Medical Care of Prisoners and Detainees

Ciba Foundation Symposium 16 (new series)

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Chairman's introduction: ethics, the doctor, and the prisoner

ANTHONY STORR

I am particularly glad that the Ciba Foundation has organized this symposium on the Medical Care and Protection of Prisoners and Detainees, since I have been much concerned about the ethical position of doctors in regard to various procedures which go on in prisons and camps. In England, it has proved difficult for doctors to get guidance on such matters. A lady doctor from Northern Ireland wrote to the General Medical Council quite recently asking for guidance about the ethical position of doctors who might be concerned, for example, in interrogation procedures. The General Medical Council was not willing to lay down any kind of guidelines. As the Council is much concerned with the ethical behaviour of doctors, and is most anxious to protect the public from drunken doctors, drug-taking doctors, immoral doctors and inefficient doctors, it seems strange that it is not prepared to proffer any advice on the doctor's moral obligations in camps and prisons.

I hope that those of you at this meeting who work in prisons and camps may have some better advice to offer us, especially in the fields of interrogation and physical punishment. Restriction of diet, for example, is widely used in many prisons as a punishment. But no doctor could think that severe restriction of diet is likely to be anything but harmful to the prisoners under his care, unless they are grossly obese. What then is the doctor's duty?

In the Isle of Man delinquent youths are still birched as a judicial punishment and, according to Manx law, a doctor has to be present on these occasions. What is he to do? If he regards this kind of punishment as a barbarous anachronism, should he agree to participate on the grounds that he may prevent the infliction of too much pain on the occasional youth who is too ill to stand it, or should he refuse to attend in the hope that he might embarrass authority and speed the reform of the law?

I first became worried about the part that doctors play in various camps and

prisons throughout the world in 1960, after a lecture given by the late Professor Alexander Kennedy, then Professor of Psychiatry at the University of Edinburgh. He was rash enough to reveal that during the Second World War he had been employed at an interrogation centre in Cairo in advising how methods of psychological pressure could be brought to bear on prisoners from whom information was wanted. This disclosure created a certain amount of unease, more among the general public than among the medical profession. What, they asked, was a doctor doing in this context? Surely a doctor's job is to heal the sick, not to instruct governments on how to break down prisoners mentally in such a way that they give information? I took this view myself, although I knew that not all my psychiatric colleagues shared it.

In 1960 there was still considerable public interest in the so-called brainwashing techniques, as practised by the Russians and the Chinese. The Korean war, with its revelations as to how nearly a third of Americans captured had been persuaded to collaborate, was still fresh in people's minds. There was a lingering feeling that the British Army didn't behave like that, although of course no one expected that they would invariably behave to prisoners with saintly forbearance. The best I could do at the time was to write an article called 'Torture without Violence'.[1] In it I deplored the fact that doctors could lend themselves to use by governments in the way which Professor Kennedy had indicated, and I suggested that his conduct was contrary to the Hippocratic Oath, which indeed it was. He made no reply, perhaps because of ill-health, and in fact he died within a few months of publication of this article.

There were various repercussions from my article. One lawyer wrote to say that he had knowledge of British methods of interrogation and that these included what he called drug-induced hypnosis performed by doctors. It emerged that there was a special training centre for interrogators, and this still exists in Sussex, though what goes on there is difficult to find out. From time to time the government actually refuses to allow people even to mention where it is and clamps a D notice on this information, as they did when I talked about it on television. Eventually we got as far as persuading a Member of Parliament, Francis Noel-Baker, to ask the Prime Minister, then Mr Macmillan, a question in the House of Commons. Mr Macmillan evaded the issue, saying that it was not in the public interest to reveal what methods of interrogation were taught to British interrogators or what part doctors played in this. He did, however, write 'I can give an unequivocal assurance that in the training of British interrogators the use of brainwashing, drugs or physical violence is expressly and emphatically forbidden.' I gave up enquiry at this point because it seemed difficult to carry matters beyond the Prime Minister.

