Commentary

...but everywhere lives in chains?

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The prisoner looked lethargic and listless. Manacled to one of a trio of prison officers, he hardly raised his head when I poked mine through the curtains of the cubicle in the Emergency Department. The patient but fatigued cluster of trainees was in the periphery of my vision, silently willing me to hurry up with post-take ward-round, and not dwell overly on the young man with new onset jaundice. A polite request to the prison officers to step outside was met with hostile body language and an abrupt refusal. A brief inquiry established that the patient was a first-time remand prisoner with no history of violence or attempting to abscond. Although assessment of the patient would entail sensitive life-style questions, the monosyllabic replies quickly established that the prison officers had little time for such niceties. Still, a little early to telephone the prison Governor to negotiate further, I continued with the ward round, aiming to revisit the situation after giving some time for all parties to reflect on the situation.

As I returned to the Emergency Room, one of the prison officers was waiting outside the cubicle to greet me. ‘He’s happy to see you with us in the room, Doc’, he said. The lightness of his tone contrasted with that of the even more cowed prisoner who failed to meet my gaze as I entered and muttered in a low monotone: ‘It’s alright, Doc’. Uncertain that this constituted a valid consent, I let the team off to their well-deserved toast and coffee in the doctor’s residence and telephoned the Governor. A short conversation with an Acting-Governor was abrupt and to the point: the manacles would stay on and a prison officer would stay in the room. No clarification was offered as to the grounds for denying the right to privacy and confidentiality. As I reckoned that there was little hope of getting much satisfaction from the Head of the Prison Service or the Department of Justice on a Saturday morning, and as the patient was in no imminent danger, I kicked for touch.

Aiming to tell the prisoner that I could not assess him more fully, but that we would hold him in hospital until the matter could be clarified, I passed on my message to the patient. It was received with a stoic silence, one which seemed to hold more than a shadow of derision for my well-intentioned naïvete, as well as irritation that the pantomime would not be to his advantage once back in prison.

On Monday, medical records signalled that the patient was a former patient of one of the other physicians and the prisoner was transferred to his care. I scrutinized the Internet and the journals for guidance in the area but with little to show for my efforts. I composed an indignant letter to the head of the Prison Service, outlining my concerns and faxed it to him. Whether by coincidence, routine procedure or as an unlikely effect of my letter, the guard detail was reduced on the patient subsequently. A few days later, he successfully escaped from both the hospital and the custody of the state.

‘There you go’, said the habitués of the consultants’ coffee room, with whom I had shared the events of the previous days. ‘Weren’t they right not to leave him unfettered with you?’ In vain I protested that ‘they’ had got it doubly wrong: over-protective...
and intrusive when the patient required confidentiality, and then unable to guard him when confidentiality was no longer a primary issue. Opinions were clearly divided from the sympathetic to those who were confirmed in their suspicions that I really did belong in either an ivory tower or a home for the terminally naïve. The juniors discreetly avoided discussing the case. In a hospital serving two prisons in its catchment area, prisoners frequently attend, and usually provoke little discussion, apart from an episode where a machine-pistol was discharged in the Emergency Department while a prisoner was attending, a very traumatic event for staff, patients and families.

However, over the next few months, the episode revived dormant memories of a 1-day visit to a prison as a medical student, and uncomfortable insights of a prison medical system that was grossly insensitive to standard care of patients, assessing new prisoners medically in front of not only the prison officer, but also the other prisoners. Almost certainly unfairly, I had presumed that the academics in the university department concerned were aware of this and tolerant of the distortion of medical professionalism. More than 20 years after the event, both sets of experience led me to provide a submission on prisoners to a review of the ethical code of the Irish Medical Council, and to initiate some modest research in the area. Sadly, my co-researchers and I were unsuccessful in persuading a new Irish longitudinal study on ageing to include prisoners, given not only the worldwide increase in prisoner populations but also the proportion of older prisoners.

Yet with my eyes now opened, I have been astonished at the relatively unquestioning acceptance of diminished medical privacy for patients in informal discussions with medical and nursing colleagues from many (but not all) parts of the world. Frail older patients, those with terminal illness, and expectant mothers near the point of delivery have all been assessed and treated while shackled to prison officers. This widespread passive collusion in the abuse of prisoners’ right to confidentiality is poorly covered in guidance from regulatory bodies, medical indemnity bodies or the medical literature.

Perhaps the most striking manifestation of our agnosia to this deprivation of rights to privacy was the astonishing sight of Saddam Hussein undergoing a televised medical examination, and the lack of subsequent comment in medical and nursing journals: surely as professions we can do better?

