or for treatment as a condition of a probation order under

Section 3(2) of the Powers of the Criminal Courts Act 1973. They will also be making arrangements for treatment or psychiatric surveillance of certain prisoners after release, or when released on Licence by the Parole Board with a condition that a particular form of treatment is followed and which has been agreed upon prior to release. Reports are also called for by the Court of Criminal Appeal, the Parole Board and the Home Office.

In addition to the reports requested by an appropriate body, an even greater number of reports are submitted to Courts voluntarily by the medical officer who, having interviewed the man routinely or for any other reason, forms the opinion that a report to court may be of assistance in his disposal by that court.

ADVICE TO THE HOME OFFICE, GOVERNOR AND HIS STAFF

The medical officer is a member of the senior management team and is expected to advise on matters concerning:

Food
Hygiene
Working conditions
Suitability of candidates for employment in the Service
Fitness of members of the Service
Accidents to inmates and staff
Assaults upon staff and inmates
Fitness for adjudication
Self-injury
Food refusal
Petitions to the Home Secretary, letters to Members of Parliament (a popular pastime for inmates)
Fitness for inmates to be transferred to other establishments

Throughout the day in a busy local prison, or training establishment, the 'duty medical officer' will be expected to see prisoners who have requested to see a doctor in between the morning surgeries, accidents; and here the doctor has ample opportunity to maintain his skill, and advise on the day-to-day running of the wards and out-patient departments. In the prison hospital the doctor can treat his patients within the constraints of his facility, and

obtain such specialist advice as he deems necessary. Certain types of elective surgery, e.g., hernias, varicose veins, haemorrhoids, ENT surgery, ophthalmic surgery, plastic surgery and orthopaedic surgery can be undertaken at one of the four larger establishments equipped for this work where local NHS surgeons undertake operating sessions during the week and medical officers attend to the post-operative care in consultation with the surgeons.

From all this one can see the variety of work which is undertaken by doctors in the prison medical service under the title "Prison Medicine". The doctor will be encouraged to pursue post-graduate studies and it is perhaps noteworthy that at the present time over half the full-time medical officers possess post-graduate qualifications - the majority being in psychiatry.
In conclusion, I would say that "Prison Medicine" is not a special form of medicine practised within the penal system, but comprises the provision of a comprehensive medical service within certain legal constraints. It utilises the full resources of the National Health Service and a variety of doctors each with special skills - some of whom are members of the Medical Civil Service whilst others are general practitioners engaged in a part-time capacity. To all this is added a number of highly skilled consultants employed on a sessional basis and with whom experiences can be shared. One cannot deny there are many difficulties and problems, but to the full-time medical officer it can provide facilities to practise a wide and satisfying speciality with opportunities of post-graduate study and promotion in a very interesting and ever-changing population.

DISCUSSION:

The question was raised whether there were ethical problems involved in the fact that the prisoner who was dissatisfied with his treatment was not free to go to another doctor. The speaker said there were two courses for action. In a small establishment the visiting doctor, who was a general practitioner outside, would deal with him as he would a patient outside. If he felt there was justification in the man's idea that he was not getting better he could arrange for him to be referred to an NHS consultant, or arrange for the consultant to pay a domiciliary visit.

In a larger establishment he would refer the case to a member of the full-time medical staff. They would discuss the patient together and if necessary ask a third doctor or call in an NHS consultant. If after all this the patient is still dissatisfied he can in the last resort see the Governor, petition to the Home Secretary or write to his Member of Parliament. Doctors with experience know that some prisoners who are bored, are not really concerned so much about their health, as playing a sort of game. The general practitioner outside can have a patient removed from his list, but the medical officer cannot.

Other contributors mentioned that the prison doctor tended to be self-protective in issues of this kind. If they have the slightest doubt whether the prisoner had some real justification they would tend to get the opinion of a consultant, especially in cases where there was a risk of litigation after release.

As regards the steps which a prisoner who was dissatisfied with his doctor could take, it was not quite the same as outside, where he could go somewhere else. If the prisoner was really dissatisfied, he would certainly get to see

a consultant. In fact, where there was a definite condition to be dealt with, e.g., the hernia that might require operation, he was often treated more quickly than he would be outside where there were long waiting lists. In some respects the prison service relieved the pressure on the NHS.

With regard to the screening process mentioned, by which a prisoner would have to go through his landing officer and the hospital officer, the visiting general practitioner would see all those who reported sick in the morning. After that the hospital officer dealt with first aid emergencies, and any minor complaints himself and if necessary called the medical officer, or advised the prisoner to report sick next day, rather as a medical secretary does in an outside practice.

Under the National Health Act of 1948 everyone has a right to choose the doctor who will treat him; but the Prison Rules 1964 (rule 17) state "the medical officer of a prison shall have the care of the health, mental and physical, of the prisoner". This was the legal difference.

In the case of a physical condition, it was suggested, the transaction was straightforward. But the real problem was what was the role of the whole time medical officer or psychiatrist in the institution; whether he would go out and look for the psychological problems and situations of conflict or wait for a prisoner to become ill and then treat him. This depended very much on the whole time medical officer, and whether he involved himself in the total institution. With experience he could detect that the numbers of prisoners reporting sick were reflecting tensions, general or personal, within the institution and could often advise. To do this he had to be there all the time and be available when management decisions were being

taken. The visiting psychiatrist was not there all the time; in any case it was often a personal question whether he wanted to involve himself in matters of this kind.

In the general discussion a participant observed that most complaints of the sort which reached the Howard League and other outside people did not relate to specific physical conditions, but to more vague psychiatric disorders. They really implied a sense of psychological neglect by the total institution. Prison life tended to be like a journey on a bus, you get in and later get off without anything important happening in between. The period of time in prison is not used constructively (with some notable exceptions) for the man's benefit. Whether it is possible to make imprisonment constructive or not is another matter, but at least the prisoner does not feel that it is constructive. In a few prisons the prisoner does feel that it has not been merely a waste of time. One might suppose that the role of the principal medical officer was to involve himself in this charge or at least assure the prisoner that he was concerned about it, and was looking for it.

Prison medical officers saw all new receptions and knew from previous experience that some admissions should be seen early and at length, to forestall trouble - otherwise they would be likely to turn up in a crisis when they were less responsive to treatment. This was sometimes impossible because of pressure of work, but whenever possible he would find the opportunity.

These considerations depended upon the primary object of a prison. In a remand prison there was less time to consider the total welfare of the community, which was in any case a constantly shifting one, but it was very

much the responsibility of the governor with assistant governors and a whole range of specialists to ensure that this kind of concern was being taken care of. Often a member of the visiting staff, a teacher for example, could provide information about a change in the prisoner. It was a matter of good communication which depended upon the way the institution organised itself.

Apart from this crisis-spotting, which was usually quite good, there was the issue of what the prisoner was there for. In some places the prisoner could feel that the time was used positively. It was difficult to keep this perspective in mind, especially when prisoners returned again and again; but sometimes a change in behaviour could alert the staff and give a key to facilitating some continuing change.

When people asked if the prison medical officer was encouraged to see himself as involved in the business of promoting change, the answer must be that it depended on the size of the prison staff. If there were several doctors and visiting psychiatrists there was opportunity to involve themselves in promoting a change. The visiting practitioner to a small prison could not be expected to involve himself in the same way.

In the USA there has been difficulty in recruiting talented and well qualified doctors in any type of institution. At the time of conscription (during the Vietnam war) and when a number of young doctors had entered the service, they had considered themselves self-appointed agents of change. More recently recruitment tended to be from doctors with foreign medical qualification who sometimes did not even speak the language easily. There was a need to think of continuing education, research opportunities etc, something to bring a

more creative group into these difficult and demanding positions.

