

CANDLES IN THE DARK

MEDICAL ETHICAL ISSUES IN NORTHERN IRELAND DURING THE TROUBLES

James McKenna, Farhat Manzoor and Greta Jones



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FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

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The Nuffield Trust

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1. Introduction

This publication tells the story of the Troubles from the viewpoint of health professionals. The focus of the book is on the various venues – general practice, hospitals and prisons – in which medical care was dispensed during the period of the recent civil conflict in Northern Ireland, and on the doctors, nurses and patients who were involved. It is a record, not of the broader organisational or administrative issues connected with health, but of the more personalised accounts of reaction to the turmoil which engulfed Northern Ireland in the late 1960s. The work is based on interviews with health professionals who lived and worked through the period and, to a lesser extent, those with whom they came into contact, including patients, hospital administrators, chaplains and politicians. The purpose of these interviews was basically to elucidate the strains and tensions which the Troubles in Northern Ireland placed on them, and to give an account of how they coped.

The framework within which these interviews were conducted was to identify what the key issues were considered to be for those dispensing health care during the period. It deals with the obstacles, both physical and emotional, placed in the way of the health professions. Also framing a large part of the interviews was the question of how far the ethical codes governing medical practice were affected and to what extent these were delivered successfully, even under the strains of intercommunal strife and conflict. The narrative is based primarily upon personal testimony, although the political background to the Troubles, and many of the main events, are sketched out. This is done in order to provide some explanation of the events described and to contextualise the individual narratives.

The period covered encompasses the political upheavals in Northern Ireland from 1969 until the second ceasefire in 1998, but it is not a political history. Indirectly, considerable light is thrown upon the impact of politics on the medical profession and also upon the everyday life of the Northern Irish community. However, its chief objective is to ask the

following question: how difficult was it to conduct medical work in the circumstances of Northern Ireland during this period, and to maintain the medical codes of ethics governing health care?

Doctors and nurses are governed by a set of professional ethics which are conveyed in training. However, until the publication of the Report 'Tomorrow's Doctors' by the United Kingdom General Medical Council (GMC) in 1993, there was no formal or mandatory provision for training in medical ethics in place in British medical schools – certainly not at Queen's University Belfast, which continued to supply the majority of Northern Ireland doctors in practice during the period. Following on from the GMC report, special provision for ethical training began to be introduced into medical education. In the Republic of Ireland, from where doctors in Northern Ireland often were recruited, medical ethics courses were more common. In both jurisdictions the ceremony of taking the Hippocratic Oath was an important part of graduation. Students were required to take the oath and usually this was the moment when doctors would be addressed on the wider issues of their duties and responsibilities to their patients. However, in the oldest school of nursing in Northern Ireland at the University of Ulster, a full module on nursing ethics was taught from 1977 onwards. This contrasted somewhat with the rather sparse teaching on the subject given to doctors.

Therefore, for doctors, a great deal of medical training in ethics was through contact with teachers and colleagues. It is not suggested that this was not an effective and meaningful source of ethical training. All the professionals who operated in the Troubles were clear about the values that they were expected to display. As one doctor said:

I don't remember very much about ethics training...but I do remember a very strong informal ethos, which was that we were doctors, we were Health Service and we would treat everyone with respect – and regardless of who, why, where, their involvement, non-involvement and what part of the community. (D 500)

In the absence of formal training, the understanding of what was required of them was gained by osmosis, absorbing the general ambience of medical practice. These values were to save life, to dispense care without favour or discrimination, to treat the patient with consideration, to minimise suffering where possible, and to act only with the patient's benefit in mind. Other practical applications of the ethics described in 'Tomorrow's Doctors' were the right to appropriate care, the importance of patient consent, the right to confidentiality and proper information, and the opportunity to complain if they so wished.

These basic values continued to be delivered during the Troubles. However, as will be recounted in the narrative that follows, the Troubles brought increased strain and often difficulty in maintaining them. This arose partly from the sheer physical problems of delivering health care at a time of civil disturbance: for example, how far one should put one's own life at risk or persevere in getting to and from work in frequently dangerous situations. When civil authority was not present, to what extent should one negotiate with those acting outside the law to facilitate access? Perhaps more significantly in the long run, how could one keep out of medical practice the tensions and conflicts that were driving the wider community apart and creating mutual suspicion and hostility? These questions certainly had an impact on the circumstances in which medical care was delivered. While the considered opinion of people from both sides of the political divide, including patients, is that medical care continued to be given to the highest standards, this narrative recounts just how difficult and problematic this could be.

Medical professionals operate under the law as well as a code of professional ethics. The conduct of certain medical procedures – for example, assisted suicide and abortion – are subject to the law. There are laws in Britain which require medical professionals to report gunshot wounds to the authorities. However, in Northern Ireland, as well as the general law, special emergency provisions were in place which sometimes required medical professionals to take responsibilities beyond what would normally be expected of them. Emergency temporary legislation was introduced into Northern Ireland by the Civil Authorities (Special Powers) Act (Northern Ireland) 1922 (Donohue, 1998). This Act had been designed originally to expire automatically after 12 months, but in practice the Stormont Government renewed it for another 12 months in 1923 and every year thereafter until 1928, when it was renewed for a continuous five years. In 1933 the Act was made permanent by a legislative provision to the effect that it would remain in force until Parliament determined otherwise, and was replaced by the Northern Ireland Act in 1973. Furthermore, in 1971 a regulation (Statutory Rule and Order) was added to the Act, which stated:

It shall be the duty of every person who has reason to believe that any other person has died or received grievous bodily harm or has been wounded as the result of the discharge of any firearm or explosive device or by any offensive weapon immediately to inform a member of the Royal Ulster Constabulary or a member of Her Majesty's Forces on duty of all the facts and circumstances of the case so far as they are known to him. (Emergency Provisions, Civil Authorities (Special Powers) Acts (Northern Ireland) 1922–43)

Although the Statutory Rule and Order (1971) remained on the statute book, it was not enforced. Instead, the practice of using administrative returns as a substitute for the information was adopted. This meant that, in future, hospitals would aggregate figures for statistical purposes, including all injuries sustained as a result of civil disorder, and the aggregated figures would be officially available. In addition, internment without trial was allowed by the Special Powers Act, but was abandoned after its brief application in the early 1970s. Indeed, all the extraordinary legal measures allowed in Northern Ireland governing the treatment of suspects and prisoners were superseded in time by Westminster legislation or challenged in the courts over the next two decades.

As the conflict became increasingly internationalised, European human rights legislation and the protocols drawn up by international medical organisations also influenced the treatment of detainees. Sometimes, as we shall see, medical professionals took the lead in challenging the operation of certain procedures allowed under emergency legislation or sanctioned by the authorities. These were important questions for medical professionals, because they were expected to attend and examine prisoners in detention, and later on they were often at the frontline in prison disputes. However, the legal framework was not necessarily the most important point of reference for medical professionals. In many respects, the medical code of ethics went further than legislation in protecting suspects and prisoners, because it required the active advocacy for, and protection of, patients' rights. Sometimes this was a challenge to procedures in police stations and prisons.

This book is structured in the following way. First, a general historical and political background is given, together with a survey of the medical services in Northern Ireland. Following on from this, the impact of the Troubles on general practice is discussed, and then the effect on the hospital system. Two chapters are devoted to prisons: this is the area where the question of medical care and the respective duties of the medical profession to the state, the public good and patients is the most fraught and difficult. Prisons also raise in the most dramatic and public way the conflicts which can arise in the delivery of good medical care based on accepted codes of ethics. However, the number of prisoners was small compared to the population as a whole. For most people it was the doctor's surgery and the hospital that provided the most common experience of health professionals, although of course for medical professionals these categories overlap. A general practitioner (GP) might visit a police station or prison; a nurse may have been attached to a community practice and at another time worked in a hospital; patients might encounter health professionals in all three locations. Therefore, the conclusion reflects more generally upon the routine and constantly arising conflicts and

problems for the delivery of health care to which civil conflict in Northern Ireland gave rise, as well as the extremely difficult problems of the prisons.

Memory and history: the case of Ireland

Most of what follows is based on oral history (the methodologies used are described in Appendix 1). However, some things need to be laid out at the beginning to explain and elucidate. In particular, since the narrative relies to a large extent upon oral history, this can be problematic. It is a powerful explanatory tool and indispensable in explaining Irish history,¹ but historians have pointed out how contentious these memories often are – they differ according to the community from which they emanate. Each side has its own historical memories, particular historical rituals and communal celebrations. These represent opposing – and sometimes extremely polarised – views of Irish history.

Much of previous oral history work in Ireland has built itself around the two communities' views and memories, but there is even greater complexity. There have been suggestions that there is a 'state' view represented by the British Government and the successive Northern Ireland administrations into which popular Protestant communal feeling can be subsumed, and an 'oppositional' ideology represented by Catholic nationalism. However, this is a simplification.² In Ireland in the 20th century, there have been three states in operation at any one time in the territory of Northern Ireland: Westminster, Dublin and a devolved government at Stormont. As with many national conflicts, there is not always one stable central focus against which opposition emerges, but several. Each can shift in their relationships with each other and with the main communities. Similarly, within these communities themselves there are struggles over meaning and interpretation of the communal narrative (Roulston and Munck, 1988). These are certainly subordinate to the main divisions between the republican and loyalist communities, particularly to the set of beliefs which on both sides define 'the other', but exist nonetheless. At times, loyalists as well as republicans have found themselves in

1 See the recent Irish Government support for historical research conducted jointly by Queen's University Belfast and University College Dublin into the history of commemorations of 1916. (In Daley and O'Callaghan, 2007)

2 In fact, the Protestant community has a narrative of events which is deeply opposed to official state policy in many areas: security policy, abolition of the Royal Ulster Constabulary (RUC) and the Anglo-Irish accord of 1985, to name but a few. The burning of Margaret Thatcher in effigy by Protestants during the protests against the Anglo-Irish Agreement of 1985, and subsequently on Eleventh Night bonfires, recalls this. Neither is this entirely a response to the Troubles. Historically, many Presbyterians will recount long memories of the untrustworthiness of Britain, compounded by an uneasy historical relationship between Presbyterianism and the state going back many centuries.

opposition to the Westminster and Northern Ireland governments, as well as to Dublin. Similarly, republicans in Northern Ireland have regarded the Dublin Government as their historical enemy.

Benedict Anderson (1983), using Renan, has pointed to the importance of imaginative reconstruction of a community and communal life in the rise of nationalism and survival of nation-states. So these constructs are at the heart not only of popular history, but also the political history of states. In his original lecture, Renan also identified the problems for historians:

‘Forgetting’, I would even go so far as to say historical error, is a crucial factor in the creation of a nation, which is why progress in historical studies often constitutes a danger for (the principle of) nationality. (1994: 45)

Thus for Renan the construction of a communal ideology involves “shared acceptance of a subjectively agreed but probably erroneous view of the past” (1994: 45).

This point has been made by historians of the Great War in Ireland, a war which was officially ‘remembered’ and commemorated at the time and remained a powerful memory for the participants and their families, but was officially ‘forgotten’ in the Republic for a considerable part of the 20th century, re-emerging there only recently as an object of state commemoration (Jeffery, 2000). This shows how contingent and politically determined remembering can be. It also reminds us that there are not just two opposed or conflicting communal narratives in Northern Ireland, but also interpretations of the past which come from at least three major political sources: the Republic, the Northern Ireland Government up to the imposition of Direct Rule, and the British state. The effect of these communal memories can be to skew narrative and to be imposed on the facts and realities of history. This is a tribute to the power of imagined communities, but not necessarily to their ability to evoke the complete experience of the past (McBride, 2001).

Events over the last 30 years have shown the vigour and ongoing relevance of these communal acts of ritual, remembering and commemoration (Dawson, 2005). Also, the Troubles have reinvigorated and created more ‘memories’ which often are linked into the existing dominant narratives in the two communities. Because the communities in Northern Ireland have grown up with these, they are aware of what their place is in these narratives and where they belong. Often, a participant derives the meaning of their individual experience from these communal narratives, or links it to them. Therefore, it is important for the historian to be aware of how this might influence testimony. Broader political events tended to reinforce and reinvigorate the struggle over identity in

Northern Ireland. This gives rise to a second important point in the case of Northern Ireland, that communal remembering can act as the means to political mobilisation. In the words of Paul Gready, “Struggles over the meaning of the past are also struggles over the power in the present” (2003: 4).

Due to awareness of this problem, the researchers made conscious efforts to ensure that both communities were represented fully. This meant asking about religion and politics upfront. One question was directed at the problem of bias against ‘the other side’ and how it might affect attitudes. This allowed the participants to reflect on this issue which is, of course, a central one in the Northern Ireland situation. However, after that, the questions were the same to both communities. Most importantly, the researchers – and hopefully the participants – were aware that this research was delving not into familiar political territory, but into a previously untouched area of shared civic space.

This is an important point. The research done here aims to recover one area of memory in a sphere which is expected to transcend communal divisions. It examined an important set of ethical and cultural referents affecting people’s perception of themselves and their place in society, which cannot be subsumed easily into the main traditions: namely, the professional ethos of health professionals. All the participants brought their communal memories and values to the interviews. However, what they were asked about collectively was to recount how the values of the medical and paramedical professions were affected by stress and the pull of conflicting loyalties.

In a sense, the values and ethos of a profession are official ideology. They describe a set of assumptions transmitted by ‘authority’ in training which lay down the rules by which conduct should be governed. This includes: dispensing the best available care; treating all patients equally without regard to their character, background or any other personal considerations; and making the spaces of the hospital, ward or surgery available to those in need. All the participants, whether patients or professionals, were aware of professional and ethical codes that should determine medical care. This was a shared ‘inner space’ at work, just as the site of medical care was expected to be a shared physical space. This is particularly true of the Health Service (HS), which is a civic institution highly prized on both sides of the community in Northern Ireland. The HS is considered to be important to the wellbeing of both communities: the expectations are that it is shared, and that its representatives will act according to the ethics described previously.

The participants were not asked about the more familiar iconic events of the recent past experienced by both communities, but about the dynamics of work. The very fact that this work had to be conducted in new and often dangerous situations, including

heightened communal tension, meant that a new and largely unfamiliar situation had arisen. Many had reflected upon the meaning of some of their experiences, but in the case of the participants, had not given them public expression before. They were approached as representatives of their profession rather than members of their respective communities. While the communal dimension was not ignored and formed an important part of the research, patients were asked to comment as patients and professionals as professionals. They were asked about experiences which do not fall easily into pre-existing paradigms of believing and memory by the two major traditions. The researchers gained from this the view that, by asking the participants to articulate their experiences, in fact they had elucidated historical memory rather than merely tapping into a pre-existing one. What emerges during the testimonies collected here was a great deal of common perception, not about the political or historical significance of events, but about their emotional and ethical impact. The testimonies were not all the same – some were markedly different. Even so, they focus on certain problems and situations, and convey a great deal of common ground in identifying the problems of delivering health care during the Troubles.

2. Background

As William O'Connor Morris said in 1895 of historical writing on Ireland:

To this hour Ireland has produced no genius who has been able to bridge the chasm existing between her divided people, to do justice to the sons of English and Scottish colonists and to portray the habits and life of the Celtic Irishry. (O'Connor Morris, 1895: 60)

It is arguable that this remains true 100 years later. Given this problem, it is important to place the work of health professionals during the Troubles against the historical background. This in itself is not easy, due to both the amount of material on the subject and its fraught and contested nature.

The Troubles in Northern Ireland emerged out of a long and complex history. Many of the narratives carry the story back hundreds of years. In reality, regardless of the mutual antagonism that probably originated in that period (remnants of which survive today), the Troubles in modern Ireland are much more a product of the rise of nationalism in the 19th century.¹ There are certain common linking themes with previous ages – religious conflict being the most obvious – and it is fashionable to refer to age-old prejudices and antagonisms as the fundament of the recent Troubles. However, this background sketch will try to make the conflict understandable in terms of 20th-century history and politics.

Following a period of disturbed political history, Ireland was partitioned in 1922. This is the moment in the 20th century out of which the modern Troubles eventually emerged. In the south, 26 mainly rural and Catholic counties became independent from the UK in

¹ The longest period mentioned usually dates back to 800, but most historical accounts begin with the plantation of Ireland in the 17th century. Ironically, one effect of the rise of nationalism and the resulting Troubles was to revive narratives of the strength of ancient communal feeling and to emphasise the basic historical 'irreconcilability' of the conflict.

that year although, nominally at least, they were still a dominion of the British Empire. By 1949 even this tenuous link had disappeared, when southern Ireland became a fully blown republic and severed the last remaining ceremonial ties with the UK. However, the emergence of a southern state was accompanied by violence. Before the outbreak of the First World War it was anticipated that Ireland would move to a Home Rule parliament, but this prospect had aroused intense antagonism in the northern, mainly Protestant and industrialised counties of Ireland. The Protestants represented only a small fraction, ten per cent, of the population in the south, but were a majority in the northeastern counties. Even pro-Home Rule premiers such as Gladstone, Asquith and Lloyd George were inclined to believe that there should be special arrangements for the north-east.

The emergence of Sinn Fein in 1905 complicated the picture. Sinn Fein represented a much more extreme faction within Irish nationalism, embracing physical force and the separatist tradition. The majority of Irish nationalists supported the more moderate Home Rule party and, with the outbreak of war in 1914, all political parties with the exception of Sinn Fein rallied around the defence of the Empire. On Easter Monday 1916, revolutionaries mounted an insurrection centred on Dublin: the Easter Rising. They were disappointed in their hope of a general uprising but, with the subsequent execution of the insurrection's leaders, public antagonism turned to sympathy among Catholics and nationalists. Together with disillusionment with the war, this propelled Sinn Fein into a position in which it could overtake the more moderate nationalists of the old Irish Parliamentary Party in the election of 1918.

After 1919, insurrection broke out in Ireland initiated by Irish Republican Army (IRA) militants, and there followed a period of bloody confrontation between the IRA and the British Government. Sinn Fein leaders both north and south were forced to enter negotiations: this led to the Anglo-Irish Treaty of 1922 and subsequently to a split in their ranks, which occurred between those prepared to accept the Treaty with the British Government and those who wished to resist it. Civil war in the south ensued and while the pro-Treaty faction won, many from the anti-Treaty position eventually embraced the new order. However, this faultline in Irish politics in the south has resonated for a long time. An element of Irish political society remained unreconciled to the Treaty; in their eyes they were the heirs to Sinn Fein and 1916, not those who had embraced the Treaty. They regarded any government formed under the terms of the Treaty as illegitimate and, from time to time, they used the weapons of subversion and physical force against successive Irish governments (see Hennessey, 2005).³

Formation of the Northern Ireland state

When the south of Ireland was given its independence, the northern Protestants under the leadership of the Ulster Unionist Party decided on a measure of local self-government within the UK under the Government of Ireland Act 1920. During 1920–22, there was a sectarian undertow to political violence in Ireland; Protestants in Cork suffered heavily (Hart, 2003), but so too did Catholics in Belfast. The Roman Catholic minority, which formed around one-third of the population in the north, felt strongly that partition had been imposed on them against their will (Boyle et al., 1975).

In theory, Northern Ireland was supposed to be a non-sectarian state in which the democratic rights of all its citizens were to be assured. The Government of Ireland Act made precise stipulation for this. However, the reality turned out to be different. Both states in Ireland at this time saw themselves in denominational terms and failed to protect the rights of minorities. In the north, the system of local government was structured so as to guarantee the supremacy of unionists, even in areas such as Derry where they were in the minority (Elliott, 2000). At the time, the nationalist minority declined to recognise the new state, but as time went by, most nationalists decided on an unwilling recognition of the need to come to some accommodation, at least in the short term, with the Stormont Government. They sent members of parliament (MPs) to Stormont and Westminster. However, the chances of enjoying political power were remote. The nationalists discovered that the institutions established were arranged so as to exclude them successfully from positions of power (Darby, 1983[1976]). They had a prejudice against the state, and the state had a prejudice against them, creating what David Trimble, the former leader of the Ulster Unionist Party, described in 1999 as a “cold house for Catholics”.

Nevertheless, by the 1950s there were signs that some Catholics were prepared to accept equality within Northern Ireland rather than advocate the more traditional aim of securing a united Ireland. With the retirement of the prime minister, Lord Brookeborough, and his replacement by Terence O'Neill, it seemed that the situation might improve. In 1964 O'Neill declared, “my principal aims are to make Northern Ireland prosperous and to build bridges between the two traditions” (Darby, 1983[1976]: 24). O'Neill hoped that long-term

3 The IRA remained in existence. In the Second World War it allied itself with Hitler and intensified its campaign in the north. In 1956 a new campaign opened in Northern Ireland but petered out after a few years. Before the modern Troubles broke out in Northern Ireland in 1968–69, the Irish police reckoned that the IRA had a membership in 1966 of 1,039. Although weapons training continued, its energies were more directed towards social and civil rights agitation.

economic improvements would mean that Catholics would begin to accept the existence of Northern Ireland. However, the failure of O'Neill's government to deliver on its liberal rhetoric caused considerable frustration and bitterness among Catholics.⁴

As a response to the disappointment, the Northern Ireland Civil Rights Association was formed in 1967. It demanded the right to:

- participate in the election of central and local government through a fair electoral system;
- pursue legitimate political and social objectives without interference from government;
- share equitably in the allocation of state resources; and
- be free from arbitrary arrest or detention.

Attention was focused on allegations of gerrymandering of electoral boundaries by the unionist government, of discrimination in government schemes for social welfare and economic development, and of the infringement of basic legal rights under the Civil Authorities (Special Powers) Act (Northern Ireland) 1922. The Association's campaign was modelled on the civil rights campaigns of the United States, involving protests, marches, sit-ins and use of the media to publicise minority grievances.⁵ What gave a unique flavour to the civil rights movement was the sense of it mobilising a new generation untainted by past conflict on a reform agenda (Prince, 2006).

However, the civil rights movement found it hard to control the more confrontational groups that emerged from its ranks, some of whom were split over the pace of reform. In 1968–69 the worst civil disturbances seen in Northern Ireland since partition occurred. In summer 1969, large-scale intercommunal violence erupted, and British troops were deployed on the streets of Belfast. The Stormont Government's inability to control affairs in the province led to its abolition in 1972 and the imposition of direct rule from Westminster. The old political faultlines re-emerged in Northern Ireland. Although the

4 A number of actions by the government caused most concern. These were the closure of the main rail link to Derry, the decision to create a new university at Coleraine instead of Derry, and the establishment of Craigavon as a new growth centre.

5 It had some success: for example, the Government decided to replace Derry City Council with a Development Commission, and abolished the business vote.

British army was seen by Catholics initially as their protectors, with the formation of the Provisional IRA in 1970, the nature of the British army's involvement changed. This was compounded by the split in the IRA in the same year, leaving the more nationalist and less socialist wing (the Provisionals) in effective control in the north. At this stage, all the old insecurities re-emerged among the unionist population. Was the new IRA campaign a return to the unfinished business of 1922? How far was the civil rights movement merely a cover for a resurgence of the old agenda? At the same time, similar questions dogged the nationalist and republican movement.

