7 weeks in HMP Bristol with the prison GPs

This Autumn, I was lucky enough to spend some time shadowing the prison GPs at Horfield Prison in Bristol. It's a category B prison- so lots of the patients are unsentenced, or on remand- so they don't stay very long- either they go back into the community, or they get moved onto a different prison. With the prison GP, I did normal general practice clinics, with two emergency slots each session, care & separation (segregation/seg) rounds, and substance misuse rounds on the wings.

Prisoners, legally, are entitled to the same quality of healthcare as those in the community. There's chronic underfunding and understaffing of prison healthcare services, so despite the intention to provide equivalent services, prisoners face "poorer health outcomes, including excess mortality".[1] A report from January 2024 discussed the median age of death in prisoners- 67.5 years, vs 86.7 years in the general population.[2]

HMP Bristol itself has had safety issues raised in its recent inspection reports. In 2023, there was an urgent notification from the chief inspector of prisons, which noted that HMP Bristol was one of the most unsafe prisons in the country, with some of the highest levels of violence, self-harm and suicide in the country. [3] There was a follow-up report in 2024, which reported improvements in some areas- but not in safety.[4]

HMP Bristol is a Victorian prison, with cells originally designed for one prisoner. Most of these cells (pads) now hold two prisoners. It has a problem with overcrowding, it has rats all over the site, and there is a huge illicit drug issue. Mental health outcomes are low, not least because "the majority of prisoners [are] locked up for 22 hours a day".[5] I saws severely ill patients, floridly psychotic men who, while waiting for mental health beds, were being isolated from the general prison population in the 'care & separation unit' (the seg) for weeks, or months, at a time. Their mental health would often deteriorate in isolation. An IMB review in 2024 reported that all over the country, challenging behaviour was being managed with isolation. Unwell men sometimes spent hundreds of days in separation units.[6]

Therefore, prison GPs have a difficult job. As part of healthcare, GPs work alongside the prison (i.e. prison management, officers, governors), but they don't work 'together'. The two ultimately have different management, different methods, and ultimately, different goals. I quickly learnt that in prison healthcare, there is a lot of negotiation and compromise.

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[1] McLintock, K. and Sheard, L. (2024) Prison healthcare in England and Wales is in perpetual crisis, The BMJ. Available at: https://www.bmj.com/content/384/bmj.q562

[2] Lacobucci, G. (2024) Prisoners die from natural causes 20 years earlier than the general population, finds review, The BMJ. Available at: https://www.bmj.com/content/384/bmj.q198

[3] HMP Bristol Urgent Notification (2023) HM Inspectorate of Prisons. Available at: https://hmiprisons.justiceinspectorates.gov.uk/hmipris_reports/hmp-bristol-urgent-notification/

[4] HMP Bristol Inspection Report (2024) HM Inspectorate of Prisons. Available at: https://hmiprisons.justiceinspectorates.gov.uk/hmipris_reports/hmp-bristol-3/

[5] HMP Bristol Urgent Notification (2023)

[6] Mental health crisis forces prisoners into inhumane isolation (2024) Independent Monitoring Boards. Available at: https://imb.org.uk/news/mental-health-crisis-forces-prisoners-into-inhumane-is

For example, we relied on officers (runners) to bring our patients to clinic. They often would arrive late, leave early, and fail to find the patients. While prisoners do have access to GPs, sometimes easier than in the community (the waiting list was about 8 weeks), they have limited access to external healthcare, including hospital appointments. The officers have capacity for about two external appointments a day for the entire prison- but that also includes emergency appointments. Thus, vital healthcare could often be delayed or cancelled at short notice. Prisoners, again and again, were denied the chance to get better.

I had never felt the divide so strongly when, a week into the placement, we received a 'code red' – regarding a man (a wheelchair user) who's fingers had been slammed in a prison door by an officer, causing a complete amputation of one of his fingertips. I felt somewhat righteously (and internally) angry- here was a tiny microcosm of the prison; violent, restrictive, discriminatory. The officers had caused harm to our patient. And healthcare were there to fix it (or rather, to stem the bleeding and organise an ambulance).

