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Text prepared by the medical members of the CPT [July 1999]

In order to facilitate the drafting of CPT visit reports, whilst guaranteeing that all necessary aspects of a prison medical service are examined, a list of questions and principal themes to be taken into account has been drawn up. This list is not exhaustive, but aims to offer an aide memoire for persons requested to evaluate the medical service in a prison.

A. The comprehensive evaluation of a prison medical service involves the completion of the following steps, in order to provide detailed answers to the questions set out in points B and C:

- *an initial interview with the doctor in charge of the prison medical service, which may be supplemented by interviews with other members of the prison medical and health care team;*
- *a visit to all of the establishment's medical facilities (medical consulting rooms, infirmary, etc.) in order to evaluate the manner in which those premises are equipped, and the treatments available;*
- *an examination of a number of medical files, including of a representative "sample" of patients selected by the medical members and of the files of any prisoners identified by non-medical members of the delegation as requiring follow-up or evaluation by a medical member ; in addition, it is suggested that it may be useful to attend several medical consultations, in order to evaluate the manner in which they are carried out (time allocated per patient, type of anamnesis and clinical examination, etc.);*

- *interviews in private with a number of patients (in conjunction with the medical files which have been examined);*
- *a final talk with the doctor in charge of the prison medical service, in particular, to ask supplementary questions;*
- *visits to external medical facilities (a closed ward in a civil hospital, etc.).*

B. In accordance with the CPT's specific mandate, it is appropriate to verify the following aspects as regards screening for *violent* situations:

- Systematic preparation of a traumatic injuries report in the event of allegations of violence (on admission and during time spent in prison);
- Methods of writing reports on traumatic injuries and examining their content (account given by the alleged victim of violence, detailed medical examination, doctor's conclusion);
- Existence of a register in which traumatic injuries reports are recorded (with any statistical record);
- Submission of traumatic injuries reports to an independent authority responsible for investigating the facts (existence of a specific procedure for this purpose);
- Possible use of forensic expert opinions.

C. In addition, as indicated in the 3rd General Report on the activities of the CPT, covering the period 1 January to 31 December 1992 (CPT/Inf (93) 12, par. 30), "*an inadequate level of health care can lead rapidly to situations falling within the scope of the term 'inhuman and degrading treatment'*". Thus, in order to make an effective evaluation of the medical service of the prison visited, attention should be paid to the matters listed below:

1. Organisation of the prison medical service

(out-patient consultations; infirmary and/or prison hospital: cf. item 5 below):

- 1.1. *Medical and paramedical staff numbers* (if possible, request an organisation chart, indicating the number of general practitioners and specialists in internal medicine - "initial contact doctors" - other specialists, in particular in psychiatry, dentist(s), nursing staff, psychotherapist(s), psychologist(s), etc.).
- 1.2. *Hours of presence of medical and paramedical staff*. Existence of an *on-call service* at nights, at weekends and on public holidays (presence of a doctor and/or nurse in the prison).
- 1.3. *Visits to doctors*: access to the "initial contact doctor" (by letter, through a request to the nursing staff or prison officers); operation of the medical emergency system; access to specialists; medical criteria and arrangements for the transfer of prisoners (by ambulance or other vehicle, time required, etc.) to the infirmary or hospital (within the prison or outside). Attendance of dentist, including in emergency cases.
- 1.4. *Nursing care*: organisation (planning of daily activities, regular meetings with the medical staff, etc.);

participation of nursing staff in the distribution of medicines; etc.

- 1.5. *Medical files*: existence of individual files; guarantee of confidentiality (list of persons with access to medical files); arrangements for the transmission of medical data when a prisoner leaves the prison (on transfer to another prison or on release); archiving of medical files.
- 1.6. *Medicines and other treatments*: budget available to guarantee equivalence of care; pharmacy reserves available; supply of medicines; role of the pharmacist; etc.
- 1.7. *Medical service facilities*: number of rooms for visits to doctors and nurses; radiology room; laboratory; dental surgery; operating room (minor surgery); etc.

2. General medical aspects:

- 2.1. *Most frequent pathologies*: morbidity and mortality rates (ask whether there are statistics on the number of medical consultations - possibly classified according to the different specialities - and ask the number and causes of *deaths* which have occurred during the previous calendar year).
- 2.2. *Paraclinical examinations* (blood tests, X-rays): list of examinations systematically carried out on prisoners on their admission (according to the legislation in force) or usually offered on a voluntary basis (based on purely medical criteria).
- 2.3. Compliance with the principles of *consent to medical treatment* and of *confidentiality* (presence of prison officers during medical consultations; transmission of diagnoses to judicial and/or administrative authorities). Modes of transmission of *information*

to inmates (if necessary, using interpreters).