The course of the Troubles

Broadly speaking, the Troubles can be divided into a number of different periods. The first period, from 1967–68, saw clearly the early beginnings of a new movement, shaking off the dust of two generations – an integrated civil rights movement with a non-violent strategy (Shivers and Bowman, 1984). The second significant period occurred in 1969–72, characterised by widespread civil disruption on both sides of the community. It saw the re-emergence of politically motivated violence, through bombing or civil disobedience, in an aim to bring about short-term political change (Darby and Williamson, 1978). It was during this period that the Social Democratic and Labour Party (SDLP) and the Alliance Party were formed; the British Government sent in troops in 1969 and internment was introduced in 1971. It was also during this period that the IRA (which, it is widely accepted, was largely moribund) came to be reformed (Boyle et al., 1975). For the people in the poorer areas of Belfast this new organisation, renamed the Provisional IRA, offered defence against loyalist incursions into Catholic areas and a more traditional right-wing, pious nationalism (Elliott, 2000). The most important year during this period, if it is possible to single one out, was 1972. This was the year that saw Bloody Sunday, Bloody Friday, the abolition of Stormont and the imposition of Direct Rule (Bew, 2005; Bew et al., 2002).

The third significant period was 1973–75. The abolition of Stormont and the growth of the IRA and its campaign alarmed the unionist majority, leading to the emergence of paramilitary groups in Protestant areas (O'Callaghan and O'Donnell, 2006). These years were marked by serious violence, including a bombing campaign of economic and commercial targets by the IRA which was designed to damage the British and Northern Irish economy (McEvoy, 2001). This period also saw an attempt by the British Government to encourage a workable government in which Catholics and Protestants would share power. However, the 1974 loyalist workers' strike brought the services and

industries of the province to a complete standstill, and led to the failure of the power-sharing executive comprising the SDLP and moderate unionists.

The fourth definable period of tension was 1979–81. In the mid-1970s, a much tougher security strategy was adopted by the British Government, resulting in falling casualty rates. Some of the measures created a 'ring of steel' around Belfast city centre, routine searches of shops or buildings, and stop-and-search by the army on city streets. In the border areas it led to army road blocks and a more proactive searching out of paramilitaries. However, the downside to this was the use of techniques which, in the opinion of many, went beyond acceptable practice in a country not officially at war and dealing with a civilian population. In particular, the treatment of people in custody and prisoners became the subject of scrutiny and campaigns to stop or eliminate practices that were considered to be serious violations of human rights and ethical norms. (These had an impact upon the prison medical service and will be discussed at greater length in a later chapter.)

During this period, the prisoners in the Maze Prison, popularly known as the 'H blocks' because of their architectural shape, began a campaign for political status. This was marked by the 'Blanket Protests', in which they stripped and refused to wear prison clothes, and 'the Dirty Protest', in which they refused to wash and smeared their cells with excrement. Eventually, a group of republican prisoners went on hunger strike in 1980, in a direct confrontation with Margaret Thatcher's government. Ten of the hunger strikers died in 1981; more were seriously ill but recovered, although not always without damage to their health.

The hunger strikes had an enormous emotional impact on the Catholic community and helped to propel Sinn Fein, the political wing of the IRA, to a much more prominent public role and increased political success. This period of the early 1980s during and after the hunger strikes once again mobilised mass demonstrations and some civil unrest among the Catholic community, although not on the scale of the late 1960s and 1970s. However, it did give a new lease of life to the Troubles. The Protestant community, which was already feeling under attack during the hunger strike campaign, was alienated further by the signing of the Anglo–Irish Agreement in 1985 between the Irish and British governments. For the first time, this gave the government of the Irish Republic a recognised role in Northern Ireland. The Agreement was directed at improving the security situation and stopping the rise of Sinn Fein by its political concessions to nationalism. It produced a modest but temporary resurgence in the fortunes of the moderate SDLP. However, the negotiations that led to it had been conducted without the knowledge or participation of unionist political representatives. This, and the enhanced role for the Republic of Ireland in the Agreement, led to increased paramilitary activity

from the Protestant community. The result was that in the period leading up to the 1990s, the overall casualties increased. Moreover, the IRA campaign did not diminish appreciably. Bolstered by an arms shipment from Libya in the mid-1980s, its bombing campaign became more sophisticated and deadly.

Nonetheless by the 1990s, 20 years of IRA activity had not changed the minds of the British or Irish governments about the need for unionist consent to any change in the status of Northern Ireland. If anything, the effect of 20 years of bombing had hardened the attitude of unionists to Irish republicanism and its goals. Therefore, a period of negotiations between the Irish and British governments and the Provisional IRA and its political representatives began. At first this took place in secret, while the campaign of violence was still taking place, but gradually it became known that a process of government negotiation with the Provisional IRA was in train. This did not contribute to stability on the unionist side: the British and Irish governments published the Downing Street Declaration of 1993, based on the consent principle, in order to reassure unionism while offering the prospect of all-party talks to Sinn Fein and the IRA – if it went on permanent ceasefire. A ceasefire called in 1994 was broken in 1996 by the IRA, with the bombing at Canary Wharf, in London's Docklands. Another was called in 1997 shortly after the election of the Labour Government, which provided a window of opportunity leading to the negotiation of the Belfast Agreement, signed on Good Friday 1998 (the Good Friday Agreement). This instituted for 19 months a government which included all political parties in Northern Ireland with significant representation.

The period following the Good Friday Agreement has been, by no means, one of political stability; neither was the ceasefire total or satisfactory for several years after the Agreement was signed. However, that is a different story. From 1998 onwards, casualties as a result of the Troubles began to drop and the direct effect of the conflict on medical services diminished, if not completely, then at least substantially. Therefore, the narrative presented here comes to a close. The next section describes the structure of medical services in Northern Ireland, and estimates the kinds of injuries and problems that the Troubles presented to the medical services.

The health services in Northern Ireland

On 5 July 1948, following the National Health Services Act 1946, the UK government established the National Health Service. An agreement between the Stormont Government and Westminster in 1946 ensured that Northern Ireland would be entitled to the same standards of health and welfare services as those in Britain. The pre-war,

unconnected administrative systems of independent voluntary hospitals, Poor Law infirmaries and dispensaries were swept away. They were replaced by the Northern Ireland Hospitals Authority on 24 September 1947, when the unionist minister of health and local government introduced the Health Services Bill in the Northern Ireland House of Commons. The Bill came into effect on 4 February 1948. Only one hospital, the Mater Infirmorum ('Mother of the Sick'), did not join: this was because it was a Catholic hospital. In the south, the Catholic Church had very strong influence over the health services and resisted government encroachment into them partly in order to ensure retention of the Catholic ethos. The Mater only became part of the NHS in 1972 after seven years of negotiations with the government. At the time it was decided that the Mater would participate fully in the NHS, with the terms of a settlement safeguarding the "character and association" of the hospital, and for which a defence clause was contained in the lease of transfer of the hospital. A further organisational change, significant in both political and health service terms, occurred with the establishment of the present pattern of health and social services boards in 1973, following the Macrory Review on local government administration (Government of Northern Ireland, 1970). There were important implications politically, because the local authority boundaries changed. Their functions were reduced greatly and there was controversy about the attenuation of local authority influence. Social Services became combined with Health Services.

The health services were not insulated from the question of religious representation in employment. Efforts were taken in society in general, including the health services, to address religious imbalance. Some figures are presented in Table 1 from the Eastern Health Board covering the Greater Belfast area, showing the situation which had been arrived at by the date of publication of the report (1992).

The hospitals

The hospitals described below will play an important part in this story, and the following passages describe their history, location and ethos. From August 1968 Northern Ireland in general, and Belfast in particular, was the location of recurrent episodes of civil disorder.⁶ In Belfast every hospital received its share of the casualties from the disturbances, but the Royal Victoria Hospital, being the main accident reception hospital, took care of the majority of the casualties. The hospital service in Northern Ireland has its roots in the voluntary hospitals, which grew up in Ireland during the 18th and 19th centuries. The

⁶ It needs to be remembered that Northern Ireland has had to face periods of civil disorder throughout the 19th and 20th centuries. From the 1830s, rioting was an annual occurrence in July and August.

Table 1: Religious breakdown of staff working in the Eastern Health Board area

Religious breakdown by health service unit in Eastern Health and Social Services Board				
Unit	Protestant	Roman Catholic	Not known	Outside NI
Mater	24	67	4	5
Royal Victoria	38	53	5	5
Ulster	73	14	6	6

Religious breakdown by occupation				
Occupation	Protestant	Roman Catholic	Not known	Outside NI
Nursing	33	57	5	6
Medical and dental	56	21	7	17

Nursing composition in units		
Unit	Protestant	Roman Catholic
Belfast City	47	42
Mater	15	77
Royal Victoria	53	36
Ulster	72	16

All figures, which have been extracted from larger tables, are in percentages, which do not all add up to 100.

Source: Eastern Health and Social Services Board, Equal Opportunities Unit (1992).

Royal Victoria Hospital was Belfast's first hospital: it came into being when a small hospital and dispensary was opened by public-spirited individuals on a charitable basis. The Belfast Dispensary and Fever Hospital opened in 1797 in Factory Row; its name was changed to the Belfast Fever Hospital in 1817 when it was moved to purpose-built premises on Frederick Street. Later, in 1847, the name was changed to the Belfast General Hospital, and to the Belfast Royal Hospital in 1875, after it received a royal charter. A new charter in 1899 occasioned the change to the Royal Victoria Hospital. The hospital soon grew out of its Frederick Street premises and moved to Grosvenor Road on 27 July 1903. By the 1960s, the hospital was a mixture of both old and new,

with tall, sleek and modern buildings rising from the same large site which housed more traditional buildings (McCreary, 1976).

Belfast's other major hospital is the Belfast City Hospital. The City Hospital came about due to the Irish Poor Relief Act 1838, which provided for the creation of workhouses in Ireland. In March 1839, the Belfast Board of Guardians purchased the land where the original workhouse was built, at a cost of £7,000 (Craig, 1985). The workhouse was opened on 11 May 1841. From the onset it was intended that some arrangements would be made within the workhouse for the treatment of the sick and poor, but that it would not be a hospital. However, due to a lack of beds in the county and city's infirmaries to deal with the sick, many patients who were ill claimed that they were destitute in the hope that they would be sent to the workhouse and, once inside, that they would be taken to one of the few rooms set aside for the sick, known as the infirmary. In the early 1840s the demand for hospital beds in Belfast was increased by fever epidemics, and the workhouse infirmary came to play an increasing role in the care of the sick. As a result, in 1847 a permanent fever hospital for 350 patients was built; it continued to grow and in 1948 the number of beds rose to 1,432. The hospital became known as the Belfast City Hospital in 1948.

The Mater Infirmorum opened in Belfast in 1883 (Casement, 1969). The hospital was the inspiration of the Order of the Sisters of Mercy, which had been established in St Paul's Convent on the Crumlin Road since 1854. The sisters had been very keen to make provision for the sick poor of the area, and they were backed in this idea by the Catholic Bishop of Down and Connor, Dr Patrick Dorrian, who bought them Bedeque House for the sum of £2,300 (Verzin, 1987). From Dublin, where the order had another branch, the sisters brought to Belfast an experienced nurse to come and organise the new venture: Sister Mary Magdalene from Dublin's Mater Misericordie Hospital. The hospital's prospectus read:

This institution is established for the relief of the sick and dying poor, without distinction of creed, and is supported by voluntary contributions. Aid is denied to no one, so far as the funds of the Institution allow. Sickness and destitution will ever be the only necessary passport to the Wards.
(Verzin, 1987: 566)

The hospital had not been open for very long when all those concerned realised that its accommodation was quite inadequate, and by the end of the century there was widespread support for extending it. The new hospital was opened officially on 23 April 1900, and supported itself as a voluntary hospital. In 1948, while the other hospitals in

Northern Ireland joined the NHS, the Mater decided that it did not wish to join. Its motivation for this was complex, but one of the major factors was the Northern Ireland Government's decision to exclude from the local Act the Stokes Clause, which would enable health service hospitals to preserve their religious affiliations. For the next 26 years the Mater maintained itself financially through private donations, church collections and the proceeds of locally run football pools. It joined the NHS in 1972 when it was agreed that a safeguard in the Health Services Act 1971 would apply to the hospital on transfer.

In addition to the Belfast hospitals, another hospital saw both civil disturbance and the other aftermaths of the Troubles. Altnagelvin Hospital is situated in Londonderry, on the Protestant side of the city: Catholics have to cross the Craigavon Bridge to reach it. It remains the only major hospital in the area and was the first new hospital built after the Second World War. Altnagelvin incorporated the former City and County Hospital, and the former Londonderry and North-West Eye, Ear and Throat Hospital. In addition, smaller hospitals outside Belfast and Londonderry such as Omagh, Enniskillen and Daisy Hill at Newry were affected by the Troubles to a degree.

The structure of health services in Northern Ireland was basically similar to that of the UK. Take-up of health services was high, and this reflected both health problems and a tradition in Ireland going back to the 19th century of accessing a state-supported dispensary system attached to the Poor Law. Most doctors were recruited from medical schools within Ireland, predominantly from the medical faculty at Queen's University Belfast, although hospital training took place in other venues. Nurses were generally trained locally. There were some doctors and nurses who were inward migrants or had worked outside Northern Ireland, whether in the Republic, Britain or even further afield. However, most were drawn from the community in which the Troubles took place. Thus, much of what transpires in the following narrative differs significantly from the experience of medical professionals in disaster areas, or those brought in to deal with conflicts in other parts of the world. An additional strain existed for the medical professionals in this study because in most cases they were drawn from the two communities and shared the collective memories and attitudes of those communities. However, to qualify this briefly: in the historical account above, the authors have tried to show that even within the two opposing sides, there was a variety of views, attitudes and political formation. One effect of the conflict was that at times of crisis, people were forced into identifying with their respective community, and many who were put into that position thought of this as an unhealthy thing. The Troubles helped to create monolithic blocks, drowning out voices of dissent or alternative ways of thinking within them.

The casualties

By the late 1990s, more than 3,200 people had been killed and more than 40,000 injured in the Troubles. From 1966–99, 2,037 civilians were killed: out of these, 1,232 were Catholics and 698 were Protestants. For the same years, 392 republicans and 144 loyalists were killed. The security forces also had major casualties: the army lost 503 men while the Royal Ulster Constabulary (RUC), Ulster Defence Regiment (UDR) and Royal Irish Regiment (RIR) lost 505 (McKittrick et al., 1999). Of the deaths, 58.8 per cent are attributed to republican paramilitaries, 28.9 per cent to loyalists and 10.1 per cent to the security forces; the perpetrators of 2.2 per cent are unknown.

These figures remind us of the deep intercommunal aspect of the conflict. Although it was depicted often as a fight between the British state and republicans, the chief victims were the civilian population. The majority of deaths occurred in Belfast, especially the west and north. The border counties of Armagh and Tyrone also suffered disproportionately. Londonderry experienced the effect of severe civil disorder at the beginning of the Troubles, including Bloody Sunday. The hospitals had to tackle gunshot wounds, in which Northern Ireland subsequently became a world expert, and the aftermath of explosive devices. Saving life was an immediate priority, but many victims were left also with a range of permanent disabilities, some extremely severe. Thus treatment for many victims of the Troubles involved constant trips to hospital or rehabilitation centres, often for life. In addition to casualties as a direct result of bombing and shooting, the medical service witnessed a steady stream of victims of summary justice meted out by paramilitaries to members of their own community. This type of justice has evolved since 1969 and is a range of punitive measures against people who “violate some community norm, as defined by the paramilitary grouping” (Knox and Monaghan, 2002: 172). In other cases torture, punishment and occasionally execution of suspected spies or informers (known colloquially as ‘touts’) were carried out during the Troubles by both sets of paramilitaries. Although official statistics were not recorded by the police until 1973, generally it is held that the paramilitaries had engaged in systematic violence against individuals and groups since the very early days of the Troubles (Kennedy, 1995[1994]). Informal justice was a graduated scale of sanctions escalating from threats or warnings, through curfew, public humiliation, exile and punishment beating to knee-capping or, in exceptional circumstances, execution (Thompson and Mulholland, 1995[1994]: 51). Beatings were usually carried out using weapons such as baseball bats, golf clubs, pickaxe handles, drills, iron bars, hammers and hurley sticks spiked with nails to inflict puncture wounds. Assaults were aimed at bones to cause multiple fractures (Knox and Monaghan, 2002). According to police

statistics, between 1973 and the end of June 2000 there were 2,303 paramilitary punishment shootings and from 1982 to the end of June 2000, 1,626 beatings. Approximately 25 per cent of all those attacked were under the age of 20. Beatings and shootings happened most often in the urban paramilitary heartlands, with the highest proportion of republican attacks occurring in west Belfast, and the highest proportion of loyalist attacks occurring in north and east Belfast and the Shankill Road area (Feenan, 1999). One of the most common forms of punishment was tarring and feathering: one example of this was the case of Marta Doherty from Derry, who made the mistake of falling in love with a British soldier (McCreary, 1976). Another instance of informal justice was the case of Andrew Kearney who, on 18 July 1998, was taken from his flat in the New Lodge area and shot in both legs by the IRA. Five men were involved in the attack, during which Kearney was held down and shot in each knee and in one ankle. Eventually he was taken to the Mater Hospital, but died on the way. Kearney was punished because he had been involved in a number of non-political confrontations with local republicans. He had been threatened previously and had a reputation for getting involved with fights (McKittrick et al., 1999).

The Troubles followed a pattern of periods of intense activity usually accompanied by civil disorder, and stretches of more ritualised confrontation between the security forces and the IRA. In addition, paramilitaries were regularly murdering each other. In 1972 the most deaths occurred, numbering 496 people. This was also the year in which both the majority of civilians and army personnel were killed: more people died in that year than in the whole period from 1991–99 (McKittrick et al., 1999).

In the history of the Troubles certain key events of death or mayhem stand out because of the emotional impact, level of casualties or political implications (usually all three). The following include a few of the most heinous tragedies:

- Bloody Sunday, 30 January 1972, when 13 people were killed;
- the Abercorn bombing, 4 March 1972, when two people died and 130 were injured;
- Bloody Friday, 21 July 1972, when 11 people were killed and 130 were injured;
- the Enniskillen Poppy Day bomb, 8 November 1987, when 11 people died and 63 were injured;
- the Shankill Road bombing, 23 October 1993, when ten people were killed;
- the Omagh bombing, 15 August 1998, when 29 people were killed and 220 were injured.

Bloody Sunday

Bloody Sunday is remembered for being one of the worst single days of violence during the Troubles, and for the fact that 13 unarmed men were shot dead and a further 14 wounded by members of the Parachute Regiment in Londonderry. The deaths brought the conflict to a new and more precarious point in Northern Ireland. The shootings occurred at the end of a civil rights march attended by around 10,000 people. The march was organised by the Northern Ireland Civil Rights Association to protest against the policy of internment without trial, and the brutality inflicted on those who had been detained in internment operations. It was intended that the march would assemble in the Creggan Estate and proceed from there to Guildhall Square.

The march had been peaceful on the whole, although it was illegal and representations had been made to call it off. As the marchers made their way through the Creggan Estate, their numbers began to swell. The participants included many women and children, and the atmosphere was relaxed at first; however, by the time the marchers reached the Bogside, their numbers had increased from around 10,000 to nearer 25,000. When they found themselves blocked by army barricades, some of the demonstrators began to throw stones and bottles at the soldiers. The soldiers responded at first by spraying the demonstrators with purple dye, then firing rubber bullets at them (Mansbach, 1973). The army shot 27 people; of these 13 died. Dr Raymond McClean ran a makeshift field hospital in a sweet shop, treating nearly 1,000 casualties over a two-day period without running water or proper medical supplies. The authorities insisted that no action would be taken against injured persons reporting to Altnagelvin Hospital (White, 1984). However, many of those injured during the day chose to go across the border to the hospital in Letterkenny, 20 miles away, rather than to Altnagelvin. By this stage in the Troubles many Catholics routinely avoided going to Altnagelvin for injuries sustained in riots, as they were worried that they would be reported to the security forces and prosecuted. The previous year Seamus Cusack, an unemployed welder aged 28, had been shot by the army. He was taken to Letterkenny Hospital instead of Altnagelvin, where he died: immediate treatment might have saved his life.

After the event an army statement from Major-General Robert Ford denied that the army had fired first, stating: "There is absolutely no doubt that the Parachute Battalion opened only after they were fired on" (Bew and Gillespie, 1999: 44). However, witnesses including several leading Northern Irish politicians and some priests claimed that the paratroopers had been the first to open fire, and had fired directly into the crowd (Mansbach, 1973).

The events of Bloody Sunday created a wave of anger throughout the Catholic community, leading to months of violence. Rioting and shooting broke out in nationalist areas all over Northern Ireland, as the nationalist community vented their anger at what they saw as mass murder meted out to their community by the armed forces of the British Government. The casualties from the day arrived at Altnagelvin in ambulances, normal cars and army vehicles. Once they were in the hospital they were taken to the small casualty department, as there was not enough time to get the Great Hall cleared. Due to the high number of casualties, this meant that many people had to wait around in corridors and at the sides of wards, while relatives and the police had to wait in the reception area. As a result of the confusion, feelings were running high: for example, one doctor observed a civilian spitting at the paratroopers who were at the hospital (McCreary, 1976). Regardless of all the confusion and panic, the hospital did an excellent job, and it was due to the hard work and dedication of its staff that the number of dead did not exceed 13.

The first civilian who arrived at Altnagelvin to be treated was John Johnston, who had been injured in William Street by the first Parachute Regiment shots. Johnston was attended at first by Dr Raymond McClean at someone's house, then he was taken to Altnagelvin by Father Joseph Carolan. On the way to the hospital, Father Carolan had to argue his way through army and police road blocks (Pringle and Jacobson, 2000). The hospital was also the site of a number of shootings. One attack happened on 11 November 1980, when Corporal Owen McQuade was murdered by the Derry brigade of the Provisional IRA as he sat at the wheel of a minibus in the hospital driveway. He had been waiting for a friend who was visiting his wife; the killers drew up in a hijacked car and began shooting (*Belfast Telegraph*, 12 November 1980). By the time medical staff reached the site it was too late, and McQuade was dead. Another incident occurred on 5 October 1981, when Hector Raymond Hall, who worked at the hospital, was shot dead by the IRA. Hall had just finished work for the day, and was sitting in his car with a friend in the ambulance depot of the hospital when two men approached the car and shot him. The other passenger was injured and was treated at the hospital.

The Abercorn bombing

The Abercorn Restaurant in Belfast was bombed by the IRA without prior warning. At the time, Belfast was undergoing an extremely difficult period: a daylight bombing campaign had been causing large-scale damage to many of Belfast's buildings. The bomb went off at 4.29pm, killing two people and injuring 130. One minute earlier an unknown man had phoned a warning to the Post Office exchange, saying that a bomb

would go off in Castle Lane, but did not give an exact location. The bomb was small, only 5–10lb, and exploded in a confined space, causing horrendous injuries. It blew out the front of the restaurant, throwing passers-by across the street. The police found it difficult to get to the restaurant as a result of the crush of people trying to get out of the rubble. Once the army, police and ambulance crews arrived, they rescued as many people as they could, and these were taken to Belfast's main hospitals.