In England it was said that the medical civil service provided many opportunities for post-graduate study and also research opportunities as well as part-time service in the NHS.

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MEDICAL SERVICES FOR OFFENDERS

Strengths and Weaknesses of the Joint Appointment Consultant Post

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and to the Home Office

INTRODUCTION

The establishment of consultants in forensic psychiatry jointly appointed by the Home Office and the National Health Service was the end result of several years of increasing concern about the structure and work of the Prison Medical Service and the quality of psychiatric practice within it.

In 1961 The Lancet, in a leading article, called for an official enquiry into the future of the service and in November 1962, Mr Leo Abse, MP, asked the Home Secretary whether, "In view of the inadequate numbers and sparse psychiatric qualifications within the Prison Medical Service and the present increase in penal institutions, he would, after consulting the Minister of Health, appoint a Committee of Enquiry into the structure and function of the Prison Medical Service and its relationship with the NHS?" Mr Henry Brooke (then Home Secretary), replied that such an Enquiry was about to be set up with the assistance of Professor Denis Hill and Dr Peter Scott. It is reported that Mr Abse welcomed this and expressed the hope that full

attention would be given by the Committee to the manner in which the Prison Medical Service was at the moment so totally insulated and isolated from all the modern trends in the Health Service.

Against this background of unrest and criticism the Working Party on the Organisation of the Prison Medical Service was set up. This was eventually under the chairmanship of Mr E H Gwynn and will be referred to as the Gwynn Report. It consisted of eight members, five of them medical, and the purpose of the Working Party was, "To review the functions and organisation of the Prison Medical Service and its relations with the National Health Service and to consider in what ways the resources of the general medical services, and in particular the psychiatric services, could best be used to ensure the full development of the medical services in prisons".

The Working Party observed that the Prison Medical Service for some time had experienced difficulty in attracting recruits, particularly young psychiatrists, it noted that the need for medical services and in particular psychiatric assessments and reports will continue to grow. They recognised the need for specialisation and for an increased provision of psychiatric services for the examination and treatment of offenders both in custody and in the community. It was felt that the way to meet this need was by the appointment of psychiatrists by the Home Secretary and Regional Health Authorities jointly. They would serve part-time in the prison and part-time outside, and possibly also in a teaching post, and it was said that they should be altogether full-time or maximum part-time appointments carrying NHS gradings, pay and conditions of service. It was anticipated that close links with general psychiatry outside prison would be an essential result of these proposals and by devoting a sufficient proportion of time

to work in prison establishments the doctors would acquire a thorough acquaintance with them. There was, they warned prophetically, "Some risk of segregation and rivalry", but it was essential consultants should be treated as having equality of status with senior medical officers and principal medical officers and that all should work together on a footing of equality as members of a team in all matters. These ideas were related, the Report said, to the needs of that time (1964), "That great changes were occurring and the organisation (then) recommended may well need to be reviewed and adapted in the light of future developments".

I make no apology for this lengthy historical note because our new species of psychiatrist has its origin in the recommendations of this Report and the seminar today is a useful opportunity to take a cool look at the joint forensic appointment twelve years later. In fact, we have nearly ten years' experience. The first three posts were established in 1967 and now there are eight of us (or possibly nine by the time I read this paper).

What has been achieved during this period? How far have the joint appointment consultants fulfilled the principles that were laid out by the Gwynn Working Party?

PRISONS

In the Prison Medical Service I think it is true to say that our impact has been slight. There are a number of reasons for this. Firstly, it would seem, with hindsight, that the Gwynn Report was too optimistic about the ease with which a new breed of doctor on a different career structure could be integrated and accepted into a long-established and

traditionalist service. Secondly, the doctors of the Service had expressed no desire to welcome psychiatric specialists into their ranks, were hopelessly ill-prepared to recognise and accept them and many resented the intrusion. A considerable number of medical officers regarded themselves as competent to carry out the psychiatric tasks which now might be allotted to the forensic psychiatrists and their own evaluation of the service seemed to be at odds with the analysis of the Gwynn Working Party. It is this conflict that is at the core of some of the difficulties that have emerged in developing the joint consultant posts.

From the outset, I believe that the newly appointed psychiatrists had their own conception of their task as consultants and as specialists in the forensic psychiatry field, most of them wishing to develop a specialised service and treatment role. The prison medical officers no doubt had their own view. So what were these newcomers to do?

One role was clear. They could do some of the psychiatric reports. Indeed, that was one of the essential tasks assigned to them by the Gwynn Committee. But no one wanted them to take away the work that was considered most interesting and even prestigious, and no method or agreement had been established or direction given to the prison doctors to agree which cases the forensic psychiatrists should properly have referred to them. The result has been the development of a variety of arbitary, irrational and haphazard referral practices in different centres, each medical officer using the psychiatrist in his own way, not always appropriately and usually on a basis of amicable if uneasy agreement.

But what of treatment? The Gwynn Report clearly mentions the treatment role of the joint psychiatrist and the consultant would expect to carry

out treatment and teaching as part of his traditional and expected role. However, Gwynn did not think through this aspect of the work. Would the consultant have beds? Full clinical responsibility? Trained nursing staff and junior staff? There is no answer in the Report. The result has been almost no development of the treatment role in the prison hospital and little enthusiasm for providing the consultant with his essential needs. Perhaps the most essential need is full clinical and legal responsibility for treatment, with authority to lead a therapeutic team itself responsible directly to the consultant. This would, it seems, require alteration in the Prison Rules to allow the senior medical officers' absolute responsibility for medical and health care to be shared with the consultant. Perhaps it would need new legislation. There appears to be little demand for such a change and consequently very little treatment is in fact given by the consultants who have been appointed. Their role remains advisory and in any case the place of psychiatric treatment within prison is another debating point, while the possession of any special expertise in this field on the part of consultants is sometimes challenged by the medical officers.

We could, however, play a part in management decisions in the running of the total institutions, sitting on committees, the Senior Management Team, taking an advisory role in this capacity, planning future policy and developments. But few have detected any call for them to take part in these activities either, and where attempts have been made they have been rejected.

The consultants essentially also have a teaching role. All consultants are expected to teach. Perhaps here at least a place might be found.

Outside, forensic psychiatrists become clinical tutors within the postgraduate training scheme. Medical Officers no doubt equally require and would wish for postgraduate training in their own setting. Hospital officers require to be kept up to date and to receive further training. Regrettably, however, this too has not been a fruitful area of growth so far.

In short, the forensic psychiatrists have totally failed to make the impressions in prisons that the Gwynn Committee had hoped for. Most have struck a cordial and friendly personal working relationship with medical officer colleagues, but whereas in the Health Service there have been many requests and expectations for contributions in the clinical, educational and management fields within the prison there has been very little response to the psychiatrist's presence. None have felt that they were playing a worthwhile role, making a new contribution or justifying the establishment of the appointment. All have felt to a greater or lesser degree frustrated, while carrying out the work which has come their way.

The entree to the prison hospital has, however, on the positive side, allowed for the development of training programmes for NHS trainees in psychiatry and the teaching of undergraduates, both of which are among the most useful functions of the appointment. The post has also increased the integrity and regard of the courts by emphasising the forensic psychiatrist's independent status as an objective expert and the courts have tended generally to respond generously to the forensic psychiatrist's local contribution. Under the aegis of the Home Office the post has allowed the development of extremely valuable links with the Probation, Aftercare and other services, well within the spirit of the Gwynn Report, breaking down the barriers

between the prison and the outside world. The prison medical officer in the past had few outside links; the forensic psychiatrist is very obviously a man with a foot in at least two camps. I think it is also true to say that the quality of psychiatric reporting within the Prison Medical Service has slowly improved within recent years and I would dare to say that this is in no small measure due to the influence of the joint appointment forensic psychiatrists.