- 2.4. *Treatment*: arrangements for the distribution of medicines; types of treatment available in respect of the different medical specialisations; possibility of prescribing special diets; application of national screening programmes and programmes for the treatment of certain diseases; etc.
- 2.5. *Care for those suffering from chronic complaints* (in particular, management of patients with physical handicaps, mental illness).
- 2.6. *Care for pregnant women*: medical monitoring, maternity ward, etc.
- 2.7. *Care for minors*: assistance of psychologist(s); educational programmes, teachers or apprenticeship supervisors; links with the outside world (families); etc.

3. Specific medical aspects:

- 3.1. *Transmissible diseases* (hepatitis, tuberculosis, AIDS, etc): provision of information, prevention, education, screening, implementation of a national programme; existence of a health education programme for inmates and prison staff; possible discrimination against those suffering from certain illnesses (especially AIDS patients).
- 3.2. *Dependency* (drugs, alcohol, medicines): arrangements for dealing with intoxicated persons and those in the process of withdrawal when they are admitted to prison; existence of rehabilitation programmes for drug addicts with a view to their future release; implementation of national programmes on drug addiction; etc.
- 3.3. *Mental health*: provision for prisoners with psychiatric disorders; identification and management of persons likely to commit suicide; where *cell(s) equipped with means of physical*

restraint exist, admission criteria, length of restraint periods, frequency of supervision by doctor and/or nurse, existence of a register, etc.; existence of electro-convulsive therapy: indications, methods, etc.; administration of psychotherapeutic treatment under restraint: criteria, methods, etc.

- 3.4. *Mothers with children*: medical/social support in the prison (post-natal arrangements, crèche, nursery) and living conditions; medical criteria used to decide whether to separate mother and child and for the decision on child placement.
- 3.5. *Public health aspects*: monitoring of food (daily menus, kitchen inspections) and hygiene (showers and other sanitary facilities), as well as heating, ventilation and lighting (especially in cells); assessment of the consequences of prison overcrowding (exercise in the open air, activities available, area per prisoner available in the cells; etc).

4. Prison medical aspects:

- 4.1. *Medical examination on admission to prison*: delay as compared to admission to prison; evaluation carried out by medical and/or nursing staff; types of examination carried out (clinical examination, blood test(s), radiography, etc.); steps to ensure continuity of care ; etc.
- 4.2. *Hunger strikes*: medical supervision of prisoners on hunger strike; criteria for their transfer to hospital; information about changes in health transmitted to the authority concerned; in case of forced feeding: indication of legal basis, conditions and practical arrangements.
- 4.3. Access to prisoners subject to *solitary confinement* or housed in *top security areas*.

- 4.4. *Humanitarian assistance*: medical provision for "particularly vulnerable" persons, especially the elderly, the disabled, children living with their imprisoned mothers and the terminally ill; possible intercession by the doctor with the authority concerned to make arrangements for prisoners who are seriously or terminally ill (suspension of sentence, early release, transfer to an appropriate care facility, etc).
- 4.5. *Interface between the prison medical service and external health services*; follow-up care after leaving prison; involvement of social workers, etc.

5. Prison infirmary and/or hospital:

- 5.1. Numbers of medical and paramedical staff, working hours; organisation of the care provided by doctors and nurses; most frequent medical and surgical cases; morbidity and mortality rates (request statistics showing the number of patients admitted to hospital in the previous calendar year, types of pathologies, number of deaths and their causes); provision for patients with psychiatric disorders: existing therapies, administration of psychotherapeutic care under restraint (criteria, methods, etc.), existence of electroconvulsive therapy (criteria, methods, etc.); existence of cell(s) equipped with means of physical restraint (cf. "Mental health", in item 3 above); types of premises available (operating theatres, X-ray equipment, etc); number of patients' rooms and the capacity of each; patients' living conditions (food, exercise, activities, visits, etc); available budget for ensuring the equivalence of care; professional status of medical and nursing staff (independence, in-service training); etc.

