A PIECE OF MY MIND

# Osler in Jail

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**The front door** to the Nashua Street Jail is a two-inch–thick wall of steel and bulletproof glass. I show my identification to a correctional officer behind the security window, and enormous unseen motors spin to life and slowly slide the panel closed to trap me in the anteroom that provides access. A buzzer sounds, and the identical back door begins to rumble open. The buttons in the elevator don't work; the officer watching me over video surveillance directs it to the appropriate floor.

When I exit on the medical unit, the officer at the desk briefly looks up from his newspaper to wave hello. I proceed to the nursing break room. It's dingy and windowless, with a water cooler, a fridge, steel lockers, a lunch table with uneven legs, and a couch whose fabric manages to be scratchy even through clothes. In a neat, even script of red marker the room's whiteboard pronounces:

The good physician treats the disease; the great physician treats the patient who has the disease. —Sir William Osler

Osler, a conspicuous humanist, certainly meant for this instruction to evoke compassion and a broadly curious concern for his medical students' patients. But in jail it clangs with a sinister undertone. Exactly what about our patients besides their disease should we be treating?

The Nashua Street Jail (NSJ) is a maximum-security facility that houses about 700 men only 400 meters from the Massachusetts General Hospital (MGH). It was built in 1990 to replace the 19th-century era Charles Street Jail, a hulking mass of gray stone that was subsequently bought by the hospital and converted to a luxury hotel complex. (Apparently, before the hotel opened, someone smirked and named it The Liberty.) Despite the NSJ's size and proximity, I've found that most staff at MGH are unaware it exists. More than one person I talked to confused it with the Massachusetts Eye and Ear Infirmary, a brutalist concrete monstrosity that admittedly does look more penal than the jail itself.

I go to the jail every other Thursday evening to see inmate-patients in a student-run clinic. Osler, an early champion of pulling medical students out of the lecture hall and onto the wards to learn medicine from real patients, would have loved it. Supervised by a resident and attending physician, two student medical teams each see several patients, alongside student dentists and psychiatrists. Concurrently, other teams lead a health education program for inmates and chip away at a research project.

Some aspects of the clinic are strange. Students are given officious titles, presumably to enhance the prominence of the clinic's resume line item. Medical students are "Senior Clinicians" or "Integrated Clinicians." The guy who picks up the pizza is the "Senior Director" for the day. But the clinic has its heart in the right place. All the staff care earnestly about providing medical care to our uniquely vulnerable patient population. And students work hard, sometimes seeing patients until 9 PM after a full day in the hospital.

I've found that people at fancy cocktail parties can be skeptical about the value of providing care in jails. Once an acquaintance asked me, "Why would you want to treat criminals?"

"Well, most people are there awaiting trial and presumed innocent, so really the correct term is 'detainees.'"

This statement is technically true, but it has the unfortunate effect of seeming to concede that convicted inmates might no longer deserve medical care.

In many ways, treating patients in the jail is like treating them in any other clinic—most of our patients have chronic diseases like diabetes and hypertension. But after being at the jail where everyone is accused of something, on the hospital wards I hear the rhetoric of culpability more acutely. I now notice how blame drifts through the wards like a sour mist, settling over encounters with smokers who have lung disease and injection drug users with endocarditis. I hear it in the snip of judgment in discussions of our patients with obesity, or alcoholism, or who don't take their medications as prescribed. Likewise, I feel more attuned to the extra glow of warmth that we radiate to the patients we judge to be righteous, or adherent, or perhaps just more like ourselves.

Just like on the outside, in jail we ask people about their lives, their jobs, and their family. We ask them about their sexual encounters and their drinking and drug use. At this point in the conversation, patients sometimes ask me, "Do you want to know what I'm in for?" Legal charges shouldn't affect your diabetes care, so I always answer the same way: "No. But if you want to talk about it, you're welcome to." Nobody ever does.

At first, I was curious what my patients were accused of. But I began to realize that the instinct to stratify patients by the nature of the crimes of which they are accused came with a terrible weight. What must I do if one patient's crime is worse than another, or another is truly innocent, or another was compelled by uniquely desperate circumstance?

The answer, of course, is nothing. It's easy to say that disease should not be a tool of retribution and that all patients deserve our care and aid. But the human instinct to assign blame, to divide the saints from the sinners, runs deep; throwing it off takes practice. In jail, we have the opportunity to step into our patients' lives, currently organized by culpability in the most extreme way possible, and practice ignoring it. This opportunity is what I am most grateful to my incarcerated patients

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for, and I like to think they have taught me to better meet all my patients without judgment.

I don't know how Osler would have applied his admonition to "treat the patient with the disease" to incarcerated patients, or even to patients with diseases we currently are tempted to think of as products of human vice or frailty of character. I wonder if this understanding of illness would be so modern as to be unrecognizable to him. Osler was most concerned with establishing the virtue of medicine as a profession, at a time when physicians competed with quacks and charlatans. The virtue of his patients doesn't seem to have troubled him. In Osler's writing, patients are a teeming and indistinct mass of joy, suffering, whimsy, and sorrow that clearly thrills him, but for me never comes into focus as a collection of particular individuals.

In *Aequanimitas*[1] (literally "equanimity"), one of his most famous meditations on the character of physicians, Osler exhorts his students to cultivate the "bodily virtue" of imperturbability in the face of suffering and uncertainty. But even through his Victorian noblesse oblige, he also recognizes the universality of human weakness with special humility. He writes:

*Curious, odd compounds are these fellow-creatures, at whose mercy you will be full of fads and eccentricities, of whims and fancies; but the more closely we study their little foibles of one sort and another in the inner life which we see, the more surely is the conviction borne in upon us of the likeness of their weaknesses to our own. The similarity would be intolerable, if a happy egotism did not often render us forgetful of it.*

I like to think that this humility would have driven Osler to approach the care of even his most compromised patients with the same equanimity, unmoved by their virtue or their guilt.

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1. Osler W. *Aequanimitas: With Other Addresses to Medical Students, Nurses and Practitioners of Medicine*. Philadelphia, PA: Blakiston; 1922.

It is a terrible, an inexorable, law that one cannot deny the humanity of another without diminishing one's own: in the face of one's victim, one sees oneself.

James Baldwin (1924-1987)



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