The Prison Inmate's Right to Treatment and the General Hospital: A Case Report of Acute Intermittent Porphyria

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INTRODUCTION

The general acceptance of the unsentenced prisoner's right to medical treatment1,2 will result in physicians' diagnosing and treating more patients from a segment of the population which, until recently, was relatively neglected. Since it will not be feasible to establish comprehensive medical services in each jail, it is likely that referrals will be made to general hospitals and that more inmates will be seen in the hospitals' emergency departments.

This paper describes an unsentenced prisoner whose "obnoxious" behavior, coupled with the emergency room staff stereotyping of all inmates as malingerers, led to a delay in arriving at the diagnosis and treatment of his illness. Because of the complexity of the case material and the difficulty in arriving at adequate care for the patient, it will be instructive to review the case in some detail.

Case Report

"WW is a 21-year-old, single, black male who in October, 1974, was arrested on charges of assault and reckless endangerment. While driving on a college campus, he hit a student and then smashed his car into the side of a building. When the police arrived he actively resisted arrest. The police subdued him and brought him to the emergency department of a local hospital, where WW was examined and no physical injuries were noted.

Shortly after his arrival at the county jail, he became uncooperative and assaultive. Because of the non-goal-directed nature of his behavior and some clouding of his sensorium, he was transported back to the emergency department, where he became unmanageable. He was seen by the resident in psychiatry on duty in the emergency department and thought to be merely an unpleasant, hostile, and aggressive individual. WW was referred to the jail on no medication.

The jail medical staff requested a consultation from the Mental Health Clinic for Socio-Legal Services. This clinic provides psychiatric evaluation and treatment to individuals who are referred by the criminal justice system. A more detailed description of the clinic is contained in a paper by Barry, Babigian and Pederson.3 On interview by one of the authors (SP), WW was found to be an angry individual who answered the...
first questions with brief concrete statements and subsequent questions with incoherent responses. In order to decrease WW's agitation and further evaluate his mental status, WW was sedated with chlorpromazine 100 mgs IM and transferred to an observation cell. There he became more agitated; further psychiatric evaluation at that time was unsatisfactory. Over the next day he became autistic and refused to eat or drink.

After twenty-four hours of not eating or drinking, WW showed mild signs of dehydration. At this time, he responded to questions by nodding and he complained of some vague abdominal pain. He permitted a physical examination and was found to have bilateral hyperreflexia with absent Babinski signs. Palpation of his abdomen revealed some diffuse tenderness. Because of his physical condition, he was transferred back to the emergency department for his third visit; he was given IV fluids. Following rehydration, WW became unmanageable and was quickly returned to the jail.

He was placed in an observation cell and once again refused to eat or drink. The next day he was dehydrated and for the fourth time returned to the emergency department. The ED staff by this time was furious with both WW and the jail staff. WW received a cursory physical examination and one ED staff member was reported to have said, "Get him out of here! He belongs in jail." WW was then transported back to the jail.

WW's parents, who live three hundred miles away from the city in which their son was arrested, were contacted. They reported that their son had been suffering from stomach pains for several months and had lost considerable weight during this time. WW's family physician was called. WW had consulted him regarding some vague abdominal discomfort; however, no clear etiology had been determined and WW had been treated symptomatically. Repeat physical examination revealed bilateral hyperreflexia with some lateralization to the left. Cogwheel rigidity was noted in the left elbow and a question of nuchal rigidity was raised. On mental status examination WW rambled incoherently; he was withdrawn and motionless and made no apparent effort to follow the instructions of the examiner.

In light of the above information, concern over the cursory examinations WW was receiving in the emergency department caused a call to be placed to the Neurology Service requesting a comprehensive workup. WW was then brought to the emergency department and seen by a neurology resident. A metabolic cause for his difficulties was considered and a Watson-Schwartz test performed. It was positive and the diagnosis of Acute Intermittent Porphyria was made. Resistance to admitting WW to the hospital crumbled; he went to the Neurology Service, where he received extensive evaluation and treatment. Two weeks later, because of difficulty managing the patient's behavior on the Neurology Service, he was transferred to the Psychiatric Service. After one month on the Psychiatric Service, he was discharged and returned to the jail. He remained there several days and then went to court, where his charges were adjourned in contemplation of dismissal. WW returned to live with his parents. Eight-month follow-up revealed no recurrence of physical symptoms or behavioral problems.

Discussion

The complex task of diagnosis of disturbed behavior involves the clinician's awareness of the dynamic interaction of problems in the patient's physical-chemical hemeostasis and psychosocial conflicts. Arriving at the correct diagnosis is made even more difficult when a jail comes between the patient and the hospital.

The inmate status radically alters the individual's view of himself and decreases his flexibility in meeting his needs. The dehumanization which results from loss of contact with the outside, as well as the uncertainty of the new inmate's status, increases his vulnerability to illness. If he feels ill, the inmate must convince the jail staff that he needs medical attention. He may do this by displaying disturbed behavior; WW did.
so by being uncooperative, aggressive, and assaultive. When the inmate goes to the ED, he is viewed as both a prisoner and a patient. This role ambiguity encourages the use of the stereotype that all inmates are malingerers—they aren't sick; they're just trying to get out of the noxious jail environment.

WW was suffering from Acute Intermittent Porphyria, which initial cursory ED evaluations failed to uncover.\textsuperscript{10,11} Repeat visits, rather than resulting in more comprehensive evaluation, led to even briefer examinations and increasing anger towards him. The vigorous rejection of WW by the ED staff resulted from the interplay of: one, the staff's considering him a malingerer; two, his obnoxious behavior; and three, the low incidence of his illness. Only after repeated phone calls to the hospital by the Mental Health Clinic staff was a metabolic cause of his abnormal behavior considered.

This case points out the need for individuals working in either of the two systems, the jail or the hospital, to have a close working relationship. This will be even more important with the anticipated increase of referrals of prisoners to general hospitals. A mental health clinic which actively provides psychiatric evaluation and treatment of inmates is in an excellent position to act as the liaison between the jail and the hospital. Further work is needed to explore the extent of this role for the mental health clinic and to devise programs to implement this liaison function.

References