From time to time afterwards various disturbing allegations of brutal conduct

on the part of the British Forces emerged from Cyprus, Aden and other trouble spots. Then came the revelations about Northern Ireland. We learned that detainees who had not been convicted were being starved, deprived of sleep, made to assume uncomfortable postures such as standing spreadeagled against a wall for hours at a time—in one case for as much as 43½ hours in six days—and, more sinisterly, being hooded and exposed to continuous noise for long periods of time. These revelations shocked a great number of people and eventually an enquiry was set up under the chairmanship of the former Ombudsman, Sir Edward Compton.

His report, the Compton Report,[2] though deploring the use of brutality, alleged that the methods of interrogation in Northern Ireland were not brutal. The hooding, the posture on the wall and the continuous noise were, Compton alleged, designed primarily to stop internees communicating with each other. A secondary effect, the report went on, might be to render the men so treated more susceptible to interrogation. Compton says 'It can also, in the case of some detainees, increase their sense of isolation and so be helpful to the interrogator.'

Any uninformed person reading the Compton Report would have concluded that although what was done to internees was not very pleasant, there was little evidence of severe physical pressure being employed. Some men had complained of being knocked about, or being made to do unaccustomed physical exercise, or being forced to stand up against the wall again after they had collapsed. But the tenor of the report was that, although more supervision of interrogators was desirable—and it must be remembered that the interrogations were carried on by the Royal Ulster Constabulary and not by the British Army—not much harm was being done and possibly some unpleasant procedures were temporarily necessary.

It was at that point that I thought that specialized psychiatric knowledge became relevant, because anybody who had read the literature on sensory deprivation and its effects must have concluded that a variant of sensory deprivation was being used as a method of breaking down internees. The hooding and the continuous noise were designed not to isolate men from each other but as a deliberate method of producing mental confusion and disorientation. I was not an expert in this field but I knew that the effects were so disturbing that even a high proportion of healthy volunteers who were acting as experimental guinea pigs, and being paid, pressed the panic button long before the experiment was up. In conditions of mild sensory deprivation many volunteers endured only an average of 29 hours, and in more rigorous conditions only one man in ten endured more than ten hours. If no limit in time is set to such experiments, fears of insanity and confusion may come on within as little

as two hours. People lose all sense of time, they become hallucinated and the experience is very like a bad trip after LSD. I knew moreover that an interesting fact had emerged from the Princeton experiments,[3] which were originally conducted partly with a view to determining what would happen to astronauts: if the experimenters used Princeton students, some became paranoid and thought the experimenter had abandoned them, but when the experimenters had run short of their own students and had to seek volunteers from further afield, the number becoming paranoid was very much higher. If the very mild degree of distrust which one might feel at entrusting oneself to the care of university professors not of one's own university became so quickly magnified under sensory deprivation, what, one wondered, would be the effect of sensory deprivation upon men who knew themselves to be in the hands of enemies?

At the time of publication of the Compton Report, I was asked if I would write an article on its psychiatric aspects for the *Sunday Times*, and I did so immediately.[4] I tried to make it clear that physical brutality was not the only kind of brutality that mattered and that techniques using sensory deprivation could produce a state equivalent to a temporary episode of insanity, that no one could possibly know what the long-term after-effects of such procedures would be upon the men to whom they had been applied, and that the Home Secretary had no business to say that these methods had no serious sequelae, as he had been rash enough to do in the House of Commons. I thought it important to explain all this because I surmised that the general public would have no idea that any method of psychological pressure without actual physical torture could be expected to have serious effects.

After various further protests a group of three Privy Counsellors, Lord Parker, Lord Gardiner and Mr Boyd-Carpenter, were appointed to investigate the whole question of interrogation further and I found myself giving evidence before them. I repeated to them what I had said in the article, further reinforced by study of the literature. I discovered that some of the literature on sensory deprivation is still classified, so that one cannot get hold of it. It seems that government departments are very quick off the mark in spotting techniques coming out of psychological and physiological research which may be of use to them. The Parker Committee were primarily interested in whether these techniques could be used in moderation, without much risk of serious after-effects. They told me it was undoubtedly true that much useful information had been obtained by these methods, and no doubt some lives had been saved as a result. I hesitated to comment on this since no literature exists, as far as I know, on the effects of sensory deprivation employed as an interrogation technique on enemies. All I could say was that we knew that so-called traumatic neuroses had been known to result from procedures which were much less severe, that

producing psychotic symptoms in normal people by methods like the use of LSD was fraught with risk, and that one could only tell what the effects would actually be after a long-term follow-up of the people concerned.