Bloody Friday

During the afternoon of Bloody Friday, the Provisional IRA planted and exploded 22 bombs in Belfast, including one in Oxford Street bus station, which killed 11 people: two soldiers and nine civilians. The bomb injured approximately 130 others and produced widespread confusion and panic in many parts of the city. In addition to the bombs, there were numerous hoax warnings about other explosive devices, which added to the chaos in the streets that afternoon, as shoppers and others heard bombs go off all over the city. The carnage was so bad that body parts had to be collected in plastic bags. The nine fatalities were caused by two of the 22 bombs. The car bomb, which exploded at Oxford Street station, killed four Ulsterbus employees and two soldiers. Another car bomb went off outside shops at Cavehill Road in north Belfast, killing two women and a 14-year-old schoolboy. Some of the other targets included:

- Eastwood's Garage, Donegall Street;
- the railway bridge, Botanic Avenue;
- the footbridge, Windsor Park;
- Windsor Park football ground;
- Brookvale Hotel;
- the M2 flyover bridge; and
- the LMS railway.

All 22 bombs went off within an hour and a quarter during the afternoon. The city's hospitals were put on full alert as the toll of injuries began to mount. Bloody Friday led to the decision by the British Government to implement 'Operation Motorman', when the British army entered and ended the 'no-go' areas of Belfast and Londonderry. Later, six more people were killed and more than 100 injured by a Provisional IRA car bomb in

Lower Donegall Street, Belfast. The Provisional IRA had issued no warning, but a hoax call had led shoppers intentionally to where the bomb was planted. The deteriorating situation led the British prime minister, Edward Heath, to announce the suspension of the Stormont Parliament on 24 March. The Northern Ireland (Temporary Provisions) Act 1972 suspended the Northern Ireland Government and vested all powers of the governor and government in a newly-created secretary of state for Northern Ireland (Hennessey, 1997).

The Enniskillen bombing

During the annual Remembrance Day ceremony in Enniskillen, a bomb planted by the IRA exploded at the War Memorial, killing 11 people and injuring 63. The bomb, which had been hidden in a community hall, exploded without any warning. A total of 21 people received hospital treatment; most of these were treated at the Erne Hospital in Enniskillen. At the hospital, staff worked under enormous pressure: they were used to dealing with victims of the Troubles before, but never on this scale. Off-duty medical staff volunteered their services to deal with the volume of casualties. As it was a Sunday, only one ambulance crew was on duty when the first emergency call was received. The four other ambulances were unmanned, but their crews quickly arrived to help with the rescue operation. Inside the hospital there was the normal nursing staff, but the hospital was working with a reduced medical staff. Only one of the two consultant surgeons was on duty. Hospital administrator Norman Hilliard stated after the event:

Various department heads were alerted and some additional staff contacted. But most staff came in voluntarily. This applied to every department in the hospital and it made all the difference on the day. (*Belfast Telegraph*, 10 November 1987)

Surgeons at the hospital operated for a total of 14 hours in the two hospital theatres. Senior nursing officer Ethel Dundas recalled:

We had a contingency plan to deal with such an emergency. ...Every section of staff throughout the hospital played their full part. Many didn't even clock in when coming on duty and night staff who had just gone home returned to work throughout the day. (*Belfast Telegraph*, 10 November 1987)

Local general practitioners (GPs) helped to treat the less seriously injured, cleaning and stitching wounds. This assistance from GPs helped to relieve much of the pressure on the

hospital staff. Some of the victims were taken to other hospitals in Northern Ireland: the most seriously injured were flown by army helicopters to Altnagelvin Hospital in Londonderry; two casualties received treatment at the intensive care unit at the Royal Victoria Hospital in Belfast, while one 15-year-old boy was given treatment at the City Hospital for a fractured leg and head injuries (*Belfast Telegraph*, 9 November 1987)

These incidents by no means cover all the innumerable, large-scale atrocities inflicted over the years.⁷ They are singled out for their scale of political impact. More poignantly, the pages of the leading Belfast newspapers in the 30 or so years of the Troubles often record individual deaths or wounding, usually of the security forces, in an almost routine fashion. Not all these deaths made headline news: individual families were put through immense trauma and suffering which often, if not forgotten, were given little public prominence.

For a period of around three years at the beginning of the Troubles, the extent of conflict and civil disturbance from both communities in Northern Ireland threw all agencies of the state into chaos. Together with the appearance of troops on the streets and increased security measures, this suddenly created a vastly different environment in which medical care took place. From 1969 to the mid-1970s there was a period of maximum chaos involving injuries from civil disturbance as well as terrorist and paramilitary activity, which caught medical professionals and hospital administrators off-guard. Some of the narrative of these years records the heroism of the medical professionals working in this environment, but also the mistakes, confusion and ethical dilemmas which had never been experienced before. Therefore, much of the present narrative describes how medical professionals had to learn to cope and to install procedures and conventions to help them do so.

A second period from roughly 1976–79 was marked by sporadic civil disturbance and a more ritualised confrontation between the army and the IRA, the latter organised around bombing and attacks on the security forces and the Protestant community. An increased security crackdown, and the use of much tougher techniques by the police and security services in the late 1970s, gave rise to particular concerns about the ethics of doctors

⁷ These include ten protestant workmen returning home in a minibus at Kingsmill, County Armagh, 5 January 1976; seven Protestant workmen killed by a bomb on 17 January 1992 at Teebane crossroads, and five Catholics killed in retaliation on 5 February 1992 at Sean Graham's bookmaker's shop on the Ormeau Road, Belfast; and the gruesome sectarian murders of Catholics by the 'Shankill Butchers' in the 1970s.

working alongside the police and security forces during this period. Casualties dropped markedly between 1977–79, but the strategy of hunger strikes by the IRA in 1980–81 led to more civil disturbance, increased paramilitary activity and the rise of Sinn Féin. The Anglo–Irish Agreement in 1985, when the British and Irish governments undertook to closely consult on matters connected with province, led to an increase in activity by loyalist paramilitaries. The troubled late 1980s saw a rise in casualties again, although not to the same level as the early 1970s. At the beginning of the 1990s a process of slow negotiation between the IRA, British and Irish governments began, leading eventually to the IRA ceasefires of 1994 and 1998. This was conducted against a background of continuing violence, peaking in 1991. Generally, periods of political tension and uncertainty, such as those generated by the negotiations in the 1990s, were accompanied by increased paramilitary activity, so the graph of death and injury often rose or fell in response to perceptions of the direction that political events were taking. For health professionals, this meant that they were presented with a constant series of challenges, because the ‘weathercock’ of politics and paramilitary activity sometimes changed rapidly and in unexpected directions.

There is another aspect to this background. Northern Ireland was affected severely by the Troubles and at times looked as though it might be slipping out of control. However, it never reached a period of sustained civil war, however much this might have threatened from time to time. Inhabitants experienced a lot of routine disruption to their normal lives and some periods of severe disruption but, except for those at the centre of the conflict, most were able to pursue their occupations, rear their families and travel. They also visited the doctor and attended hospital. Just how much the Troubles interfered with this will become evident in the narrative. Looking back, many participants said that it was amazing how people got through it all. However, they did – and not all of the memories of the last 30 years are about the political situation. Many memories of encounters between doctors and patients resemble those experienced in other parts of the UK or the rest of Ireland. The following chapter attempts to highlight the unique nature of the experience for health professionals living and working in Northern Ireland during the Troubles.

3. Family Doctors

On the whole, the working life of the majority of general practitioners (GPs) did not change during the Troubles. However, there were notable exceptions to this when incidents occurred adjacent to surgeries. One example came to light in the interviews:

An IRA gang had taken over a flat above a shop on the Antrim Road. And they put in a call, which had been done on other occasions, to the police station, saying there had been a robbery in the shop and that police would arrive up in their Land Rover. And they had a gun called an M60, which was a mounted machine gun and it could fire through the Land Rover and kill them all before they got out. That gang, they were rumbled. Somebody spotted something or information was passed, and instead of the police arriving, the SAS arrived, because we have Girdwood barracks which was very close.

The SAS, they broke out of the car that they were in and one of them was shot, very severely shot, these were big bullets and he was lying [there], and I heard this. I was in the surgery and I heard 'rat-a-tat-a-tat', like somebody running a stick along corrugated iron. And not long before had been Bloody Sunday. And I knew that somebody had died on Bloody Sunday, because nobody had had the sense to stick a finger in the bullet hole and stop the blood flying out of them: it was only a leg wound, but they bled to death. So I thought, I['d] better go up – and I went up and this guy was lying on the courtyard in front of the shop. And I knelt down and there was a shout of "Get away, get away!"

And at that moment one of the local solicitors who was a bit politically involved arrived at my elbow and held my stethoscope up to show that I was a doctor. I didn't know the gun was just above me, I didn't see the gun, I just saw this guy lying there. And you might say in a sense that I was doing what I was trained to do without any regard for the situation. What I

was doing, of course, was entirely foolish and dangerous, and I should have been shot for doing what I was doing. (D 11)

Between the episodes of extreme tension were the more routine problems of delivering health care at times of civil disturbance. Nonetheless, even for the GPs not directly on the frontline, their physical environment deteriorated considerably, and the problems that presented in their surgeries were affected by the Troubles. Of the challenges that GPs encountered in general, the most commonly experienced was the problem of travel. Location was a major issue, because in the early days of the Troubles there were significant population movements in Belfast and Londonderry, leading to increased religious segregation. This meant that patients and doctors might have difficulty in accessing either the surgery or the patient as easily as before the Troubles. A GP noted:

The other thing that we noticed was that populations moved, people moved out of areas, there was ethnic cleansing going on. So our practices changed and people moved out of our way, and because it was your bread and butter as a doctor to keep patients on your list – you maintained these patients on the lists, even though they were living quite far away from the practice. (D 11)

The notorious ‘peace lines’ which grew up during the Troubles were in fact interfaces guarded by the security services (and often local residents or paramilitaries) which separated the warring communities. They eventually assumed a physical presence, with walls and barriers erected to make policing them easier. However, this changed the geography of an area; so too did security and paramilitary activity. Street lighting might be destroyed or switched off; streets would empty at night, and even finding one’s way around familiar streets could become problematic. One GP recalled:

Street signs, lights, door numbers, they were all mythical, none of them existed for a period of time. So when street signs appeared in Irish, for example, well, I learned Irish, but there are many doctors who didn’t learn Irish, and many nurses who didn’t learn Irish. (D 11)

Parades and demonstrations in Northern Ireland, even if non-confrontational, always had posed a problem for routine care at certain times of the year. One nurse recalled:

I was out on a Saturday morning, and there was some special parade on...I had a diabetic down in Victoria Street, I would have had another one along the Shore Road. And these patients, you know, I was trying – I could normally get

them done between, say, 8.30 and 9.10, sort of that time. But when I drove along North Queen Street, I said [to those blocking the road] “Look, I’ve an urgent diabetic!” Ten minutes makes a lot of difference in the morning if you’ve got three or four, and maybe other injections in the morning. No way was I allowed to drive in between these bands, and that. And those bands were coming from the areas around where the diabetics were, like. No way was I allowed in. Just, that was it! I had to just sit there! (Smyth et al., 2001: 84–5)

However, the scale of disruption caused by the Troubles was much more serious. Getting to the surgery could be problematic for a number of reasons. When bombs exploded in populated areas, disruption to movement was always extensive. For example, at times of civil disturbance, buses had both passengers and crew turfed off and the bus set alight or used as a barricade. Bus and train schedules were interrupted frequently. The security forces set up checkpoints, notably at the border with the Republic and in areas of violent activity. While border crossings were always checked, other security force road blocks were unpredictable, for obvious reasons. In rural locations close to the border, some roads were permanently blocked, and this could give rise to long diversions. Even in areas little affected by the Troubles, consideration always had to be given to travel problems. Members of each community would become acutely conscious of travelling near or through territory associated with the other side: many in the population avoided the stress by not circulating. At times of peak violence, Belfast was eerily still from early evening onwards, but GPs and practice nurses did not have the luxury of staying at home. For the general public, when illness struck, when patients and their relatives had no option but to go the surgery, the natural stress of the occasion was accentuated by social upheaval and travel hazards. These hazards could escalate from irritating to dangerous. One health professional working in the community health service recalls: “I do remember occasionally in North Belfast going off duty at night in the dark with no lights and hearing gunfire around me, being scared” and being wary of straying into a wrong area (of the opposing religious denomination), because that “could be very dangerous at that stage” (M 89). The participant states that it meant that sometimes one had to stay the night at a friend’s house, but in most cases, according to the following quotation, sheer determination was the solution: “We just plodded on our bike” (M 89).

The practical problems arising from this situation were that “[a]s a result of this situation, during the period 1973–74, staffing levels in some areas of Northern Ireland dropped with staff moving to areas where there was less violence and where they felt safer” (Taggart, 1973). An additional problem encountered by health workers in the north and west of Belfast was the lack of access to facilities across peace lines which patients were

unwilling to cross, therefore it was necessary to duplicate certain facilities. Sectarian patterns of service use were noticeable. A survey of the Suffolk interface illustrated that Catholics used the Royal Victoria Hospital, while Protestants used the City Hospital, even though they lived in the same area (Shirlow, 2004). This meant that the health and social services had to spend additional money to cater for the effects of sectarian fragmentation. The head of the residential facility for elderly people described the difficulty posed for her work by this situation:

Nobody likes to come into Shankill from Woodvale...and there is no way they are going to let their mother or their father, or even residents themselves are not going to come down that far. (Smyth et al., 2001: 91)

The health professionals most affected by the difficulties of movement and access were in the ambulance service. Although all the participants expressed praise for the work of the ambulance service, there were some who recalled that in the early days of the Troubles, some ambulances would not go into areas where there was violence. As one public representative stated: "Ambulances refused to go to the town of Coalisland on a number of occasions, even when there were a number of people injured" (M 94). As a public representative, he had tried to convince them that they were not in danger.

As a result, people had to be taken to hospital in cars. The considerable pressure that crews were put under has been recounted by a number of writers on health care during the Troubles. The ambulance service was recorded as "relatively easy to disrupt", but having "a rapid recovery rate" (Darby and Williamson, 1978: 6). As well as the gruelling nature of dealing with the aftermath of explosions, "frequently unexploded bombs were in close vicinity. Regularly they were shot at when travelling close to an army vehicle" (Taggart, 1973). In response, the crews were issued with heavy-duty plastic helmets with a large red cross on the front and back, and behind the seats of each cab the crews carried riot screens to protect windows and doors. Additional problems encountered by the ambulance service were that, like other vehicles, they were searched by the security forces, especially during the night. One participant claimed: "There were nights when the army was not very helpful and this rebounded badly on the ambulance service, because the people blamed them rather than the army for [the] delay" (M 73). Added to this was the problem of widespread road closure, traffic jams, diversions and passing through narrow barriers. One participant related an incident which involved his wife:

My wife conceived some ten years after the youngest one...he was born on the night of Motorman, that was the big army push...My wife took bad, she took ill, and the doctor came out to her...From the time the doctor called

for her and said he needed one [an ambulance] it was about one and half hours, and that was due to the fact that this area here was in a state of torment...to get here he had to do a semi-circle around the city and come in from the Lisburn side.

On the Falls Road the driver was shot at and the driver panicked and accelerated over ramps and my wife was thrown around. She was fortunate to survive. I didn't learn about it until three days later, when my child died...But as I say, we put it down to a lot of what happened through no fault of their own, through no fault of the ambulancemen. (M 123)

Intimidation

Unofficial road blocks in city and country tended to be manned by masked men and were very frightening at times during the Troubles. Frequently they bounded the fringes of ghetto areas. There were three large-scale explosions of Protestant civil disturbance during the Troubles: the Ulster workers' strike of May 1974, a smaller one in 1977, and the widespread disturbances over Drumcree, particularly in 1996. These involved a considerable shutting down of the normal life of the province. Although there were fewer casualties and the Protestant paramilitaries were involved in only minor confrontations with the security forces, there was serious interruption to travel. Often, medical professionals were reliant on passes issued by paramilitaries. While this gave some protection, as we shall see, it often involved unpleasant and tense negotiation, and could not always be relied upon: one nurse recalls:

great difficulty during the workers' strike getting to work. Also, during that period of time developing, and having to develop, a working relationship with some of the local paramilitaries, particularly if I was going out into the community, and particularly into Rathcoole. And indeed at one stage, being given a pass by the UDA [Ulster Defence Association] to be able to move in and out. (N 8)

The general intimidatory atmosphere that could arise in these situations can be gauged in this recollection:

When the UWC [Ulster Worker's Council] strike started, word came that you had to get a pass to get around various areas, so I queued up on the Shankill Road at the UDA headquarters which was above the Berlin Arms pub.

How did you feel that to give a service that everybody needs you had to get a pass from certain members of society?

I was very young at that stage and didn't have a strong feeling at that moment. But I thought, well, the practicality is: you need a pass, so you need a pass. I queued up the stairs and arrived up in front of the tribunal, and it was like something out of the French Revolution. Because there were flags, very similar colours of course, red, white and blue and blue, white and red, and the guy who was central to it all looked at me and said, "What do you want, doctor?" Now I was three months working in this area, I didn't know him from Adam but he knew me, and I said, "I want a pass." He said, "You don't need a pass." (D 11)

However, there was no guarantee that the events and general mayhem on the streets would not catch up with health professionals. For example, one nurse recalled:

If you were in the area where you lived, like the internment day anniversaries, you had to psych yourself up to comply with whatever the neighbourhood wanted – like allowing people the day off to bang bin lids, or join in marches in July. (N 23)

In other cases misunderstandings arose and, whereas health professionals were generally respected, it was not always easy to enforce this unwritten rule. A nurse recounted:

A friend who was in one area of Belfast went to...psychiatric nursing, and she came back in an absolute jittery state. She had been in one house and come out [sic] after about 20 minutes to find four wheels off the car. She went back into the house to make the phone call, and the lady of the house, the mother of the young lad who was having his injection, made a phone call, and in 10 minutes the wheels were back on the car. They hadn't realised it was the nurse – it was a new car, and she hadn't got the district nurse stickers up. (N 23)

In other cases more serious and dangerous situations arose:

I worked with a district midwife. I was a student midwife and I was actually working in the Ardoyne area...and one day we were up...this was in '78 – and we were driving through one of the streets coming from a patient's home. And we were stopped by two masked and armed men, and they came up to the car, and they put the gun to the window, and asked the

woman for the car – and she said “No.” And I nearly died: “Give him the car!” She didn’t. She said, “Look, you know...” And she started to talk to them and she said, “We have an arrangement with your bosses...” And there was another man with a gun. “There is an arrangement with your bosses to leave us alone, or we won’t come back.”

But she started to enter into these negotiations with them, that she said that there was an arrangement with the paramilitaries that medical teams and fire, etc. people going into those areas should be left untouched. So what happened at that point then was, I was absolutely devastated... I was shaking really, because I hadn’t come across anything like that outside of the hospital, and they just walked out of a street, two armed men, and the fact that she didn’t jump out of the car and run! But they contacted the hospital apparently later, the Royal Maternity, and apologised.

The director of nursing then told me to have a week off. I didn’t need a week off. She said because it was such a terrible experience, and she phoned me at home and said that she had been contacted by, or on behalf of, the paramilitary organisation who were involved: they had received an apology, and she was passing it on. (N 18)

Others recounted bad episodes with army road blocks. A GP in west Belfast found himself spread-eagled by the army against a wall; in another incident, he was made to drive between a kerb and a Saracen (armoured personnel carrier) in the dark. In contrast, he stated that he had not been hindered by paramilitaries from either of the communities. He had been stopped a few times in the Sandy Row area of Belfast, but when he had identified himself as a doctor, he had been told: “Away you go” (D 57).

Sectarian tension

The Troubles led to an increased identification among patients with ‘their own side’ and increased suspicions about the ‘other side’. A degree of mixed living at the start of the Troubles meant that practices were mixed, and GPs might be from a different community and religious background to the patient. Opinions differed about the impact of this. One GP believed that the waiting room was a neutral area: “We are set between the two communities here who would fight with each other at the drop of a hat, but who meet in our waiting room as though it were sanctuary” (D 11). The opinions from patients confirmed this:

To be honest, as far as I was concerned [in] my experience with my normal GP, religion didn't come into it. It wouldn't have mattered... It's people that have trained in that profession and I wouldn't expect any better treatment from a Protestant doctor because I am a Protestant than I wouldn't expect any different treatment from a Catholic doctor...it's a surgery, and I don't be at it that often [sic], and I couldn't tell you hardly their name, never mind what religion they are. (P 118)

However, this perception was fragile, and sometimes events caused it to fracture. As one patient who had served in the security forces felt:

I have my GP in [name of place] which I have said, and there is a lady there wh[o] works in the GP practice in [name of place], and her husband was actually in jail for terrorist offences. So there is that unhappy feeling every time you walk or enter through the door. If you go somewhere else you will probably find somebody else there has been connected to terrorists or something, so I don't feel myself there is any point in changing. But there is that uncomfortable...nothing has been said to me or nothing has been...apart from what I've said, I don't be in there very, very often [sic]. But if I had to go in for some particular reason, there is that feeling of discomfort, because her husband was locked up for terrorist offences.

But do you think it affects the way she relates to the patients though in any way?

Not as far as I am concerned – she has made no difference. As a matter of fact, maybe it's the complete opposite – would be completely over the top...bluff the situation off.

You mean she compensates for that?

Yes. (I 127)

One GP described his reaction to this situation as a conscious effort to resist identification with the politics of the situation:

I treated everyone, irrespective of their background. I treated British soldiers who had been shot outside my surgery, I treated civilians. I treated anyone who needed attention. I packed my medical bag each day and I hoped that I would not come across anything too disastrous...

Nonetheless, he was “conscious of the fact that some of the people I talked to had been involved in the violence” (McCreary, 1976: 238).

Others had patients who had been injured in rioting or even killed (Darby and Williamson, 1978). Unavoidably, this drew some GPs closer to the conflict than they would have liked. The problem was common to both sides in the conflict, and the reaction was to assert that loyalty to the patient took precedence over other considerations:

I got a call from a mother one night, and she said, “My son is in trouble in Dundalk,” and she mentioned the name of the hotel. I went down in the car and three or four boys had him, and I said: “Look lads, this is a patient of mine – I’m taking him home with me.” And they said, “You’re not taking his gun.” I said, “I don’t want his gun, I don’t like guns.” I said, “I’ll just take him and then there will be no further trouble.” So I took him home and that was the end of it. He was a Protestant, belonged to the UVF [Ulster Volunteer Force], and he was a B man.¹ But I mean, he was a patient of mine and that was what mattered. He was on my list of patients and I never let any of them down. (D 28)

This attitude could produce problems for GPs, as strictly speaking they were witnesses to a crime or an illegal act: a situation which affected other branches of the Social Services from time to time (Taggart, 1973):

I heard it on the news that a lot of prisoners had escaped from Newry Courthouse, and I got a call that same evening by a lady who wanted me to see a patient in her house. I went up, and he had hurt his ankle jumping down from a fence 30 feet high, and I saw him, treated and fixed up his ankle and left. I didn’t take his name or address – I just fixed him and left, and he did very well afterwards, she told me. He had escaped from the Newry Courthouse. No, there was a legal requirement to report bullet wounds, but I didn’t ask where this fellow came from. I just said, “Oh, it’s all right – I’ll fix that for you.” I would never refuse any of them anything. (D 28)

¹ A ‘B man’ meant a member of the B specials a locally-recruited, part-time reserve arm of the Royal Ulster Constabulary. Almost exclusively Protestant, they had a fierce reputation for sectarianism among Catholics. They were disbanded in 1970.