6. Outside civilian medical facilities available to prisoners:

- 6.1. Names of outside civilian hospitals which receive prisoners; criteria and arrangements for the transfer of patients to such establishments; security arrangements (prison officers outside the room door or inside the room, presence of prison staff during doctors' visits; situation of handcuffed prisoners; etc); reception and living conditions of prisoner-patients; etc.

7. Professional status of medical and paramedical staff working in prisons:

- 7.1. *Training* of medical and paramedical staff: access to in-service training programmes and/or to further training in prison medicine, etc.
- 7.2. *Administrative responsibility* for medical and paramedical staff (Ministry of Health or Justice) and the *independence* of such staff; *authority responsible for supervising* the professional work of the prison medical service (and that of the other care facilities: prison infirmary, hospital); responsibility for the *overall management of the budget* of the prison medical service.
- 7.3. *Relations between medical and paramedical staff and the authorities* (judicial, administrative and prison): distinction between the role of the patient's doctor and that of the medical expert; participation of care staff in intimate body searches; role of the prison doctor in respect of disciplinary sanctions; etc.

Health care services in prisons: principles and recommendations defined by the CPT

Extract of the CPT's 3rd General Report [Ref.: CPT/Inf(93) 12; 4 June 1993]

30. Health care services for persons deprived of their liberty is a subject of direct relevance to the CPT's mandate. An inadequate level of health care can lead rapidly to situations falling within the scope of the term "inhuman and degrading treatment". Further, the health care service in a given establishment can potentially play an important role in combatting the infliction of ill-treatment, both in that establishment and elsewhere (in particular in police establishments). Moreover, it is well placed to make a positive impact on the overall quality of life in the establishment within which it operates.

31. In the following paragraphs, some of the main issues pursued by CPT delegations when examining health care services within prisons are described. However, at the outset the CPT wishes to make clear the importance which it attaches to the general principle - already recognised in most, if not all, of the countries visited by the Committee to date - that prisoners are entitled to the same level of medical care as persons living in the community at large. This principle is inherent in the fundamental rights of the individual.

32. The considerations which have guided the CPT during its visits to prison health care services can be set out under the following headings:

- a. Access to a doctor
- b. Equivalence of care
- c. Patient's consent and confidentiality
- d. Preventive health care
- e. Humanitarian assistance
- f. Professional independence
- g. Professional competence.

a. Access to a doctor

33. When entering prison, all prisoners should without delay be seen by a member of the establishment's health care service. In its reports to date the CPT has recommended that every newly arrived prisoner be properly interviewed and, if necessary, physically examined by a medical doctor as soon as possible after his admission. It should be added that in some countries, medical screening on arrival is carried out by a fully qualified nurse, who reports to a doctor. This latter approach could be considered as a more efficient use of available resources.

It is also desirable that a leaflet or booklet be handed to prisoners on their arrival, informing them of the existence and operation of the health care service and reminding them of basic measures of hygiene.

34. While in custody, prisoners should be able to have access to a doctor at any time, irrespective of their detention regime (as regards more particularly access to a doctor for prisoners held in solitary confinement, see paragraph 56 of the CPT's 2nd General Report: CPT/Inf (92) 3). The health care service should be so organised as to enable requests to consult a doctor to be met without undue delay.

Prisoners should be able to approach the health care service on a confidential basis, for example, by means of a message in a sealed envelope. Further, prison officers should not seek to screen requests to consult a doctor.

35. A prison's health care service should at least be able to provide regular out-patient consultations and emergency treatment (of course, in addition there may often be a hospital-type unit with beds). The services of a qualified dentist should be available to

every prisoner. Further, prison doctors should be able to call upon the services of specialists.

As regards emergency treatment, a doctor should always be on call. Further, someone competent to provide first aid should always be present on prison premises, preferably someone with a recognised nursing qualification.

Out-patient treatment should be supervised, as appropriate, by health care staff; in many cases it is not sufficient for the provision of follow-up care to depend upon the initiative being taken by the prisoner.

36. The direct support of a fully-equipped hospital service should be available, in either a civil or prison hospital.

If recourse is had to a civil hospital, the question of security arrangements will arise. In this respect, the CPT wishes to stress that prisoners sent to hospital to receive treatment should not be physically attached to their hospital beds or other items of furniture for custodial reasons. Other means of meeting security needs satisfactorily can and should be found; the creation of a custodial unit in such hospitals is one possible solution.

