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Asylum seeker's 'brain death' shows failure of care and of democracy

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The news that Hamid Kehazaei, a 24-year-old Iranian asylum seeker detained on Manus Island, has been [diagnosed as brain dead](#) following his transfer to the Mater Hospital in Brisbane is a tragedy. That it is a tragedy for this young man and his family is unquestionable – but the extent of this tragedy may be much more pervasive than we realise.

If the emerging details of his case are correct, Kehazaei developed septicaemia as a complication of cellulitis (skin and soft-tissue infection) arising from a cut in his foot. This, in itself, is disturbing.

Severe infection can result in brain death – either from infection of the brain itself (meningitis, encephalitis or brain abscess), or from brain injury due to a lack of oxygen resulting from cardiac arrest (as appears to be the case here), or from reduced blood supply to the brain. Yet it is very uncommon, especially in a young, previously healthy man.

Such a case could occur in Australia and [has been described](#) in 2012 in young Indigenous adults in Central Australia. Nevertheless, severe sepsis resulting from a foot infection is preventable. And a case like this occurring in an Australian national would raise serious questions about the appropriateness of the antibiotics used and the timeliness of care.

Most cases of brain death result from traumatic brain injury, stroke or lack of oxygen to the brain following asphyxia, near-drowning, or prolonged cardiopulmonary resuscitation.

What happened to Hamid Kehazaei [raises concerns](#) about the adequacy of care provided to him during initial treatment, including wound care and antibiotics, and how soon he was transferred to expert medical care, first to Port Moresby and subsequently to Brisbane.

If this young man became ill and had his brain die while seeking asylum in Australia and while in our care, then we must examine the details of his case and ask ourselves not only whether it was preventable but whether our policies and processes actually contributed to his death.

But how can we even begin to ask these types of questions when we know so little about the circumstances in which he became ill, and his subsequent care?

Protestations that this is due to the necessity of respecting privacy and confidentiality, ethical principles that are core to the health professional-patient relationship, are to some extent correct. But they also obscure important features of this case.

The government is simply wrong to claim that this issue should not be “politicised”. What is ultimately at issue here is the way in which domestic politics and border policy impose norms (rules of behaviour) that are antithetical to medicine and health care and, fundamentally, to democracy.

Medicine, like biomedical science, requires transparency and honesty to be clinically and ethically sound. Peer review, clinical audit, root-cause analysis, family conferences, conflict-resolution strategies, case consultation, multidisciplinary team meetings, mortality and morbidity meetings, open disclosure policies: all rest on the importance of transparency and respect.

In contrast, we know very little about the people who seek asylum in Australia. Everything is secret – their arrival, their situation, their medical need, their illnesses, and their death.

This requirement for secrecy has largely overwhelmed efforts by many good people – legislators, human rights lawyers, refugee advocates, health workers, politicians and ordinary citizens – to shine a light on what is happening to people in detention.

The Immigration Health Advisory Group has been disbanded, [restricting the degree](#) to which the health professions can critique the care available to asylum seekers. And even those tasked with providing medical care to asylum-seekers [struggle to advocate](#) for the people under their care.

Policies restrict the degree to which they can care for their patients or refer them for specialist care not available in the detention centres. Contracts bind them to secrecy and many, often shocked by what they have seen, are prevented from speaking out by legal threats and intimidation long after they’ve returned to the mainland.

The language of “border control” has been used to excuse political secrecy. But such secrecy is what we usually associate with autocratic governments and is the antithesis of democratic ideals.

What this case illustrates, yet again, is that the asylum seekers detained on Manus and Christmas Islands and Nauru have been excised not only from the laws that determine access to Australia but from the care we should provide any vulnerable person for whom we are responsible. And from the ethical principles upon which medicine and our health system are based.

If we care about these people, and if we truly believe in the humane values that ground medicine and the moral principles that ground democracy, then we need to do two things. The first is to hold a truly independent inquiry into the care of people in detention. And the second is to end off-shore processing.