Relationships with the police or civil authorities might become difficult in these circumstances. Moreover, any knowledge of illegal activity that a GP had might endanger them with the paramilitaries. As previously mentioned, in 1971 a statutory order was added to the Civil Authorities (Special Powers) Act (Northern Ireland) 1922, under which doctors were required to inform the police if they came across a gunshot injury: this covered GPs as well as hospital medical personnel. Pressure from the British Medical Association (BMA) due to representations from GPs, among others, caused this requirement to become largely redundant, although it did not lift the pressure upon GPs altogether. Nonetheless, as one commented: “Both sides seemed to give members of the medical profession a fool’s pardon” (D 11). In addition, other problems were encountered:

Another area that the police are involved in, we have to cushion the situation for them, would be working for the coroner when someone dies unexpectedly, and then police have to come in and take details. I have to try to encourage the families to view the police in a different way than they would normally do, and say: “This is not their political or their paramilitary role, this is their role really, as agents of the court of the coroner, and it’s a very social role – a very proper role for them.” So that’s another type of, I think, situation that wouldn’t arise outside of the Troubles here in Northern Ireland. It may well arise in areas of the rest of the UK, where you have a lot of criminal element in an area, there may be an equivalent, but it certainly was a recurrent theme throughout all the years here in Northern Ireland. (D 11)

Specialist medical care developed as a result of the Troubles, such as bullet wounds and the effect of explosives, and was pioneered in the major hospitals. However, one area in which GPs felt increasing demands on their skills was mental health. As one GP described:

The main way in which we always saw the Troubles affecting us would be, first of all, how it affects the patients, and the biggest thing is where someone has been murdered and the family devastated – and we are cast in the middle of it. (D 11)

For most families, this was the worst case scenario. However, even for those not experiencing the impact of the Troubles so directly, there was still considerable mental stress. One political representative described this as ‘pre-trauma’:

There is also a pre-trauma here. I know that is something that probably has never been diagnosed or whatever but, because one family experience it, then the next family are sitting waiting on it, and they are sitting up to three o'clock in the morning. At one stage in this town, there was [sic] people that had bucketfuls of water, sitting at the top of their stairs in case they had to put a fire out in the middle of the night. (M 77)

In his view, there was a great deal of unrecognised psychological disturbance due to this:

We've had people who have had people, young children, you know, wetting themselves and things. I remember speaking to the headmistress of the nursery school... [there would be] nervous breakdowns, and only then would you get counselling. By which time, you know, it's like trying to shut the barn door after the horse has bolted. (P 77)

According to one public representative:

During the Troubles particularly there were a lot of young married women who lived in difficult places, like on the frontline of the Troubles, and at night-time there was a lot of people very nervous, and they did take tablets to try and calm their nerves. And unfortunately a lot of people have become addicted to these – and that is part of our problem, I feel now, within Northern Ireland. (M 66)

Breakdown of community relations

The extent to which civil disturbance could put the surgery, GP and community nurse in the firing line both physically and politically, is illustrated by the events around the Bryson Street Surgery in June 2002. Bryson Street is situated in east Belfast near the Lower Newtownards Road and the Albertbridge Road, an overwhelmingly Protestant area, and on the Lower Newtownards Road end, largely working class. It abuts onto a much smaller Catholic nationalist enclave, the Short Strand. These segregated communities live apart, but they mix when both access the same public facilities usually on or near main thoroughfares: in this case, the Lower Newtownards Road or adjoining streets. Post offices, shops, anything which brings the two communities into close juxtaposition during times of heightened tension – all can lead to incidents of conflict.

During May 2002, reports of low-level clashes in the area, often in these shared communal areas, began to reach the newspapers. These reported incidents were likely to

have been preceded by other unreported ones. On 13 May there was a protest by loyalist women at the post office in Madrid Street, near the Albertbridge Road, about attacks on Protestant homes. The picket outside the post office claimed: "We do not want to stop women going to the post office. We only want to highlight the attacks" (*Belfast Telegraph*, 14 May 2002). Nonetheless, experience has shown that both communities used access to public facilities in their area as weapons. On the whole, GP surgeries and chemists were exempt from this. Those community nurses involved in the Bryson Street incident considered it to be a rare occurrence:

I know in previous occasions I've heard people saying that during the height of the Troubles, someone was going to set fire to the surgery, and someone else intervened and said, "No, that surgery is not to be touched this time." (N161)

Even though peace walls separated the two communities, missiles were thrown over the walls, roads were blocked, and this led to confrontation with the security forces. The Protestant street nearest to the peace wall, Cluan Place, came under attack from the Short Strand, and the Catholic street Clandeboye Place on the other side of the peace wall received similar treatment. However, while these events were usually sporadic, a full-blown riot occurred following a security search of the Short Strand on the night of 14 May. On 15 May the rioting escalated into communal trouble of a serious nature. Paramilitaries from both sides were involved as respective 'defenders of their communities' and as initiating 'retaliatory' attacks.

On the night of 3 June the most serious riot yet occurred. As well as using stones and blast bombs, roof snipers directed gunfire towards the other community. In Cluan Place, "Two Protestant men boarding up houses were shot in the back and Short Strand residents dived for cover as loyalists riddled the peace lines". This led to a picket on the Bryson Street Surgery the following day from loyalist women from the Lower Newtownards Road, who alleged abuse from a nationalist attending the surgery. On 5 June, "a rumour began to circulate that one or more nationalists were 'trapped' in the pharmacy. One resident said it was when a group of nationalists 'went to the rescue', the simmering tensions on both sides exploded into violence... By late afternoon the doctor's surgery and the local post office had been closed, and short-term emergency measures put in place to deal with the medical and social security needs of the community" (*Irish News* 6 June, 2002, 'Eyewitness').

The picket was to become an issue for nationalist representatives, but it was the rioting that seriously disrupted the work of the surgery. The Bryson Street Surgery was

physically shut down for one half-day only, but the residents of Short Strand avoided going to the Lower Newtownards Road or to any facilities there during the period of escalating tension. Taking blood and collecting prescriptions became problematic, and in recognition of this, community health workers and GPs set up in the Beechfield Community Centre in the middle of Short Strand:

We went to the community centre to clinics, extra clinics as well... It was just a couple of weeks over the worst times, you know, I was part of that... The patients that would normally come out to the surgery to have their bloods done. I would have went out [sic] to do them in their own homes because they were scared to come out to Bryson Street Surgery... They made arrangements for a community worker to bring the prescriptions from them to their local community centre for collection... We had a room in the community centre and brought in all our own equipment to deal with the surgery there. It was mostly dressing and blood pressure, maybe injections, whatever the patients were due, what they would normally come to the clinic to get done [at] Bryson Street Clinic... GPs came in as well to do the clinics. (N 160)

A problem of increased workload arose from this arrangement:

Our caseload was increasing every day because the people could not come out, a lot of people...who could normally have made their way down to the surgery wouldn't go anymore, and it was affecting the chemist too – they...were doing their business elsewhere. (N 160)

Health professionals were not happy either with the fact that the surgery had ceased to operate for the whole community. They took steps to reiterate their commitment to the ethics of medical professionalism for an inclusive service available to all. They also thought that the long-term effects of segregation were bad for the patients themselves:

To be confined in the area isn't good really for their social, the social aspect of their health or generally – it causes depression and all sorts of increased tension. So we were trying to encourage people to get back to normal as much as possible. (N 160)

At one stage a group of 11 doctors from the greater east Belfast area issued a joint statement describing the picket as “indefensible” (*Irish News*, 14 June 2002). However, the problem for the medical professions was to avoid being pulled into endorsing one

side or another. Over a generation of conflict, both communities had become skilled in manipulating the situations that arose, particularly in feeding their own accounts to the media. Each represented themselves as the victimised community. Thus spokespeople for the loyalist community described Cluan Place as a “small isolated community of 25 houses” (*Belfast Daily Telegraph*, 7 June 2002) and pointed to the injuries from bullets and the residents’ precipitate abandonment of the houses there during the weeks of tension. Conversely, the Short Strand was depicted by nationalists as a community under siege. The issue of access to the surgery became one of “How are we supposed to get proper medicine? Someone is going to die.” The policy generally followed by medical professionals was practical measures to deliver the health service, and reiteration of their desire to deliver a service to all, regardless of religion or politics, combined with restraint in public pronouncements. To this was added occasional humour, to deflect the tensions that might be experienced among a group of religiously mixed medical professions. As one participant stated:

It would have been joked about... “Oh, I’ll do all the Protestant patients here and you do all the Catholics.” ... It was all joking. Whether anyone really felt that, they would have never dared say it in a serious manner. It was all in a jokey way. (N 161)

4. Hospitals and Community

Location and access

In Belfast the Royal Victoria Hospital, the main centre for trauma victims, is located in Catholic nationalist west Belfast. The hospital has one long boundary and one principal entrance in the Protestant Sandy Row/Donegall Road area, although it is separated from these areas by the dual carriageway of the Westlink. Its remaining boundaries and the site itself is on the Catholic Falls Road. For many years, the hospital was perceived as a stronghold for the Northern Ireland Establishment: its senior staff were Protestant, and its allegiances were unionist.¹ However, ancillary staff were recruited from the local area, and this meant that they were mostly Catholic and nationalist. The ethos of the hospital changed over the period of the Troubles – over time, the senior staff mix began to reflect that of the community as a whole – but its location is immutable; it is an area seen as hostile by Protestants. This situation made many patients and staff wary about being at the hospital.

Another hospital used because of its proximity to the flashpoints was the Mater Infirmorum (Mother of the Sick). This had originally been a Catholic voluntary hospital. The Mater is located in an area which is mostly Catholic. However, the actual site and some of the buildings literally project into a Protestant area – as a result, the hospital straddles one of the most fraught community interfaces in Belfast. This meant that during the Troubles, the hospital saw a lot of civil strife and violence on its doorstep and the surrounding areas.

Belfast City Hospital is located on the Lisburn Road, in an area very close to the university and religiously mixed. The Ulster Hospital at Dundonald is entrenched in a

¹ During this period there were only a few senior staff members who were Catholic.

Protestant heartland.² Many of the hospital's patients come from east Belfast and the areas around the Strangford Lough, which are predominantly Protestant. Both the City and Ulster hospitals cared for victims of the Troubles, but they were not affected in the same way as the Royal Victoria Hospital, the Mater Infirmorum and Altnagelvin in Londonderry.

Altnagelvin Hospital remains the only major hospital in the Londonderry area. It is located on the Protestant side of the city, and the Catholics have to cross the Craigavon Bridge to reach it. Because Londonderry was the site, especially in the early 1970s, of serious civil disorder, Altnagelvin experienced difficulties. Patients frequently distinguished between a hospital itself and its site. One loyalist ex-prisoner put it this way:

The vast majority here would go to the Belfast City Hospital because they perceive that the Royal is in a republican area. Now I don't think that's from a point of view of the staff that work in the hospital, but more [that people are] opposed to the geographical situation, and that they may not feel secure in going there. (P 119)

This theme recurred frequently:

In no circumstances that I can recall [was it] because of the institution itself, but because of the siting of the institution. And it has happened not infrequently that people have said, "I don't feel I can go there because of the area", "I don't feel safe. I feel I'm under threat, I feel I am being watched" or "I feel something will happen to me", "I don't know, it's an area I don't feel comfortable with", and so on. On the other hand I was talking to colleagues...we would have had patients in the security forces who would not go to the Royal. So yes, but it was always to do with the siting – not the health care professionals themselves. (M 30)

The desire to make this distinction led occasionally to denials about the influence of location. However, further questioning revealed a more complex attitude, as in this interview with a minister of religion:

Have any members of your congregation expressed any reservations about going to the Royal or the City or the other hospitals?

² The hospital dates back to 1873, with the founding of the Ulster Hospital for Women and Sick Children. It was the first children's hospital to be opened in Belfast.

Possibly – there might be a little bit, simply because they come from east Belfast and they would think of the Royal as a west Belfast Hospital. But I mean, that has always been the case in the North of Ireland, even before the Troubles ever started. People might have a little concern, but nothing major – it wouldn't stop them going. They might feel a wee bit uncomfortable while they are there, but it certainly wouldn't stop them going. (C 137)

A similar problematic attitude is revealed in this answer:

Our people on the Shankill [Road] had a terrific confidence in the Mater Hospital and quite often would have gone to the Mater rather than go to the Royal, etc. ... The Royal Victoria Hospital suffered a wee bit in the sense that they had to cross the city to get to it. Yes, they liked the City Hospital, because it was all neutral territory going through the centre. (C 157)

Problems of access dogged both patients and staff. For staff this was a particularly important issue, because it involved a sense of their duty as professionals. The extremity of the situation is encapsulated in this account from a Royal Victoria Hospital nurse:

Well, we had problems because in 1969 we couldn't get over because most of the Falls Road was on fire, and the houses and factories were burning, and there was no public transport. I went over on a motorbike, the back of somebody's motorbike, and there were times when there were riots and gunshots and mayhem around the Royal, in the Royal grounds, and burning cars and everything.

When you think back on it, nearly everybody got in. Although the part-time staff, their husbands were worried about them going to work. But sometimes we had to sleep in the hospital. I slept in the hospital a lot of times...but we seemed to manage, there is always some way. You get to know a lot of the ways, and you're up the pavement and you're down the pavement, [dodging] burning cars.

The only moment I was really frightened was [when] I ran into a gun-battle. I was coming out of Grosvenor Road [accessed from the Royal Victoria Hospital] one night, and I ran into a shooting and I didn't know what to do. So I just went as fast as I could down the Grosvenor Road, and then I was sick at the traffic lights. (M 13)

This incident related to the widespread civil disturbance at the beginning of the Troubles. The problems continued intermittently for the whole period:

In the area that I come from, the IRA during the early 1990s had a policy of human bombs which they would blow at security checkpoints. As a result, the government developed a policy of night-time closure: this meant that certain checkpoints would be closed during the night, and no one would be able to pass. This was a very big issue for about 12 months, but even before this it used to be a problem. For instance, people could not visit relatives in hospitals via a direct route – they had to take a detour which took a lot of time. Even in emergencies, ambulances could not get through. This caused many problems. (M 91)

Certain measures were taken in the case of medical professionals to ease access, for example, by issuing police passes:

I had a police pass, and some of us got police passes. You got it from one of the police stations. I got it from Queen Street, and it authorised me just to move here and there through checkpoints, and into the hospital and what I needed it for. But I didn't need it – I never needed it. You could be stopped by anybody, but I wasn't really. (N 13)

Police passes allowed passage through authorised road blocks: often, the road blocks which had to be negotiated were put up by the paramilitaries. The loyalist-organised workers' strike in 1974, which helped to bring down the power-sharing executive, was a case in point. However, as one participant pointed out, while its effect was not universally felt, it did cause problems for the hospitals:

Oh yes, the strike in 1974: the difficulties there were getting supplies in, making sure water supplies and electricity supplies [stayed on] because they were cut off at times. It was a nightmare because of the nature of the strike, which was more effective in east Belfast. It was also effective outside Belfast but it didn't affect the Royal, the City and Musgrave very much...they were in nationalist areas and nobody was holding up, nobody was obstructing anybody. Some people for the first time in their lives [were] stopping people passing and they considered themselves to be big shots as a result, so it was very uncertain. (HA 19)

Improvisation was resorted to in the early part of the conflict:

We had stores outside Belfast, we had big main stores, and what we had to do was to get hospital vehicles and paint them with big red crosses so as to get people to realise that we weren't transporting guns or anything like that. It was a greater problem getting supplies out of hospital to surgeries and places like that – I mean, there was a total breakdown of the fabric within Belfast. (HA 19)

On the whole – but not always – movement of medical personnel was facilitated. At times of high tension, if the road block was put up by members of the other community, mutual suspicion would arise. In any case, it was a tense thing to negotiate these obstacles. Even members of the same community who might not feel so personally threatened often resented the intrusion and the assumption of control and authority by the paramilitaries. One hospital chaplain trying to get to hospital recounted:

I can think of trying to get to Dundonald [Hospital] during the Ulster Workers Council strike and having to argue my way through road blocks. And I was wearing a clerical collar... But if someone had wanted to get through there and was stopped and adopted the wrong attitude, the threat of violence was always immediate...these were people with clubs and masks. (C 146)

There was also considerable tension at army road blocks. For example, sometimes medical personnel from the Catholic nationalist community suspected less than professional treatment:

We were persistently getting stopped by the army because they used to ask you, "Where are you coming from, where are you going to, why are you going there?" It was very difficult at times to think that you weren't personally being persecuted. Sometimes you got the notion from the soldiers [that] it was simply sport – that they knew they were delaying you. They could see your nurse's hat on the back shelf, and they could see your uniform folded up, and you were hardly likely to be running round with a plastic torso for fun! (N 23)

In one case the hospital took steps to rectify the situation:

I can remember one occasion, only one occasion, where army personnel made it difficult for me to gain access to a person.

Could you relate that incident, what year it was?

I can't remember, but I was simply going to relate it from the point of view that the immediate help that the hospital system gave to ensure that I gained access in order to do my work. And the hospital system apologised for any delay and said that the army had no right to delay me from gaining access to a patient at all. So I am just using it as an illustration of how much the medical staff and the hospital system were very much professional, and totally neutral and helpful to everybody, and would have stood up for other members of the staff in gaining access to do their duty. (C 133)

Sometimes there was a feeling that the outside world was not altogether well informed about the need to deal with emergencies, sometimes in very difficult conditions. According to one medical professional:

There was a report in the *Manchester Guardian* that surgeons in the Royal treated people according to their religion. The board seemed not to care, and this was a time when I was going to the hospital on the floor of an ambulance in a tin hat when I was not even on call. (D 49)

Security

Medical professionals in Northern Ireland were subject to considerable pressure, particularly in certain locations and during certain times. The political unrest brought very close to home the issues of community division. Most of the accounts above stress that access and location, over which the medical personnel had no control, was in contrast to the hospital itself, in which there was general agreement that treatment was generally unaffected and the ambience was neutral. However, although direct intimidation was rare, it did happen. In one interview a medical professional remembered:

I can recall a patient. I was called upon to give evidence in court and she was given bail. I was threatened with being shot but, on the same day, a surgeon in the Mater was also threatened with being shot, and this provided indirect reassurance for us in the Royal Victoria Hospital. ...More frequently, it was a sense of intimidation and the violence spiralling out of control – sometimes against staff, but often involving patients and visitors. (D 49)

In fact, the staff had to contend with innumerable internal problems to do with activity both in and around the hospitals, which made it a struggle to keep this the case. In the

early days of the Troubles, the military was billeted within the Royal Victoria Hospital. The presence of members of the security forces caused problems, but staff varied in their responses to this. One could take the viewpoint that their presence, although often awkward, was necessary and increased a sense of security, or alternatively, that it was unnecessary and heavy-handed. Political views entered into the equation, although there was general agreement that some army presence was unavoidable, particularly in hospitals in trouble spots. The dilemma is summed up in this response:

What about the fact that the army was situated below Casualty? Did that cause problems or concern for people?

I think it caused a concern. I think some people maybe took reassurance out of it that there was army close and they would protect them. Other people took the opposite view, that they were likely to be a source of attack, and civilians or staff might be injured because terrorists were attacking the army. I think always it's a good point for debating.

The hospital is supposed to be a neutral kind of environment, not taking part in any side. So the fact that the army is in the hospital, did that not infringe upon the idea of neutrality or sanctuary?

I think it does to some degree, yes, it's bound to.

Did nobody ever question that aspect, or was it just so busy at the time that these things didn't arise?

I don't think people questioned it very much. People were just too busy, and then once they were off duty they were only too pleased to get out and get home, away from the trouble as quickly as possible. (D 9)

The reasons for billeting and patrols will become clear in the accounts below. The overall background as regards the Royal Victoria Hospital was that this facility was in the heart of the republican stronghold in west Belfast. As previously mentioned, being sited at the junction between the Falls Road and Grosvenor Road, two main thoroughfares, the rambling, extensive hospital grounds are in close proximity to Belfast city centre. Its many buildings, entrances and underground corridors abutting onto closely packed terraced housing made it important for both the army and the IRA to secure control of the area. In the early part of the Troubles, the involvement of the army in and around the hospital roused conflicting feelings. It was clear that this was an entirely new situation, and no one knew the likely consequences:

CANDLES IN THE DARK

At that stage the army then became billeted in the basement of the Royal Victoria Hospital. They were actually down there for a period of time. In one way, it was good to have them – it made you feel secure. On the other hand, [there were] all these big men around the place and they tended sometimes not to be as quiet as they might be. It didn't last very long because just that very point was raised...they had to be moved on. But that again shows you the element of chaos that reigned, because there was no provision made for this. (N 33)

Having army personnel in the hospital meant day-to-day encounters:

We also lived with the army in the hospital because the sergeants' garrison, who were based at Outpatients, lived in the west wing, where we were students and staff nurses. And they actually lived on the same floor. (N 23)

Work carried on in the army presence, and this meant considerable adjustment on both sides. As one nurse put it:

Nobody ideally wants soldiers and big boots tramping around a casualty department. But I have to say to be absolutely fair, they did their best to keep a low profile, they did their best. I mean, young fellows coming in from the army? I mean, what do they know? But they were very tightly controlled. (N 15)

Deliberate misbehaviour by military personnel was rare, but it did happen:

It must have been pretty grim stuck there, couldn't get out, no off-duty, not getting out at night, not allowed to go anywhere even to a pub for a drink for three months when they were doing their tour in Northern Ireland. So I accept that life had not been easy. But they had been allowed out one night, or something had happened, and they had had a drink, and three or four of them came and ran amok in Casualty during the night. Now there weren't any patients in as far as I know. I was furious and I reported them – I know that one of them was a corporal, and he was demoted. (M 15)

In another case:

Three young soldiers had entered the day hospital through an open window. The cleaners had been mopping the floor and I actually found them playing with the physiotherapy equipment. Swinging on the swings,

on the waterbed, switching devices on and off. And the porter had a very strong accent, so I actually went in and asked them to leave very bluntly. But they were in no hurry to do so, and I reminded them that I would bring the police – and that didn't frighten them either. (N 23)

The more serious long-term problem was the tension caused by an army presence and the impediments it brought to day-to-day management, even routine care. Tension was a two-way process. While patients often felt unhappy at the presence of security forces, the soldiers were also under strain because, in the words of one participant, “they never knew when the enemy was going to take a pot-shot at them next” (C 27).

