

# Genitourinary medicine and surgery in prisons during the period of reform

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## INTRODUCTION

Prison reform in England began in the 1770s; before that prisoners could obtain medical attention at their own expense or, if they were lucky, funded by the authorities: 'In 1674, a Dr Hodges was paid 10 pounds: "to inform himself of the gravity of the distemper in Wood Street compter (*an archaic term for a prison*)", and approval was granted for settlement of an apothecary's bill for certain medicines used in treating the disease'. The city aldermen also paid £10: 'for his care of the prisoners in the compter' [1]. In 1735 the treasurers' accounts at Norwich castle gaol show a payment to 'Mr Thomas Ekins Surgeon, his Bill for the Cure of Mary Stephenson a poor prisoner by order £3.3s' [2]. However, it was not until reform was established in the late 18th century that more formal provision of medical care was made available, and even then its quality was very variable. The main reason for this was that until the second half of the 19th century there was little centralized control of the prison system; institutions were funded and managed at local level. In 1795 Dr John Mason Good did his best to sum up the gallimaufry:

'In modern times, the buildings allotted for the reception of prisoners and the poor, and especially in this kingdom, are of such various forms, dimensions, materials and situations, with strange diversities of customs and rules, that it is almost impossible to arrange them into regular and appropriate classes. In general however, they consist of old castles, barns or monasteries, purchased by the county or district for this purpose. Sometimes, however, they are the gift of individuals, as at SHEFFIELD, where there is a prison which was granted by the Duke of Norfolk for the confinement of debtors; and sometimes they are still private property, and subject to an annual rent for occupation: instances of which are to be found at the MARSHALSEA prison, which belongs to four landlords, and is farmed out at one hundred guineas per year' [3].

With reform came new prisons, the best of which were in the county towns, built under the auspices of, and administered by, county magistrates, many of whom were local landed gentry. John Howard, promoter of parliamentary bills allowing reform, was keenly concerned with health matters:

'I beheld in many of them [the houses of correction and city and town gaols], as well as in the *County-Gaols*, a complication of distress: but my attention was principally fixed by the *gaol-fever*, and the *small-pox*, which I saw prevailing to the destruction of multitudes, not only of *felons* in their dungeons, but of *debtors* also. [...] These effects are now so notorious, that what terrifies most of us from looking into prisons, is the *gaol distemper* so frequent in them' [4].

The solutions advocated by Howard and other reformers (many of them physicians) were that prisoners should be kept separated in well-ventilated cells, rather than confined in communal wards as formerly; and Magistrates were allowed to appoint 'an experienced Surgeon or Apothecary [...] a man of repute in his profession' to attend the prison. He should be paid from the rates; one of his duties would be to report to the justices on prisoners' health. He was to order removal of the sick to the infirmary where they would receive appropriate medication and diet, and fetters would be cut off [5].

Surgeons were the GPs of the day and were completely distinct from physicians, the latter being university educated with the degree of MD. A contemporary description (by a surgeon) reads: 'The physician, in those days, was distinguished from the common mass by an imposing exterior – He moved in a measured step and affected a meditating abstraction of countenance, with a pomposity of diction and manner which served to keep the vulgar at a respectable distance' [6]. Surgeons, significantly lower in the social scale, were more closely involved with *hoi polloi*; for instance using dialect terms in their

journals. Thus James Pearson Langshaw at Lancaster Castle Gaol wrote: 'Some of the Men decline their Gruel because it is slightly bishoped' (8 February 1848) [7]. In north Lancashire 'to bishop' is to burn, the term dating from the 16th century, a time when the local people could not but notice the bishops' enthusiasm for burning at the stake those who disagreed with them.

Surgeons were typically grammar-school products with some Latin and a little Greek, receiving most of their medical education by means of an apprenticeship, often with a family member. This was usually followed by pupillage to a hospital surgeon and attendance at privately run courses providing instruction in a variety of medically related subjects [8]. The 1815 Apothecaries Act introduced a degree of uniformity, requiring 5-year apprenticeships, attendance at courses of lectures (in anatomy, physiology, theory and practice of medicine, *materia medica*, and chemistry), 6 months' attendance at a hospital or dispensary, and then passing the (oral) examination for licentiate of the Society of Apothecaries (LSA) [9]. In addition to the LSA it was usual to obtain the diploma of member of the Royal College of Surgeons (MRCS) [10]. Clearly in this system, the quality of training depended largely on the quality of the apprenticeship; given a tutor who took his responsibilities seriously the average surgeon, already well educated in a general sense, acquired a good grasp of such medical knowledge as was available in the period [11]. Despite the designation 'surgeon', most carried out few operations beyond such emergency procedures as setting broken limbs, reducing dislocations, opening abscesses, or pulling teeth; the basis of their work was general practice, which usually included midwifery. A lucrative part of their work was the making of, and selling, pills and potions, mostly of herbal origin. The more ambitious embarked on further training, obtained a hospital post with the opportunity to carry out the full range of surgical procedures then undertaken, and eventually

became fellows of the Royal College of Surgeons.