In the event, the Parker Committee produced a report[5] in which two of them, Lord Parker and Mr Boyd-Carpenter, thought that the methods employed in Ulster could be used if they were subject to more stringent safeguards. One of the safeguards they required, interestingly enough, was that a doctor trained in psychiatry should be present to see that the prisoner was not being pressed too far. I hope people will express opinions here about whether a doctor should ever accept such a role. They actually wrote: 'We think that a doctor with some psychiatric training should be present at all times at the interrogation centre, and should be in a position to observe the course of oral interrogation. It is not suggested that he should be himself responsible for stopping the interrogation, but rather that he should warn the controller if he felt the interrogation was being pressed too far, having regard for the demeanour of the detainee, leaving the decision to the controller. This should be some safeguard both to the constitutionally vulnerable detainee and at the same time for the interrogator.'

Fortunately the third member of the Committee, Lord Gardiner, produced a minority report[6] in which he said that these methods were wholly detestable, their results were unpredictable, and they were unworthy of British traditions in the treatment of prisoners. After the publication of the report the Prime Minister said in the House of Commons that these methods would henceforth be forbidden.

The moral of that story is not so much that doctors can on occasion participate effectively in protest, important though this is. It is that this underlines the fact that psychiatric techniques, and no doubt physiological and many other medical techniques, originally designed to be helpful to disturbed individuals, can in many instances be extracted from their therapeutic setting and used for exactly the opposite purpose.

I hope that one of the things that may come out of this symposium is some consensus of opinion as to the position of doctors who may be employed in interrogation centres, and who may or may not be asked to oversee or even to participate in procedures which I would have thought were contrary to their medical ethics. Perhaps at this meeting we could give some guidance to the doctors who are actually asking for such advice and getting a very dusty answer at the moment. But before we go further with these questions of ethics, the present provisions for medical services in prisons will be examined, and we shall discuss how well or how badly the UN Standard Minimum Rules are being implemented, mainly in Europe and North America.

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Medical services in prison: lessons from two surveys

G. O. W. MUELLER

The Standard Minimum Rules for the Treatment of Prisoners approved by the United Nations in 1955[1] bind the conscience of all nations—thus falling somewhat short of international law—with respect to the extension of minimal services and human rights to those detained by governmental authority. The Rules, quoted in full in Appendix 1 of this book (pp. 197–215), are fairly specific with respect to the provision of medical services:

> 22. (1) At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.
>
> (2) Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitably trained officers.
>
> (3) The services of a qualified dental officer shall be available to every prisoner.
>
> 23. (1) In women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the institution. If a child is born in prison, this fact shall not be mentioned in the birth certificate.
>
> (2) Where nursing infants are allowed to remain in the institution

with their mothers, provision shall be made for a nursery staffed by qualified persons, where the infants shall be placed when they are not in the care of their mothers.

24. The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

25. (1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.

(2) The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

26. (1) The medical officer shall regularly inspect and advise the director upon:

(a) The quantity, quality, preparation and service of food;

(b) The hygiene and cleanliness of the institution and the prisoners;

(c) The sanitation, heating, lighting and ventilation of the institution;

(d) The suitability and cleanliness of prisoners' clothing and bedding;

(e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.

(2) The director shall take into consideration the reports and advice that the medical officer submits according to rules 25(2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority.

IMPLEMENTATION OF THE STANDARD MINIMUM RULES IN SELECTED COUNTRIES

A survey of the extent to which the Rules were being implemented was conducted by the Criminal Law Education and Research (CLEAR) Center of New York University in 1969, with 31 nations of all regions of the world responding. The survey showed the following (and see Table 1):

Rule 22. (1) General availability of medical services, including psychiatrists. Nineteen nations stated or implied that the rule was implemented. Ten stated that it was partially implemented. One stated it to be recognized in principle.

Comment: In the responses of most nations, there was either little mention of the doctor's qualifications, or the lack of trained medical staff was specifically noted. One major Latin American nation requires by law the assignment of a psychiatrist versed in criminology to each institution. One small African nation noted that it has no psychiatrists, dentists or gynaecologists in the country.