There were several examples of the essential incompatibility of the medical and security services. The astringent observation that “nobody ideally wants soldiers and big boots tramping around a casualty department” sums this up. Several of the participants fleshed out the issues and the atmosphere; there was always an element of danger arising from the presence of armed security, even in situations not immediately threatening:

But the army came in a couple of times as patients, with their guns on them, for there was accidental discharge in our resuscitation room...and the bullet ricocheted round our resuscitation room [and]...hit, in his foot, one of the orderlies. And another time there was an officer in and there was all this fussing and flapping about their men... A gun went off and the doctor was putting up an IV...there was nobody injured that time. (N 13)

The essential question arising from the conflict between the military and medical routine was whose authority was paramount in the hospital:

I mean did they get in the way, under your feet?

Yes, and they would have been pulling back curtains – they were supposed to get the names and find out who was in – and they were out at the ambulance before the ambulancemen had the patient out – they were out first of all before the doctor even saw the patient...some of the doctors objected.

So the army always stepped aside and let the doctors get on with their work, and then... ?

The army would be put out.

So you had to be quite firm with them, then?

Medical treatment did not vary. The army had no control over medical treatment, none at all. (N 13)

However, it was not at all clear in certain circumstances whose interests should take precedence. The existence of this problem was pointed out by a number of the participants:

Yes, there was an issue surrounding the interaction between professionals and the security forces. I recall one episode in which the army refused to let a patient who had been shot to go into the A&E [Accident & Emergency] department of the Mater Hospital until he had been photographed. This was very early on. There was a stand-off with the junior doctors. I think this was reported in the *Sunday Times*.

I also remember that, in the wake of the Shankill Road bomb, one of the bombers was admitted to the Mater Hospital. Members of the RUC [Royal Ulster Constabulary] were very aggressive to me personally because they wanted him out of the place. They said they couldn't guarantee his safety and wanted him in the Royal Victoria Hospital, but on that day everybody was rattled, and the RUC were as entitled to be rattled as anybody else. (D 48)

Conflict between state and hospital

A major divisive issue that arose in the early days of the Troubles was the erection of a listening device and observation post on top of the nurses' home, Broadway Towers – a hospital residential tower block adjacent to the Royal Victoria Hospital. The listening device appeared almost overnight. In the words of the nurses interviewed who were living in the block, one minute everything was normal and the next it was there:

I was a fairly senior member of staff at the Royal – this would have been in the '80s – certainly the nursing staff was unaware of it until it was practically helicoptered onto the roof. (N 23)

Also, it was erected without consultation with the hospital authorities:

Management claimed that they were unaware of that. ...I'm talking about local management. There wasn't a policy decision in the Eastern Health

Board which said they would do that, because our policy would be, “You have got to stay out – you can’t come into our site, you can’t use the site.” (HA 19)

The participants made a distinction between necessary and unnecessary security activity in the hospital:

I don’t think they spoke to the secretary of state, or if they did, the secretary of state certainly never spoke to the hospital management. Our line was very clear. The extent to which the police were there was to the extent of their guarding the people that needed to be guarded. Or to help us deal with problems where we needed the police, when we need [sic] an armed guard. But it was never a facility to assist police or army surveillance. (HA 19)

In the political circumstances of Northern Ireland, to give an opinion for or against a military presence implied a view on the conflict and the role of the army. In the words of a participant: “And it’s here that people began to be polarised” (N 33). However, even those sympathetic to the army conceded that it put the hospital in the frontline in two senses: that it made the hospital appear collusive with the security forces, which impinged upon the neutrality issue; and that it attracted unwelcome attention from IRA gunfire attempting to knock it out:

I do know that their presence there caused gun-battles and there were battles between the IRA and the army on top of the Towers. Some of the bullets went into the nurses’ flats. Because I was over there one day, I was off [from] two until five in the afternoon, and I went over with one of the other sisters who lived there, and I had to lie on the floor beside the bed because a gun-battle started. So there were frequent gun-battles, and a stray bullet would come through the nurses’ home. (N 13)

Another major problem directly affecting medical care was when the security forces pursued information from and about patients. In 1971 the Northern Irish Government introduced a Statutory Rule and Order under the Special Powers Act. Its provision requiring the reporting of gunshot was not welcomed by medical personnel in Northern Ireland. Although the Statutory Rule and Order remained on the books, it was not enforced. Instead hospitals aggregated figures for statistical purposes:

I can remember a red form which had to be filled out in terms of civil unrest. You sort of took the casualty and the name and... I can’t remember

the detail of it, but you took details in terms of what type of injury, and the time of the event and the time of the arrival. And these were collated, as I understood, and sent to, I think at the time...it was before the reorganisation – so it would have gone from the hospital to the Hospitals Authority in Adelaide Street. (HA 21)

When they realised that the names were being handed over to the authorities, many medical professionals were not “very happy about it”. In other cases there was a different opinion:

They had to do it, it was law. It was the law – I didn’t resent that bit at all. What was the law, if you suspected anybody had committed an act, broke the law, criminal, you had to do that. You had no choice. (N 13)

However, even in the case of this response there was a feeling that “there was some times when we did object [in] some cases” (N 13):

Now the idea was, when anything came in that was directly related to the Troubles, if somebody came in who was shot. It even got to the point that if somebody had been hit rioting, it had to be first of all assumed that it was politically related, so therefore it was the Troubles, as it were. So you had to inform the guardroom and a soldier was sent up to get information, and he would take information regarding name, address, whatever.

How did people feel about having to do that, having to report every person who comes in?

Well, not every person but anybody who was thought. ...Well, I suppose, especially people who came from the Protestant sector – I suppose for us it was just a question of, well, if somebody hit your granny, wouldn’t you call the police? So I would have seen it as a reasonably positive thing. (N 15)

The effect overall was to introduce an element of tension between nurses and patients. This highlighted the problem over the boundaries of state and medical responsibility. In the case of the notification of patients treated for civil disturbance, there was a clear conflict. It was protests from the medical community which eventually led to the practice being dropped which, although some nurses might think was justified, many felt actually exacerbated suspicions between patients and medical staff.

Guarding patients

Given the trouble caused by the army presence, why was it tolerated? First, whatever the general view expressed by all the participants that the hospital should be a neutral area, in reality it was the site of assassinations and murders. The security forces attending hospital as patients and either set of paramilitaries, whether under police guard or attending independently, were potential targets. However, so were hospital staff. As one member of staff recalled:

Hospitals are very public places. I mean, they are public buildings and you can't close the doors, for instance. Yes, you can close them to a certain extent, but it is a public building and the public need access 24 hours a day and it is very difficult to prevent... You wouldn't necessarily know [whether] they were gunmen or not. (N 10)

Given this, it is not surprising that there were attacks on hospital staff and patients during this period, and in some cases, fatalities. The most prominent assassinations or attempted assassinations illustrate the problem. On 28 October 1976, two loyalist gunmen murdered Maire Drumm, the leader of Sinn Fein, in a second-floor ward of the Mater Hospital. It was reported that:

[A] student nurse came face to face with the killers. The nurse, a girl, had been in a bathroom leading off the ward when she heard the shots. She came out and was told by one of the gunmen, "Do nothing."
(*Belfast Telegraph*, 29 October 1976)

A day later, a 20 lb explosive device was left near the casualty department of the Royal Victoria Hospital by a man and women wearing white coats. Twenty years after this incident, the danger still existed. On 21 December 1996, the Democratic Unionist Party politician Nigel Dodds, his wife and the policemen guarding them were attacked in the intensive care unit of the Children's Hospital at the Royal Victoria Hospital while visiting their sick son. Four shots rang through the Belfast Hospital for Sick Children and "a bullet passed through an incubator – mercifully with no baby inside" (*Belfast Telegraph*, 29 October 1976). Suspicions existed that, in these cases information about patients, visitors and medical staff who might be targeted could be emanating from within the hospital itself, and this added a further dimension to the whole question of safety within hospitals. Generally it was assumed that sensitive information facilitating targeting came from medical staff, ancillary workers, patients or visitors.

At least guarding the hospital and certain patients in it limited this activity: it was an important function of the security forces, and therefore tolerated for that reason. Similarly there was always a danger, magnified at times, of community tension, of the outbreak of fighting in the corridors between the two communities or sets of paramilitaries. For the side of the community hostile to the army, it was commonly asserted that the presence of army or other security services was in itself a provocation that led to trouble, and there are instances where this was the case. A professional attested to the divisions that this caused, for although many staff accepted their presence, “[o]ne group of people felt they had no right to be in the nurses’ home, and another group felt why shouldn’t they be: we’re British and this is the British army” (N 33).

The events recounted below show that it was not possible to resolve the problems by simply removing the security forces. Before the Troubles began, hospitals in Northern Ireland, as with hospitals elsewhere, dealt with patients needing a security presence. During the Troubles, the number of patients with a security requirement multiplied rapidly: they might be judges or high-profile politicians who needed protection; prisoners or people thought to have committed offences; or soldiers or policemen (whose occupation was often given as ‘civil servant’). Prison staff considered themselves to be at special risk in a public ward where prisoners’ relatives might recognise them. As time wore on, a special unit (Ward 18) was opened in Musgrave Park Hospital to accommodate offenders, and a military wing looked after army personnel and the occasional government minister. However, patients often needed acute care first, which was only available elsewhere. The Royal Victoria Hospital and Belfast City Hospital had small units available to patients at risk. As previously mentioned, the Royal Victoria Hospital had the most problems because it was located in a republican area and recruited ancillary staff locally. It had a naturally high volume of patients and was the sole provider for many specialities in Northern Ireland. There were no substitutes for units such as neurosurgery or cardiac surgery, so ad hoc arrangements had to remain in place for guarding some patients.

Staff remained tolerant of those guarding patients, recognising a necessity that was difficult for all. One nurse pointed out the sheer physical problems of this:

The soldiers tended to be used to guard patients and it wasn’t always pleasant. Physically the spaces could be quite small, [with] also equipment and weapons and such. It was quite scary to have a large weapon and guns, rifles, shotguns...a large piece of lethal machinery within six feet of you as you were working...not your idea of fun. (N 1)

Most of the problems were routine:

If they were anything, they were a nuisance. They didn't feel any, there was no resentment against them being there, but it's just that you have to walk round them to go anywhere. And if you have a patient in a bed and they are being guarded on either side of the bed, it means, if you take a cup of tea, you've to take three cups of tea. But there was no real, not as far as I can remember, never any resentment of them other than [that] there was just too many of them around. They took up space, or they were breathing too much air. (N 33)

The sentiment that "You just made them tea and toast" (N 25) was expressed quite frequently.

'Minders'

Because of the perceived threats in hospital it was common practice for various wounded paramilitaries to arrive with their own 'minders'. One member of the hospital staff recalls the impression they made:

It wasn't one or two minders. There would have been a lot of very big burly men...along our corridors in doorways, that you would walk along a corridor and somebody would walk out. It would have been quite frightening and very intimidating, but there is no way that those men would have left here. ...And the odd time a gun would have dropped on the ground, out of a pocket. (N 17)

Staff hated having to endure unofficial minders. According to one participant, the minders prevented staff from:

(a) getting on with our work; and (b) that there were other patients from other persuasions who may have been in the same ward. You could have two opposite terrorist organisations or members of them being on the same ward and more, and you may have had soldiers and policemen on the same ward. That happened in one of the general surgical wards that I was in at a time. (N 16)

However, the major problem was intimidation of staff:

At one point we had a patient in intensive care and he was being guarded, and he had so many minders and they were all very obviously armed. And

the staff felt that they were being watched and intimidated as they came and went from the hospital.

They were so concerned one morning by the numbers of these people who were outside of the gates that I phoned the chief executive, who has the ultimate responsibility for all issues including security in the Trust. And I asked him to help us to do something about it, and he did. He didn't tell me what he did, but he got in touch with North Queen Street which was our local RUC station as it was then, and they offered some protection for the staff while they left the hospital...just reassured the staff and told them that there would be a presence outside of the hospital, and that they would be watching what was happening.

And it was at a critical point, because these people that are armed are nervous and they are security risks themselves, let alone the person that they are guarding – and I mean, the drop of a pin triggered a response in them. They were anxious and they were looking around and...I had to advise them one night that if they heard people running upstairs, it was probably the doctors and the emergency nursing team responding to an emergency. (N 17)

In extreme circumstances when the individuals could not be persuaded to leave of their own free will or where the security forces were not present, staff had to get the security forces:

I was working at the Mater when a certain hood's son came in and he brought his own minders. When I refused to let them in because the child was on an order that he was not allowed visitors, including the parents, without supervision, and the chap was escorted by a very large man in a camel hair coat – in fact two – he tapped on the glass with his gun. I nearly passed out and we got all the other nurses, got the children behind mattresses and phoned for the police at the far end of the building, because obviously this chap's minders were armed. And at this stage, I think, when he heard the police, they very quickly disappeared in their large car. (N 23)

Added to this were the problems which arose after civil disturbance, bomb or shooting, when it was possible for both sides of the community to be admitted to the same hospital. However, most of the trouble did not originate from the patients. As one medical professional pointed out: "Yes, we had problems with visitors. In fact, in the

fracture wards a lot of the verbal and physical abuse would have been done by the relatives” (N 16). At the same time in the wards, when patients were drawn from both communities:

The majority of them, I am not saying they got on, but they didn't interfere with each other. You may have got the odd one who would have shouted abuse across at each other. (N 16)

A paramilitary agreed:

At the height of the Troubles you could have people from the different communities in the same ward. The problem did not come from the patients, but from their families who would have fights. All hell broke loose outside the hospital, and usually it was the loyalist who would be moved to a different hospital. (P 117)

Patients

A nurse from the Mater recalled the potential for confrontation between patients when two from opposing sides were admitted simultaneously:

One was an abdomen gunshot wound and the other one was a foot. So the first man came up from theatre and he was put into bed and screened...[we] put the two beds together because it was dark, the rest of the patients were sleeping. And we said, “What happened to you?” He had been shot but the guy that did it, he tripped over and he shot himself in the foot. So he was actually in the next bed to him. So we had to quickly not let on to each one of them, and rearrange the whole ward...but I don't think either of the two of them ever knew that they were beside each other. (N 25)

While stopping short of physical or verbal intimidation, not all the relationships between patients within the ward were happy, particularly if the pressure of outside events intruded on the hospital. Sometimes the tension on the ward was invisible to the medical staff when it did not result in outright violence or altercation. Patients learned to negotiate around difficult situations. The strike that took place at the Royal Victoria Hospital in 1980 illustrates this:

Initially led by 24 porters due to the accidental discharge of a rifle by a soldier in a hospital corridor on 8 April 1980, it was joined by the majority

of around 1,300 ancillary staff on 11 April. The strike which was unofficial and condemned by the regional and national leadership of NUPE [National Union of Public Employees] was to rid the hospital of soldiers and to install a security committee at the hospital to negotiate on all matters pertaining to security force access. Seven days after it occurred it was called off without any of the strikers demands being met. (*Belfast Telegraph*, 15 April 1980)³

The reflection of one Protestant in the maternity wing at the time was as follows:

Well, the rule on the ward was that nobody mentioned anything – that was the rule. In fact, I remember having a meal there, and Ian Paisley came on the TV attacking the republicans at the Royal Victoria Hospital, and everybody kept their eyes firmly down fixed on the meal and pretended not to hear, although everyone was hearing. So none of the patients discussed the incident, but they were very aware of what was going on. ...So I never got to know what their view on army patrols in the hospital was. (I 126)

Although noise from the picket lines permeated through to the maternity wing, patients were largely unaware of the fierceness of the battle going on within the confines of the hospital. At one point, pickets clashed with senior management, who were unloading 700 frozen meals for patients:

The row spilled over into the kitchen with some pickets led by a cook stormed the door shouting, “We must stop this scab labour.” A women in the kitchen retorted, “Will you let the patients get their food” and the picket replied, “I don’t care who is not getting food. You don’t know what this is about.” After further heated exchanges staff slammed the main door, and the pickets retreated. (*Belfast Telegraph*, 12 April 1980)

The patients coped with basic meals and food brought in by friends and relatives from outside. Whatever the outward indifference, various indirect indications or signs were transmitted between patients:

But there were incidents which, one of which I think I told you about before, about us all sitting around. ...First of all it was unusual to get a

³ According to the regional secretary, John Coulthard: “Our members go back in the full knowledge that the Army and cameras are there and that nothing has been achieved in terms of an investigation into the troops’ behaviour and that Mrs Inez McCormack and I are the recognised negotiators for NUPE on security matters. These are the facts and these facts will stand.”

Protestant in the Royal Victoria at that point in 1980; it mainly was middle-class Protestants like me. Working-class Protestants wouldn't go up, and therefore I think there was one other lady who was a Protestant – I couldn't be sure, but I think she might have been – I had an English accent, so I was obviously different from everyone else. And I remember the incident of us all sitting around eating food, and I suddenly noticed that everyone was sharing. ...Somebody had offered some of their food and I suddenly thought, "Oh, I should offer some of my food" – and nobody would take any of my food, and I felt a point was being made. Perhaps I was wrong. And then somebody, I thought there was a ringleader there as well.

Even within the patients?

Yes, among the patients, and she was talking about her child being born. And they asked what are you going to call it, and she said "Emmett" and they all said, "That's a very nice name" – and Emmett is a very republican name. I just felt there was a tension.

Did you feel uncomfortable being there then?

Slightly at that point. I suddenly realised that they weren't accepting my food because maybe from what I was or they assumed I was. But immediately after they broke up, one woman came up to me and talked to me – a little working-class lady from the Falls [Road]. And I thought she'd done that in order to make me feel a bit better about what had happened. And my feeling was that once this woman who I felt was a bit of a leader, when her back was turned, people were coming up to me and, you know, letting me know indirectly that they weren't...they only felt they should participate in her presence... I don't think I was paranoid, because it was only slowly and gradually that I began to see that there was reaction among the patients. (I 126)

It was the case that things moved in hospitals on a general routine, but events outside could have a dramatic impact. There were periods of both relative calm and heightened tension: these included the period of civil disturbance in the early 1970s which impacted particularly severely on Altnagelvin in Londonderry and the Royal Victoria Hospital in Belfast. The introduction of internment, for example, was particularly traumatic, according to this account of events in Belfast. The passions aroused overflowed into the hospital:

At the beginning of internment, now that is very memorable. I was in charge... . And it happened on the Sunday night/Monday morning, at four o'clock in the morning, and they started knocking on doors – well, I suppose it was half four – and Casualty went mad. We had a night sister who at that time...was normally there, was [a] very, very experienced, calm person, but one of her deputies was on and she lost it, which made my life difficult. ...

People were coming in, in a terrible state at four o'clock in the morning and [one] of the local politicians... [X] ...now he ultimately became a very moderate man and consequently lost his position, but he at that time. ...I think he was terribly upset by what was happening in his community, basically, but he actually hit me. I was trying to get them all to calm down. And you see what they were doing was, they were absolutely uncontrollable.

They were running in and out to X-ray and they wouldn't stay out of places. You would say, "Would you mind waiting outside?" "No. I know what you are like in here and you're just a soldier's whore," and you got called everything... They wouldn't stay out and they would be getting under your feet when you were trying to do procedures. And they would go into X-ray where it was dangerous and you couldn't get them to stay out. You are dealing with people who were very uncontrollable. ...

One woman said to me, "I am a domestic here." So I said, "Oh right, you are on staff?" "Yes." And I said, "Well in that case, I will be reporting you to your superior in the morning." Well, that dealt with her. She actually thought that up to that point in some way that meant that she could do whatever she liked. So it was bad when you got the crowds coming in. That was a particularly bad night, and that night sister still over the years used to say to me, "I'll never forget the sight of you in the middle of this crowd of women, and they are all trying to hit you with their umbrellas." (N 15)

Similarly there were other incidents, such as the rioting during republican funerals or in the aftermath of events such as the Shankill Road bombing, which exploded on a busy shopping street on a Saturday morning. The Enniskillen bombing on Remembrance Sunday brought relatives, politicians, community representatives and helpers from the general public into the hospital – it was hard to keep a lid on passions, which made the situation more difficult to handle. This was particularly so when rioters were brought in

for treatment, as the presence of security staff and verbal and possibly physical confrontation set off a riot in the hospital itself:

Well, they carried people in, there were people at a funeral, but the police opened fire on the funeral with plastic bullets and they carried people in from the road. Of course there was pandemonium and the police fought up and down the corridors, and stuff like that. (HA 14)

This was the background to working in the hospital system. These factors complicated the lives of medical professionals and intruded directly on the delivery of medical care. The medical profession in hospital had to put up with the presence of security, the intrusion of paramilitaries, threats and intimidation, the problems of keeping order and the attempt to manage situations which could spiral out of control. All this happened because of widespread community violence. Inevitably it focused an individual's attention on their own views and background, and to a degree placed personal strain and tension on the notions of right behaviour. The next chapter will look at the considerable emotional and ethical impact that this had.

5. Professionals in Interrogation Centres and Prisons

Much of the testimony that follows is based upon prisoner allegations. There are various reasons for this. First, there were more prisoners and they remain a relatively cohesive and well-organised group – particularly on the IRA side – even after the end of the Troubles. Also, they are willing to make themselves available to tell their stories. Second, in contrast, death (sometimes violent), retirement, resignation and dispersal affected prison staff, a much smaller number in any case. Often, those who were associated, particularly with the most traumatic episodes in the prisons, do not wish to recall a difficult period in their lives. Unlike the prisoners, they have not become integrated into a ‘heroic’ narrative, although some recent attempts to commemorate their sacrifices are now being made. However, mostly they believe that a narrative stigmatising them has been constructed in popular nationalist culture, and thus they feel they have nothing further to add. Furthermore, in most instances they conducted their work by often shielding their names and their families from discovery for security reasons, and this continues to worry some of them. However, some effort is made in this chapter to qualify the prisoner allegations and set them in context. The chapter also attempts a critical commentary on many of the assertions made by the prisoners during these years.

The Troubles brought about activity on the part of the security forces (including the police, army and prison authorities) which was unprecedented in both volume and content. There was direct physical confrontation with republican and loyalist activists. Many encounters resulted in arrest, interrogation and imprisonment. Apart from the consequences of conflict, both republican and loyalist activists were arrested for interrogation in the pursuit of intelligence. Health professionals, mostly doctors, were involved during the processes of arrest, interrogation and imprisonment. The behaviour of the security forces was called into question repeatedly, and with this came allegations that doctors had colluded in, or at least had not repudiated, questionable conduct of

which they were aware. This research collected the memories of doctors who worked in the system as well as those of prisoners from both political groups.

These incidents involved doctors, prison medical orderlies and the conduct of medical care; they involve issues of medical ethics in very raw and disturbed conditions. Doctors were caught between two forces pulling in opposite directions. On the one hand, they had duties towards the prisoners, and on the other, they had to take into consideration good order within the prison. This is illustrated graphically in this comment from a medical professional:

The difficulty was, I think, that the staff expected you to be their man, and it was difficult sometimes to make it clear to governors and prison staff that as an independent medical practitioner, your job was to look after the prisoner.

Sometimes the prison officers and police would come to you with outlandish demands. So they came to me and they wanted me, whenever I changed the prisoner's dressings, to take the dressings and put them in plastic bags and send them to the forensic laboratories, so that they could test them for bullet fragments and link him to the [incident]... . It was quite difficult to explain to them that I couldn't do that.

Sometimes you would have governors coming and saying to you: "Look, you want such and such a prisoner to go to hospital because you think he has appendicitis. He's too high-risk to go to hospital. He is going to escape. Sit on it for 24 hours and see – it mightn't turn out to be an appendix." You know, that kind of thing, or "Operate on him yourself" or something.

