THREE UNPUBLISHED REPORTS FROM CHRISTMAS ISLAND DETENTION CENTRE, 2009

AUTHOR, HOWARD GOLDENBERG

ITEM 1
THE SLASHED AND THE HANGED

ITEM 2
HUNGERING

ITEM 3
TAÁROUF

ITEM FROM BRITISH JOURNAL OF MEDICAL ETHICS

AUTHOR HOWARD GOLDENBERG

The Tooth →

February 1, 2016

The Clinician and Detention

By howardgoldenberg ¶

Recently Dr David Isaacs, a courageous Australian paediatrician, returned from a working visit to one of Australia's offshore immigration centres with distressing reports of the suffering and what he considered to be torture of the detained asylum seekers. He called publicly for doctors and nurses to question whether it is ethically permissible for them to accept employment in such settings. Since Dr Isaacs spoke out doctiors and nurses at Melbourne's Royal Children's Hospital have refused to discharge asylum seeker p[atients to island detention where they believe the children would be unsafe.
Dr Isaacs risked imprisonment for speaking out and he donated his earnings to asylum seeker relief. He then published an essay in The Journal of Medical Ethics, whose editor – an Australian medical graduate – asked me to respond. This is what I wrote. It is published here with the kind consent of the editor of the Journal of Medical Ethics, British Medical Journal.
ABSTRACT: An examination of ethical issues encountered in the author's clinical work with detained patients. The author seeks 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. Also addressed is the broader question: how – if at all – do medical ethics vary from universal ethics? The author reflects on the distinctive duties of a free human towards a detained one. And finally addresses the topical 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.

BY WAY OF INTRODUCTION

The author is a general practitioner of wide experience, having worked in Australian urban, suburban and country practices over greater than four decades; and having spent about eight weeks a year for the past twenty years working in remote clinics. These ‘outback’ postings have been predominantly in Aboriginal communities, while (in 2009) the writer worked for a time In Alice Springs Correctional Centre, and (in 2010) in an Australian Government Immigration Detention Centre offshore.

DECLARATION OF INTEREST

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 tutored the editor of this journal in general practice. Our conversations ran particularly to ethics. I became your editor’s friend, his referee, his failed marathon running mentor.
3. As a result of the foregoing I must accept partial responsibility for any ethical errors in your editor’s writing and in his clinical work.
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MEDICAL ETHICS VS ‘UNIVERSAL ETHICS’

I read with interest and admiration ‘Are health professionals working in Australia’s immigration detention centres condoning torture?’ The paper addresses a number of important issues explicitly as well as raising equally significant questions implicitly. As I read that valuable paper I found myself wondering whether any distinction actually exists between medical ethics and human ethics generally. An alternative way of formulating my question runs something like this: Why, and in what ways, should a nurse or a doctor – or any clinician – be answerable differently from any other moral agent?

At first blush there would seem to be no difference: in the encounter between any two humans who find themselves respectively in need of help and in a position to help, their inequality mandates a response. That one is sick and the other is skilled in healing is an accident, a detail. This is the bedrock ethic of the Good Samaritan.

However, if among a number of willing passers-by there be one who is a nurse or a doctor, the twin facts of clinical training and of vocation, demand that person in particular step forward and help.

Similarly, the training of the Surf Life Saver selects her to rescue one washed out to sea; and the paramedic is the one who should commence CPR in case of roadside cardiac arrest; and the infectious diseases physician respond to the Ebola outbreak.

Common to all these is a degree of risk to the rescuer; the life saver risks drowning, the paramedic risks injury from passing vehicles or hostile lawyers, the physician risks contracting infection and the asylum-seeker's clinician risks criminal penalties should she reveal official wrongdoing. Traditionally society expects its 'rescuer class' to accept those personal risks. In entering our professions we who are clinicians have implicitly accepted – indeed embraced – those risks. So much so that it was with shock that I first heard the suggestion – made in 1969 – that a doctor should not stop to help a road victim, lest the doctor be sued for an adverse outcome. (That advice was given to doctors in litigious America. The advice was ethically wrong, and in many jurisdictions laws have been passed that protect a clinician who responds ethically.)