IN THE NATIONAL HEALTH SERVICE

The other arm of the joint consultant apppointment is the National Health Service, and the evidence is that the opportunities for service here have been more far-reaching than Gwynn ever contemplated. The Gwynn Committee said that, "By developing forensic psychiatry within the Prison Medical Service in (the way they recommend) encouragement would be given for the establishment of more forensic psychiatric clinics outside the prison system". This (they said) would have three major advantages. First it would facilitate the treatment of offenders on probation or otherwise dealt with out of custody. Second, it would facilitate the continued treatment of offenders after release from a period of detention and in general would make a valuable contribution to the development of after-care. Third, it would enlarge the opportunities of remanding on bail for a psychiatric report.

In the National Health Service, the Regional Health Authorities have given considerable support to the consultants to foster these aims and I think all have units which handle an increasing number of referrals from courts and elsewhere in these and other categories. The consultants have usually been provided with rooms, beds, senior registrar, secretarial and other

supporting medical and paramedical staff. The clinical load has tended to increase steadily (and certainly in my region the numbers remanded in custody for a psychiatric report are declining). We are now seeing between 300 and 400 patients a year at our National Health Service forensic centre. There is a heavy demand for teaching of undergraduates and postgraduate medical students, probation officers, social workers, magistrates and many other professionals. Further, in the National Health Service the forensic psychiatrist is not isolated in his department. He has to play his part in the management structure in his hospital and in its local community activities. But he has a regional responsibility and most have a heavy demand from colleagues for advice and from the regional area structure to speak for the specialty of forensic psychiatry in planning, policy-making and forming decisions. Not least, most forensic psychiatrists have been increasingly involved for some time in the planning of more complex community forensic psychiatry services and regional secure units. In my own case, for instance, these planning commitments include membership of many local advisory and planning bodies including membership of the Regional Security Unit Project team. I am Chairman of the Working Party on Forensic Psychiatry Services.

Nationally the eight forensic psychiatrists in post have been called on to sit on many advisory and professional bodies, and have probably made a contribution at this level to an unusual extent in relation to their small numbers. Between them they are, for instance, members of the Advisory Council on the Penal System, the Advisory Councils for Drugs and for Probation and Aftercare and of the Advisory Committee on Alcoholism. One has been a member of the Parole Board; another, a member of the Butler Committee, and another is a member of a Mental Health Review Tribunal. Five have been or are members or officers of important committees of the Royal

College of Psychiatrists and three are members of the Joint Board of Clinical Nursing Studies. These are just some examples of these activities. Almost all have university appointments and most have published research contributions, chapters of books and other articles while they have been in post, and most have been training senior registrars.

The value (or strength) of the joint consultant post in forensic psychiatry has been its flexibility during these initial years. This has allowed a response to the request to be involved in many areas of clinical service, organisation, teaching and planning. The creation of the joint appointment has allowed the development of all these activities and during these years has encouraged the consolidation of forensic psychiatry as a specialty recognised by the Department of Health, the Royal College and other bodies.

But could not most of this have been achieved equally well from a more conventional full-time NHS post, perhaps with a requirment to act as a second opinion for the local prison medical officers when requested? Perhaps that would have occurred naturally anyway. I think the answer must be in the affirmative. Yes, this could have been attained from such a position. In comparison with the range of activities outside the prison, within it the psychiatrist has been asked to take on a very limited task which fails properly to employ his specialist skills and training.

SinceGwynn there have been very considerable changes in thinking about the treatment of offenders. We have had the Butler and Glancy Reports, the impetus to remand on bail where possible and now the development of the regional secure units. In my view, the hope for the development of the psychiatric treatment programmes or therapeutic communities in prison on

a large scale has shown no sign of fulfilment and I have serious doubts about the value of pursuing this aspiration constructively. The opportunities for contributing are in the community and the future task for many forensic psychiatrists lies there and in the development of forensic psychiatry services and secure units, aftercare and rehabilitation, and in implementing the Butler proposals.

If we are to develop a worthwhile career structure, attractive to young psychiatrists then I would suggest the answer is to develop a range of posts according to local needs and demands. Some will work almost entirely in the NHS, with perhaps one or two sessions offerred to the Home Office and to provide advice and second opinions where these are required. Others might work the greater part of their time in the prisons and perhaps these should be in the Prison Medical Service grades at SMO or PMO levels, with a few honorary sessions outside. (No one surely should work entirely in seclusion from the outside world.) Others, perhaps where other posts in forensic psychiatry already exist, might be divided more or less equally between the two areas as at present, but this I contend should cease to be the rule and may well be the most undesirable arrangement. An individual will always inevitably find himself pulled more to one area than the other. There are examples of this in other joint appointment arrangements in other fields.

In short, the joint post as it exists (or "as we know it now", as they say) must change. Perhaps it is changing already. Several posts entirely based in the NHS have recently been established and perhaps these are a natural development and response arising from the worthwhile beginnings of the last ten years. Times rapdily change and to echo Gwynn again, the

time to "review and adapt" has now arrived.

REFERENCE

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DISCUSSION

When the Gwynn Committee considered the problem of joint appointments between the Prison Medical Service and the NHS, the principal topic was whether these should be amalgamated; but this was implacably opposed, and the joint appointment system was developed as an alternative, a second best. The Butler Committee had also gone over the question and it might be regarded as settled. But the meeting was possibly making the same mistake. At the time it was suggested that one problem was that the Prison Medical Service was constantly and probably unwillingly forced on to the defensive, which absorbed much of their energies and prevented them from saying how they could improve it. It was doubtful if legislation would be necessary in order to give the forensic psychiatrist joint responsibility. But although the medical officer delegated authority for treatment to general practitioners he was in fact solely responsible and no real initiative in treatment could occur without his approval.

With regard to work partly inside and partly outside the prisons, psychiatric training should involve work in both locations, as it did now. But when it came to settling on a permanent appointment it had to be one or the other, though this did not facilitate consultation and discussion with both sides of the profession as a whole. The speaker did not agree with the suggestion

that most of the difficulties had been due to personality problems, or that matters would have been better if the first joint appointments had been to training prisons rather than remand prisons. The posts were set up mainly to improve the quality of reporting to courts and not to improve treatment within the prisons.

Some people thought that the proposed regional security units in the health service were ill-conceived, and should have been developed in the prisons; but there was very little sign that the Grendon type community therapy would develop further in the prisons in the next 20 years. There were serious doubts about the role and effectiveness of 80 psychotherapists to the prisons because improvement could not be tested by releasing the patient provisionally and it was not possible to follow them up effectively outside. This applied especially to sex offenders, alcoholics and some others.

It was pointed out that the Butler Committee did not dismiss the idea of the amalgamation of the Prison Medical Service and the NHS, it was outside their terms of reference because the Prison Service went far beyond the treatment of the abnormal offender. The most fundamental problem was that of answerability. The Prison Governor was responsible for prisoners and through him the Home Secretary was answerable to Parliament. But the NHS psychiatrist was answerable to the Secretary of State for Social Services. It was true, however, that the Chief Medical Officer to the DHSS was responsible for both medical services.

In several foreign countries the medical services in prisons were provided entirely from outside. Sometimes this was very successful, but in many cases the general standards of medical care abroad by this method fell below the level of our system.

If the Prison Medical Service did amalgamate with the NHS there might be even less chance of close collaboration with the regime. The forensic psychiatrist could not be there all the time; he would be involved in many areas inside and outside. But in some parts of the penal system, for example in Coldingley prison, a great deal of constructive work went on which helped to teach people how to get on with one another, and close study by social psychiatry of regimes of this kind could perhaps explore, expand and classify the constructive influences.

