

Correspondence

The just provision of health care

SIR,
Miss Telfer takes issue with three of my contentions concerning the proper basis for allocating health care resources (*Journal of medical ethics*, 2, 188-9). First, she rejects my claim that, underlying her belief in the likelier adequacy of state provision than private provision, is an assumption that politicians are more charitable and provident than their electorate. This assumption is said to be absent because politicians, in providing such resources, are not giving away their own money and are making such provision through the instrument of law which is more reliable than private inclinations. But it is difficult to see how, in a democratic political system, politicians - whatever their motives - can persistently flout the wishes or inclinations of the bulk of the electorate. So the attribution of greater reliability to state provision must rest either upon the assumption that democratic politicians are, on this issue, invariably willing to commit electoral suicide, or upon the assumption that politicians would prefer to become undemocratic rather than jeopardize state health care programmes. Both of these assumptions attribute greater charity to politicians than to their electorate.

Second, she argues that although state provision depends in principle upon the general retention of a sense of responsibility, in practice it undermines that sense and, thus, tends in the long term to be self destroying. It is not clear how this argument can be reconciled with Miss Telfer's previous point about the greater reliability of state provision. Nor is this the place to rehearse Kant's strictures about the common saying 'This may be true in theory but it does not apply in practice'. In any case, whether certain policies have a long-term tendency to erode the conditions for their own maintenance is an empirical (and not a philosophical) ques-

tion, with the onus of proof surely lying on those who claim that an actually existing commitment will cease to exist.

Finally, Miss Telfer suggests that an equal distribution of wealth, coupled with unrestricted personal freedom to spend one's wealth, would require a greater degree of state control over private individuals - to establish that equality - than would a system whereby the state regulates and provides a wide range of services, and confiscates accordingly. Again, this seems to me to be an empirical rather than a philosophical contention, the truth of which entirely depends upon the kind of institutions and practices adopted for conferring an equal share of wealth upon each person. What does seem to be necessarily true, however, is that under such an arrangement the allocative pattern of goods and services would more closely conform to the detailed variety of individuals' respective preference orderings than would be the case under any other arrangement.

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Medical treatment of prisoners

SIR,
The medical treatment of prisoners is an important question for a humane society, and Dr Bowden's article¹ is welcome for drawing attention to it. Recently a prisoner was injured in a disturbance, suffering a fractured hand and leg and bruises and abrasions. Shortly afterwards he was certified medically fit to undergo punishment, and sentenced to a substantial period (91 days) of solitary confinement, during which his bed and bedding were removed from his cell during the day. Despite (or because of ?) the contentious circumstances, a request by the prisoner's father for an independent medical examination was refused.

This is admittedly an exceptional case, but it is in the exceptional cases that fundamental issues stand out most clearly. There must be many prisoners in less dramatic circumstances who would say: 'I accept that the court ordered me to be deprived of my liberty; but by what right am I deprived also of a degree of choice of medical practitioners?'

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¹ Bowden, Paul, *Journal of medical ethics*, 1976, 2, 163.

The need for more special hospitals

SIR,
The articles by Drs Rollin and Norton^{1,2} in your last issue are timely because there has been insufficient consideration of the Butler Report on Mentally Subnormal Offenders³. It is true that the attempt to treat mentally abnormal offenders in mental hospitals following the Mental Health Act of 1959 has proved unsuccessful. However, the humane attitude to psychiatry which permeates most of the 1959 Act. The experience gained has been useful and the staffs of psychiatric hospitals are now qualified to comment on the problem. Very many psychiatrists are now familiar with many aspects of forensic psychiatry, and nursing staff in mental hospitals are experienced in the handling of patients who come to them through the courts. The organization of mental hospitals represents a compromise between the need to treat patients with humanity and a lack of restriction and the need to protect society from the violent patient. Since 1959 the emphasis has been more on freedom and the patient's needs and less on restriction and the need to protect society.