Prison work was part-time, the reward depending on the size of the gaol. Fairly typical was the salary at Gloucester County gaol, which at times held over 200 prisoners, i.e. £38 (plus £5 for the care of poor debtors) in 1791, £60 in 1817, £100 in 1843 and £180 in 1845, the rises to a large extent reflecting an increasing prison population. In the second half of the 18th century the average rural surgeon/apothecary could expect to earn about £400 per annum in mid-career, but from 1815 onwards an over-supply of practitioners resulted in lower earnings, perhaps £150–250 in the country and £300–500 in a town [12]. The income from any prison work had to be offset against the cost of medicines, which were usually provided from the salary, and could make considerable inroads, as the prison inspector noted at Peterborough city gaol (a small prison):

'The surgeon's salary is inadequate. He attends and finds the medicines both here and at the house of correction, for 15 guineas a year. He informs me that during this year (1835) a case of low fever occurred at the House of Correction which lasted between two and three weeks, requiring daily attention and medicines. This single case swallowed up his little remuneration' [13]. Only later (starting with the opening of Millbank National Penitentiary in 1816) were full-time medical officers employed in prisons.

Despite Howard's concern with gaol fever (usually typhus, but a catch-all diagnosis for any severe, potentially lethal fever) and smallpox, prison surgeons spent most of their time dealing with minor complaints of which 'The Itch' (scabies) and trivial gastrointestinal disturbances were the most common [14]. Among other complaints, venereal diseases ranked high in frequency and problems relating to the urinary tract were not uncommon. In the Gloucestershire prisons, when the nature of venereal disease was specified, gonorrhoea (some of which must have been the then-unrecognized nonspecific urethritis) was the most common, followed by primary syphilis (sometimes the two together), with an occasional case of secondary syphilis, venereal warts or even venereal ophthalmia (22 June 1835 Gloucester city gaol [15]). Some cases diagnosed as syphilis were probably chancroid (not recognized until much later, in 1889).

Comments in the journals kept by surgeons reflect the extent of the problem. William Vann Hadwen at Northleach House of Correction wrote: 'Venereal cases [ . . . ] more common this quarter' (16 October 1826); and: 'a large increase in venereal cases in the past three months, the chief part of them committed from Cheltenham' (28 November 1833). The sufferers were often regular cases. 'Elizabeth Stevens is again in the Bridewell [an alternative name for a house of correction] and is diseased as usual. It is not more than four and a half months since she left this place completely cured of Syphilis and is now as bad as ever. Ordered Medicines' (21 March 1832); and: 'Elizabeth Stevens, an incorrigible old prostitute is again in the Bridewell and as usual has Syphilis' (8 November 1834). Sometimes there is a note of sadness. 'Eliza Jones has Gonorrhoea. This girl is now only 17 years of age and this is the third time she has been here with the same Disease in rather more than two years' (2 December 1833). An excuse, presumably offered more in hope than in the expectation of its being believed, seems to have been taken at face value: 'Fereby has Gonorrhoea caught by inoculation from matter left on the seat of the privy' (10 November 1827) [16]. A particularly nasty case is mentioned at Norwich Castle gaol: '[name illegible] has the Venereal in the most malignant form and is in great danger from Mortification of the Penis' (27 September 1845) [17]. The treatment (where specified) of syphilis was with mercury, probably in the form of mercurous chloride (calomel), which was also sometimes used in small amounts for worms, skin disease and other ailments, particularly for diarrhoea. Mercury had been used medicinally since the 16th century and was still recommended (in the form of calomel) in medical textbooks of the 1920s [18]. Although often used in gonorrhoea, an awareness of its lack of value in this condition existed [19]. The treatment was usually discontinued when salivation started. When William Vann Hadwen stated: 'The Venereal cases (as usual) have been very numerous but I have much pleasure in stating that they all (I believe without exception) left the prison cured' (8 January 1827), he was unduly optimistic given the available therapeutic armory. Doubtless symptoms subsided and certainly patients were sufficiently content that it was common to engineer commitment to prison purely for treatment. An instance was reported at Northleach: 'I have just been to see Michael Kirwin who has venereal disease very bad and he tells me he got

committed on purpose to get it cured. I have given him the proper remedies' (13 May 1837) [20]. Also the surgeon at York county gaol stated:

'The women who are committed as vagrants almost invariably come in with the venereal disease, and most probably for the purpose of being cured, as they are not admissible into the public infirmaries: they are sent in for one month, and in the state they are, generally remain in hospital until they are discharged' [21]. (Most hospitals refused to treat venereal patients without payment. Later, 'Lock', a term descended from the old lazar houses, wards in naval towns were paid for by the Admiralty).