It might be supposed that places like Grendon could be regarded as training centres, the equivalent of teaching hospitals. This certainly went on, with attachment from all disciplines of the Prison Service and indeed the health service. But the training does not necessarily get anywhere if they go back to a rigid regime and are told by somebody higher up "You can do that there but you can't do it here".

# ETHICAL ASPECTS OF THE ROLE OF THE MEDICAL OFFICERS IN PRISON

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Dr Prewer, a doyen of the Prison Medical Service, recently admitted that he had become "complexionally superannuated from the bold and courageous thoughts of youth and fervent years". He expressed the following view: "One thing is quite certain, and that is that medicine in its wider sense is going to play a larger and larger part in both the treatment and control of those offenders who come into penal institutions, be they many or be they few": and in this context, he suggested that treatment and control are merely two sides of the same coin. I believe that Dr Prewer must be taken seriously although his attitudes and mine are polarised, at least on the dimensions of tender and tough mindedness - of conservatism and radicalism.

Perhaps it is my own comparative youth and fervour that allows me to tackle this topic in the first place - since it is studiously ignored by wiser heads than mine. In approaching the subject of the ethics of the role of Medical Officers in prisons I am filled with trepidation because the straws at which I clutch are elusive and the wind is high. I really have only three points to make:

First - an individual cannot contain the dissonance created by conflict, and, as Festinger so elegantly showed, the individual copes with the situation by repressing one element and thereby negating the conflict.

When, in the eyes of the Prison Medical Officer, the interests of the prisoner compete with those of the institution, whose cause will he champion?

Second - because the Prison Medical Officer is particularly vulnerable to the processes of institutionalisation he has an ethical responsibility to struggle against the insidious and persuasive powers of the total institution. It is his ethical responsibility because his own institutionalisation impairs the quality of health care which he is able to give.

Third - if a doctor is not acting in all respects as an individual's personal physician it is his ethical responsibility to make his position clear. He should not assume that the patient will appreciate the significance of his divided loyalties.

It is my purpose to try to argue the veracity of these three contentions and to put forward tentative solutions for the problems which they pose.

There is a popular but falsely held belief that medical practitioners are bound by the Hippocratic Oath - although to the profession its interest is mainly antiquarian.

It is obvious that the sentiments of the oath are not adhered to and that the practice of medicine at any time will merely reflect contemporary attitudes. We have all become hippocrites because the precepts of the oath are no longer tenable. Hippocrates' idealised view was supported by Virchow who described the physician as "the natural attorney of the poor", and, as late as 1957, Durkheim described the doctor as a "centre of moral life". In practice it is difficult to support their views since, in the historical sense, medical practitioners and later the profession itself have been

outstanding for their conservatism; far from exhibiting a reformative zeal they have been notable for their opposition to change. A decade ago Professor Titmuss argued that doctors had, in fact, together with other professions, become arbiters of the Welfare State. By diagnosing need and rejecting or selecting for individual services they applied the strictures or benefits which are made available to individuals by society. Titmuss believed that it was part of the process of disengagement of medical practice from the lowest socio-economic groups and he predicted a decline in the ethical component of medical services.

The real state of affairs in Britain is that most medical practitioners are contracted to serve the interests of individuals, while maintaining a varying degree of responsibility to their employer, the State. The vast majority of their work is of no concern or importance to the rest of society but occasionally the doctor finds himself as interlocutor between an individual and the State. In that situation the doctor's first concern can be his relationship with his patient or, alternatively, he can take the view that benefit of the individual is secondary to that of society as a whole. Other practitioners are contracted to the State or to the institutions of society but they do not undertake to provide simultaneously a personal medical service. Thus, a medical practitioner employed by a large company can, in the interests of his employer, provide information on an employee's health which is disadvantageous to that individual; however, such a doctor does so with the patient's consent and he does not additionally act as personal physician to that person. It seems quite ethical, therefore, for a doctor to have divided loyalties as long as his patient appreciates both the full implications of the situation and, importantly, that he also

has the opportunity to be treated by a doctor who does not have such a dual role.

In 1948 the "Universal Declaration of Human Rights" was accepted and proclaimed by the General Assembly of the United Nations. Article 5 reads:

> "No one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment"

The Standard Minimum Rules for the Treatment of Prisoners was adopted by the first United Nations Congress on the Prevention of Crime and the Treatment of Offenders a decade later. Several clauses are worthy of consideration:

> "The medical services should be organised in close relation to the general health administration of the community or nation"
>
> "The medical officer shall have the care of the physical and mental health of the prisoners"
>
> "Punishment by close confinement or reduction of diet shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it"

These guidelines clearly reflect the bipartisan nature of the United Nations' interests, that of the prisoners and of the State. Thus, two of the clauses which I have mentioned contain assertions which are essentially contradictory. It is not possible to be responsible for the physical and mental health of a prisoner and also to sanction his punishment, on the grounds that he is fit to receive it, by methods which may be prejudicial to health. Although it might be proper for a medical practitioner to act in either role - as physician-arbiter or physician-healer, it is obviously not appropriate for him to act in both capacities and this conflict was recognised by the World Health Organisation who invited the World Medical Association to provide an international code of medical deontology since

it did not believe that it was a competent body to propose or endorse an international code of medical ethics.

A recent UN publication, "Health Aspects of Avoidable Maltreatment of Prisoners and Detainees", states that medical ethics are considered to be - the rules of personal conduct governing the professional relationships of physicians, with their patients or with each other. These rules normally require that the sole object of the physician's intervention shall be to promote or safeguard the physical and mental health of his patient. The UN has endorsed the view that the World Medical Association should have special responsibility in this field of medical ethics. In contrast WHO expressed the belief that its own relation to the ethical implications of health was better expressed by the term "health ethics" which referred to the accountability of governments to their populations in regard to health matters. WHO's constitution names one single objective:

> "The attainment by all peoples of the highest possible level of health"

This implies that member governments have an ethical obligation to protect their subjects from procedures which offer a deliberate threat to physical or mental health. It seems clear therefore that the UN was aware that development was only possible if medical ethics and health ethics were treated as separate, but complementary, disciplines.

In 1947 the World Medical Association elaborated a modern version of the Hippocratic Oath which became known as the "Declaration of Geneva".

Three clauses of the declaration illustrate the dilemma which faces all doctors but especially the prison medical officer:

> "The health of my patient will be my first consideration"
>
> "A doctor shall preserve absolute secrecy on all he knows

about his patient because of the confidence entrusted in him"

The code disbars him from:

"Collaboration in any form of medical service in which the doctor does not have professional independence"

The World Medical Association has since reaffirmed its concern with the relationship between the prison medical officer and the prisoner as his patient. After approval by the Council of the World Medical Association in March 1975 a statement recommended to the World Medical Assembly held in Tokyo later that year for adoption as the "Declaration of Tokyo". One of its clauses reaffirmed the Declaration of Geneva and stated that

"A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible"

Professional independence is of course inextricably bound up with the economics of health care and what treatments are available at any one time will be related to a complex system of priorities. Even outside prisons there are evident disparities in services available in different regions and between services themselves. The recent report entitled "Sharing Resources for Health in England: Report of the Resource Allocation Working Party" has highlighted a contemporary breach of health ethics. Four times as much is spent on general hospital facilities for a person in London compared to an individual in Leicestershire. Twice as much has been spent in recent years on medical facilities south of the river Trent as north. This inequitable distribution of care is compounded by the way in which facilities and practitioners select patients who suit themselves or their services and reject the misfits. This process has been described by Bennett in the context of community health services. The services available for prisoners will therefore reflect the practice of medicine outside these

institutions - all other services select suitable cases for treatment - the prisons cannot. These considerations of health ethics should be the concern of the State and doctors cannot be held responsible for those restrictions which are imposed on their practice because of political and economic expediency.