37. Whenever prisoners need to be hospitalised or examined by a specialist in a hospital, they should be transported with the promptness and in the manner required by their state of health.

b. Equivalence of care

i) general medicine

38. A prison health care service should be able to provide medical treatment and nursing care, as well as appropriate diets, physiotherapy, rehabilitation or any other necessary special facility, in conditions comparable to those enjoyed by patients in the outside community. Provision in terms of medical, nursing and technical staff, as well as premises, installations and equipment, should be geared accordingly.

There should be appropriate supervision of the pharmacy and of the distribution of medicines. Further, the preparation of

medicines should always be entrusted to qualified staff (pharmacist/nurse, etc.).

39. A medical file should be compiled for each patient, containing diagnostic information as well as an ongoing record of the patient's evolution and of any special examinations he has undergone. In the event of a transfer, the file should be forwarded to the doctors in the receiving establishment.

Further, daily registers should be kept by health care teams, in which particular incidents relating to the patients should be mentioned. Such registers are useful in that they provide an overall view of the health care situation in the prison, at the same time as highlighting specific problems which may arise.

40. The smooth operation of a health care service presupposes that doctors and nursing staff are able to meet regularly and to form a working team under the authority of a senior doctor in charge of the service.

ii) psychiatric care

41. In comparison with the general population, there is a high incidence of psychiatric symptoms among prisoners. Consequently, a doctor qualified in psychiatry should be attached to the health care service of each prison, and some of the nurses employed there should have had training in this field.

The provision of medical and nursing staff, as well as the layout of prisons, should be such as to enable regular pharmacological, psychotherapeutic and occupational therapy programmes to be carried out.

42. The CPT wishes to stress the role to be played by prison management in the early detection of prisoners suffering from a psychiatric ailment (eg. depression, reactive state, etc.), with a view to enabling appropriate adjustments to be made to their environment. This activity can be encouraged by the provision of appropriate health training for certain members of the custodial staff.

43. A mentally ill prisoner should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff. That facility could be a civil mental hospital or a specially equipped psychiatric facility within the prison system.

On the one hand, it is often advanced that, from an ethical standpoint, it is appropriate for mentally ill prisoners to be hospitalised outside the prison system, in institutions for which the public health service is responsible. On the other hand, it can be argued that the provision of psychiatric facilities within the prison system enables care to be administered in optimum conditions of security, and the activities of medical and social services intensified within that system.

Whichever course is chosen, the accommodation capacity of the psychiatric facility in question should be adequate; too often there is a prolonged waiting period before a necessary transfer is effected. The transfer of the person concerned to a psychiatric facility should be treated as a matter of the highest priority.

44. A mentally disturbed and violent patient should be treated through close supervision and nursing support, combined, if considered appropriate, with sedatives. Resort to instruments of physical restraint shall only very rarely be justified and must always be either expressly ordered by a medical doctor or immediately brought to the attention of such a doctor with a view to seeking his approval. Instruments of physical restraint should be removed at the earliest possible opportunity. They should never be applied, or their application prolonged, as a punishment.

In the event of resort being had to instruments of physical restraint, an entry should be made in both the patient's file and an appropriate register, with an indication of the times at which the measure began and ended, as well as of the circumstances of the case and the reasons for resorting to such means.

c. Patient's consent and confidentiality

45. Freedom of consent and respect for confidentiality are fundamental rights of the individual. They are also essential to the atmosphere of trust which is a necessary part of the doctor/patient relationship, especially in prisons, where a prisoner cannot freely choose his own doctor.

i) patient's consent

46. Patients should be provided with all relevant information (if necessary in the form of a medical report) concerning their condition, the course of their treatment and the medication prescribed for them. Preferably, patients should have the right to consult the contents of their prison medical files, unless this is inadvisable from a therapeutic standpoint.

They should be able to ask for this information to be communicated to their families and lawyers or to an outside doctor.

47. Every patient capable of discernment is free to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances which are applicable to the population as a whole.

A classically difficult situation arises when the patient's decision conflicts with the general duty of care incumbent on the doctor. This might happen when the patient is influenced by personal beliefs (eg. refusal of a blood transfusion) or when he is intent on using his body, or even mutilating himself, in order to press his demands, protest against an authority or demonstrate his support for a cause.

In the event of a hunger strike, public authorities or professional organisations in some countries will require the doctor to intervene to prevent death as soon as the patient's consciousness becomes seriously impaired. In other countries, the rule is to leave clinical decisions to the doctor in charge, after he has sought advice and weighed up all the relevant facts.