Rule 22. (2) Transfer and care of sick prisoners. Twenty-two nations stated or implied that the rule was implemented. Five stated that it was partially implemented. Two stated it to be recognized in principle.

Rule 22. (3) Dental services. Nineteen nations stated or implied that the rule was implemented. Four stated that it was partially implemented. One stated it to be recognized in principle.

Rule 23. (1) Natal and children's care in women's institutions. Eighteen nations stated that the rule was implemented. Five stated that it was partially implemented. One stated it to be recognized in principle.

Rule 23. (2) Provisions for nursery in women's institutions. Eighteen nations stated that the rule was implemented. Four stated that it was partially implemented. Two stated it to be recognized in principle.

Comment: Cultural variations were quite obvious in the responses under this heading. One Scandinavian country and one socialist country allow postponement of the sentence for a pregnant woman. Children are kept in prison nurseries for six months or one year, respectively, in two of the socialist countries, and for three years in one of the East Asian countries, and seven years in yet another Asian country. In one of the African countries, it was reported to be contrary to custom to remove a child from its mother, while in another Scandinavian country, mothers are not allowed to take children with them into prisons.

Rule 24. Medical intake examination. Seventeen nations stated that the rule was implemented. Eight stated that it was partially implemented.

Comment: This low extent of full compliance for one of the most basic service requirements was particularly disheartening.

Rule 25. (1) Constant medical care. Ten nations stated or implied that the rule was implemented. Fifteen stated it to be partially implemented.

Comment: This low service rendition came as an even greater shock.

Rule 25. (2) Medical reports on dangerously ill inmates. Seventeen nations stated or implied that the rule was implemented. Five stated that it was partially implemented.

Rule 26. (1) Medical officer's advice to director of institution. Nineteen nations stated or implied that the rule was implemented. Four stated that it was partially implemented.

Rule 26. (2) Implementation of medical officer's recommendations. Sixteen nations stated that the rule was implemented. Five stated that it was partially implemented.

TABLE 1

UN Standard Minimum Rules for the Treatment of Prisoners: implementation survey (31 nations answered, of 130 asked)*

Medical services	*Implemented (No. of countries)*		
Rule no.†	*Yes*	*Partially*	*In principle*
22 (1)	19	10	1
22 (2)	22	5	2
22 (3)	19	4	1
23 (1)	18	5	1
23 (2)	18	4	2
24	17	8	
25 (1)	10	15	
25 (2)	17	5	
26 (1)	19	4	
26 (2)	16	5	

* From the following cultural regions:
Western Europe 10, Eastern Europe 3,
American 6, Asian 6, African 6.

† See text.

In evaluating these responses, it should be kept in mind that only 31 nations sent usable responses out of a total number of 130 nations. It may be surmised

that the nations which did not respond have an even lower record of implementing the Standard Minimum Rules for medical services. If that is so, and even if the self-reports of the responding nations are completely accurate, the inference is clear that a substantial part of the world's considerable prison population does not obtain the medical care which the United Nations regard as the absolute minimum level of service. This appears equally true for developed and developing nations.

IMPLEMENTATION IN AN AMERICAN DETENTION FACILITY

Unhappily, the self-reports cannot even be regarded as accurate portrayals of the true state of affairs. These can be revealed only by a detailed inspection of prison facilities and interviews with prisoners. Few nations are willing to permit this kind of inquiry. However, in the course of an overall survey we were permitted to evaluate, among others, the medical needs of, and services to, inmates of the Federal Detention Headquarters in New York City, an institution in one of the world's most highly developed nations, administered by one of the best-reputed administrative systems.

Our survey was conducted in the so-called West Street Detention Headquarters, a federal 'jail', operated in the City of New York primarily for the purpose of detaining persons charged with crime and pending trial on federal criminal charges. The average length of stay of the 296 inmates in the facility on the day of assessment in 1970 was, according to our findings, 117 days with a median of 74 days. The facility is a converted warehouse, in which inmates are kept in cage-like cells typical of jails all over the world.

The researchers of CLEAR Center administered questionnaires to all inmates and conducted interviews.