The Prison Medical Officer is in a particularly delicate position in regard to the ethics of his practice. What is tolerated by one generation is intolerable to the next - a good example is given in "Rules and Standing Orders for the Government of Local Prisons" of 1911. Then the Prison Medical Officer evidently supervised punishment procedures as some sort of referee:

> "Rule 87. Dietary punishment shall not be inflicted on any prisoner, nor shall he be placed in close confinement, nor shall corporal punishment be inflicted, unless the medical officer has certified that the prisoner is in a fit condition of health to undergo the punishment.
>
> Rule 88. All corporal punishment shall be attended by the Governor and the medical officer. The medical officer shall give orders for preventing injury to health as he may deem necessary."

While such supervision benefitted some prisoners - in that it excluded the manifestly unfit from punishment and prevented irremedial injury to those who were punished - it also protected the State from embarrassment due to any excessive zeal on the part of its agents. The medical officer could presumably overrule the Governor, though only on medical grounds. The doctor would, after a flogging, presumably tend the wounds which he himself had authorised.

The same "Standing Orders for the Government of Local Prisons", of 1911 also stated:

> "Rule 287. In the event of a prisoner refusing to take food, the medical officer must consider the advisability of compulsory feeding in an early state, in order that weakness of a serious character may not ensue. Although discretion must rest with the medical officer, even forty-eight hours, as a general rule would appear to be an exceptionally long period, and a limit which should not be exceeded unless there are good medical reasons for doing so."

This rule was obviously intended to deal with fasting suffragettes and the prison medical officer was expected to begin forced-feeding within forty-eight hours of the first refusal of food. A similar restriction of the doctor's independent practice by directive can be seen in other rules concerning forced feeding which were effective up to 1969 and which appear to protect the State from the injudicious feeding of individuals who could have been released from prison.

> "Should a prisoner (convicted in a colonial court) refuse food, full details will at once be submitted to the Commissioners for the decision of the Secretary of State, as to whether the provisions of the Prisoners (Temporary Discharge for Ill-Health) Act, 1913, shall be applied, and the medical officer will not resort to artificial feeding until the decision is communicated to him."

Another example of the vicissitudes of the public conscience is evident in the Report of the Committee of Privy Counsellors of 1972, which was appointed to consider authorised procedures for the interrogation of persons suspected of terrorism. It was noted that discomfort and hardship are clearly matters which any person involved in crime, under ordinary conditions, will suffer and that is accepted not only as inevitable but permissible. It would obviously be wrong to challenge the ethical position of any practitioner who makes a contract to provide his services to any organisation which functions legally. However, the passive participation of physicians in procedures which are detrimental to health is questionable. This position was well illustrated in the

Compton Report's description of the cooperation of medical practitioners in in depth interrogation which was later shown to result in physical and mental injury and was declared to be illegal by the Report of the Committee of Privy Counsellors. It was Dr Prewer who drew the comparison between prison medicine and that in the armed forces. In a penal context the ethics of a medical practitioner's involvement in disciplinary procedures is also questionable since the very processes of punishment deprive the prisoner of his right to conditions favourable to health.

In this balancing act on the ethical tightrope the Prison Medical Officer is in the spotlight while his NHS colleagues stand in the wings. Who, 20 years ago, would have imagined that a Regional Health Authority would give the following advice in September 1976:

> "The Chairman of the Psychiatric Advisory Committee, having circulated his colleagues, agrees that the following constitutes good clinical practice.
>
> Psychiatrists should be advised that it might be wiser if ECT were not given to those patients who do not wish to receive it. In cases where consent is withheld, and yet in the opinion of the Psychiatrist a course of ECT should be given, then at least two procedures are suggested which might with advantage be taken:
>
> (1) the opinion of a second consultant should be sought
>
> (2) the consent of the nearest relative should be obtained."

The recommendation goes on to delineate the boundaries of independent practice thus:

> "In the case where a patient is unable to give consent and requires ECT urgently - as possibly a life-saving measure, e.g. a stuporous patient, the consultant should be able to exercise his clinical judgment without the need of a second opinion."

The Prison Medical Officer is a tailor-made scapegoat whose "spoiled identity" is renowned. This is reflected in a recent paper by Dr Topp who states that "unproductive boundary antagonisms are likely to occur"

because the Prison Medical Officer is not fully and completely accepted by his NHS colleagues as possessing equal specialist skills. The Prison Medical Officer perhaps unfairly, is often the target of attack. Do not doctors in Special Hospitals also perform a function as agents of social control? Whether this is seen as a preventive aspect of the practice of medicine could be debated - but control they do. Do consultants at the Special Hospitals really have complete clinical independence in deciding upon the care of a person for whom they are allegedly responsible? Individuals who have been selected for special attention as recommended by the Aarvold Committee exemplify the situation where the gloved hand of the Civil Service is more than usually obtrusive.

The Prison Medical Officer is in an inenviable position in that he faces difficult problems of both medical and health ethics more frequently than his colleagues; his employer is the organisation which has overall responsibility for State security.

If a criminal offence is committed, the offender becomes liable to punishment; imprisonment is one form of punishment and its purpose is clear. Harris' Criminal Law states that imprisonment is: "Punishment by the State not for the purpose of affording compensation or restitution but as a penalty for the offence and in order to deter the commission of similar offences and in some cases for the reform of the offender." Dr Scott, I know, has disagreed with this view and a more euphemistic statement of intent is contained in "Prison Rules" which describes imprisonment as "training and treatment" with the purpose of assisting prisoners "to lead a good and useful life".

The Prison Medical Officer who works in a legal punishment establishment finds himself in a uniquely divisive position, acting on behalf of a total institution and yet with the responsibility for the individual prisoners who are under his care. The institution itself makes particular demands because some of its activities are related to national security but staff indeed have to struggle hard against forces which institutionalise them. Medical Officers also sign the Official Secrets Acts Declaration of 1911 and 1920 which emphasises that they are liable to prosecution if they publish (in a speech, lecture, on radio or television, in the press or a book, either orally or in writing) any information which they may acquire, without official sanction. The declaration warns that the consequences following a breach of the provisions may be serious and even if the Act were repealed Medical Officers would still be bound by Civil Service rules which would exercise similar constraints.

It would be profitable here to re-examine the features of the total institution in order to appreciate its power and persuasiveness*. In 1961, Erving Goffman described the central feature of the total institution; it broke down the barriers which separate three spheres of human behaviour, sleep, play and work. These activities are normally engaged in with different authorities and without an overall rational plan. We do not normally sleep with the people we play with, nor do we work with them; each has a separate doorstep which is sacrosanct to the other. In the total institution all aspects of life are conducted in the same place, under the same single authority. Each phase of the daily activity is carried out in the company of others, all of whom are treated

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* Note that it affects staff and inmates alike.

alike and required to do the same thing together. All phases of the activity are scheduled and the sequence of activities is imposed by a system of formal rules. Finally, and importantly, the various enforced activities are brought together in a single rational plan which is purportedly designed to fulfil the aims of the institution.

I believe that Goffman was not commenting on whether or not there is a better way, but he showed that our society is organised in a manner which makes the handling of many human needs - and that is what our society sets out to do - only possible by the bureaucratic organisation of large groups of people. Such government is a key fact of a total institution.

Everyone does what is clearly required of him, under conditions where one person's infraction is likely to stand out in relief against the visible, constantly examined compliance of others. Groupings occur, a large managed group, conveniently called inmates, and a small supervisory staff. Each group conceives of the other in terms of a set of narrow stereotypes. Staff feel superior and righteous; inmates feel inferior, weak, blameworthy and guilty. Social mobility between the two groups is restricted, one of the supervisory staff's functions is to control communication with higher staff levels. Characteristically, the inmate is excluded from knowledge of the decisions taken regarding his fate. Such exclusion gives staff a special basis of distance from and control over inmates. The fabric of the institution comes to be identified by both staff and inmates as somehow belonging to the staff and so when reference is made to the views of the institution, by implication such reference is to the views and concerns of the staff.