ARE DETAINED PATIENTS DIFFERENT?

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'); their complaint, their pathos, was the detained condition, to which more familiar clinical entities were superadded.

To a man – and the great majority in my care happened to be adult and male – patients 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 replaced trust in fellow humans with mistrust, 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 anti-patient and the anti-doctor. 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. 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, faith, kindness. I do not suspect any such intent on my island. But the outcomes here are as certain as they are 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 wrongness 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 dehumanizing 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

behavior of the captors. Doctors drank every night, smoked heavily, suffered nightmares. More than one guard attempted suicide, one successfully.

In one more than one instance my medical superior refused my referrals for imaging, apparently on the unspoken grounds such 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 voice was 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 VS IMMIGRATION DETENTION VS CUSTOMS DETENTION

The author of 'Condoning Torture?' 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 with 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 when they were admitted to the Clinic 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.

Offshore detainees manifest a critical and unique pattern of behaviour which distinguishes them from the great majority of patients of my clinical experience in other settings: they see it in their interest to achieve, demonstrate and maintain the worst health possible. The purpose – or the function – of this 'poor health' is to qualify for urgent transfer to 'the mainland', a location endowed with a mythic access to liberty in Australia proper. Thus the asylum seeker will exaggerate or fabulate to save himself. The clinician is mistrusted (like all in authority, for all have 'lied', and lied maliciously to drive the poor patient mad); in turn the clinician is unable to take symptoms at face value. Trust, the substrate of every decent clinical encounter, is shattered. For the clinician and the imprisoned person have opposite objectives.

Quite different are the assumptions in Alice Springs Correction Centre where eighty percent of prisoners are Aboriginal. Here transparency is a cardinal virtue. Prompted by blackfella outrage and whitefella shame, and by the political hazard of failing to care well for imprisoned indigenous people, authorities hasten to identify risk of harm to their charges and to act upon it. Often warders and clinicians over react, such are the anxiety and the dread of misreading need through the clinician's cultural subliteracy.

SHOULD A DOCTOR ACCEPT WORK WITH DETAINED PERSONS OFFSHORE?

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

The author of "Condoning Torture" suggests Australia's treatment offshore of detained refugees constitutes torture. The writer 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 a clear ethical path. He authorizes each individual to forge a personal response. This seems to recognize the moral autonomy of the individual practitioner, as well as the individual responsibility of the individual. As the Mishnaic sage Hillel taught: if not me, then who? If not now, then when?
The author breaks the decision 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 more offends ethically than to desist.
3. In answering the second question I must consider how much my gags prevent 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 clinical need. 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 a medical professional. That profession implies first and foremost a refusal to do no harm. If and when I form the belief 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. That is my lifesaver, my paramedic, my infectious disease specialist moment, my moment of familiar medical hazard. A hazard, yes, but in our relatively non-totalitarian system, a hazard without risk of death. Safer far than the ebola risk. Safer than the choices of a psychiatrist in the Soviet Union, safer than those of doctors under the Third Reich. A hazard but not a mortal 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 it from the rooftops. And conversely, if I find my hypothetical centres to be objectionable I must call for their improvement or their closure.

Those are equally clear ethical imperatives – not matters of narrow medical judgement but the call of every citizen. In the end the doctor, the nurse, the guard, the journalist, the therapist, the pharmacist, the interpreter, the public servant all answer to an ethic which is universal. Medical ethics represents but one corner of that wide universe.

Should Nurses and Doctors Accept Work in Australia's Detention Centres?