Findings

Our study revealed medical needs as a major factor in jail life, and therefore in jail planning:

15% of our sample population stated that their health was unsatisfactory at time of admission;

14% stated they were under a doctor's care at time of admission;

16.5% stated that they were taking medication for physical illness;

77% of the inmates needed some form of medical treatment since being detained;

40% (approximately) were receiving regular treatment from the medical unit. Careful and prolonged treatment is needed for some inmates (bladder infection, influenza, serious stomach trouble, etc.), and for many others a daily dose of antihistamines is sufficient;

62% of the sample population indicated a history of previous illness ranging from stomach ulcers to major operations.

As an example of the treatment needs at West Street, the records for the month of December indicated that: 19 clinical laboratory procedures were performed (16 urine analyses and three haematology tests); 28 persons were immunized against smallpox, tetanus or influenza; two persons were treated for gonorrhoea; and 6480 pharmacy preparations were dispensed.

Again, during the month of December when an average of 5.2 men were living in the hospital on any given day:

34 inmates were hospitalized for medical reasons;

20 inmates were hospitalized for psychiatric reasons;

107 were hospitalized as domiciliary patients (and therefore medical technical assistants and the hospital itself were mostly used for custodial aspects).

The jail has a limited staff of four full-time medical technical assistants and one part-time physician. Due to lack of personnel, therefore, the service schedule can only provide a medical technical assistant on duty every day from 8 a.m. to 12 midnight, with the doctor himself in the institution two hours a day (10 a.m. to 12 noon), five days a week. Under this schedule, the jail has a physician for only ten hours a week, and it is totally without medical help from 12 midnight to 8 a.m. daily—eight crucial hours in the dead of night. It is true, of course, that the doctor is always on call in case of emergency, but it takes him at least fifteen minutes to get to the jail if he can get a guard to drive him, which is not always possible because of staff problems.

The major factor in the lack of medical care at West Street, then, is a shortage of personnel. The following description of practices must be understood in this light.

On admission to the jail, a new inmate is given a cursory medical examination if the infirmary is open. The inmate is asked about present complaints, past medical history, heart problems, tuberculosis, venereal disease and drug addiction. He is also asked if he is under a doctor's care and whether or not he is taking any medication. All of this information is recorded according to the inmate's response, with very little chance of verification, including the verification of his answers about drug addiction. At present, there is no way of readily determining whether or not a man is an addict, unless he admits it. Our statistics show that 25 per cent of the sample population admitted to drug use at the

time of detention, and 55 per cent of this group admitted to habits costing over $100 per week to maintain. It is the doctor's opinion, however, that it is not crucial to determine drug addiction immediately on admission, because if a detainee is currently on drugs the staff will know within 24 hours, when he begins the process of withdrawal. However, if a man admits to drug addiction he is instantly treated with methadone and will continue with this treatment for eight days, receiving 10 milligrams of methadone daily. The only other medical treatment regularly administered at intake is for those with a history of venereal disease, who are immediately given penicillin.

The major flaw in this intake process is that the jail physician does not see everyone and may not see someone for a week. If a man is not admitted during the hours of 10 a.m. and 12 noon, there is a good possibility that he will not see a physician for at least 24 hours. Furthermore, if an accused is admitted to the institution before arraignment, which is usual for anyone admitted after the courts have closed at 5 p.m., he will be detained until the following day, when he will be taken to the Federal Court for arraignment before a commissioner. This of course prevents him from seeing the doctor during the morning sick call, and if a man has to go to court for several days in a row, as happens in many cases, it may be a week before he sees the physician. It is obvious, then, that an inmate could be in serious need of a doctor's care and not receive it for several days. And should a man leave the institution for court in the early morning and return late at night, which is possible, he may not even see a medical technical assistant.

As for dental and optical care, the jail doctor is prohibited by a Federal Bureau of Prisons regulation from obtaining glasses or teeth for any unsentenced inmate. He is furthermore prohibited from sending any unsentenced inmate to any other institution where such help could be given to him. There is a jail dentist, however, who sees men every Tuesday and Friday at 12.30 p.m.

The hospital facilities at the jail are adequate to handle most regular medical problems. The seven-bed infirmary even has oxygen to deal with heart attacks of a less serious nature. It has no facilities, however, for detecting drug addiction, which involves a special type of urine analysis. The institution is now forced to send urine samples to a commercial laboratory.

