The clinician and detention

Howard Goldenberg

I have worked in Australian urban, suburban and country general practices for more than four decades, and spent about 8 weeks a year for the past 20 years working in remote clinics. These 'outback' postings have been predominantly in Aboriginal communities, while in 2008 I worked in Torres Strait on behalf of the Department of Customs, charged with medical assessment and initial treatment of illegal fisherman captured in Australian waters. In 2009, I worked for a time in Alice Springs Correctional Centre, and in 2010 in an Australian Government Immigration Detention Centre offshore.

I therefore read with interest (and admiration) the paper titled 'Are health professionals working in Australia's immigration detention centres condoning torture?' in this issue. The paper addresses a number of important issues and questions. In this short commentary I will draw on my personal experience to clarify in which ways, if any, the detained patient might differ from the generality of patients, and hence to identify any distinct ethical duty of the clinician towards them. I outline my personal response to the suggestion that a doctor or a nurse should positively refuse to serve in an immigration detention facility on the grounds that to do so would be to condone or facilitate torture.

ARE DETAINED PATIENTS DIFFERENT FROM OTHER PATIENTS?

Perhaps the essential difference of an involuntarily detained patient from other patients is in relation to their clinical attendants: their would-be helpers are, inescapably, also their captors.

My detained refuge-seeking patients resembled all patients in that they were variously unhappy and anxious; their understanding of their condition was inadequate; and they were sometimes unwell, although not in the way they understood themselves to be.

These *were* patients (although my employers insisted they were 'clients'); however, their complaint, their *pathos*, was the detained condition, to which more familiar clinical entities were superadded.

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Male patients—and the great majority in my care happened to be adult and male—in immigration detention suffered from a spiritual malaise, an affliction I have not seen described and which I struggle to categorise. Its features include an inversion of belief such that the detained person replaces trust in fellow humans with mistrust, with an expectation of mendacity and malignity of purpose. Thus the clinician, ostensibly present to help, was felt to be the adversary, present only to frustrate and harm the detained one. Our method of harm was supposed to destroy sanity, literally to drive mad the supplicant for our help. The two protagonists became, respectively, the antipatient and the antidoctor. The inversion of belief was pervasive. Hope, the constitutional belief in life and its goodness, were alien, felt to be elements of the fabulous, not congruent with life as it was now known. Significantly, in a community of almost one thousand believers the mosque was largely unattended.

This inversion of the spiritual substrata of life reminded me of Primo Levi's descriptions of that distinctive moral universe, the Nazi concentration camp, where the SS intentionally destroyed a world of hope and faith and kindness. In Levi's analysis each of these three elements - which are socially virtuous and utile in the world outside the camp - become dangerous and harmful within the camp. I do not suspect any such intent on my island. But the outcomes here are just as certain even if unintended.

An unanticipated hazard was experienced by carers, both among the guards and the clinicians. The hazard was moral in nature. Quickly many came to sense wrongs in the system. The wrongs included treating as criminals persons who had broken no law; imprisoning persons who had shown every desperation to be free; humiliating our patients with a dehumanising system of identification by boat number rather than by name. All who worked in the Centre understood we were functioning parts of an unkind system: while we were to do no harm, we were to delimit our own capacity to do good.

Evidence of the moral hazard, the sense of our violence against our own values, emerged in the behaviour of the captors. Doctors drank every night, smoked heavily and suffered nightmares. More than one guard attempted suicide, one successfully.

In more than one instance my medical superior refused my referrals for imaging, apparently on the unspoken grounds that they would have to take place outside the detention centre. In one case, evidence of acute lumbar disc herniation indicated urgent CT scanning. This would require transfer to the mainland. My boss said: "No. That can't be done." Knowing that it could be done and it should be done, I asked, "Why can't it be done?"

Displeased by my insubordination she stepped forward, stopped half a pace from me and shouted, "You can't ask that question!"

For months following my return to the mainland, my reunion with friends and family, my resumption of normal medical work, I experienced nightmares. In those dreams I was a member of a tribunal, sitting in judgement on refugees' pleas for asylum. In those dreams no voices were heard; supplicants argued mutely; mutely, we judges refused their pleas. The whole was an accusation against my implicated self, against my silent self.

CRIMINAL DETENTION VERSUS IMMIGRATION DETENTION VERSUS CUSTOMS DETENTION

Isaacs refers to both criminal detention and immigration detention. I have worked in both categories as well as in compulsory detention for customs. In all three cases detained persons are held inside locked areas behind high fencing in locations beyond view of the public. These arrangements serve to ensure 'security', an idea which has become elaborated of late, broadened to encompass more than one understanding: 'security' has evolved from the safety of the detained person and of the community to *security of secrets*. Briefly put, locked behind a series of heavy steel doors, detained persons remain invisible to outsiders and hence vulnerable to abuse. These are the settings which some refer to as 'Black Sites'.