By howardgoldenberg ¶ Posted in Asylum Seekers, In Detention, Life, Medical
¶ Tagged detention, doctors, ethics, Manus Island, medicine, Nauru, refugees, torture ¶ 6 Comments

In 2010 I worked in an Australian detention centre for short time that felt like a long time. The experience was the worst in my fifty years in Medicine. I signed a confidentiality agreement, sewing my own lips in the process. I saw no atrocity, no wrongdoing, other than torture by impersonal and meandering bureaucracy. Yet the suffering was general; it saw inmates, guards, nurses and doctors all resorting to self-harmful acts. I saw honourable people treating the detained with skill and humanity. I saw them constrained by employers and distrusted and insulted by patients, who felt sure that we too were liars. Yet we did some good. People, whether sick in body or in spirit, were treated with kindness and respect.

For six months after I returned to the mainland I was visited by dreams in which I sat on Tribunals without name, determining the fate of nameless individuals doomed by history and by Australian laws. Captive in these dreams, I doled unequal laws to defeated supplicants. I'd awaken and ask myself, did I really do that? But, inescapably, I knew I was implicated.

My island was a paradise of procedural propriety compared to today's islands of Nauru and Manus. Doctors and nurses have returned from these places with distressing reports. Some have argued that, knowing what is now known, it is in unethical to work in these places; that the system tortures inmates; that participating is to become complicit in torture. More moderately, all clinicians and observers who return seem to agree that incarceration harms the inmate. The first law of medical ethics being, first do no harm, is not an ethical practitioner obliged to refuse to share in that harmdoing?

A new element affecting the work of a detention clinician is the outlawing of reporting wrongs seen in that work. Offenders face the threat of two years gaol. Nice systematic irony: to protect the liberty of Australians we incarcerate boat people; to protect the integrity of the system we incarcerate truthtellers. Interestingly, the flood of job offers to work in Detention that recruiters used to send to remote doctors such as myself has dried up. Someone, somewhere must have decided Australian clinicians are unreliable.

What then must a nurse or a doctor or a psychologist or a psychiatric nurse do? If offered, may we accept this work? Even if we are forbidden to speak of what we see?

I compare the situation to working with patients in places of dangerous epidemic disease. The first such case I read of was the cholera that broke out in eighteenth century Naples, where a young Swedish doctor left his fashionable private practice in Paris to work with the afflicted. He found himself working alongside a young nurse who was both beautiful and a nun. At any moment the disease might take them. The two work steadily on, afflicted by the losses and by the erotic fever that seizes them both. The drama of the two who risk all for strangers has never left me. The doctor, Axel Munthe, wrote of this in his memoir, *The Story of San Michele.*
We saw just such heroism played out by Australian nurses and doctors who went to Africa recently to save people from Ebola. We saw it, and -as a nation, as individuals – we prayed for our heroes and we applauded them.

Nothing new here: nurses and doctors work with AIDS, with multi-drug-resistant TB, with Lassa Fever. It is natural to the species to measure the need before the personal risk.

The second precedent is an unhappy one; during the twentieth century doctors working under dictatorships accepted orders, accepted payment, enjoyed promotion and protection, and participated in abuses ranging from imprisoning sane dissenters in psychiatric institutions, to 'eugenic' murder, to torture. And being bought, they shut up about it. If clinical ethics learned anything from these abuses it was the imperative to speak out.

In the light of history I see the duty of free citizens, clear and uncomplicated. It is to go to the camps, to do such good work as might be done, and to speak out.

REVIEW ARTICLE

Mental health implications of detaining asylum seekers: systematic review

Katy Robjant, Rita Hassan, Cornelius Katona

The British Journal of Psychiatry Mar 2009, 194 (4) 306-312; **DOI:** 10.1192/bjp.bp.108.053223

Abstract

Background
The number of asylum seekers, refugees and internally displaced people worldwide is rising. Western countries are using increasingly restrictive policies, including the detention of asylum seekers, and there is concern that this is harmful.

Aims
To investigate mental health outcomes among adult, child and adolescent immigration detainees.

Method
A systematic review was conducted of studies investigating the impact of immigration detention on the mental health of children, adolescents and adults, identified by a systematic search of databases and a supplementary manual search of references.