By their very nature prisons exist outside the community and this separateness fosters an inwardlooking defensiveness. They are understaffed and overcrowded with inmates. The work of the Prison Medical Officer is particularly difficult because of the strictures which are imposed on medical practice in prisons and because of the continuing struggle which must be exercised against the processes of institutionalisation. To the prisoner, the doctor is sometimes seen as merely a facilitator of the process of punishment and this experience will perhaps colour his attitudes to the medical profession and the way in which he is able to use it, both within and outside the penal setting.

How can a doctor serve two masters? In his work the Prison Medical Officer has a dual allegiance, to the State and to those individuals who are under his care. To my mind, this can only result in activities which largely favour the State. In the historical sense medical practitioners have always emphasised the sanctity of the relationship with their patients but the development of medical services in prisons has, perhaps necessarily, focussed more on the partnership between doctor and the public health aspects of the institution. Imprisonment in itself could be seen as prejudicial to health as are disciplinary methods which are more obviously detrimental and which must prejudice the doctor's role as the prisoner's personal physician.

One clause of "Standard Minimum Rules for the Treatment of Prisoners"which was quoted earlier states that: "The medical service should be organised in close relation to the general health administration of the community or nation". However, the Butler Committee has commented that there have been consultant appointments held jointly between the NHS and the Prison

Meidcal Service where the essential linkage between services has not taken place; this was attributed largely to the continuing isolation of the Prison Medical Service. The dangers inherent in this division are obvious for Titmuss has warned that a separate State system for a minority group tends to be seen as a poor standard system recruiting the worst rather than the best categories of staff and, if the quality of personal service is low, there is a danger that there will be less freedom of choice and more felt discrimination.

What then are the issues which must be faced? The first can be discussed under the title of health ethics; that is "the attainment by all peoples of the highest possible level of health". Standard Minimum Rules for Prisoners categorically state that it is incumbent on governments to give prisoners "access to the best facilities for medical care that it is feasible to provide". In addition, Minimum Rules state that "the medical services should be organised in close relation to the general health administration of the community or nation". That, it seems, is an indisputable ethical responsibility. It is echoed in the recommendations of the Report of the Home Office Working Party "The Organisation of the Prison Medical Service" which was published more than a decade earlier. In their recommendations to the Butler Committee most jointly appointed forensic psychiatrists favoured unification of the NHS and the Prison Medical Service but the recommendation was dismissed by the Butler Committee. The isolation of medical and paramedical staff in prisons continues and the behaviour which Dr Topp has described as "unproductive boundary antagonisms" would, more aptly, be designated as belonging to the "closed shop"; closed shops are, of course, the breeding grounds of suspicion, jealousy and distrust. To combat the effects of institutionalisation it is essential for prison

medical staff to develop extra-penal links; they have that ethical responsibility to their prisoner patients.

Secondly, medical ethics demand that the doctor shall not take advantage of his image as a personal physician if he is not, in all respects, acting in that capacity. It is surely unethical for a doctor to betray the trust of the patient even if that trust is only an assumption. It is surely the responsibility of a doctor in prison to make it clear that he is not acting as the patient's personal physician and that what he learns of the patient may be used against his interests. The reality of the situation is that the prisoner does not have access to a personal physician during his term of imprisonment.

When I was first faced with the task of examining the ethical aspects of the role of medical officers in prisons my presentiment reminded me of a powerful allegory which we can all interpret differently. Franz Kafka's book The Castle was first published in 1926. The story is of the arrival of a stranger in a village which is seemingly ruled by the Castle which stands above it. The traveller, K, struggles against the ubiquitous, elusive and anonymous powers which the Castle seems to exert, a Castle which determines and yet simultaneously opposes his every step. K had been summoned by the Castle to work as a surveyor and his circumstances were such that he could not return home. The Castle however denied his existence and demanded that he justify his presence in the village. K felt that he had lost himself and that he had wandered into a strange country, further than ever man had wandered before, into a country so strange that not even the air had anything in common with his native air.

Direct intercourse with the authorities was particularly difficult for all they did was to guard the distant and invisible interests of distant and invisible masters. The major means of communication between the village and the Castle was by telephone, at least that was what K believed. However, he learnt that his contacts had been illusory. There was no fixed telephone connection with the Castle, no central exchange which transmitted calls further. When anybody called up the Castle from the village the instruments in all the subordinate departments rang, or rather they would have rung if practically all the departments didn't leave their receivers off. Now and then, however, a fatigued official felt the need of a little distraction and he hung the receiver on. Thus, if one wanted to speak to a particular official it was more probably a little copying clerk from a different department who answered. Although the clerk's utterances had no official significance K was assured that their private significance - in a friendly or hostile sense - was very great, generally greater than any official communication could be.

These contradictions engendered in K a belief that, in spite of his wretchedness, in an almost unimaginable and distant future he would excel everybody. K was later ostracised by the villagers but then he felt freer than he had ever been and at liberty to wait as long as he desired. In the end K was to find partial satisfaction at least. He was not to relax in his struggle to validate his existence, but was to die worn out by it. Round his death bed the villagers were to assemble, and from the Castle itself was the word to come that though K's legal claim to live in the village was not valid, yet, taking certain auxiliary circumstances into account, he was to be permitted to live and work there. With this, he died.

Whether I have validated my existence here today is for you to judge. I cannot, however, be expected to have communicated with you if you persistently leave your receivers off! Before expiring I will summarise my position.

It appears that there is a conflict between medical ethics and health ethics which cannot be resolved by the appointment of an individual as guardian of both. I believe that it is essential to provide a separate and independent health service to prisoners which should be intimately linked with extra-penal facilities. At present the Prison Medical Officer is responsible for all aspects of the prisoner's health, both personal and social. The personal aspects of health care could well be provided by doctors who are employed by the NHS and have contacts with extra-penal health and welfare facilities. For certain subspecialities of medicine, eg. psychiatry and general practice, experience in prison medical practice would be invaluable and would additionally provide for an exchange of ideas and opinion. Those aspects of medical practice which were related to the public health aspects of prisons and medical administration would continue to be served by medical officers who were contracted to the Home Office; such doctors would not be involved in the personal aspects of health care.

These proposals would facilitate the establishment of two levels of medical practice within prisons, as exists outside. One group of doctors employed by the NHS would provide a personal health service for prisoners: they would be governed by a system of medical ethics. Another group would concentrate on the administrative aspects of health care and would be employed by the Home Office as civil servants. The two groups would be linked by a common profession but they would have contrasting functions and interests. A dialectic

would emerge which would result in continuing and critical self-assessment and, hopefully, development. This process can only occur between individuals, it cannot exist within an individual because the demands of the institution and prisoner are overwhelming but divergent and an individual copes with this conflict by the psychological defence mechanism of repression. In such a situation it is most often, of course, the prisoner's interests which are restrained.

Finally, the sole purpose of this contribution is to enhance the role of the Prison Medical Officer. He faces issues which others choose to ignore, he throws into bold relief difficult ethical problems and he practices in the ultimate total institution.

DISCUSSION

On a point of fact about Northern Ireland, Lord Parker and Mr Boyd Carpenter took the view that the interrogation methods were all right if a medical officer stood by to see that they were used with what they called moderation. It was only Lord Gardiner who said the whole barrage of techniques was unacceptable and only because of his minority report the Prime Minister of the day, Mr Heath, finally forbade the use of these interrogations.