In the case of my island Detention Centre, the detained resided in their quarters, out of reach and sight of clinicians, who saw and treated them only once they had been admitted to our clinic, which was located in a second secured area. The communicating door between the broader compound and the clinic was manned by the bulkiest of the male guards, charged with selecting and admitting our patients according to acuity of need. In practice

these selections were opaque; we clinicians could never know who was excluded from our view and on what basis.

SHOULD A DOCTOR ACCEPT WORK WITH DETAINED PERSONS OFFSHORE?

This question arises because of the apprehended dual possibilities: first that a doctor will participate in or facilitate wrongdoing; second that having witnessed harm to patients, the professional will be constrained from 'whistleblowing' against that wrong. The latter risks are real. Under new Australian legislation a clinician who speaks out is open to prosecution and if convicted, to imprisonment for up to 2 years for revealing secret information. An additional constraint is the confidentiality agreement employees are required to sign as a condition of employment.

Isaacs suggests that Australia's treatment offshore of detained refugees constitutes torture. He adduces evidence for that suggestion but stops short of declaring categorically that such treatment is torture. At the same time he acknowledges the clinical needs for care of the refugees. He writes: 'Australian health professional thus face a major ethical dilemmas. Individual health professionals need to decide whether or not to work in immigration centres. If they do so, they need to decide for how long and to what extent restrictive contracts and gagging laws will constrain them from advocating for closing detention centres'.

I find the author's formulation of those questions helpful in pointing out a clear ethical path. He authorises each individual to forge a personal response. This seems to recognise the moral autonomy of the individual practitioner, as well as the responsibility of the individual. As the Mishnaic sage Hillel taught: *If not me, then who? If not now, then when?*

My own approach to the decision breaks it into two or three parts:

1. *Will I work there? (Do I have the right to do so? Do I have the right to decline?)*
2. *If I do accept that work, I must do so provisionally, ceasing when I form a judgement that to continue is more ethically troublesome than to desist.*
3. *In answering the second question I must consider how much my contractual confidentiality prevents me from doing needed good.*

The argument allows me to approach the questions as follows: Here, in the offshore 'facility'—a black site or a blackish site or at the very least a grey site—we have sick human beings. Our government, their custodians, seeks to employ doctors, nurses, psychologists, mental health nurses to attend to their clinical needs. The employer presents the qualified clinical professional with a contract to perform professional duties and to treat the conditions of the workplace confidentially. The government does not stipulate, 'You must agree to torture your patient'.

On the basis of my own experiences, where I was not required to do positive harm but I was constrained from doing some needed good, I could sign the contract and enter upon my employment in good faith and in the assumption of my employer's good faith. After all, I was employed as a medical professional. That profession implies first and foremost a refusal to do any harm. If and when I form the belief that my employment required me to do harm, I must refuse and make clear my reasons for doing so, both to my superiors and to my peers. Where possible I must make this clear also to the detained person. Should my employer dismiss me I must make public my employer's wrongful instruction and my actions and the circumstances of my dismissal. I run a risk in doing this—the risk of incarceration. A hazard, yes, but in our relatively non-totalitarian system, a hazard without risk of death. Far safer than the risk of an infectious diseases specialist treating patients with Ebola. Safer than the choices of a psychiatrist in the Soviet Union, safer than those of doctors under the Third Reich. A hazard, certainly, but not a moral hazard.

On the other hand if no objectionable command requires me to take a self-sacrificial stand, I remain free to work, to watch, to listen and to consider. And upon making my judgement I should speak out. If all is kosher, if detained persons are treated with full human dignity and compassion, then I must cry that welcome news from the rooftops. And conversely, if I find centres to be objectionable, I must call for their improvement or their closure.

Those contrary alternatives are equally clear ethical imperatives. I suggest they are not matters of narrow medical judgement but the call of every citizen. In this sense, the ethical questions identified by Isaacs pertain equally to the doctor and to the nurse in detention centres, but also to the guard, the journalist, the therapist, the pharmacist, the interpreter, the public servant. Why should a nurse or a doctor —or any clinician—be answerable differently from any other moral agent? All answer to an ethic which is universal, to care, to avoid harm, to resist evil. Medical ethics represents but one corner of that wide universe.

Competing interests (1) I worked in Alice Gaol for lower-than-average wages; I worked offshore for inflated wages; I banked all proceeds and I paid tax on them. (2) I have written and published elsewhere on these themes and continue to do so. They constitute a substantial element in my forthcoming book, 'Burned Man' (in press, Hybrid Publishers, for release in August 2016). (3) I signed a confidentiality agreement.. Fortuitously however, while in the process of preparing a report for publication, I was released from this undertaking when the senior civil servant in (the then) Department of Immigration and Customs gave a candid public description to a Parliamentary Committee of all I had seen and more.

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