In the silence surrounding this breach of basic privacy lie the seeds of the challenge to medical professionalism posed by prisoners. Do the wrongdoings perpetrated by Saddam Hussein (and by extension, by all prisoners) weaken the imperative to provide consistent levels of courtesy, privacy and dignity when providing health care services? It is telling that my literature searches came across much about overt abuse and torture, and an appropriately strong reaction and condemnation from professional organizations. In contrast, there is little on the everyday erosion of rights to privacy and erosion of prisoners.

In the face of the abuse and torture of prisoners in Iraq and Guantanamo Bay, this might seem like small beer, but as the aphorist Chamfort wrote, in great affairs men show themselves as they wish to be seen; in small things they show themselves as they are. It is through attention to the ‘small things’ of universally ethical clinical practice with all prisoners that we can calibrate our moral compasses on the ‘great affairs’ of the due place of physicians in interrogation and overt abuse of prisoners. Few of us will serve in setting involving overt torture, but many will encounter prisoners in some stage of the professional lives, and our colleagues in military health services can only be a reflection, or amplification, of our general professional mores.

The available literature on prison care is troubling and shows that prisoners have poor expectations of health care services (usually with cause), that the public (of which we too are a part!) harbours significant fear about prisoners, and health care workers score poorly on attitudinal surveys on prisoners. Those directly involved with the provision of prison medical services are familiar with Croaker’s dilemma, as to whether physicians serve prisoners or prisoners. This is a professional debate central to other disciplines which balance institutional and individual needs, such as occupational health. It sometimes seems that those in hospitals and other outside health services are not so frequently confronted by this challenge overtly, and may fail to see how they adopt positions which are an unconscious extension of the penal system.

What underlies this unhappy state of affairs? To paraphrase Talleyrand’s dictum on loyalty, ethical probity is a matter of timing: against a background of negative attitudes to prisoners and widespread tolerance to erosion of privacy, some may harbour a fear of appearing quixotic. Indeed, this is not just a generic quixoticism—in the second part of Don Quixote, the protagonist takes pity on a group of prisoners and orders the Sergeant of their detail to unlock them. Through the interference of the hero, the prisoners manage to escape and they set upon Don Quixote and Sancho Panza, beat them soundly and steal their clothes. While Cervantes pinpoints the dangers of acting rigidly on the basis of
principles without listening to others and remaining flexible, his mastery as a novelist is to leave us with sympathy for the prisoners too, almost certainly a reflection of his own years in a North African prison.

Is it the strangely familiar ‘otherness’ of prisoners which is at the root of our alienation and retreat from normal standards of care? The familiarity arises from the ubiquity of prisons as the setting of television dramas and films, the ‘otherness’ from the lack of contact that middle-class healthcare professionals have with not only prisoners but also with their milieu. Equally, we may have little insight into the nature of the working lives of prison officers, often struggling with great humanity in the face of inadequate resources and training in a system whose reality is far from the rehabilitative milieu that governments might wish to portray. Their professional lives and careers are so affected by a prisoner absconding (an infrequent event in healthcare attendances), that a wider dialogue and a more structured interface between prisons and outside health services is needed to protect prisoner privacy from an emphasis on the risk of absconding to the exclusion of other needs.

Yet, I have cautious optimism that we can do better. Medicine continues to display a strong streak of self-examination and altruism. We all continue to fill out surveys and questionnaires whose final result will inevitably show some deficit or inadequacy, and my colleagues responded wonderfully to a survey we carried out on prisoners in the general hospital. At an organizational and professional level, the benefits to all of promoting trust and confidentiality within health services to prisoners need to be more widely diffused, with the most potent example being the control of infectious diseases. The British Medical Association guidelines, less familiar than might be hoped, are a good template for discussions between prisons and health services, balancing the goals of privacy and confidentiality with those of safety and security [British Medical Association. Providing medical care and treatment to people who are detained. http://www.bma.org/ap.nsf/Content/Restraint (Accessed 31 October 2008)].

Student attachments for nurses and doctors to prison medical services would also be a useful start for universities, benefiting both students and the medical services and ideally tied in with clinical ethics and medical humanities programmes. Oscar Wilde’s *Ballad of Reading Gaol* and *De Profundis* provide food for thought, with telling insights into the attitudes of the middle class to prison—‘With people of our own rank it is different. With us, prison makes a man a pariah. I, and such as I am, have hardly any right to air and sun. Our presence taints the pleasures of others. We are unwelcome when we reappear.’ At another level, the remarkable PEN anthology of prison writings, *Doing Time: 25 Years of Prison Writing,* is approachable and revelatory.

Inaction is not an option, and disentangling ourselves from an accretion of habit and fear of the unknown which have restricted the professional exercise of privacy with our prisoner patients is an imperative: in the words of Rousseau, man is born free, but everywhere lives in chains. In truth, some chains are more visible than others.

Reference