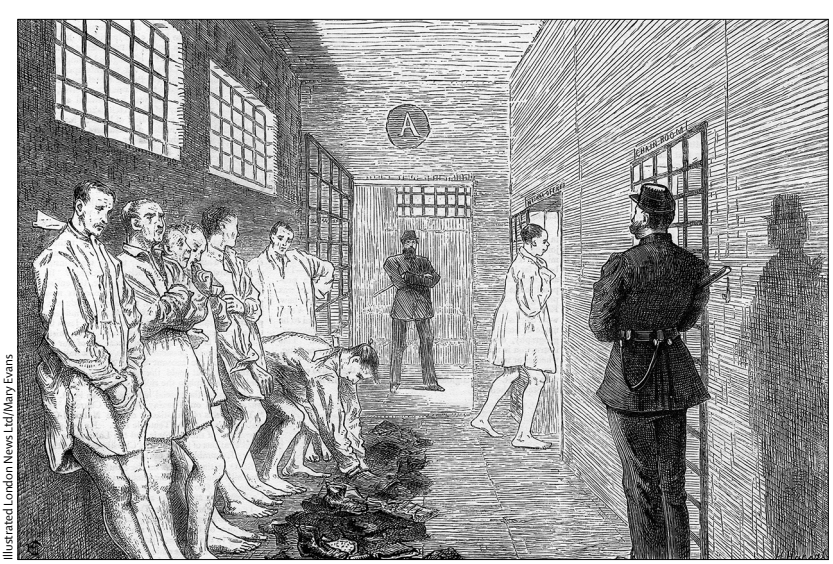
The art of medicine

Victorian systems will not solve modern prison health problems

For the **Digital Panopticon: Tracing London Convicts in Britain and Australia, 1780–1925** see https://www.digitalpanopticon.org/

Prisons have been the default punishment for offenders in the UK since convict transportation to Australia was phased out in the mid-19th century. Since that time, prison populations have grown considerably. England and Wales have more than 83 000 prisoners, one of the highest numbers in Europe. Victorian prisons and the ideas that informed their design are still in use. An outdated prison estate contributes to prison violence, high prison staff turnover, and, crucially, wastes opportunities for creating modernised health care for prisoners. Although they were a model that was adopted across the world, these historic spaces experienced considerable problems in disease and prisoner management. The Victorian prison system was designed to "grind men good", but more often than not consigned inmates to poor health and scant chance of reform. This heritage, we argue, remains far too resonant.

The Victorian prison authorities walked a tightrope. They oversaw a system designed to be punitive enough to deter further offending through harsh conditions and hard labour, such as the treadmill or breaking rocks in quarries, but with a need to maintain low costs while keeping prisoners healthy enough to work. Prevention of disease was therefore a priority in overcrowded, poorly ventilated prisons where infectious diseases flourished. Efforts to overcome these challenges were bolstered by the Prison Reform Act of 1877 that united national and local prisons under the British Government and began the modern prison medical service in England and Wales. It was crucial to sustain the health of prisoners so that they could work during their sentence and be healthy enough to secure employment on release. In pursuit of this objective, the health and biometric details of convicts were assiduously recorded by the prison authorities. These histories were collected and analysed as part of the Digital Panopticon project, led by Liverpool University, that provides data on the lives of thousands of people who were either imprisoned in British prisons or transported to Australia. To evaluate convict health between 1853 and 1890, we have been working on a pilot study that uses data from the Digital Panopticon on height and weight to calculate body-mass index (BMI) and standardised diseases from prisoners' medical histories using the WHO International Statistical Classification of Diseases and Related Health Problems (ICD-10). Although the bodies of men and women have changed over time, the general trend has been for western European generations to be taller and heavier than those in the past. We would expect a contrast in weight and height, but that BMI would enable useful comparison. Moreover, inadequate diet, nutrition, and living conditions for poor and marginalised populations in the 19th century leads to an expectation that convicts would enter prison malnourished and that they would most likely experience harsh conditions and substandard diet during their incarceration, exacerbating their poor health. But we found that most women and men arrived in prison within what would now be considered normal BMI ranges for this period and most were in the same BMI category at committal and release. Surprisingly few convicts lost considerable weight in prison.



Illustrated London News Ltd/Mary Evans

Prisoners at Millbank Prison, London, await inspection by a medical officer (1873)

The medical records of 324 prisoners (139 women and 185 men) that we examined indicate that the health of prisoners was more than a passing concern in Victorian prisons. Of those, more than two-thirds received medical treatment or attendance while in prison, many for more than one incident of illness. Men experienced more sickness than women but there were differences between the sexes in the range and severity of disease experienced. Whether from violence or work, male prisoners had more injuries than women. By contrast, women presented with infectious and parasitic diseases at a higher rate than men; they also suffered from musculoskeletal and related connective tissue disease at twice the incidence of men. So-called debility (physical breakdown or malnutrition) was fairly common for both sexes and accounted for between a fifth and a quarter of documented disease, which was generally remedied by a stay in the infirmary and a more nutritious diet.