The Butler Report was published because two mentally abnormal

offenders, Terence Iliffe and Graham Young, went on to commit further murders on being returned to society. However, neither of them was treated in an ordinary mental hospital or by psychiatrists from mental hospitals working in the community. They were both discharged directly to the community from a special hospital (Broadmoor) and were supervised by psychiatrists from Broadmoor. Therefore the responsibility for the errors of judgment in relation to these two men cannot be laid at the door of the mental hospital service or of the mental Health Act 1959.

In spite of this consideration the Butler Report recommends the establishment of secure units for mentally abnormal offenders in regional mental illness hospitals. It is easy to understand why the Butler Committee did so. Such a recommendation had been made by the Working Party on the Special Hospitals in 1961 but had never been implemented. Apart from that there has been a large decline in the population of mental hospitals since 1954 whereas the population of the special hospitals has increased and the populations of the prisons has increased. In 1954 the mental hospital population in England and Wales was 212 268. In 1973 the figure was 146 797, a decline of 65 471. (The figures for 1976 should show an even greater decline in numbers.) There is evidence that the special hospitals (Broadmoor, Rampton and Moss side) are overcrowded. The total number of patients in the three hospitals was 2354 in 1973. Currently the prisons are more overcrowded than they have ever been. There are 42 000 prisoners in prisons built to house only 37 000⁴. It is axiomatic that when the mental hospital population declines the prison population rises. Therefore it was self evident that the Butler Committee should look again to the mental hospitals to ask them to set up special secure units. After all there should be considerably more space available now than there was in 1961. The reason why units were not established after the 1961 report was simply because no hospital wished to be regarded as a regional centre for mentally abnormal offenders. At a time when psychiatry was trying to get away from the image of high walls and locked doors it would have been a backward step to set up secure units.

Now in accepting the Butler Report the Government is attempting to sugar the pill for the mental hospitals which establish secure units by offering more money for training and research and it is possible that nurses in such units can earn more money than they would in the ordinary way. Thus many mental hospitals threatened by closure are now clutching at the straw of the secure unit as a means of staying in business and preserving their identity. This is, in spite of the fact that much has been achieved in recent years by the open-door policy in mental hospitals, in spite of the fact that the mental hospitals hold no responsibility for the errors of judgment which led to the setting up of the Butler Committee, and also in spite of the fact that only one member of the Butler Committee came from the staff of a mental hospital.

In my view, the reforms should take place in the special hospitals. In the first place they are inadequate in number. It is of interest that Scotland, with a population of 5 000 000, has its own special hospital at Carstairs. England and Wales, with a population of nearly 50 000 000, have only three special hospitals with a fourth in process of erection at Park Lane, Manchester. In the second place the medical staff have an unenviable task with no extra awards for the hardship of the job. All other grades and types of staff in special hospitals are paid more than their counterparts in conventional hospitals. The psychiatrist tends to earn less than his counterpart in a conventional psychiatric hospital and considerably less than the average family doctor or the average prison doctor. He does not have the right to discharge patients: that right is vested in the Home Secretary. It must be disheartening to bring a patient to recovery by treatment and then to find that early discharge is not possible. Much of a psychiatrist's time in the special hospitals is spent in treating the mental and physical trauma arising from life in an overcrowded environment and not enough time is left for the assessment of patients for discharge.

One obvious reform is to devise some form of extra payment for the special hospital psychiatrist. It is unlikely that the Department of Health and Social Security would approve of such a proposal because

it creates precedents. Another reform is to build more special hospitals: money is unlikely to be available for this. However, there has been a decline of over 65 000 in the mental hospital population. Therefore it might be possible to hand over existing mental hospitals to the Special Hospitals Division once their remaining patients had been transferred elsewhere. A similar operation was done in war time when mental hospitals were turned into general hospitals and military hospitals. It can be done again; it need only involve one or two hospitals but it will leave the great majority of mental hospitals free to look after their own patients with the emphasis on liberty rather than on compulsion and restraint.

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¹Rollin, Henry R, *Journal of Medical ethics*, 1976, 2, 157.

²Norton, Alan, *Journal of Medical ethics*, 1976, 2, 160.

³Report of Mentally Abnormal Offenders, 1975, Cmnd 6244.

⁴*Guardian*, 1977, 15 January.