Where there is gonorrhoea, urethral strictures will follow; unsurprisingly these provided work for prison surgeons. C.J. Phillips at Littledean house of correction (Gloucestershire) was luckier than he realized to get away with the following intervention:

'Mr Parsons [previously treated for venereal disease] generally better, complaining of difficulty in passing his Water, examined him with a Bougie and found him to be strictured' (25 January 1826): Mr Parsons considerably better as to the Venereal disease but labouring under hydrocoele and Dropsy of the Scrotum [ . . . ] action may be necessary, [*presumably tapping the hydrocele, a quite common procedure*] but at present I do not consider it in a fit Shape (10 February 1826). Mr Parsons being seized with shivering, succeeded by fever in the course of yesterday [ . . . ]

(11 February 1826).

Clearly Mr Parsons suffered a urethral perforation followed by urinary extravasation and bacteraemia, but he survived. Other surgeons experienced familiar-sounding problems. At Norwich: 'but after considerable difficulty I have passed Bougies into his bladder, the only means that can be employed in such cases' (17 January 1846) [22]; and at Gloucester city gaol, Mr Parker went in at night and 'after a considerable time' passed an instrument into the bladder in a case of retention, whilst on the following night: 'I was with him an hour and a half when I succeeded in getting an instrument into his bladder' (30 September and 1 October 1835) [23]. Less fortunate was a 48-year-old at Millbank penitentiary, known to have a stricture, who died on 8 December 1848 from: 'fever and ruptured urethra' [24]. Spontaneous rupture

of the urethra is rare, so this death probably followed a bouginage. Similarly, in 1832 there was a death at York castle county gaol from 'Spacelus [sic] of the Scrotum, from long continued Stricture. A very old man' [25].

Elective procedures were rare in prisons (and indeed were actively discouraged by the inspectors) but the surgeon at Devizes house of correction is recorded as having performed a castration [26]. There was even what seems to have been an early example of the practice of intermittent self-catheterization: 'I have directed Mr Jeffs [the governor] to allow the latter [Thompson, a venereal patient] to receive some catheters he has been in the habit of using' (Gloucester City gaol, 4 April 1832) [27].

Children and juveniles were quite commonly imprisoned (in the years 1843–1847, at Littledean house of correction 4% of those imprisoned were under the age of 14 [28]), so unsurprisingly there were cases of nocturnal enuresis, particularly so at Lancaster Castle gaol. There, blistering was the treatment of choice, as in: 'Langton wets the bed again, he will require another blister or two' (5 May 1847). In another instance, despite its being effective, blistering did not gain the patient's approbation: 'Butterworth [a juvenile bed-wetter] is cured, he does not like the blistering system' (3 May 1844) [29].

Skills regarding the differential diagnosis of haematuria were required at Norwich Castle gaol. Prisoner Thomas Sizer had been under the care of the surgeon (Mr Scott) on 8 April 1826 and was then transferred to the Norfolk and Norwich Hospital (no details are known of this episode). Seventeen years later, on 30 April 1843, Scott saw the newly imprisoned Sizer again: '[. . .] in a very precarious state and he passes a large quantity of blood in his urine.' A week later he was still in a precarious state and consultations were held both with Alfred Master (another surgeon of Norwich who frequently deputized for Mr Scott) and Mr J.G. Crosse. The latter had made the transition from GP/surgeon to consultant surgeon at the Norfolk and Norwich Hospital, and went on to win the Jacksonian prize of the Royal College of Surgeons for his treatise on bladder stone [30]. He wrote: 'Having learnt of the deception practised by this Man when he was confined in the Jail 18 years ago, and having examined fully into the history and present symptoms of the Bleeding from the Urethra, under which he now suffers, I

entertain a strong suspicion that *the passage* has been intentionally lacerated and the blood has been produced thereby – were urine to get into the wounded part and become diffused, his case might quickly become dangerous, but such an evil being avoided and further injury by the patient's hands being prevented, healing might take place.'

The evil was avoided and although Sizer had another episode of haematuria he was able to leave the prison hospital on 19 May [31]. Feigned and factitious illness was common because, as was reported from Warwick County house of correction: 'There is no situation in life in which it becomes so strongly the interest of an individual to feign or to prolong sickness as here' [32]. The principal incentive was a desire to avoid labour on the tread-wheel but another reason can be inferred from James Neild's description of the facilities (which were good but not atypical) at Ipswich Town and Borough gaol where: 'The Infirmarys have iron-framed and latticed wooden bedsteads, with a mattress to each, two blankets, two sheets, and a coverlet, and the sick are well supplied with suitable food, and wine, if necessary, at the discretion of the surgeon' [33].

My comprehensive study of medical care in English prisons (1770–1850) has provided a favourable impression of both the level of education of the surgeons supplying this care, and of the generally high quality of their work. Most prisoners came from the lowest echelons of society for whom normally medical care was expensive and consequently, elusive. When imprisoned they usually received better medical attention than they could have hoped to receive at liberty, and the available statistics suggest prison mortality rates were no higher (possibly even lower) than amongst comparable cohorts of the general population. Most images of prisons in this period as squalid and unhealthy slums are at variance with the facts I report [34].

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#### CONFLICT OF INTEREST

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