48. As regards the issue of medical research with prisoners, it is clear that a very cautious approach must be followed, given the risk of prisoners' agreement to participate being influenced by their penal situation. Safeguards should exist to ensure that any prisoner concerned has given his free and informed consent.

The rules applied should be those prevailing in the community, with the intervention of a board of ethics. The CPT would add that it favours research concerning custodial pathology or epidemiology or other aspects specific to the condition of prisoners.

49. The involvement of prisoners in the teaching programmes of students should require the prisoners' consent.

ii) confidentiality

50. Medical secrecy should be observed in prisons in the same way as in the community. Keeping patients' files should be the doctor's responsibility.

51. All medical examinations of prisoners (whether on arrival or at a later stage) should be conducted out of the hearing and - unless the doctor concerned requests otherwise - out of the sight of prison officers. Further, prisoners should be examined on an individual basis, not in groups.

d. Preventive health care

52. The task of prison health care services should not be limited to treating sick patients. They should also be entrusted with responsibility for social and preventive medicine.

i) hygiene

53. It lies with prison health care services - as appropriate acting in conjunction with other authorities - to supervise catering arrangements (quantity, quality, preparation and distribution of food) and conditions of hygiene (cleanliness of clothing and bedding; access to running water; sanitary installations) as well as the heating, lighting and ventilation of cells. Work and outdoor exercise arrangements should also be taken into consideration.

Insalubrity, overcrowding, prolonged isolation and inactivity may necessitate either medical assistance for an individual prisoner or general medical action vis-à-vis the responsible authority.

ii) transmittable diseases

54. A prison health care service should ensure that information about transmittable diseases (in particular hepatitis, AIDS, tuberculosis, dermatological infections) is regularly circulated, both to prisoners and to prison staff. Where appropriate, medical control of those with whom a particular prisoner has regular contact (fellow prisoners, prison staff, frequent visitors) should be carried out.

55. As regards more particularly AIDS, appropriate counselling should be provided both before and, if necessary, after any screening test. Prison staff should be provided with ongoing training in the preventive measures to be taken and the attitudes to be adopted regarding HIV-positivity and given appropriate instructions concerning non-discrimination and confidentiality.

56. The CPT wishes to emphasise that there is no medical justification for the segregation of an HIV+ prisoner who is well.

iii) suicide prevention

57. Suicide prevention is another matter falling within the purview of a prison's health care service. It should ensure that there is an adequate awareness of this subject throughout the establishment, and that appropriate procedures are in place.

58. Medical screening on arrival, and the reception process as a whole, has an important role to play in this context; performed properly, it could identify at least certain of those at risk and relieve some of the anxiety experienced by all newly-arrived prisoners.

Further, prison staff, whatever their particular job, should be made aware of (which implies being trained in recognising) indications of suicidal risk. In this connection it should be noted that the periods immediately before and after trial and, in some cases, the pre-release period, involve an increased risk of suicide.

59. A person identified as a suicide risk should, for as long as necessary, be kept under a special observation scheme. Further, such persons should not have easy access to means of killing themselves (cell window bars, broken glass, belts or ties, etc).

Steps should also be taken to ensure a proper flow of information - both within a given establishment and, as appropriate, between establishments (and more specifically between their respective health care services) - about persons who have been identified as potentially at risk.

iv) prevention of violence

60. Prison health care services can contribute to the prevention of violence against detained persons, through the systematic recording of injuries and, if appropriate, the provision of general information to the relevant authorities. Information could also be forwarded on specific cases, though as a rule such action should only be undertaken with the consent of the prisoners concerned.

61. Any signs of violence observed when a prisoner is medically screened on his admission to the establishment should be fully recorded, together with any relevant statements by the prisoner and the doctor's conclusions. Further, this information should be made available to the prisoner.

The same approach should be followed whenever a prisoner is medically examined following a violent episode within the prison (see also paragraph 53 of the CPT's 2nd General report: CPT/Inf (92) 3) or on his readmission to prison after having been temporarily returned to police custody for the purposes of an investigation.

62. The health care service could compile periodic statistics concerning injuries observed, for the attention of prison management, the Ministry of Justice, etc.

v) social and family ties

63. The health care service may also help to limit the disruption of social and family ties which usually goes hand in hand with imprisonment. It should support - in association with the relevant social services - measures that foster prisoners' contacts with the outside world, such as properly-equipped visiting areas, family or spouse/partner visits under appropriate conditions, and leaves in family, occupational, educational and socio-cultural contexts.