The majority of consultations I saw were opiate substitution therapy (OST) based. Bristol prison has a huge drug problem.[7] I learnt so much about how important OST is, both in prisons and in the community- the research shows quite clearly that opiate substitution therapy reduces drug deaths, illicit drug demand, and reduces/prevents withdrawal symptoms.[8] OST is also (legally) risky for the doctor prescribing it. We had to deal with a lot of UTI (under the influence) events. If the prisoners were using illicitly on top of their methadone (opiate substitute) prescriptions, we would have to reduce their dose of methadone. It's all because of risk management and custody rules. I think I was more interested in the rules around gabapentinoid prescribing.

I met a man who had been recommended pregabalin for his back pain by a physiotherapist. He was utterly focused on that medication- he wouldn't accept anything that wasn't pregabalin. I could get where he was coming from- to him, the physiotherapist was the expert. This was something that might help his pain.

In custody, the rules are different than in the community. The risks and side effects of gabapentinoids can be severe, especially if combined with opiates, as well as the massive 'street value' of the drug- all of this means that in HMP Bristol, there are only about 5 patients who are prescribed pregabalin. They can only have it with a recent letter from a pain management specialist. If inmates come into prison on pregabalin prescribed by their community GP, they will be supported with a detox as soon as possible, usually by about 50mg/week.

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[7] HMP Bristol Inspection report (2023) HM Inspectorate of Prisons. Available at: https://hmiprisons.justiceinspectorates.gov.uk/hmipris_reports/hmp-bristol/

[8] Department of Health and Social Care (2017) Drug misuse and dependence: UK guidelines on clinical management, GOV.UK. Available at: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

This patient did not understand why the GP couldn't give him pregabalin. She tried to explain to him that the custody rules were different, and he just got more and more frustrated. I found it to be an interesting, although somewhat unsatisfying, way of consulting. The answer was always the same from the GP, but the patient tried so many ways of trying to convince her. And every time she repeated the same thing, over and over again. Eventually, he gave up. She made sure he had a good supply of paracetamol and naproxen from the meds hatch.

In October, on a prison shutdown morning, the doctor tasked me with designing a leaflet for the patients explaining the reasons behind the different gabapentinoid rules in custody. I spent the morning creating something I was quite proud of- the doctor printed loads of copies out, laminated it, and emailed it to all of healthcare.

However, having looked back at it, I would redesign it- specifically regarding its reading age. It hadn't even crossed my mind that words like 'licenced', 'identified' 'minimal' would raise the reading age of my poster to 17.7 years old. According to the Shannon Trust & an Ofsted report from 2022, 57% of prisoners have a reading age of below that of an 11-year-old.[9][10] If I were to design a patient information leaflet again, I would keep reading age in mind as a priority.

I had this preconception before I started that I wasn't 'tough enough' to be a prison GP in the future. Part of me thinks I'm barely tough enough to be a normal GP! But I learnt a lot from the healthcare staff and the prisoners too. First and foremost, that 'tough' is not what I needed to be, and not what patients needed either. It was compassion, not toughness, which had to be the basis of every interaction.

Being a GP in a prison was about doing the best you could in a limiting situation- for people who had never once been given a chance. It was about using the resources available to us to make even the smallest difference. Prison-specific healthcare could sometimes involve writing to the prison management team, getting people stable on opiate substitute therapy, and helping patients to understand what to do to manage their health when they got out. But it was the generic GP skills- being good at listening, being effective at symptom management and prevention, and providing reassurance and support- that seemed to mean more than ever in the face of a broken prison system.

So toughness for the prisoners was not the answer. But toughness is still a good skill to work on, because now I have seen for myself this system that repeatedly fails an ever-growing population of vulnerable people. *That* is something to be tough on.

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[9] Merrill, I. (2024) Learning to read in prison – it's just the start, Shannon Trust Available at: https://www.shannontrust.org.uk/stories/learning-to-read-in-prison-its-just-the-start

[10] Ofsted (2022) Prison education: A review of reading education in Prisons, GOV.UK. Available at: https://www.gov.uk/government/publications/prison-education-a-review-of-reading-education-in-prisons