So their priorities were the security of the prison. The prison governor always felt that his main job was to make sure that the number of prisoners locked up at night matched the numbers that he should have. An escape seemed to be the worst thing, even worse than a suicide. Because a suicide, you could always try and blame it on the medical profession, but an escape was very big stuff, and there were some massive escapes from the prisons, people running down the road. (PS 62)

Rules and regulations applied to the delivery of medical care in prisons, but at the same time, this was a situation of unprecedented crisis for which no clear guidelines existed. Added to this was another factor: throughout the Troubles, events in the prisons were

scrutinised closely from the outside. Rioting and protests in relation to the decisions taken in the prison took place frequently during this period. Prison staff were 'legitimate' targets in the eyes of republicans and loyalists, and many lost their lives during the Troubles at the hands of paramilitaries. The effect of the Dirty Protest and hunger strikes was to increase the threat of assassination and bombing. This added to the bitterness of the atmosphere in the prison. It meant that often, doctors were divided in their sympathies between prisoners' suffering, particularly during the hunger strikes, and the tension and threats experienced by prison authorities who faced their own form of summary justice meted out by paramilitaries.

In addition, these dangers were not confined to prison staff. Several doctors gave testimony as to the personal dangers they faced. As one recalled:

One evening in 1991 one paramilitary type outside fired shots at me as I was leaving the prison, and it has always left me a bit apprehensive. But it also made my views on things less liberal. It had some effect on my belief systems. It is difficult to know exactly how much, but it moved me slightly from the Centre to the Right. (PS 4)

During the Dirty Protest, one doctor, was involved in an incident described by a colleague:

Now one of the doctors was in a car with a prison governor on the Crumlin Road, Dr [X], when a motorcyclist stopped the car and fired shots in the window. It didn't hit the doctor, who I don't think he was intending to hit, but killed the governor, who then fell across the doctor's lap – and that kind of thing made the doctors somewhat right-wing. (PS 62)

In addition, prison medical staff were considered vulnerable by some prisoners to manipulation. A former prison governor stated:

A problem in dealing with the terrorist prisoners was that they were highly manipulative... . So they had a rough time – the doctors – to be impartial and to treat illness, and not to be used by the inmates. (PS 61)

This led to behaviour described as:

Very very conditioning, tremendously conditioning. For weeks prisoners would just shout at you and not cooperate with anything – and then they do cooperate, then want to go back to the shouting. I think doctors have

suffered from that attempted conditioning. Doctors generally were well able, saw what was happening and were well able to deal with it. (PS 61)

A decision made on medical grounds could have an impact on the war over status and demarcation of authority within the prison. This was the case in the Dirty Protest (as will be outlined in the next chapter). A visit to the prison doctor led to struggles over wearing prison uniform – a major issue of conflict between prisoners and prison staff – which put doctors in the frontline. More seriously, during the Dirty Protest, prison doctors were accused of colluding by ordering forced washing in the cause of hygiene. Ex-prisoners gave bitter evidence about this. However, the relationships between prisoners and doctors were transformed for the better during the hunger strikes, as several testimonies relate.

Further difficulties arose because most of the medical professionals working in prisons were recruited from the Protestant community. This has to be seen in the context in which there existed:

an old feeling that goes back many, many years on the Catholic side, that you shouldn't work for the Crown. So there was that, but I think most of the reason was fear that you would get bushwhacked. (PS 4)

The distance that this could lead to was cause for reflection by some doctors. For example, the extremes to which prisoners were prepared to go in the hunger strikes provoked this response:

One of the things is that the two communities in Northern Ireland are so separate that it's very difficult for somebody from a kind of Protestant background, which is all about rationality, to look into the mind particularly of a rural, committed Catholic person who would more have links back to martyrdom of the middle ages or something. I cannot think of any loyalist hunger strikers, and there has been plenty of them, ever taking it the distance. You need a lot of support outside, but you need a certain kind of mental approach. (PS 4)

Another pertinent point is the importance of the prisoners' story to the republican narrative. To the republican movement, the men and women imprisoned for acts of terrorism were the new generation of martyrs who could rightfully take their place alongside those of 1916 and 1919–22. For this generation everything was recast into 'victims' and 'oppressors'. Much of the prisoner narrative follows this format. However, it is fair to

say that there are also more nuanced accounts and a surprising degree of self-questioning by those in the thick of the struggle in the prisons. In addition, some of the prisoners' stories enjoy a measure of corroboration; nonetheless, the deeds on their side were excused or legitimised. Often, it was hard for one side of the community to appreciate how differently the other side saw their actions.

The hunger strikes in particular were a major means of legitimising the ongoing struggle in the eyes of the Catholic community, and were instrumental in helping Sinn Féin to rise to political prominence. The period of the hunger strikes was the moment when many unionists felt the gulf appreciably widen between the two communities. To them, regardless of the individual courage involved, the hunger strikers were simply a form of 'suicide bomb'.

Most of the time, the prison medical service worked to a routine; however, the background to this was not at all normal. As previously mentioned, there was a toll: 23 members of the prison service were murdered by the IRA – there were more who were injured or escaped attack – as well as the threat of breakout. Guns and other weapons were either constructed in, or smuggled into, the prisons for use by paramilitary prisoners against prison staff. The presence in the same institution of both republican and loyalist prisoners complicated matters further. Although loyalists and republicans were officially segregated, this did not prevent the assassination of Billy Wright, a prominent loyalist, by members of the Irish National Liberation Army (INLA), a republican splinter group, on 27 December 1997. It was rare, but deaths also occurred in the prison at the hands of fellow paramilitaries. The practice of 'shutdown', which closed off the blocks to staff at certain times unless an emergency occurred, left the paramilitaries in charge of their wings. So, for long periods in the course of the Troubles, prisoners had a great deal more formalised control of what went on in the prison than would be the normal experience in the rest of Britain. For example, this extended to discipline internal to the group, in which the paramilitary hierarchy outside would be replicated inside the prison.

However, there were periods of normality. The prison medical routine is recalled by a republican prisoner who was in Crumlin Road for 19 months in 1978–79:

Was there a procedure in Crumlin Road, how you would see doctors?

The procedure was you would have had to ask to see them, which is quite reasonable, and then you would have seen them, although in the company

of prison staff, which was not the appropriate manner – at least we thought – for conducting an [examination].

Was there ever a complaint on that matter?

I don't believe there was. I was never aware of any in Crumlin Road Prison. It was taken as the norm – that's how it had been, and that's how it was, and people maybe focused on much more important issues than a three-minute stint or two-minute stint in with the doctor and prison staff being there. It wasn't a major issue, but from the doctor's point of view it should have been, shouldn't it? But no, I was never aware of any proactivity by the medical profession. (P 114)

Not all the prisoners were dissatisfied at all times with the medical services provided in prisons. In many instances, the services worked. A republican gave credit for at least one episode:

A guy called [X] had that threatening appendix or something, and he'll tell you the two doctors, or the doctor, they sent him out to the hospital, the hospital sent him back. And the prison doctor – this is contrary to what people would want me to be saying or for anyone to hear, maybe it's not what you are about – but whoever the doctor was at that time, insisted that they deal with him and sent him back out a second time. So some of them were OK, you know what I mean? They were humanitarian, or maybe they were saying, "I'm not going to have something on my hands too." (P 121)

Among the positive comments was that of a prisoner who was subject to ill-treatment during interrogation later condemned by the Bennett Report (the "Hooded Man"), who praised the medical service in Crumlin Road. He was in the Maze Prison from autumn 1971 to May 1972:

We devised a programme for the whole day – exercise, learning, classes and so on. Part of that was to devise a system for medication for anybody who needed it, and we appointed a person who was 22 years in the Queen's Lancashire [Regiment], who was a medical orderly with the army but who was now interned with us. His name was [X] and his job was to go round each morning when the people would get up, or a bell would go or whatever it was. "Are you OK, did you want to see a doctor?" or whatever it was. And he would have recommended what you want. So then the doctor

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would come in, roughly about 11 o'clock, and the list was there for him and it was quite normal and quite natural, no problem.

You were saying then, once the orderly had given the order to the doctor, then prisoners went to see the doctor?

That is correct. (P 109)

However, even if things went normally, there was among many of the participants a feeling that often compassion was lacking. A spokesperson for a loyalist prisoners' aid group commented:

In prison the level of service they received was basic... . The prison doctor only knows what is reported to him. The mental state was not addressed because it was not identified. Lack of compassion from the doctors: the need was addressed, but the compassion was missing. During the loyalist hunger strikes there was not much communication between the doctors and the prisoners. It was in, do the job and out – very authoritarian, nothing personal. His job was to check to see if they were still alive. (P 117)

When asked how people were treated by prison doctors, a loyalist ex-prisoner replied:

I think, my opinion was the doctor sort-of maybe pretended that he cared, but he didn't care. Just his reaction, it's as if... "Right, who's next?" And he didn't really want to listen. (P 115)

Whether this feeling arose because of the isolation and alienation produced by the prison experience itself, the personality of the doctor or their political views, is more difficult to disentangle. However, the comments on this resonate with a theme picked up in other chapters, that there was poor understanding of the psychological stress affecting individuals because of the Troubles. In a few cases, the action of doctors may have added to that stress, as one republican claimed:

He seemed to have a dismissive attitude... . He was moved to Long Kesh and then we then asked for his removal, because we said he wasn't acting in our best medical interest. Some of the things you couldn't even repeat that he had said to people. He would go: "What's wrong with you this morning? Did you not get a good sleep last night?" And he would say to people: "What's wrong with you – are you not getting enough sex?" Something like that. There was no women in the prison so...or men or whatever, if you

were the other way. But he would say these things, but it was just dismissive... . So we hadn't confidence in [him]. (P 110)

A Catholic prison chaplain made allegations about the experience of one female prisoner. A dismissive attitude or indifference in normal circumstances was unwelcome but tolerable; in more extreme conditions, it could aggravate a crisis severely:

Father [W] rang at the time to say that a man called [X], a young man...had been shot dead by the army in Ballymurphy. Now [X] had a young sister he was very close to in Armagh prison. So the women used to listen to a little portable radio to the 11.55 news at night, so they were very anxious that I got over there quickly before they would hear this on the news to break the news to...his sister. So I went over. It was late at night...it was between 11[pm] and 12[am] that I got this word, so it was quite a hurry to get over before this particular time...

The guards already knew that her brother had been shot dead and they hadn't told her of course, but there were two or three of the women prison officers there who knew what was happening and they seemed to be pleased. They were smiling and joking and that upset me. And then I went to the cell; they opened it up for me. ...So [his sister] was obviously very close to him; they were near one another in the family. So she went hysterical and she began to shout. ...She thought she could see him and all this, and I was holding her and trying to calm her and talk to her, and she almost escaped. She did run out and back in again. ...I needed more time to calm her down.

And at that moment the official prison doctor arrived and he came in with his little bag with a very scowling face on him, and he just shouted [at her] (C 140).

A republican hunger striker described the doctors as "a very mixed bag". He went on to say:

Now I can remember one doctor who only lasted a short time, which spoke volumes to me, the fact that he only lasted a short time in jail who was very, very sound. And he would always have made a point of addressing you by your first name, christian name, Dr [X] you called him...really good...really interested as a doctor. A lot of others, also very good maybe,

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didn't get as personal in that sense, but were certainly interested in the nature and all the rest of it. (P 113)

In many cases relationships were not fraught. A GP remembers providing a service or 'GP outpost' to the prisoners in Long Kesh around 1971. Not only were the prisoners easy to deal with, but they appreciated the break from routine:

Yes, just put their name down on a list, and they did have huge numbers, about ten per cent per day. And to see the doctor they came out, got a bit of a walk and so on; met their colleagues and so on and so forth while they were sitting waiting. (PS 60)

Some of the problems encountered would be similar to those experienced outside the prison. The same doctor reported:

Now I can think of quite a few occasions over the years when prisoners asked to see me on their own, and I can only think of one or two occasions when they became unpleasant. One guy was addicted to various analgesics and when he got the hospital officer out of the room he started ranting and shouting, saying that if I didn't give him the tablets...But he didn't say he would break my leg – he said he would break his own leg in the surgery. And another one said that the doctor touched him in some kind of way that was a bit sexually explicit. But that, I think, it was mainly a hype by the prison authorities, who were worried that the doctor might be put under pressure. (PS 60)

One republican had some sympathy for prison doctors, and told of fairly innocent collusion between doctor and prisoner:

I think, in terms of the prison...there was no doubt that the medical profession were nearly, sort-of hemmed in... . Nearly as high as eight out of ten people who went out to the doctor were going out for something that they should have been allowed to ask for if you were going into a pharmacy. Literally, if you wanted a plaster you had to go out... . And a good example of it was [that] you weren't allowed at a particular time, from 1981 as far on as I can mind, you weren't allowed open-toed sandals. The only reason that you could wear open-toed sandals was if you had athlete's foot and the doctor recommended it.

So I would say that there was a phenomenon in Long Kesh that people, a high proportion of the male population, had something wrong with their feet. And I would say that 95 per cent of them had nothing wrong with their feet. Well, the doctor got to the stage that he knew if I came out and said "Doctor, I have a bit of a rash between my toes," he would say, "Do you think a pair of sandals would cure it?" And you would say "Yes." So he knew the game. He knew that I was out to get a pair of sandals and I wasn't going to get them unless he signed a form for them. (P 122)

Most prisoners reported a patchy service which was seriously compromised during times of crisis. Also, they might go through several institutions while in custody; this fact meant there were distinct differences in how they were treated. A republican recounted an unexceptionable experience as a juvenile at Crumlin Road:

It was just a case of settling down and coming to terms with being in prison. In terms of any dealings you had with the medical profession you had MOs [medical officers], medical orderlies, which were screws who had maybe undertaken presumably some form of training... They would come round with, like, a sort-of trolley, and they would have various forms of medication tablets and stuff like that. They would only issue on the word of a doctor.

By and large during my initial remand period, my first one in jail, you never encountered any problem meeting a doctor. The doctors would have been there and you would have requested the previous evening or that morning. Then your name would have been put on the list; you would have been called out any time from about 10.30 'til maybe 12.30 that morning to see the doctor. So you see the doctor depending on the nature of your complaint. He would have looked at you, seen you and dealt with you, and prescribed whatever it was. They would give us things like that, so in that respect there, if I went to see a doctor, they were always OK. You know what I mean? Because you weren't doing anything out of the ordinary. (P 121)

His experience changed dramatically on his transfer to an adult prison.

I turned 17 and I went across to the mainstream prison and it was a total transformation. But, nevertheless, I mean, even in terms of the doctors when they came to examine us going through from one part, leaving the

prison and then returning, they never bat an eyelid – they just got them in, check your numbers: two off, two on – that was it... I went to the H Block. It was about September or October 1977... A lot of beatings was [sic] handed out then. Doctors came round the next morning. They sort-of looked in the door. Look, I mean opened your door: “OK, yip,” closed the door and walked away...

So there was a thing called, what we referred to in our wing – I was in H4 – we called it the ‘Bad Week’. It was actually a fortnight, but it was only called the Bad Week because it was really intensive and the screws just beat everyone. Coming in and out with a wee black book, it was all this psychological stuff, saying: “Right I’m seeing you tomorrow morning – no, no, no, seeing you on Wednesday morning.” And you were sitting going from Monday night... and you were hearing the beatings taking place. There wasn’t a doctor in sight. We all requested to see the doctor – no response. Now again that could have been the screws. I’m trying to make some sort of justification here, but it could have been the screws not informing them. (P 121)

Interrogation

Internment without trial has been a weapon in the security armament which has been invoked several times both in the history of Northern Ireland and in the Republic of Ireland, almost exclusively against those of republican orientation. It was reintroduced in Northern Ireland on 9 August 1971 by the prime minister and Minister of Home Affairs, Brian Faulkner. The British Home Secretary, Reginald Maudling, commented that although internment was a very ugly thing, political murder was even uglier.

On 9 August 1971 at 3am, 342 men were swept into custody. It is of little relevance to this study that those arrested were mainly youngsters or elderly relics of former republican activity – the current activists were in hiding because of the long notice in the build-up to the decision. It is of rather more relevance that the republican cause was set alight by the decision to use a system that was anathema to the entire minority population of Northern Ireland. Internment was phased out slowly in the mid-1970s, regarded as a failure both in terms of security and the bad political effects that it had. However, during the period, allegations of brutality against detainees surfaced.

The arrested persons were taken to one of the three regional holding centres: Magilligan Weekend Training Centre in County Londonderry, Ballykinler Weekend Training Centre

in County Down and Girdwood Park Territorial Army Centre in Belfast. Once it was decided who was going to be released, those left were kept on the *Maidstone* (a prison ship), Crumlin Road Prison or Long Kesh.

The first detention or interrogation centre was established at the Palace Barracks in Holywood, and consisted of four prefabricated huts surrounded by a corrugated iron fence. It was for the use of the Special Branch of the Royal Ulster Constabulary (RUC), and it was here at this centre that suspects were detained under Regulation 10 of the Civil Authorities (Special Powers) Act 1922, which authorised the “detention for a period of not more than 48 hours of any person for the purpose of interrogation”. At the Palace Barracks, interrogations were carried out by the Special Branch, which consisted of members of special patrol groups. The Palace Barracks was closed down in June 1972 due to allegations of mistreatment of suspects. Some of these allegations of mistreatment and lack of care from doctors at the barracks were noted by Father Faul, a prominent Catholic priest well respected in the community. Father Faul gives examples from men who claimed that doctors in the barracks had not given them the medical care that is their duty (Faul and Murray, 1972). Subsequently, the decision was made to decentralise; this meant that suspects were questioned at police stations and holding centres. Castlereagh Police Station in east Belfast was chosen to take over some of the workload from the Palace Barracks. In addition to Castlereagh there were established holding centres in the Gough Barracks in Armagh, the Strand Road RUC Station in Derry and the Omagh RUC station. For example, between August 1971 and November 1974 there were 1,105 complaints of assault and maltreatment lodged against the RUC, and 1,078 against the army (Amnesty International, 1978).

The government set up a committee of three British privy councillors headed by Lord Parker, which reported on 9 February 1972 (Parker, 1972). The committee was asked to investigate the methods used to interrogate detainees, in particular the ‘five techniques’ associated with ‘in-depth interrogation’ (see below). Lord Parker and a second committee member decided that the techniques could be justified under exceptional circumstances, but the third member of the committee, Lord Gardiner (later the Lord Chancellor) disagreed with the other two, stating that:

The blame for this sorry story, if blame there be, must lie with those who, many years ago, decided that in emergency conditions in colonial-type situations we should abandon our legal, well tried and highly successful wartime interrogation methods and replace them by procedures which were secret, illegal, not morally justifiable and alien to the traditions of what I still believe to be the greatest democracy in the world. (Bew and Gillespie, 1999: 46)

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The prime minister, Edward Heath, announced later that the techniques would not be used again.

Thereafter, the security forces pursued the normal practice of arrest, interrogation and charge or release. In the aftermath of bombs, shootings and explosions, there were accusations of ill-treatment of suspects – some justified, others concocted. However, in the mid- to late 1970s suspicions arose again of a serious problem of systematic ill-treatment during interrogation along organised lines, approved from the top. This episode involved issues of medical ethics and brought doctors briefly into the political arena as whistleblowers.

As a result of allegations of brutality in interrogation, the government set up a series of inquiries. The first, chaired by the British Ombudsman Sir Edmund Compton, reported on 16 November 1971 (Compton, 1971). In his report, Compton rejected the allegations of brutality, but accepted that there had been ill-treatment. This was because of the application of the five techniques, which had been used successfully in Aden, Cyprus, Kenya and Malaya. Suspects' heads were covered with a black hood for a long period of time. They were exposed to incessant and repetitive noise of a kind calculated to make any form of communication impossible. Also, they were made to stand against a wall with their legs apart and their hands raised for periods of six to seven hours at a time. They were deprived of food and sleep. The final official British committee to consider the treatment of detainees was the Bennett Inquiry (1979), chaired by Judge Harry Bennett, an English judge. Its remit was to "investigate police procedures and practice relating to interrogation" rather than to look at the question of ill-treatment. It reported in March 1979 with several recommendations that will be referred to later.

However, on 2 May 1974, the European Commission on Human Rights began to hear a case against the British Government brought by the Irish Government over the treatment of prisoners (*Republic of Ireland v. UK*, Series A, No. 25 [1978] ECHR 1). The Commission found that indeed the treatment of prisoners did amount to torture. However, this finding was overturned later by the European Court of Human Rights. It ruled that the interrogation methods employed "did not occasion suffering of the particular intensity and cruelty implied by the word 'torture'". However, the subjects did suffer "inhuman and degrading treatment".

Medical procedures were in place at the holding centres intended to ensure good practice. When a suspect was detained, they were offered a medical examination before interrogation. If the suspect arrived during normal working hours, the examination was given by a full-time medical officer employed by the Department of Health and Social

Security (DHSS) and seconded to the Police Authority. If the suspect arrived out of working hours, they were examined by a doctor employed on a part-time basis. These initial medical examinations were important in that they were meant to establish not only whether a suspect was fit for interrogation, but also whether they were injured before arriving at the police station. The examination was voluntary and many of the suspects refused to have one. For example, at Castlereagh, more than 50 per cent of suspects declined to have an examination (Taylor, 1980). The procedure used by the doctors was that, during the examination, they would make their own notes and enter them on a prisoner arrest form. This form detailed the prisoner's history from the time that they were arrested to the time of their release or move to prison. A detailed record of the prisoner's medical examination was made on the prisoner medical form. This form noted whether there had been allegations of ill-treatment and whether there was medical evidence consistent with the complaint. The procedure is described by one doctor involved:

You would come down to the station in the morning, usually about seven o'clock or half seven, and there would be four or five people that they would have lifted. Sometimes they were in boiler suits because they had taken their clothes for forensic purposes, and they were usually not in particularly amicable form. So I brought them into the medical room on my own and explained to them who I was, gave them my name and so on, and I showed them the medical form that I was going to examine them with and I explained the benefits of it. They could be held for up to seven days, you see. And I said, "If you don't have a medical examination, and I come to examine you at the end of the seven days and you say that you had two or three bruises, the police would say that those bruises happened prior to you coming in. So really it's in your interest to have the examination."

Some agreed to it and some didn't. And then I usually came down once a day. We had an arrangement. I came down once a day and saw them all and asked them had they had any problems and, if they had, bring them out and examine them, and you saw them again at release. (PS 62)

Medical facilities at the holding centres were inadequate. For example, at Long Kesh, when the detainees arrived they were informed that a doctor would be available daily and that, in cases of emergency, there was a bell in each hut which would bring medical assistance. In reality, what happened was that the bell was ignored by the warders, and no doctor came if the bell needed to be used during the night. John McGuffin illustrates an example of this in his book *Internment* (1973): he relates an incident when a detainee,

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William Skelly, suffered an asthma attack with bronchial complications. After ringing the bell he was only given medical attention after 95 minutes.