The idea of a dual responsibility, the individual health of the prisoner being in the hands of the health service and the administrative side in the hands of the Home Office, was interesting and worth exploring, but what would happen if they violently disagreed?

It was curious that relations in prison were always portrayed in terms of conflict. It could be in terms of discussion and debate; the public health

and administrative aspect need not necessarily be in conflict with the medical ethical code of those who provided personal health care.

Some felt that it was quite possible for a doctor to maintain his first duty, which was to the patient, whether as a member of the community or as a prisoner, and could fight for him inside and outside prison without a troubled conscience. And most Prison Medical Officers would say the same.

Following the policy suggested might lead to difficulty in other services. The strength of the Probation Service is surely that it provides the two things, care and control. Parents have to adopt this dual policy. The ethic proposed was frankly the basis of much of our trouble today, and following it would cause infinite trouble.

The Probation Service, however, was not subject to the institutional power to which the Prison Medical Service was exposed. This may be why the Prison Medical Officers are the last to admit that there is any ethical conflict. People outside can see it and are troubled by it. It is perhaps the processes of institutionalisation which in Goffman's terms has a powerful effect on their attitude and practice. Perhaps they are saying that they are not affected by the total institution.

These observations should also be extended to the Special Hospitals and the medical officers' powers and responsibility there. There was in fact a close similarity to the Special Hospitals.

The care and control concept underlies much of what people are trying to do. The whole problem of lunatic asylums, of taking people off the streets

because they are a danger to themselves or others, was founded upon it and it is still done today. If this was completely jettisoned, something would surely be lost.

The problems seemed to centre upon the struggle to find some alternative to the parens patriae concept, which seems to have gone too far. Quite evidently there were parents who could successfully handle the conflict of care and control, and children who could handle the conflict as well. Institutions recognise role conflict and set up controls and balances. But it need not be conflict all the time. There would be people who took on careers with the perspectives which went with these careers, who could nevertheless discuss, clarify and work out the best interests of the individual and the state. What seemed essential was that those psychiatrists who adopted this work should be particularly talented and well selected.

Everyone recognised that there is a conflict between the interest of the patient and that of the state. One could institutionalise this by having a different person representing each interest, as the speaker had suggested. But it might be better for one person to work out a compromise. The practical problem is that outside there is the view, rightly or wrongly, that Prison Medical Officers are too institution-minded and that in weighing up the balance there is a bias that is somewhat different to that of the psychiatrist outside. This balance might be achieved more successfully, as has been said, by amalgamating the services inside and outside than by having two authorities who surely would inevitably come into frequent conflict.

An experienced medical officer had said that he appeared seven times more often in court for the defence than for the prosecution. The record of protecting the individual from the rigours of the law is quite good. Nevertheless it was not fair that the doctor should be cast in an authoritarian

and controlling role with an assumed monopoly of so-called goodness, help and comfort. Perhaps the solution was to look at the checks and balances and the conflict-resolution procedures, which had not been discussed very fully. What is needed is an independent person who in some way constitutes both aspects. The medical officer does take that role and his reports are seen by the prosecution and the defence but he is not often seen as favouring the defence as much as was implied earlier. The psychiatrist for the defence is identified with the prisoner but this re-emphasises the prison doctor's position in relation to the state and prosecution. The joint consultant, however, is very much in the middle, identified for the prosecution when inside, and outside with the defence, and if anyone is an all-purpose witness it is he. Judges seem to see him as independent, like the forensic pathologist. The medical officer is not allowed to give an opinion at the request of the solicitor for the defence, entirely independently, nor is the joint appointee when operating inside. This was probably a mistake; both should be available, and so come to be seen as independent and more objective in orientation.

In practice, however, this would mean that the prisoner would be faced with two doctors and would obviously identify with the one most likely to give him relief. It would be training him to anti-social attitudes and following his needs irrespective of those of society. We want him to identify with someone who wants him to cope with his own control, and whom he sees as representing both sides.

Much of the discussion really seemed to involve the adversary model of justice. At a recent foreign conference experts were often envious of the Anglo-Saxon adversary system, which was very different from the European,

because when there was a conflict it made the conflict explicit, and invited conflict-resolution. The conflict model has its problems, but it does not necessarily lead to bloodshed.

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## PRACTICAL CONSTRAINTS OF THE WORK OF THE PRISON MEDICAL OFFICER

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Apart from his role in certain screening procedures such as 'reception', the Prison Medical Officer usually becomes involved with an individual when a prisoner complains about his physical or mental state or, less commonly, his condition attracts the attention of prison staff. Otherwise, the Prison Medical Officer's role is roughly analogous to the Regimental Medical Officer's or the Community Physician's job. He is responsible for the maintenance of standards of hygiene and factors influencing the health of the inmates of the prison. He is seen as a member of the senior management of the institution at least by prisoners.

While the prison surroundings and everyday patterns of living within the prison are not specifically <u>designed</u> to provide a painful experience for the inmate, it is probably true that less trenuous efforts are made by Government to protect prisoners from distressing experiences compared with the consideration shown to less 'blameworthy' individuals. The Prison Medical Officer is confronted with the problem of being involved in institutional care while he

labours under difficulties including overcrowding and the inability to reject incoming prisoners who could more appropriately be placed elsewhere. He has little or no direct control over these crucial forces. Sometimes a mental or even a physical disorder arises from some unavoidable aspect of imprisonment and the Prison Medical Officer must resort to treatment methods less desirable than the simple expedient of removing the prisoner from the circumstances which may be harming him.

One might argue that the practical constraints on the work of the Prison Medical Officer are less pronounced in the area of physical medicine than in the sphere of psychological understanding and psychiatry. Prisoners have ready access to medical practitioners and can receive the benefit of consultant opinions and hospital treatment with the same facility that the citizen in the community enjoys. It is true that the convicted prisoner has no choice of doctor but I personally doubt whether the standard of physical medicine would be significantly improved even if radical changes in the prisoner's access to doctors of his own choice could be arranged.

The topic of psychological treatment may be more complicated. Surveys differ as to the extent of mental disorder in prison populations. The use of a narrow definition of mental disorder limiting the term to mental handicap or mental illness allows a significant proportion of the prison population in need of treatment to go uncounted. It is commonplace knowledge that disorders of personality manifested in many areas of functioning besides antisocial behaviour are widespread, especially in recidivist offenders.

My complaint is that it almost seems to be assumed that only prisoners

who make a point of complaining are in need of assessment and perhaps treatment. I would contend that at least the recidivist should be carefully assessed at the beginning of a sentence.

Psychiatrists practicing in a hospital setting usually place emphasis on the 'milieu' and its impact on patients. In the prison setting, the doctor does not control every aspect of life which the prisoner patient experiences. At the same time, the doctor has a similar status and common interests with the Governor grades and so appears to give his tacit approval to circumstances which he may consider undesirable and in need of reform. It is my impression that one of the most important roles for the medical officer from the Home Secretary's and Government's viewpoint is that his daily presence within the institution is taken as an unspoken statement that facilities are of an acceptable standard to the medical adviser. The Prison Medical Officer may feel himself torn between two opposing views: a tendency to accept prisoners' critical, angry, resentful comments about his experiences on the one hand or quietly colluding with apparently complacent management on the other.

The Prison Medical Officer has opportunities to influence what takes place within the prison. I believe this is not only the product of some respect for his professional expertise in itself, but probably also depends upon his status as an independent professional with credentials acceptable in the community as a whole outside the peculiar norms of a prison. Prisons are "total institutions" which tend to make people inward looking so that the staff as well as the inmates become disinclined to hazard their comfortable prejudices and vulnerable self-esteem in the hurly burly of the wider community. However, this bracing, if occasionally painful stimulus is essential to prevent the development of a prison staff mentality which

abhors the unconforming thought. Many assumptions become agreed among the staff of a prison but if these go unquestioned when they should be, this must unfavourably influence behaviour and relationships between staff and inmates. The need of the prisoner to contemplate in advance, problems and stresses in the community before they are actually encoutered on release might be an example of something that can suffer.