Results
Ten studies were identified. All reported high levels of mental health problems in detainees. Anxiety, depression and post-traumatic stress disorder were commonly reported, as were self-harm and suicidal ideation. Time in detention was positively associated with severity of distress. There is evidence for an initial improvement in mental health occurring subsequent to release, although longitudinal results have shown that the negative impact of detention persists.

Conclusions
This area of research is in its infancy and studies are limited by methodological constraints. Findings consistently report high levels of mental health problems among detainees. There is some evidence to suggest an independent adverse effect of detention on mental health.

The number of asylum seekers, refugees and internally displaced people worldwide rose to 20.8 million at the beginning of 2006.[1] Western countries have increasingly resorted to policies aimed at reducing the numbers of individuals seeking residency. These ‘policies of deterrence’ include the reduction of access to healthcare services, education and employment as well as an increase in the practice of detaining individuals who are seeking asylum[2] and the provision of time-limited rather than permanent protection. Immigration removal centres in the UK are secure environments where asylum seekers and other categories of foreign nationals are detained. Individuals are held within these centres for an indefinite period while awaiting the outcome of administrative processes regarding their application for leave to remain in the UK. The majority are deemed by the Home Office to have exhausted their legal processes and to be ‘failed asylum seekers’ awaiting removal to their country of origin or to a third country. Some, however, are still in the process of legal appeal and others initiate fresh asylum claims while in detention. Another group that may be detained in these centres are foreign nationals who have completed prison sentences for offences committed in the UK and are awaiting or contesting deportation. Within the UK there is a capacity of 2557 places for immigration detainees and deportees. In 2005, a total of 29 210 individuals left detention. Of these, 59% were deported from the UK. The rest were given temporary leave to remain or were granted bail to live within the community until the outcome of their claim was determined.[3]

Under the 1951 United Nations Convention on the Status of Refugees, a refugee is an individual who has successfully completed the legal processes required to achieve permanent residency within the host country. Refugees are therefore not detained in immigration removal centres. Asylum seekers are entitled to recognition as a refugee if they have a well-founded fear of persecution because of race, religion, nationality, membership of a social group or political opinion. Asylum seekers have often experienced traumatic events in their country of origin. Individuals detained within immigration removal centres could, therefore, be described as a vulnerable group particularly susceptible to the adverse effects on mental health associated with detention. According to Home Office guidelines, individuals who are experiencing mental health problems should not be detained unless there are exceptional circumstances.[3]

Mental health of asylum seekers

Research suggests that asylum seekers and displaced persons worldwide report high rates of pre-migration trauma,[4] and therefore of trauma-related mental health problems. In a meta-analysis of worldwide studies investigating the mental health of refugees (including asylum seekers and displaced persons), Porter & Haslam found high rates of psychopathological disorder among refugees worldwide compared with non-refugee control groups.[5] There is therefore consistent evidence to suggest that asylum seekers and refugees have higher rates of mental health difficulties than are usually found within the general population. The process of seeking asylum in Western countries places additional demands on this group. These include stressful legal processes. In an Australian study comparing post-migratory stress in refugees, asylum seekers and immigrants, Silove *et al* showed that the ' refugee determination process' (including interviews by immigration officials) was regarded as stressful by asylum seekers.[6] In addition, a Dutch study showed that longer asylum processes result in increased risk of psychiatric disorder.[7] The authors also reported increased anxiety, depression and somatoform disorders in individuals who had lived in The Netherlands for more than 2 years compared with refugees who had arrived within the preceding 6 months. Consistent with these findings was the observation of high rates of post-traumatic stress disorder (PTSD) symptoms in both groups. Post-migratory stressors seem, therefore, to be negatively affecting this population, who are already vulnerable to mental health difficulties as a result of their previous exposure to traumatic events.