Complaints began to mount from prisoners, their relatives and legal and religious representatives which threw considerable doubt upon the conduct of these procedures. People brought in for interrogation complained from the beginning of being abused. There can be no doubt that abuse occurred; this was confirmed in the reports already mentioned and by the European Court of Human Rights in 1978. The European Court's description leaves no doubt that the behaviour of the security forces should not have been condoned by health professionals.

Health professionals (almost exclusively doctors) inevitably became associated with procedures surrounding arrest and interrogation. What light is shed on their behaviour by the evidence collected in this research? The evidence is remarkably consistent. The first extract is from a republican:

Yes, I was arrested and I was about 14 years of age and your parents weren't allowed to be there. So when you were being beaten, the army doctor – now this was the early 1970s – the army doctor would have come in, and really just filled in the form and looked at you, and walked out. He knew what was happening, but ignored it.

Did you actually say to the doctor that I have been beaten?

Yes.

And what did he say to you?

He just filled the form... . The form was 'What's your name, what's your address and what's your age and what I have alleged had happened.' He wrote it down and then he just got up and disappeared. He would have no interest.

So when you complained did he not take any notice of it at all?

No, totally ignored it. (P 111)

The next participant is also republican:

When you went to Castlereagh it would have been anything from 24 hours to a week, and you would have been questioned about various things. On a

couple of occasions you were brought into this room for a doctor to see you. The doctors' names I cannot recall. I don't know.

But normally, if you were arrested from home, you were just thrown into the cell, and then from the cell you were taken to interrogation, and maybe 48 hours later a doctor would have come in to see you and you could have been standing there totally... I don't know the best way to describe it, but you would have been spread over and the doctor would have come in. You would have been sitting down in a chair and he would have asked you, by and by, like: "How are you?" At that stage you didn't speak, you know. But even if you didn't speak or not, he would have been able to see that you were totally dishevelled looking. And although you had no blood trickling down, you would have seen the blood in your nostrils if he had looked at you, your hair, tufts of hair pulled out, and stuff like that.

I'm just trying to recall back [sic] the first time. I was 16 and you would have been kicked up and down the barrack yard. So any of the doctors came in, they were sort-of matter-of-fact. They came in: "Such and such, are you eating?" Say: "Yes." "Have you been sleeping?" "No." "Why are you not sleeping?" "Don't get a chance to sleep." Things like that, you know. This was all part and parcel of this trying to break you down, you know, over a period of time. The doctors were totally indifferent. I just seen [sic] that doctor as an extension of the RUC, a part of the interrogation centre. I had belt marks all over me. I am just giving you one quick example of Castlereagh. I had belt marks all over my legs and my back and stuff where they were beating you. (P 121)

The next republican participant was arrested several times but was not always abused:

I was arrested on a number of occasions – the first time would have been October 1972.

And where were you taken to?

I would have been held in what was formerly the Victoria RUC Station in the Strand Road in Derry. I was arrested by British soldiers and we were physically assaulted and the doctor made records of the marks, etc. on our bodies.

Did he not question where you got the marks or... ?

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He asked us, and I would have told him that we got them as we were being arrested.

Was there a change in his attitude, or what was his attitude towards you?

In fairness, it's that far back and there was no great sense of contention around it because, in those days, it was a frequent thing that people when you were arrested, the soldiers, you would have been beat up.

The doctors would think nothing of it?

It would be unfair to say that, possibly, in 1972.

So during your next arrest then, what was your experience of the medical profession then?

I was subsequently arrested again and interned without trial. Again it would have been the doctors, there was no brutality involved. You were taken then to what was called a military holding centre. I wasn't brutalised, and prior to going to Long Kesh, I would have been seen by a British army doctor but I had no complaints. There was no brutality as such.

When you were examined by army doctors or whatever, did you ever get from them a feeling that they thought of you as maybe a terrorist or a criminal or something, or was it always very objective?

I think it was merely they were going through the motion[s]. I think the fact that you were arrested, they had a view of you, obviously.

In 1977 I was arrested and taken to Castlereagh. I spent six days in Castlereagh. I was badly brutalised. There was a number of us. Four of us were taken together and we were subject to a very rigorous and very brutal interrogation. The doctors there certainly had nearly...they treated you as if you were there to be processed and that was it. A good example, which is a very small example of it but which became very glaring at my trial: when I was arrested in Derry, I was stripped of my clothes and they gave me a boiler suit and I refused to wear it. So when I went into Castlereagh, all I was wearing was a pair of trousers which were my own. Photographs taken of me, etc.

And when it came to the trial, the doctor who was giving the evidence from the RUC end of things...was asked about my demeanour when I came into Castlereagh holding centre. The other person arrested along with me was actually brutalised in Strand Road Barracks. I wasn't, and I had made no complaint. But the doctor was asked, "Did he notice anything untoward in my demeanour?" and he said "No." And the barrister pressed him and said "Absolutely nothing?" And he said "No."

Well, this isn't a point of contention in terms of the outcome of the trial, but Mr [X] came into Castlereagh RUC station and he wasn't wearing any clothes. And the doctor strenuously said if that was the case, he would have recorded it and it would have been in his notes. So he was asked to go to his notes and read all his notes out, and there was no reference to the fact that I was naked from the waist up. And my barrister, who was [Y], said to him: "Are you saying that Mr [X] was clothed?" He said. "What I am saying, very definitely saying, is if he had been naked, I would have recorded it – I wouldn't have allowed this to happen."

So they produced photographs and what they actually said was...this isn't a point of contention, this isn't a point that the RUC were saying I was clothed. (P 122)

Another republican met a doctor in Gough Barracks:

I wasn't examined by him, nothing. All he asked me was: "Have you any complaints?" I said: "No" and he said, 'Right – cheerio, away you go.' That was the extent [of it], and I had got a few hammerings and beat up and everything in the place, but I wasn't making no complaints to no one. All I wanted was out...he was bound to have seen the bruises on me. ...He should have took a record of them but he had no intention of doing that, and he asked me, was I going to complain? And I said no, and that was out the door. So that was the way they were treating it. (P 108)

A loyalist spoke similarly:

I went to Castlereagh after interrogation with the police. I found that the doctor that came in had no sympathy for you. He just wanted to get his forms filled: "Are you OK?" I found that...that was known as the police

doctor. I don't think he believed what was going on, the interrogation and getting whacked round the ears, hit below... . They were too frightened.

The doctors?

They were too frightened to say anything.

But would he not notice a bruise or something or whatever?

My ears were pure black and he didn't notice them. He just sort of skimmed over, "Are you all right?" I found that yes, there was discrimination there. Not religious-wise, but he was a police doctor, so he was for the police... . I found that as absolutely true. I experienced it first-hand. I got a terrible beating in Castlereagh, and when I went to the doctor, he didn't want to know.

This was the prison doctor [who] didn't want to know, or your own doctor?

No, the police doctor at Castlereagh, and it was an outside doctor who works for the Police Service.

What period of time was this, just to put it into context?

I was taken in at five o'clock in the morning in the '80s, around about '84 – I was taken into Castlereagh. Went in and seen [sic] the doctor, he examined me OK. Then after about the third interrogation I got a terrible beating and I took a sort-of panic attack, and the police panicked and terminated the interrogation. And then the doctor was sent for and he examined me, and he said that there were to be no more interrogations for the rest of that night. And then the next morning the doctor seen [sic] me again and there was a short interview, and then I was released. And when I was released I went straight to my own doctor and he examined me, massive bruising around my ears which that doctor didn't say. The doctor did say: "Is there anything you want to say?" and I just said: "I am too frightened to say anything." (P 115)

The final testimony comes from one of the interned republicans whose case was brought to the European Court. He had been subjected to the regime described in the Compton Report:

Four people were taken from Magilligan, four from Girdwood, four from Ballykinler, and we were known as “the 12 hooded men”. Now we were put through a constant process, which is described in these books. It involved depriving people of sleep and all that sort of thing. You’ll see our various reactions to it. In the course of that, I was examined by a doctor. My last memory of that doctor was when he was leaving. He said: “If I am needed to despatch him, you’ll find me at the country club.”

Did he check you or did he medically examine you at all?

Yes, and I presume that he went through whatever he went through. I don’t know, I can’t remember that, but you want my last impression – that’s it. After about five days or whatever number of time it was, we were taken then to Crumlin Road Prison and I was taken directly to the prison hospital and I was examined there by a doctor. Now that was a different thing altogether, because I was back in civilisation and I knew then that I was going to live if I recovered. So I got the best treatment in the hospital, no problem.

It was the Crumlin Road Prison hospital, or hospital ward?

It was a prison hospital. There is a prison hospital in the Crumlin Road. (P 109)

Doctor protests

It was the situation at interrogation centres that led to one of the first conflicts between the authorities and doctors in the course of the Troubles. There was undoubtedly a much more systematic tough and severe treatment of arrested suspects during the mid- to late 1970s. This amounted to the use of interrogation techniques which have variously been described as “brutality” and “torture”, and the officially admitted “ill-treatment”. The police surgeons that examined prisoners who came to be charged following interrogation were so concerned that the Northern Ireland Police Surgeons Association issued a memorandum in 1977. The Association made it clear that it believed that a “significant amount of ill-treatment of a non-self-inflicted kind occurred in a number of police centres throughout the province”. The memorandum further concluded that: “Doctors have to uphold their medical position as neutrals. That is the role, which their profession demands. It is also the role which following the Strasbourg hearings, the doctors should carry out to the letter” (Taylor, 1980: 179).

During March 1977 the police surgeons decided that something had to be done. As a result, they took the decision to complain to the Police Authority, which informed the

chief constable of the situation. As time progressed and nothing happened, the Police Authority became concerned about not only the volume of complaints – which had risen from 1,366 in 1975 to more than 2,000 in 1977 – but also about the fact that its concerns did not seem to be taken seriously (*Belfast Telegraph*, 24 March 1979). However, there was some movement at the end of 1977, when the Chief Constable decided to set up a liaison committee to deal with possible problems.

The issue caused the resignation of one doctor and a request from another to be moved. One police surgeon raised the question of interrogations at Castlereagh, and another resigned his position over the situation at Gough Barracks in Armagh. Both actions received wide publicity in Northern Ireland and elsewhere. One police surgeon wrote of his concerns to the Chief Medical Officer and, in January 1979, appeared on the ITV programme *This Week* to make his concerns public. In the case of both doctors, they received support from their respective professional organisations, the Forensic Medical Officers' Association of Northern Ireland and the police surgeons. The president of the British Police Surgeons (Dr Stanley Burges) also lent his support. This was on the grounds of doctors' independence and also their unique position as watching over the interests of the public in general. Moreover, as the doctor in the case of Gough barracks pointed out, international consideration was also a factor. In his case,

he could not accept the conditions in Gough holding centre complied with the recommendations set down under the Declaration of Tokyo... . The declaration adopted by the 29th World Medical Assembly in October 1975 defines the course to be taken by doctors working in interrogation centres. (*Belfast Telegraph*, 24 March 1979).

The Secretary of State, Roy Mason, responded to this activity by launching the Bennett Inquiry, a limited inquiry of three members beginning in June 1978. The restricted terms of reference, which excluded any investigation of allegations of brutality, were to investigate “police procedures and practice relating to interrogation rather than to look at the question of ill-treatment”. The Bennett Report was published on 16 March 1979, and its recommendations were that the supervision of interviews should be strengthened; prisoners should be seen by a medical officer every 24 hours and offered an examination; and that detectives should be rotated and given other duties. The most important aspect of the report was the recommendation that closed-circuit television should be installed in the interview rooms to enable the uniformed branch to monitor interrogations, and that solicitors should be given unconditional access to their clients after 24 hours (Bennett, 1979). However, the Chief Constable and the Secretary of State refused to admit that ill-treatment had occurred. There followed the appointment of an Independent

Commissioner of Detained Terrorist Suspects – the first was the distinguished lawyer, Sir Louis Blom Cooper.

Following the Bennett Report the treatment of detainees improved, although the recommended recording of interviews took a long time to implement. The procedure now is that detainees are seen at admission and on each successive morning. If a complaint is made, the custody officer is informed, a report is sent to the Ombudsman, and the Commissioner has to be informed. The Commissioner has not received any complaints against doctors.

Some doctors claimed not to be aware, or that it was not a significant part of their experience. Nonetheless, many would still testify to the problems that could arise between the police and doctors. This strongly suggests that some doctors found managing relations with the security services to be a problem, and that this may have caused a few to avoid confrontation:

The Gough Barracks had no lights; the cells that they were kept in had no windows. There was a long corridor – males on the top, females on the bottom. But you didn't have a watch and there was no light came in [sic] and there was always two staff on. So they brought them out for short bursts of questioning, maybe two hours at a time, but questioning would go on from early morning to maybe 11, 12, one, two in the morning. You could, as part of your examination, say that somebody was unfit to be questioned for a short time, or possibly not fit to be examined – sometimes they brought in a woman [who] was pregnant or something. Occasionally, people threw themselves down the stairs or something when they found that the questioning was becoming too severe.

Dr [A] has made allegations...

He has.

Were you working at the same time as him?

Just after it. I think the main allegations were made around about 1976–77. And there was another doctor...his name escapes me, yes [B] was one of them. He was in Castlereagh but there was another doctor that... [C], yes he and [A] had made comments and [A] had said that he had been threatened by the police... [A] had been quite forceful and spoke out and he might have left maybe a year, 18 months after I started. I think there

might have been another doctor called [D who] took over from him, but by the time I started, it seemed to have finished. I personally, my time there, I mightn't have examined that many, a few hundred. I can't recall seeing anybody who had been given a proper thumping or anything; there might have been the odd mark.

They got a guy in who they thought had been guilty of a lot of offences, and because he was so taciturn, somebody had thumped him in the face – broke his nose – which had wrecked the case. But most of it was done through psychological methods, and those methods, as I say, involved interviews at peculiar times, food given at peculiar times. The prisoners were a bit suspicious of us.

As part of the establishment?

Well, up to a point. But I think over the years they found that the doctors were honest to their profession.

I think if you had got to the stage where the police had come out of a cell and said: "Look, doctor, we are asking you to examine this guy. He has got a few marks but we would rather you said you didn't see them," then you would be in big difficulties. But I don't recall that ever being suggested. In fact, sometimes the relationship between the doctors and police was a bit tense for one reason or another. (PS 62)

Some of the doctors attending those interrogated may not have been aware of the interrogators' behaviour. They may have worked in centres where abuse was rare, or worked at times when abuse was not occurring. However, there were also problems of whistleblowing in a divided society. Some felt that the protesting doctors were, however inadvertently, joining in a generalised attack on the security forces being conducted by the IRA, or feeding the IRA's propaganda campaign. Moreover, some among the majority community were not sympathetic to the plight of republican prisoners suspected of serious crimes. Even indirectly, this could exert pressure on individual doctors. This happened on both sides of the community divide. In spite of this, doctors did act to bring the abuse going on at that time under control, even though it put them in the spotlight and opened them up to accusations of partiality. Interestingly, they referred to rules, obligations and codes of conduct which are not only integral to the medical mission, but also to international conventions regulating medical behaviour. Medical ethics was put under strain, but it did emerge as a potent force in regulating the situation

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which had arisen. However, it seems undeniable that prisoner abuse in this period was, to use a current term, 'institutionalised'. It was recognised by successive inquiries, and the government accepted that corrective measures were necessary.

6. Prison Protests

There were prison protests throughout this time. These ranged from complaints directed through official channels to really serious incidents involving violence against prison staff and destruction of the prison. Because paramilitary prisoners regarded themselves as prisoners of war, this meant that there was a duty incumbent upon them to escape whenever possible. Several spectacular escapes of mainly republican prisoners took place during the Troubles, in some cases involving death or injury to prison staff. In addition, there were incidents of attacks on prison staff within the prison. In one situation, following an explosion on the Crumlin Road engineered by republican prisoners, loyalist prisoners attempted to bring their protests at the ending of segregation in certain facilities to the authorities' notice by attacking the prison doctor:

In 1991 there was a bomb explosion within the prison, and I was actually in the canteen where the bomb went off and was injured as part of the bomb. But what we found was that the authorities didn't really know how to deal with it, and they didn't know how to cope with the prisoners that were traumatised. There were no facilities set up to deal with it.

With the exception of the ones that were critically injured who were taken out to the Royal Victoria Hospital, the other ones that had minor injuries weren't receiving any sort of professional help. It was very, very poor service that they were getting. For three days after it, those people with small wounds that weren't even being properly dressed weren't being changed. ... Because of the whole forensic situation, for three days we had to keep the clothes that were soaked in blood still on us. We weren't able to wash or change.

I think – and this is a personal opinion – I think at the time that the doctors would have loved to have been able to have brought in other professional help. Because it was a prison situation, it wasn't possible to do that.

I can remember it actually got to the stage, believe it or not – and this can be checked – where the doctor was attacked. The doctor was attacked and it was a female doctor. The doctor was attacked to highlight the need for medical attention to be brought into the jail. And it actually got so bad, a plan was devised among loyalist prisoners at that time to attack the doctor and the female doctor was attacked.

In what manner?

A prisoner tried to strangle her. He got her by the throat and choked her. The doctor was attacked, and to be honest the attack was never...they were never going to kill the doctor – it was just to highlight the situation. And things did change slightly after that. So that was a serious time, and it was a time when there were severe problems and difficulties between the medical service and the prisoners. But what was happening was a lot of prisoners were having difficulty serving time. They were having difficulty coping within the prison, so they run to the doctor on a daily basis... . There would have been a large number of prisoners [who] would have been to the doctor every single morning, and then they got different types of medication. Medication to calm them down and basically help them cope with life behind bars – and everybody on the wing knew who these people were. (P 118)

The doctor's account of the episode shows considerable *sang froid*:

Well, it's only really one incident which sticks out in my mind, and that was when a prisoner who was extremely angry about something that had happened down on the wing came out to see me and still had a lot of unresolved anger. I think just prior to seeing me [he] had been involved in a fracas with one or two of the prison staff, and he actually came round the table threatening me – and I did feel in danger at that time, but that is only an isolated incident. (PS 27)

However, isolated incidents could escalate very quickly: in some cases, they led to insurrection within the prison. Here is a republican ex-prisoner's account of the aftermath of a protest in Crumlin Road Prison:

I was back in again in 1974 in Crumlin Road. You heard of Long Kesh being burned down. This was around about that time. The day after we

heard it was burned down, we barricaded ourselves in our wing and we took four or five prison orderlies hostage. We took all the doors off ourselves. We left no doors on. And the Brits, they came in through the roof and they dropped in CS gas on the top of us and all of that there, so it became a mirage. Actually they didn't do it until...we released the prison officers, because they promised us that they would not do anything on us [sic] if we released the prisoners, and we did.

But they didn't stick to their word. They dropped in the CS gas. They were picking us out in five or six to run the gauntlet, and they were beating the living daylight now. I ended up with 47 stitches in the head. (P 108)

Of course, the aftermath of this was casualties among both prisoners and staff. The prisoner recalled his medical treatment following the retaking of the prison:

So you were beaten and you were lying on the ground. When were you given medical attention?

I'd say they gave us the beating around about five or six o'clock in the evening. Ten o'clock that night was the first time they decided that [indiscipherable] them. They brought us out and set us into a chair. I was brought out and set into a chair, and I don't know if it was a doctor or not there, was no anaesthetic, no nothing. A boy with a needle and thread, and he took into us and the head was sewn.

You were given stitches without any anaesthetic?

With no nothing, absolutely nothing. Sat down. Hold on to the side of the thing and you were stitched up.

Can you remember anything? The person who stitched you up – you were saying he was wearing a white coat. Was his attitude towards you sympathetic? Was he caring, or what was his kind of attitude?

One of them had virtually his arm around your throat while he was holding you down in the seat while you were being sewn up. It was absolutely brutal, you know, and 48 lacerations to the thing and across the back as well. It was a brutal...you were just stitched up as you were. They are there...all the scars is [sic] still there... . You'll see them. ...They are all there. (P 108)

Special status

Other events within the same time frame had effects on prisoners and their medical care. Republicans and, to a degree, loyalists always have considered their engagement to be in an 'honourable' war: when captured, they were regarded by their fellow paramilitaries and sometimes also their community as prisoners of war rather than criminals. They felt that this should be recognised by the prison authorities and the government. The struggle to obtain this status was a persistent cause of unrest and conflict in Northern Ireland's prisons.

In June 1972, republican and loyalist prisoners who had been convicted were granted the status of prisoners of war – a decision that led to much difficulty. They were allowed to wear their own clothes and received extra family visits. This continued until 1976, when the decision to end 'special category' status was linked to the ending of internment in 1975, and was part of a policy to 'normalise' or 'criminalise' IRA activity. In September 1976, the first convicted republican activist to be told to don prison clothing declined to do so. He was placed in a cell naked and covered himself with a blanket. The dispute over wearing prison clothing leading to republican prisoners stripping themselves and wrapping themselves in blankets gave rise to the description 'Blanket Protest' or 'Going on the Blanket'.

In addition, prisoners were penalised by loss of remission and visiting privileges. When prisoners broke up furniture, it led to the removal of beds and lockers. Prisoners had a mattress, three blankets and a towel. The dispute intensified over a row about washing. Their subsequent refusal to wash gave rise to the description 'the Dirty Protest', which saw prisoners refusing to leave their cells, smearing excrement on the walls and draining urine away through cracks. Both the Blanket and Dirty Protests put a particular strain on the medical service in the prisons. The interactions between prisoners and guards led to escalating animosity. On the one hand, republican activists were determined to reassert through protest their special status; on the other, prison guards, who dealt on a daily basis with the prisoners, sought to reassert their authority and keep disruption and deterioration of conditions to a minimum. During this time, a similar routine to that of more normal days was carried out. As one ex-prisoner recollected:

I think it was about once a week the doors opened. Remember you obviously were...you just had a blanket and nothing else. The doors opened once a week, I think it was, and the doctors came in: "Any complaints?" Or "Do you want to see a doctor?" You just said: "No." The door just shut and that was it – he went down round the whole wing. (P 111)

Some medical care was dispensed without controversy. The same prisoner remembered treatment for a tooth abscess:

Yes, during the Blanket I contracted an abscess in my tooth and it was a pretty bad one, so I got permission from my own people – the republican comrades – to go to the hospital to see a dentist.

He was a prison dentist?

He was a dentist that was hired by the prison system who came in from outside, he was pretty good.

So how long between when you first started having the toothache to when you were seen by the dentist?

Maybe within 24 hours, I think, 24 hours or 48 hours, I am just not sure.

