

Lessons From Our Learners

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Systematic Cycles of Futility

Zachary J. Baeseman

As we walked up to the suicide cell I was not exactly sure what I would see. The nurse had previously explained to me that when an inmate says that he or she is going to take their life they get an empty cement cell with only a padded vest to wear. Later, if they seem to be behaving, they are allowed one padded blanket to cover up with. Even though I had known all of this before I approached the cell, the reality was still unnerving.

The nurse clanged on the trap in the door and announced simply, "Medicine." No reply.

She clanged on the door again and repeated, "Medicine."

I peered through the window in the door from behind the nurse to see a lump of green padded material on the floor in the corner of the cell—it moved very slowly. A disheveled man in his mid-30s

poked his face through the 16" by 6" trap in the door. His hair was in disarray, he hadn't showered in at least 3 days, and his lips were cracked and dry. He struggled to form speech due to his parched mouth and prolonged silence. He received his medicine from the nurse—the usual ibuprofen treatment that seemingly every inmate received. This was probably the 50th instance this morning alone in which the nurse had dispensed ibuprofen.

She asked him, even at this point not using his name, if he could use some water—he did not have any free access to water to prevent him from drowning himself in a toilet, sink, shower, etc. He nodded and thanked her. He then asked when he was going to be moved into the general population. He suggested that if he had a private cell in general population (ie, segregation) he would be fine. This was obviously not feasible while he was still suicidal.

The nurse asked, "What brought you in here?"

"I broke my parole."

I was stunned. This inmate had merely broken his parole, declared suicidal intentions, and landed himself in jail under these harsh conditions. Why wasn't he in a hospital? I couldn't help but wonder how many times this cycle had been perpetuated—here sits a person with mental health issues using the only resources he has probably ever known. I came to find out later that this was approximately the 15th time the inmate was in this particular county facility alone; of course he was also a frequenter of most of the other facilities in each of the four neighboring counties.

His main concern at that moment was how to contact his wife, who did not have access to a telephone and probably had no idea where he had been for the past 3 days. As he told his story, I got the sense that he wasn't exactly sure how he had gotten here; I wasn't even sure he had a wife. He looked directly into my eyes as he gave his testimonial; there was something queer about his gaze. I could see different emotions run through him as he explained his story. In some instances his affect

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seemed inappropriately blunted. It was subtle, and I am not even certain it is describable. Something seemed “off” in his expression.

I asked the nurse if this patient had any psychiatric history of schizophrenia—a concept that seemed to be a radical idea to her. We had not seen any symptoms of schizophrenia in our brief interaction with this convict, but I had seen his subtle look before, interviewing patients on the psych ward. She explained to me that other than being suicidal because he was a convicted child molester, there were no other psychiatric issues that she could see. In the pit of my stomach I felt a sense of disgust at this man’s designation, “Child Molester.” The nurse made her bias clearly evident in my interaction with her, as would be my own bias if I were not mindful of my feelings. I found myself silently reaffirming and challenging my beliefs—“Quality health care is a basic human right for all individuals. You still believe that, don’t you?”

Later that afternoon, I approached the social worker who came to the prison to interview the suicidal inmate and raised my suspicions about the patient being schizophrenic. I asked if it would be all right for me to sit in on the interview. She was excited to have a medical student tag along. At the prison, it wasn’t often that someone took an interest in her work.

I was shocked to discover that the entire interview was done through the trap in the door. After eliciting an extensive history of previous suicide plans and many failed attempts, we finally got to my question.

The social worker asked, “Do you hear voices?”

The inmate put his head down and started to laugh. He must have thought the idea was so absurd that it was laughable. For a moment, I felt like a fool for relying on my intuition. Then, the inmate slowly raised his head. Clearly, it was not a funny laugh but rather a laugh when nerves are running high. The inmate’s laugh was out of insecurity and embarrassment that people might think he was “crazy.”

He timidly replied, “Are you seriously asking?”

The social worker replied, “Yes.”

“Then, yes. I do hear voices from my friend Smokey,” he said.

He proceeded to relay an elaborate description of his Irish friend named Smokey, who happened to be talking to him at the present moment. Smokey always spoke in a thick Irish accent and was currently sitting in the corner of the cell. The social worker and I both looked to the corner where the inmate had pointed to see nobody else was present. He had known Smokey and a few other “friends” for about 10 years now. I did the quick math,

putting him somewhere at his early 20s for onset. Astonishingly enough, throughout this patient’s pervasive history of being in and out of jail, no one had ever asked him if he heard voices.

If a decade ago this patient had been placed on a different environmental track with insurance and a primary care provider and access to essential resources, could the indefinite psychological damage to the victims and families have been averted? We will never know. This patient used the only resources available to him—a county detention facility. There is no foreseeable reason that his cycle will be broken. It is really not surprising why recidivism is so common in the prison system. “If you always do what you’ve always done, you’ll always get what you’ve always gotten.”

One way or another we are all going to pay for the health care our country requires. Connecting the dots is the easy part. The only relevant point is whether or not it is in the plan, as opposed to paying for it in the hidden costs mostly unknown to society at large.

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