Prison medical officers played a key role in augmenting diet and getting prisoners back to health, although they had a contradictory role in also overseeing harmful and draconian punishments. Sick prisoners were, at least

ostensibly, treated by skilled medical practitioners who provided better health care to prisoners than they could access outside prison. Most medical officers were physicians or surgeons at the height of their careers—and all were men until the 20th century. William Augustus Guy, for example, was Physician to King's College Hospital and Professor of Forensic Medicine at King's College London. For several years he was also Medical Superintendent at Millbank Prison. He published widely, including *Guy's Principles of Forensic Medicine* (1844), a standard work that ran to several editions. The prison medical service was probably attractive to elite professionals like Guy because it provided a status that allowed them to practise with relative impunity and supplied a steady stream of convict patients for research and publications.

In addition to their day-to-day rounds of treating prisoner patients, medical officers documented the biometric characteristics of prisoners. They decided who was strong enough for prison labour and who could withstand punishments, such as solitary confinement or a bread-and-water diet. Despite, or because of, the amount of illness they confronted, cynicism trumped sympathy. Men like Tennyson Patmore, medical officer of Wormwood Scrubs in London, warned against overly harsh testing for so-called malingerers but was nevertheless scathing of those who used sickness to avoid prison labour or punishment: "Criminals undoubtedly appear to graduate with highest honours in malingering, which is not surprising considering what they have to gain by a successful exhibition, which may procure for the 'insane' adept the genial luxuries of asylum life with its tobacco, cricket, dances, and so on; for the 'rheumatic' expert rest from the treadmill and the crank; for the 'dyspeptic' juggler white bread in place of brown, and cocoa instead of 'skilly'; not to speak of the Elysian delights of the prison infirmary, where an undetected 'paralytic' scamp may lie in ease and luxury".

Prison medical officers had an experiential authority that was used to shape contemporary social theory towards emerging scientific ideas about eugenics in the last decades of the 19th century. Prisoners with mental illness, infections, or other disease provided the medical profession with a unique set of highly detailed and medically valuable data. The period that saw the growth of medical capacity in prisons also witnessed vast changes in medical professionalisation and knowledge production. The perceived moral and physical weaknesses of convicts were presented as evidence of inherited criminal tendencies and their poor mental health regarded as signs of inherited mental degeneracy. 19th-century medical officers played an important but misguided part in developing ideas of the criminal mind. Eugenics-minded doctors were unsympathetic to mental illness in the prison and they undoubtedly underdiagnosed and misdiagnosed such disorders. As the 19th century progressed, prison medical officers used the data they collected in the prisons to become powerful authorities contributing to contemporary debates on health and eugenics. Their story is one of risk, responsibility, and professional power, within the wider sociopolitical context of eugenics and penal and medical power, creating an indelibly controversial heritage.

Today, a more sympathetic attitude towards prisoners' complex health needs prevails among health professionals who work in prisons, yet society still tolerates a situation in which many prisoners endure ill health, particularly mental health problems. Conservative surveys estimate that at least one in seven prisoners have depression or psychosis. Substance misuse also disproportionately affects the prison population. And people with mental disorders in prison are at increased risk of self-harm, suicide, and violence.

Modern society feels distanced from Victorian approaches to mental and physical health in prisons because medical science has brought curative and health benefits to everyone, including prisoners. Yet, we still lack an all-encompassing strategy, involving policies across different sectors, to manage the health needs of prisoners, reduce the inequities they face, and improve their wellbeing. Custody presents challenges but also an opportunity to rethink how we approach these public health issues; in the UK various organisations, including the Howard League, have argued that a clean break from the past is needed to make better use of spaces of punishment.

Prisoner health services are now commissioned by National Health Service (NHS) England. However, the overlapping health needs of populations at risk of offending, non-custodial offenders, and ex-prisoners are also commissioned through clinical commissioning groups and local authorities. Despite their combined objectives to address the health inequalities of those entering or leaving the criminal justice system, in our opinion, the health of prisoners and ex-prisoners is not prioritised and is under threat from local government cuts to funding and conflicting budgets and policy pressures. Ex-prisoners return to families and communities. Effective strategies for better managing and improving the mental and physical health of prisoner populations could improve lives, relieve stress on the NHS, and cut costs for high-demand areas of the UK supporting prisoner populations and their families. The challenges are significant but the human and financial costs will continue to rise if we remain rooted in a Victorian past.

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The data discussed in this essay was originally collected for the Arts & Humanities Research Council-funded project Digital Panopticon (www.digitalpanopticon.org) that has been completed.

Further reading

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