Medical care at the jail is thus subject to some limitations, but not to the extent that psychiatric care is. The doctor, as the chief medical consultant of the Federal House of Detention, is not permitted to send a man to Bellevue or any other hospital for psychiatric care, or even call for a psychiatrist to determine a possible need for such care, without a Federal Court order. And, as might be expected, this is usually impossible to obtain at the moment it is needed. Such a court order must be expedited through the US Attorney, whose

final judgement must rest on the doctor's advice anyway, since the Attorney is not competent in determining psychiatric needs.

These limitations would be somewhat less important were it not for the additional reluctance of the jail authorities to pay the $150 per day it costs to send a man to one of the city hospitals.

In one sphere the medical facilities programme is most impressive: that is in the keeping of medical records. The hospital has several systems of medical records. The primary system is a card file with basic medical information about each inmate's medical and personal history. The initial examination by a medical technical assistant extends to any previous history of serious illness and any type of current treatment. Those under treatment when they arrive generally receive continued treatment; and, as already mentioned, inmates who admit to using heroin or other related drugs are put on an eight-day course of methadone as withdrawal treatment, though no one is forced to undergo this treatment. Any further medical treatment is recorded on a man's medical card.

The other record systems in addition to the card file include:

(*a*) A follow-up folder containing detailed records of men who stay in the hospital while they are at the jail;

(*b*) a methadone withdrawal treatment folder;

(*c*) an immunization treatment folder;

(*d*) a record book documenting all heavy medication—including frequency, amount and time—given to inmates;

(*e*) A Bellevue Register book containing referral sheets of serious medical cases or medical emergencies sent either to Bellevue or St Vincent's. The referral sheets document the specific complaint, though no similar book exists for inmates sent to a psychiatric ward by court order;

(*f*) a quarterly report written by the head medical technical assistant which gives a statistical breakdown of the medical activities of the previous quarter, accompanied by a short narrative of the previous quarter.

One final problem as to the state of medical services at the jail remains, namely the problem of the lack of a chief medical officer. The jail physician does not regularly act as the chief medical officer of the institution. Thus, neither he nor anyone else in his place is regularly consulted on matters of discipline, hygiene or diet. This is a lacuna which should be filled.

Living conditions

The law requires us to presume that the detainee is innocent until convicted by a court of competent jurisdiction. It also says in effect that he is being

detained solely because he lacks the funds to make bail. Consequently, logic and equity dictate that the detainee must be given as much freedom as the accused man who makes bail—limited only by the necessity for him to be detained.

Given these conclusions, the physical conditions under which the detainee is forced to live at West Street can only be described as abominable. During the period our interviewers were present in the jail, men were sleeping on the floor because of overcrowding; the sleeping areas had vermin; supplies of clothing and blankets were insufficient; and contacts with the outside world were so severely limited as to be virtually non-existent. Where the detainee was permitted a visit by either his family or his attorney, the rigidity and severity of the restrictions imposed on that visit eroded its value.[2]

Recommendations

Our recommendations for an amelioration of the deplorable condition of medical services in the Federal Detention Headquarters included the following:[2]

> *(1) Space.* There should be an adequate infirmary of ten beds with a psychiatric unit for persons awaiting transfer to a psychiatric hospital or for those in need of instant, supervised isolation. This should be a 'quiet room' removed from the jail atmosphere. The infirmary should also include a waiting room, a medical consultation room, an administrative office for the doctor and the medical technical assistant on duty, a small conference room (to be used for staff meetings, as well as a consultation room for the psychiatrist on duty), a laboratory and a pharmacy.
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> *(2) Equipment.* In addition to the present equipment at West Street, there should be a more elaborate X-ray machine and improved facilities for urine analyses and blood tests.
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> *(3) Personnel.* A doctor should be present in the institution for two sick calls, from 10 a.m. to 12 noon and from 7 p.m. to 9 p.m. There should also be a doctor on call 24 hours a day with easy and quick access to the jail. In addition to sick calls, the doctor should spend at least five hours a week in administrative work. He is to be the chief medical officer for the institution, which will require him to oversee all medical operations as well as all other medical aspects of institutional operations.
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> Medical technical assistants should be in the institution around the