The ability of the medical officer to cross the boundary between the inside and the outside of the prison must depend on his own capacity to work and feel accepted in both settings. I do not advocate the fusion of the Prison Medical Service with the NHS. However, I do think that if Prison Medical Officers were more involved with the larger medical community certain benefits would be likely to follow. Ill-informed and unconstructive criticism from doctors outside the Prison Service is in my view facilitated by the ignorance that most doctors have of practitioners in the Prison Medical Service and their work. It is uncommon for bodies representing the profession as a whole to express any solidarity with the Prison Medical Officers when they are subject to unsympathetic critical appraisal. Again while there is no defined training grade for Prison Medical Officers, the complexities of prison life and procedures and the peculiar difficulties that arise from dealing with patients who often have a pathological antipathy toward authority figures requires particular expertise which takes perhaps four years to acquire. However, I suggest that the medical officer may become so over-specialised in this field that he begins to feel that he is after some years' service unqualified to work outside the Prison Medical Service. I doubt that this can be a healthy development as reduced professional self-esteem and confidence could follow. A proportion of his time spent working in an NHS setting could help to increase the

movement of doctors in and out of the Prison Medical Service. Benefits flowing from this might include an improvement in the integration of prison and health service facilities which deal with the same offender patient as he passes backwards and forwards between the community, hospitals and the prisons.

If doctors individually and collectively are to express views about what should take place in prisons, they should at the same time ask of the Prison Medical Service what practical help and professional support the Service would like to receive. Moreover, it would be a refreshing change if the unique knowledge and perspective of Prison Medical Officers could influence the attitudes and practices of doctors, especially psychiatrists, in the NHS.

I personally hope that there will soon be an end to conferences, advisory documents and public statements which offer tactlessly worded advice to the Prison Medical Service and give the impression that inadequate consultation has taken place with the doctors who carry out onerous duties. Prison Medical Officers may include among their numbers the unimaginative, the complacent, the over-sensitive and even the incompetent. In these ways some may resemble inferior doctors found elsewhere. Too often unconstructive criticism is made of the Prison Medical Service without examining the difficult predicament of the medical officer. Unless one really believes the Prison Medical Service is to be disestablished and the care of prisoners will be returned somehow to visiting NHS medical practitioners, all would be well advised to discover what sort of interventions or advice is considered likely to be ameliorative. It does not ring true to say Prison Medical Officers allow themselves to be associated with an inhumane system when medical and psychiatric services in particular are so disgracefully inadequate in the community.

DISCUSSION

Many doctors found that the Official Secrets Act did not cause any particular difficulty. Officials have to submit papers for publication and often receive very useful comment. As long as views are said to be personal, objection is rarely raised.

This does not apply equally to all staff however. Doctors are privileged in being able to express their views in learned journals. But it is not clear why prisoners should not have access to journalists and absurd that a prison officer with 20 years experience cannot say anything but a doctor can.

A previous speaker said he had submitted his paper to the Home Office but had not been asked to take anything out of it.

Prison officers tended to live together in special housing and spend their leisure in the same social clubs, so that the effects of institutionalisation continued. It was true that there was no embargo on the Prison Officers Association and Governors drawing attention to this but it was a matter that needed study and attention.

On the question of prisoners being allowed access to their own doctors, the regulations allowed this on remand but not after conviction: but this was at the Governor's discretion.

The medical report could have an influence on conviction if details of the crime were mentioned in cases where the question of responsibility arose. A good report does not include matters of this kind, and the judges are

experienced in ignoring information of that kind; but being human it is not always easy for them to be assured of this. Some psychiatrists appearing for the defence take note of this and prepare two reports, one for before and one for after conviction.

In the Special Hospitals the situation was different. The inmates were formal patients, suffering from one of the recognised disorders. It made a considerable difference because it was implicit that there was a treatment component in their detention. Secondly everyone, unless subject to a restriction order (and then, after a certain time), has access to a Mental Health Tribunal. This has a psychiatric member and although the tribunal is not obliged to accept a further psychiatric opinion on the patient's behalf, in practice they always do. An independent opinion can be presented to the tribunal; patients may have one or probably two independent medical opinions. Secondly, the responsible medical officer is required to justify continued detention and give reasons for it. This was very different from prisoners who were not getting any benefit and were being detained only in the interests of general or personal deterrence.

This procedure operated when an appeal on psychiatric grounds was held but if, for example, a Special Hospital patient wanted to complain that his bad leg was not being treated effectively the situation was different. In practice the responsible medical officer would be a fool if he did not obtain a consultant's opinion about any treatment of this kind which aroused conflict.

A further essential difference between Special Hospitals and prisons is that prisons are subject to Home Office policy. In Special Hospitals the

consultant staff control in a more complete sense the milieu - the keys, the doors, the walls, staffing and supervision etc. This seems to create an altogether different ethical situation - to be responsible not only for the patient individually but for the regime as well.

A further difference was noted. In all hospitals and other institutions except prisons, the standards of quality of work were subject to independent scrutiny. There is a hospital advisory service - a relatively independent group which can publicy discuss what it feels to be important. Training is subject to scrutiny by the College of Psychiatrists as an independent body. The Prison Medical Service, however, is seen by many as a more closed institution. It is subject to scrutiny by the Home Office but not publicly and not from an independent body.

No one would want to see a statutory interfering supervising organisation in relation to the individual clinical work of doctors, but one result of the present organisation is that it lacks a self-critical element and does not set up a self-scrutinising organisation which would call for general improvements. The individual medical officer is immunised against self deception and collectively held illusions in relation to the institution as a whole. For example, there is some criticism of reports to court, that they only say whether the prisoner is psychotic or not, or needs hospital treatment; if not, there is some phrase about being fit for any disposal. No one, however, says that if 500 reports a year have to be written, it is impossible that adequate standards should be achieved. It is difficult to write more than two thorough reports a day. Whether a man is psychotic or in need of hospital treatment is a very simple matter, probably decided in the first few minutes of an interview. It is much harder to have a grasp of the social personality, interactional

problems in the background, either from interviews with the family or getting information from other sources so as to offer the court something more substantial.

One possibility was that the court should not be so free to send a person into custody, or should have to justify it.

It was difficult to say at what point outside scrutiny began to be described as interference. There are other forms of check, for example, the community health councils or a health service commissioner. There seemed no reason why a prisoner should not be allowed without censorship to communicate with one of these.

The difficulty was that, as matters stood now, hours and hours of time, which could be better spent in improving the therapeutic role, had to spent in prisons writing reports or dealing with MPs queries which were based upon manipulative behaviour or litigious activity which did not really involve questions of illness at all seriously. An extension even further of these procedures would make life intolerable.

If prisoners had access to their doctors it would be possible for the Prison Medical Officer to show that he was doing as good or better job, and it would provide him with an argument for insisting that he have more time to do it. In practice very few prisoners have their own doctor and in other cases they might find it hard to get one to come in and deal with manipulative behaviour in any way that was different from that of the Prison Medical Officer.

In the concluding discussion it was suggested that since the Butler Committee had been unable to discuss the amalgamation of the Prison Medical Service with the NHS, the last chance for it to be considered might be a submission to the Royal Commission on the Health Service. However, since this had been appointed by the Secretary of State for Health, it was doubtful if it would say anything about the Prison Medical Service. There were many practical problems in organising a service which probably only dealt with 5000 out of 40,000 prisoners, and then usually only in relation to minor physical ailments.