According to the circumstances, a prison doctor may take action in order to obtain the grant or continued payment of social insurance benefits to prisoners and their families.

e. Humanitarian assistance

64. Certain specific categories of particularly vulnerable prisoners can be identified. Prison health care services should pay especial attention to their needs.

i) mother and child

65. It is a generally accepted principle that children should not be born in prison, and the CPT's experience is that this principle is respected.

66. A mother and child should be allowed to stay together for at least a certain period of time. If the mother and child are together in prison, they should be placed in conditions providing them with the equivalent of a creche and the support of staff specialised in post-natal care and nursery nursing.

Long-term arrangements, in particular the transfer of the child to the community, involving its separation from its mother, should be decided on in each individual case in the light of pedo-psychiatric and medico-social opinions.

ii) adolescents

67. Adolescence is a period marked by a certain reorganisation of the personality, requiring a special effort to reduce the risks of long-term social maladjustment.

While in custody, adolescents should be allowed to stay in a fixed place, surrounded by personal objects and in socially favourable groups. The regime applied to them should be based on intensive activity, including socio-educational meetings, sport, education, vocational training, escorted outings and the availability of appropriate optional activities.

iii) prisoners with personality disorders

68. Among the patients of a prison health care service there is always a certain proportion of unbalanced, marginal individuals who have a history of family traumas, long-standing drug addiction, conflicts with authority or other social

misfortunes. They may be violent, suicidal or characterised by unacceptable sexual behaviour, and are for most of the time incapable of controlling or caring for themselves.

69. The needs of these prisoners are not truly medical, but the prison doctor can promote the development of socio-therapeutic programmes for them, in prison units which are organised along community lines and carefully supervised.

Such units can reduce the prisoners' humiliation, self-contempt and hatred, give them a sense of responsibility and prepare them for reintegration. Another direct advantage of programmes of this type is that they involve the active participation and commitment of the prison staff.

iv) prisoners unsuited for continued detention

70. Typical examples of this kind of prisoner are those who are the subject of a short-term fatal prognosis, who are suffering from a serious disease which cannot be properly treated in prison conditions, who are severely handicapped or of advanced age. The continued detention of such persons in a prison environment can create an intolerable situation. In cases of this type, it lies with the prison doctor to draw up a report for the responsible authority, with a view to suitable alternative arrangements being made.

f. Professional independence

71. The health-care staff in any prison is potentially a staff at risk. Their duty to care for their patients (sick prisoners) may often enter into conflict with considerations of prison management and security. This can give rise to difficult ethical questions and choices. In order to guarantee their independence in health-care matters, the CPT considers it important that such personnel should be aligned as closely as possible with the mainstream of health-care provision in the community at large.

72. Whatever the formal position under which a prison doctor carries on his activity, his clinical decisions should be governed only by medical criteria.

The quality and the effectiveness of medical work should be assessed by a qualified medical authority. Likewise, the available resources should be managed by such an authority, not by bodies responsible for security or administration.

73. A prison doctor acts as a patient's personal doctor. Consequently, in the interests of safeguarding the doctor/patient relationship, he should not be asked to certify that a prisoner is fit to undergo punishment. Nor should he carry out any body searches or examinations requested by an authority, except in an emergency when no other doctor can be called in.

74. It should also be noted that a prison doctor's professional freedom is limited by the prison situation itself: he cannot freely choose his patients, as the prisoners have no other medical option at their disposal. His professional duty still exists even if the patient breaks the medical rules or resorts to threats or violence.

g. Professional competence

75. Prison doctors and nurses should possess specialist knowledge enabling them to deal with the particular forms of prison pathology and adapt their treatment methods to the conditions imposed by detention.

In particular, professional attitudes designed to prevent violence - and, where appropriate, control it - should be developed.

76. To ensure the presence of an adequate number of staff, nurses are frequently assisted by medical orderlies, some of whom are recruited from among the prison officers. At the various levels, the necessary experience should be passed on by the qualified staff and periodically updated.

Sometimes prisoners themselves are allowed to act as medical orderlies. No doubt, such an approach can have the advantage of providing a certain number of prisoners with a useful job. Nevertheless, it should be seen as a last resort. Further, prisoners should never be involved in the distribution of medicines.

77. Finally, the CPT would suggest that the specific features of the provision of health care in a prison environment may justify the introduction of a recognised professional speciality, both for doctors and for nurses, on the basis of postgraduate training and regular in-service training.