Asylum seekers in detention

Asylum seekers who are detained in the host country experience a further and more specific set of stressors, reflecting the detention process itself and the detention centre environment, which may adversely affect their mental health status. These include loss of liberty, uncertainty regarding return to country of origin, social isolation, abuse from staff, riots, forceful removal, hunger strikes and self-harm.[8–10] Given the well-documented vulnerability of asylum seekers as a result of experience of trauma prior to arrival, a number of clinicians have expressed concern that detention increases mental health difficulties in adult and child asylum seekers, and have called for an end to such practices.[11–13] This conflicts with current government policy aimed at reducing numbers of asylum seekers.[2] The practice of detaining asylum seekers is therefore currently a prominent and contentious issue in terms of policy, health and social care. These issues are outlined in more depth by Steel & Silove.[14]

The aim of this review was to identify studies that have investigated the impact of immigration detention on the mental health of detainees held in Australia, the UK and the USA. Studies that investigated the impact of detention on children and adolescents were included in the review. The results of these studies were reviewed in order to consider whether there is evidence for an association between increased prevalence and severity of mental health problems and immigration detention.

ITEM 2

Authors Emily Hadgkiss, Emergency Practice Innovation Centre, St Vincent's Hospital Melbourne Dr Carolyn Lethborg, Social Work Department, St Vincent's Hospital Melbourne Dr Ahmad Al-Mousa, Ecumenical Migration Centre, Brotherhood of St Laurence Claudia Marck, Emergency Practice Innovation Centre, St Vincent's Hospital Melbourne

Executive Summary Australia is one of many countries that receive asylum seekers, fleeing their home country seeking refuge somewhere free from conflict. Only those who are fleeing from persecution for one of five defined reasons will meet the definition of a refugee and have the right to enter (with or without authorisation) and stay in Australia under the United Nations Refugee Convention. According to data from the Department of Immigration and Citizenship, after an extensive determination process, many asylum seekers arriving by plane, and almost all of those arriving by boat, are found to be genuine refugees. They receive permanent protection visas and become part of the society with the same rights and responsibilities other Australians have. However, this determination process often takes up a considerable period of time, sometimes years, during which asylum seekers are awaiting a decision, either in immigration detention or in the community. Asylum seekers already have a higher risk of experiencing a range of illnesses and a more urgent need for health care compared to the rest of the Australian population due to a history of inadequate nutrition, health care and social security supports in the country they fled, chronic stress and/or factors surrounding their journey to Australia. The stress caused by (sometimes lengthy) immigration detention, prolonged uncertainty regarding their visa application, and not having control over their own, or families', living circumstances and futures is substantial. This period of uncertainty in the setting of previous trauma often leads to the development or exacerbation of mental illnesses including Post Traumatic Stress Disorder (PTSD) and depression. In addition, from a "Social Determinants of Health" perspective, asylum seekers are met with either restrictions to, or a failure to improve, almost all of the below domains: • Income and social status • Social participation and social support networks • Education • Health literacy • Healthy living conditions • Racism, discrimination and culture • Early life factors and genetics • Individual behaviours and lifestyle factors • Access to health care These areas of deficiency highlight ways that Australia is breaching several human rights treaties including the Refugee Convention, and conventions regarding Economic, Social and Cultural Rights, Civil and Political Rights, the Elimination of all Forms of Racial Discrimination, against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the Rights of the Child. Thus, asylum seekers are one of the most vulnerable groups in the Australian community and therefore a change is needed in the way we view their rights and welfare. Overcoming the barriers to accessing health care for this population is an urgent starting point. Many have complex mental health needs, need culturallyappropriate services, require an interpreter and have limited resources. Existing health services for asylum seekers are stretched and remain relatively unsupported, operating with very limited budgets and often relying on volunteers and professionals providing pro-bono services

ITEM 3

Med J Aust. 2001 Dec 3-17;175(11-12):596-9.

The mental health implications of detaining asylum seekers.

Steel Z[1], Silove DM.
Author information

Abstract

The possible mental health impact on asylum seekers of Australia's policy of mandatory detention is an issue of special relevance to health professionals and the public. Independent commissions of inquiry in Australia have found varying degrees of mental distress to be common in detained asylum seekers. Research studies in Australia and elsewhere suggest that detained asylum seekers may have suffered greater levels of past trauma than other refugees, and this may contribute to their mental health problems, with their detention providing a retraumatising environment. Studies are urgently required to examine the mental health consequences of detention, and to determine the effect of detention on acculturation and adaptation for asylum seekers subsequently released into the community.

- [Med J Aust. 2001]

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However, if among a number of willing passers-by there be one who is a nurse or a doctor, the twin facts of clinical training and of vocation, demand that person in particular step forward and help.
Similarly, the training of the Surf Life Saver selects her to rescue one washed out to sea; and the paramedic is the one who should commence CPR in case of roadside cardiac arrest; and the infectious diseases physician respond to the Ebola outbreak.

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To a man – and the great majority in my care happened to be adult and male – patients 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 replaced trust in fellow humans with mistrust, 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 anti-patient and the anti-doctor. 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. 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, faith, kindness. I do not suspect any such intent on my island. But the outcomes here are as certain as they are 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 wrongness 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 dehumanizing 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 behavior of the captors. Doctors drank every night, smoked heavily, suffered nightmares. More than one guard attempted suicide, one successfully.

In one more than one instance my medical superior refused my referrals for imaging, apparently on the unspoken grounds such 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 voice was 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 VS IMMIGRATION DETENTION VS CUSTOMS DETENTION

The author of 'Condoning Torture?' 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 with 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 when they were admitted to the Clinic 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.

Offshore detainees manifest a critical and unique pattern of behaviour which distinguishes them from the great majority of patients of my clinical experience in other settings: they see it in their interest to achieve, demonstrate and maintain the worst health possible. The purpose – or the function – of this 'poor health' is to qualify for urgent transfer to 'the mainland', a location endowed with a mythic access to liberty in Australia proper. Thus the asylum seeker will exaggerate or fabulate to save himself. The clinician is mistrusted (like all in authority, for all have 'lied', and lied maliciously to drive the poor patient mad); in turn the clinician is unable to take symptoms at face value. Trust, the substrate of every decent clinical encounter, is shattered. For the clinician and the imprisoned person have opposite objectives.

Quite different are the assumptions in Alice Springs Correction Centre where eighty percent of prisoners are Aboriginal. Here transparency is a cardinal virtue. Prompted by blackfella outrage and whitefella shame, and by the political hazard of failing to care well for imprisoned indigenous people, authorities hasten to identify risk of harm to their charges and to act upon it. Often warders and clinicians over react, such are the anxiety and the dread of misreading need through the clinician's cultural subliteracy.

SHOULD A DOCTOR ACCEPT WORK WITH DETAINED PERSONS OFFSHORE?

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

The author of "Condoning Torture" suggests Australia's treatment offshore of detained refugees constitutes torture. The writer 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 a clear ethical path. He authorizes each individual to forge a personal response. This seems to recognize the moral autonomy of the individual practitioner, as well as the individual responsibility of the individual.

As the Mishnaic sage Hillel taught: if not me, then who? If not now, then when?
The author breaks the decision 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 more offends ethically than to desist.
3. In answering the second question I must consider how much my gags prevent 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 clinical need. 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 a medical professional. That profession implies first and foremost a refusal to do no harm. If and when I form the belief 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. That is my lifesaver, my paramedic, my infectious disease specialist moment, my moment of familiar medical hazard. A hazard, yes, but in our relatively non-totalitarian system, a hazard without risk of death. Safer far than the ebola risk. Safer than the choices of a psychiatrist in the Soviet Union, safer than those of doctors under the Third Reich. A hazard but not a mortal 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 it from the rooftops. And conversely, if I find my hypothetical centres to be objectionable I must call for their improvement or their closure.

Those are equally clear ethical imperatives – not matters of narrow medical judgement but the call of every citizen. In the end the doctor, the nurse, the guard, the journalist, the therapist, the pharmacist, the interpreter, the public servant all answer to an ethic which is universal. Medical ethics represents but one corner of that wide universe.