I asked for tablets and that and I wasn't given them. I asked the screws to send me in the OC [Officer in Charge] in the wing I would have asked him to send stuff round... . They were saying, "If you want medication, put on your uniform and go to the hospital" – go to what's known as the ordinary wings. So my doctor came round and within 24 hours or 48 hours said, "You need to see a dentist, you've got an abscess." (P 111)

In the view of this patient, even in the fraught conditions pertaining at this time:

The doctors inside even after the Blanket and hunger strike with the greatest respect, there were some who were sound. [On the other hand] some of them in my eyes really hadn't a clue. (P 111)

However, against this, the reality was far from normal. The cells of the protesting prisoners became progressively filthy, as did the inmates. This was uncomfortable for all, but also posed a potential health hazard. At this stage, the republican prisoners were under what they considered to be military discipline from their own side in the struggle for political status. This meant that doctors' visits had to be cleared with their commandants. Crucially, nothing was to be done that would concede to the authorities any of the areas around which the prisoners were fighting. For example, it became a bone of contention as to whether inmates would wear prison uniform, as the regulations required. When a request came from a prisoner to see the doctor, often a struggle with the prison staff would ensue. Prison staff would attempt to enforce the uniform rule for

the medical visit, the inmate would resist, and the doctor was caught in the middle. However, the real bone of contention – an issue which damaged the relationship between prisoner and doctor during this time – was that of forced baths. A prisoner recalled that he was bathed without the presence of a doctor:

I did get a forced bath. I had to go to court one day and they took me out. No doctor there, and these screws took me away from the block out of my cell, and took me to one of the punishment blocks, and they filled the bath with cold water. It was humiliating and degrading. Put me in a bath of cold water, because I was going outside the jail to the courthouse. And they had scrubbing brushes you would use in the house – and they scrubbed me down with cold water and all sorts of stuff that burnt your eyes. There was no doctor present for that, and that was that. (P 111)

Forced baths involved physical restraint and coercion, and were brutal and demoralising both for those subjected to them and for many conducting them. Usually they were administered on the advice of a doctor, and this caused medical professionals to be at the frontline in the prison battle:

They would have a look at you from a distance. They had a look at you from the...the cell door...and they'll have a look and say, "Yes, he needs them, he needs them, the bath." So many of the prison staff, including the medical staff, knew they were drawn into the "This must be finished".

This was to strike terror – so what would happen is, if he named you and that fellow, and that fellow over there, at some stage indeterminately later the doors opened and in would come a gang of the prison staff. Drag, beat, forcibly take out, search and throw [you] in a closed cell in the back of a bus, naked. Take you to another location. Bring you into a very hostile atmosphere, totally isolated from other prisoners, with other members of staff who were – this happened to me, so I know what I speak of – and kept, sort-of... When people are dressed differently it's scary, you know? The waterproofs up and hats on, and rubber gloves on and hosed. And they quite literally hosed me with freezing water in a room that I couldn't get out of, because they were there. I was put in there and they hosed me.

They subsequently held me down into a bath, which was empty, with a bar of soap about... I don't know...it was big bar of Lux soap, and they literally washed my body. Rubbed it because my body was wet with the shower, the

hose. They rubbed it and then they had hand-held scrubbing brushes. Now you may think... I don't really care what you think, I'll just tell you.

There was hand-held scrubbing brushes which were probably, I'd suggest, actual brushes that should have been on a... [broom handle] but they were held, they weren't these massive ones, they were about this size and very long, very stiff bristles, nowadays they would be nylon. But they weren't nylon, they were the big, sort-of... I don't know what you would call them – and they literally from there to there scrubbed me and lathered me up, moved away and hosed me again. Now I am talking about all over my body. Did they care that I was hygienic? And that was ordered by a doctor. It was the doctor who would have ordered this. (P 114)

Another ex-prisoner's comment illustrates the breakdown in relations with the medical profession in the prison at that time:

I suppose the doctor, I do remember there was one we called by a nickname. The idea was not to look at him because you didn't want to catch his eye, because if you caught his eye that meant you were getting three forced baths in a period of a week. It was very clear to us what was happening – was that the screws was saying to the doctor, "Go and pick so many out," and if they had particular pet hates they would have pointed you out. The rationale was, I think: "Oh yes, he looks as if he could do with a wash."

Do you think that the doctors were aware that these were the type of baths you were given, or how you were scrubbed?

I don't know, I honestly don't know.

Now, if you have that volume of injuries and if you have a history or an ongoing weekly record of people getting abused and beat[en], then why wasn't there something done about that?

Now, if someone did do something about it, that was fine. If somebody did raise that issue back then, then they are to be thanked for doing that. But as I recall, it was not the case. But for him to go up and down those wings – I'll be honest with you when I said you didn't look at him, because you didn't want to catch his eye in case he pointed at you. (P 120)

Speaking of the role of doctors in the forced washing, another republican said: “I think it was a most blatant case where the medical profession were used to justify or excuse or whatever.” He alleged that one doctor:

stood there as people were dragged naked up the wing to him, and from a distance of anything from 10–20 feet he would have said: “Yes. Hair lice.”

About one set of forced washing, the prisoner claimed:

What they did was go in and do half a dozen first. All of those people had to be taken to outside hospital that evening because one had a broken arm, another had a fractured skull all the rest of it, and then the following days the rest of the people were done. It was only stopped because there was such an outcry. But the outcry wasn't from the medical profession. Well, certainly not public that we seen [sic]. It was more priests that came into the place and solicitors who went public on it. (P 113)

However, in some of the testimonies from prisoners, there was an awareness that the confrontation had been brought to the medical staff's door by the prisoners themselves, and further, that political views influenced the view of what was right or wrong in these circumstances:

Many, many prison staff personalised their political views into their daily work views, and the prison medical staff have to be included in that. At least they manifested that. There was nothing in their behaviour which indicated to the contrary. Therefore, one has to assume that that is how they also felt...very, very possibly thought they were doing the right thing when they saw people like me as their enemy.

During the Blanket [Protest] the prison doctors had to be integral to putting [the] squeeze on the prisoners because of their living conditions...but we opted to be there because we had no other options, and we lived there as we lived and the doctor came in to examine us. We didn't ask the doctor to come in, but there was a rule made up that the doctor had to come in and examine you, and if he thought that you weren't very healthy you were dragged out – and that was the concern they were showing to you. But in the main, because of the prevailing atmosphere, the lack of sympathy from the doctor we just ignored...people put up with things that under normal circumstances they would have gone [to see the doctor]. (P 114)

It was difficult for doctors in the prison medical service to negotiate this minefield. In the view of one prisoner, the forced bath was:

a good example of where it was abused by the administration as a way to come at you, a way to brutalise you, and doctors signed forms to say that it was medically necessary; whereas our doctors had disputed whether it may not be necessary. (P 112)

In his eyes, this made the doctor a part of the prison administration which they were fighting: “They were basically there to literally rubber-stamp whatever the procedures were” (P 112). Issues of prison discipline and being drawn into one side or other in this conflict put a considerable strain upon doctors.

The hunger strike

The second protest, after the Blanket and Dirty Protests were called off, was the hunger strike. Both loyalists and republicans adopted the hunger strike, but the loyalist hunger strikes were intermittent and quickly abandoned. In contrast, for the republicans, the hunger strike of the early 1980s was the most significant iconic moment in the history of republican incarceration during the Troubles. There was loss of life both inside and outside the prison over the issue, and severe community tension. In the end, the aftermath was the abandonment of the attempt to impose normal prison conditions on paramilitary prisoners. Thereafter, commandants controlled a great deal of discipline within the organisation in the prison and their respective wings, prison staff only intruded at agreed times, and significant privileges over uniform, and organisation of time were allowed to each paramilitary group within general incarceration. On entry a prisoner could declare an allegiance to one or more paramilitary groups and, if they were accepted, could expect to be transferred to their wing. To get to this situation involved a long series of protests. The hunger strikes were a severe test of the medical service within the prisons. The first involved seven men and began on 27 October 1980, and ended on 18 December with no deaths. It was called off on the understanding that the concessions over status were to be resumed. However, by 1 March 1981, republican prisoners concluded that they had been misled. The Dirty Protest was abandoned and one republican, Bobby Sands, commenced the hunger strike that was to lead to his death. Others joined him in succession: altogether ten men died in the strike, which lasted until 3 October 1981. When the strike started, relationships between doctors and republicans appeared to improve. A major contributory factor was the abandonment of the Dirty Protest. As one ex-prisoner who was not on hunger strike recalled:

Well, once the hunger strikes started, the living conditions of the people on protest, the other prisoners, changed, because we moved into a washed situation. So once that changed, obviously policy changed towards us, and the regime wasn't as oppressive. And I have heard very, very good reports of the treatment by some of the medical staff up in prison hospital. I wasn't up in the prison hospital. I don't know how it was, but I have heard decent reports about that. But bear in mind, the atmosphere had changed. (P 114)

A hunger striker who had been trenchantly critical of the doctors' earlier behaviour praised both the doctors and medical orderlies:

In 1979 you were in the H Block then, the hunger strike. What about your experience with the doctors during that period?

Well, I would say that in fairness from the prison warder medical orderlies, their behaviour was exemplary. They were very good. I think they handpicked the prison warders who were the medical officers – I think they handpicked them because they were people whom you would maybe have known and seen about, and they were people who were much dedicated to what they were doing. They maybe seen [sic] themselves not as prison warders, but certainly as nurses and behaved accordingly... . There was one man in H5 who to me was a gentleman, always was a gentleman. And he would have told you that in the canteen and the mess, even in the car park, there would have been warders from our blocks would have called him a 'Provo Welfare Officer' because he didn't beat people. His thing was, he was in his job was [sic] to keep us locked up and to [guard] us but not to beat us. (P 122)

There were several possible reasons for this. Besides the abandonment of the Dirty Protest, doctors were faced with an essentially passive, self-inflicted condition which aroused compassion for the individual, if not for the cause which sustained it. Ethically and medically, dealing with hunger strikers was extremely stressful, but not in terms of prison discipline. Considerable effort was taken to get the treatment right. A doctor recalled:

I mean, I was around in the time when the Chief Medical Officer of that day with his team, I remember they would have gone into session at short notice if there was something happen[ing] at the hunger strike at the Maze. And I mean, they spent hours and hours and hours trying to get this right

in terms of protocols and ethics, and they were in touch with the GMC [General Medical Council]. They had two lead consultant physicians who were the two that wrote the thing up, who were there to deal with the nutritional aspects of it, and they, there was a model they couldn't... . I mean this is my objective view – they couldn't have done more to handle it in an appropriate way for health professionals: it was unknown territory. (PS 4)

The policy laid down was non-confrontational: for example, the decision was taken not to force-feed prisoners. This reduced medical care to examination, information to the patient and intervention to treat the conditions that arose both during, and because of, the hunger strike, but no intervention over the refusal of food. A history of how this was done is given in the following extract, which shows a degree of 'hands-on' care, but careful avoidance of administering any treatment without the patient's consent:

Once you were then on hunger strike, did the doctors ever feel that it was there duty to intervene or to... ?

No, absolutely not... . For some reason the name of the doctor escapes me, but he would be well known, and...he committed suicide. He would have been the senior doctor, and despite some criticism during the Blanket Protest, again during the hunger strike to me personally, and I would say to the other six people on hunger strike – the first hunger strike in 1980 – he acted in a very professional and humane way. Now I would say in the course of conversation he may have said things like, you know, "Your body is being depleted of A, B, C and D, and this is what comes about of it."

They then would have invited a number of consultant doctors from the Royal Victoria Hospital. And there would have been an eye specialist... [Dr M] was very straightforward. The examination he gave you was very thorough... . I think [Dr M] left during the 1980 hunger strike to go to some job in the Middle East and [Dr F] took over, and I think [Dr F] got really involved, and really in my opinion took his professionalism to another level. I think he became really, sort-of, concerned if you know what I mean, and a good example of it was the medical orderlies tell us...

Our hunger strike ended on 18 September. We were on it 53 days, but [Y] had from about 46 days really deteriorated, and he was in the prison hospital that night, and [Dr F] was there and stayed overnight, stayed a

long time. But the medical orderlies told us the next day that if he hadn't been there, [Y] was on the verge of a heart attack – and it was [Dr F] who spotted this. And he actually sent an ambulance from the gates of Long Kesh to Musgrave Park to test how long it would take before he would move him, and then moved him subsequent[ly].

In their view, if you had a heart attack you wouldn't have come out of it because your body was that weak – you wouldn't have been able to survive it. So it was that type of thing, and then afterwards he would have come in, and I would say the post-care we got was exemplary. We got good care afterwards, and I would say it was down to people like [Dr F]. So I have always had a... I have never met the man since but even talking to him when he came in. We would have got examined by him every day for maybe a week, ten days, and he showed – this may be wrong, because a whole lot of the medical people were doing the same thing – he definitely had warmth and humanity about him. (P 122)

Another hunger striker also praised the medical care:

The prison doctors...the guy who was a doctor then committed suicide later, and whether it was connected it to the hunger strike or not, but I always found a marked difference [with] him. I had very good personal relations with him. I was on first name terms, he was the main doctor at that time. I would say probably the hunger strike posed a lot of questions then, because you are a doctor and people are dying around you, and there is nothing medically wrong with them, and then you feel powerless and all the rest of it. The facilities was then found, you were moved to the prison hospital three weeks after you began the hunger strike. At the start when we began it, we were told how it would endanger our health and all the rest of it, but how they aren't authorised or wouldn't be intervening in any way.

The doctor informed you of this?

Yes, it was part of British Government policy. They are employed by the state in the hospital and I suppose they go along with whatever. And the ruling by the British Government was that people wouldn't be force-fed, so I assume that they would have been in breach of that. Plus to do so, but I suppose they would have had to forcibly feed us, so therefore I would

imagine that would be contradictory to the Hippocratic Oath, or to the essence of the Hippocratic Oath.

During it, every day we were just taken out and you were weighed, blood pressure taken and just generally checked your health, and checked urine samples and all, which I suppose even to show that we weren't eating because it would show up. So in relation to that sense with the medical doctors there was [sic] some other people who were in the medical profession, but generally they were prison officers who had some medical training which varied from pretty good to fairly hostile. (P 113)

Access for the prisoners' families and representatives eased. Also, the hunger strikes attracted international attention: to some hunger strikers, this certainly seemed to have softened official attitudes:

I don't want to question people's professionalism, but there is absolutely no doubt that there was a focus. There was an international focus on the hunger strike. So you couldn't have reports coming out because we had access to lawyers every day of the week. Our families after a certain period were coming in every day in the week. So I think the last thing that they wanted was that we weren't getting proper medical attention, when this was international headlines. That's not to say that the doctors wouldn't have acted in that way anyway. But I think there was [sic] some medical orderlies prior to the hunger strike who wouldn't have given you a drink of water if they had been able to stop you from getting a drink of water. I think they handpicked the medical orderlies who were down the wings with us, to ensure that there were people who we knew and we knew would be. (P 122)

Doctors' testimony

So far, most of the testimony has been from prisoners. However, both prison staff and doctors have their own interpretation of how the medical service was conducted and what happened at times of crises. Their accounts do not always contradict those of prisoners. There were specific problems to do with conducting medical examinations in prisons which formed a backdrop to the job done by the medical doctors there. One issue was the sheer numbers:

Some of the prisoners that I have spoken to...were saying, sometimes they felt it difficult to convince the medical staff that they had a serious ailment because there was so many people going with minor [ailments], just to get excuses, just to get tablets, medication.

You did always have to watch that, because on some mornings you might have a hundred prisoners presenting for what was called 'sick parade', and there was always the danger that you didn't remain alert and that you missed something. (PS 27)

In addition, prisoners were not above abusing medical examinations:

Well, there was a book called the *Prison Rules*, and it was quite an ancient document. And one of the things it said was that if a prisoner asks to see a medical officer, they had to see them that day, and that sometimes was problematical although we always did our best to make sure that we did see [them].

Outside, you say you want to see your general practitioner, you make an appointment – but the *Prison Rules* said that if you wanted to see the doctor, you had to see them that day. Which meant that occasionally in the Maze [Prison], prisoners would start some sort of protest, and one of the protests sometimes would be that they all put their name down for the doctor on the same day, and that of course causes enormous problems. (PS 62)

A further problem of demarcation between prison rules and normal medical practice was in prison staff's reluctance to allow examination without a guard being present. In these circumstances, doctor–patient confidentiality was never achieved completely:

But in the prison there was this, I suppose, habit going back many, many years that the doctor didn't see them [without a guard], and you were always told by the staff all the reasons why you shouldn't see the prisoners on their own. Now, in the police station, we saw them on their own. The prison hospital officer that helped you on sick parade – they were reluctant to let prisoners see the doctor on their own. Quite often prisoners said: "Can I talk to you on your own, doctor?" Sometimes I did speak to them on their own. (PS 62)

Institutionalisation

The particular problems of dealing with the situation in Northern Ireland prisons during the Troubles deeply affected prison medical staff. Doctors were stressed and concerned by their environment, which differed from the situation to which they were accustomed. One particular problem was that working in the prison made staff a target for assassination on the outside; this was particularly the case at times of political tension:

Did doctors feel threatened either within the prison or by paramilitaries outside in how they conducted their jobs?

Yes.

Within the prison and even outside the prisons for their families and for themselves?

I think we all did at that time, because in my time two prison officers were murdered. But the threats were there, there were car bombs, and if you were a doctor and did your job professionally and didn't give into any of that, then you might be considered a target, and would want to check your car very carefully in the morning. (PS 61)

As two doctors recalled:

I do remember one of the doctors complaining that he had to get bulletproof glass in his windows, because he had been involved in prescribing medical baths which, unknown to him, turned out to be quite brutal. But of course it is possible he did know. Looking back on it I think he was so old he didn't know. (PS 4)

Well, that was probably the reason why I left the Prison Service. At home we had a couple of phone calls, where someone said, "There is a bomb which has been left outside your door." And then I was approached by the police and told that a certain – well, it was the loyalist paramilitaries – had the number of my car and they felt that I needed to change my car and take extra precautions. And I just felt for myself, but certainly not for my family. I didn't want that and I then asked to be moved, so yes, but that was after three years... .

I think that of all the aspects of prison medicine and how it compares with being a general practitioner, it was the acknowledgement that somehow this huge gulf between what you wanted to be and what you felt they thought

of you... . I can't remember any time when I felt that prison rules were set either to become [sic] between that relationship or to make it easier. (PS 27)

Whatever efforts were made to establish relationships, the feeling that prison medical staff were 'part of the establishment' could not be overcome. In the opinion of the same doctor, it was:

relatively more easy to do with patients who weren't paramilitaries because, it just was easier. But there was a sense that with patients who were paramilitaries, that you were treating not a patient but quite an organised group of people, and so the ability to break in and win confidence, you knew, was going to be much more difficult. (PS 27)

Moreover, attitudes arose because of the conflict that intruded occasionally into the treatment of prisoners, although it was recognised that they were inappropriate for a person working in the prison service:

Well, I remember a dental officer coming to me and saying he wasn't prepared to treat this particular chap because he had been involved in killing a boy, a young man, who was exactly the same age as the dentist's son. Some sort of politically motivated murder, and he wasn't prepared to treat under those circumstances. This was in prison. The dentist was fairly new to the business and I had a long chat with him, and we came to what I believe was a reasonable approach to the thing. But I said to him that if that is your approach, then there is no place for you in the prison. One of the probation officers had said to me, "You can love the sinner and not the sin." It is difficult to do that. Obviously, the question has to be posed in terms of whether or not I would have felt that it impacted badly on patient outcomes, and I don't think it did. (PS 62)

This was a perennial problem for medical professionals working in Northern Ireland during the Troubles. For those dealing with prisoners, this might have been a serious issue, given the nature of the offences of which the prisoners had been convicted. In one doctor's view:

The thing is that I found that, once you got to know the people over a period of time, you forgot about the things that they had done. That human aspect was there in all people and you have to get below it. If I was to have

said: “I’m going to let that guy die with his bad heart because of the horrible things he did,” then there is no place for you.

Well, this is a positive comment I think. One of the things that did surprise me was [in] the Prison Service, most of the doctors were Protestant, and there were comparatively few complaints at all...from time to time, but I don’t remember anybody saying that you discriminated against me because I am a Catholic. Republican prisoners would have that sort of gripe if anybody had, but I don’t remember a single complaint. But they did an extremely good job and because in effect there were very, very few complaints of any significance, I would say absolutely none on the political/religious – not one that I am aware of. (PS 60)

Added to this consideration was the relationship with prison staff. As previously mentioned, the particular problem for prison medical staff was that often they were caught in a three-way relationship between prison staff, prisoners and their professional duties:

What do you think your duty was to the prison staff as well as to the patients?

Quite clearly none at all. Now the duty to them was about trying to have a relationship which allowed you together to ensure that patients, prisoners, came to no harm, and that what you were doing wasn’t causing more harm. So in a way you had to influence the prison establishment and you also had to gain their trust, and for them to believe that you had integrity as a doctor – and if you said this needed to happen that there was a great chance that it would happen... . You had to keep yourself alert to becoming institutionalised yourself.

So I do think that the most important aspect of the work that you are doing would be to hear what prisoners thought. Because what I was thinking, or indeed still think, may well be covered by having become unbeknown to myself and despite my own efforts, become institutionalised... . And certainly the more tense it is, then everyone’s relationship begins to become fractured and displaced. Well my senior at that time was Dr [P] who had nursed, and I mean nursed, most of the hunger strikers and had been there when many of them died. When I was working at the Maze Prison, one Friday afternoon at five o’clock [P] and I parted company at the prison gate. He went to his home and I to mine, and the usual parting comments... . At

seven o'clock that evening, I got a phone call to say that he had shot himself and he was dead.

Did he ever discuss with you the pressures that he had been under and how difficult he found the situation?

Oh yes, I think it never left him and he often recounted how he felt at that time and what he had gone through at that time, not in terms of what he himself had suffered but...yes, and especially the families. But also each individual hunger striker. It was a very traumatic time for Dr [P] to come through all of that, and in a way I wish he was here today to tell us all what that was...like. (PS 27)

A doctor who had spent several years working in prisons widened the description:

When I worked for the prisons, our job was primarily to treat the prisoners, help with the prisoners. We also had to treat prison officers in emergencies so I didn't see much of the ongoing psychological aspects of it, but I did treat them for immediate injuries, maybe in a riot or something, and that kind of thing. I certified dead one of the hunger strikers...

But the prisoners who are part of a group learn to cope with prison better, particularly if they believe that in some way that the offence that they are charged with was reasonable in some way or was justified in some way. We found it very very difficult to get qualified nursing staff. We generally had people called hospital officers and they were prison officers who we interviewed to see if they had some of the caring profession about them, and then we sent them on a three month course to England to train them to be a kind of medical orderly. Some of them were quite good at it...but others were absolutely hopeless, and sat on major medical problems for days...

The previous, [Q], he's dead now, but he would have been the Chief Medical Officer when most of the Troubles were going on. And we would have fairly frequent meetings with them and it was useful to have that support, because it meant that if you were asked to do something that was unethical, you could have gone to [Q]. ... So I think the best way is to have it the way we ran it, with the independence of being in the Department of Health and Social Services, and giving you some distance from the prison –

that you weren't totally dependent on that, and also that you had career opportunities...

The Red Cross came quite regularly to the prison. They weren't particularly interested in ordinary prisoners. They were interested mainly in what they called 'prisoners of conscience'. And prisoners were able to see them on their own and then they would come and talk to us about issues that they raised. They could also occasionally get their own general practitioner in, you could ask to see your own general practitioner...

People on the Blanket Protest complained they weren't being checked properly. What is your response to that, that they weren't examining the patients, they were just looking through the doors?

Yes, it's a long, long time ago, but yes I do remember that there was part of the prison rules was that all prisoners should be seen every so often. So once a week all the prisoners were seen and going round the cells, but as you say that was mainly a bit of a whitewash, really. You opened the door, you would see two figures dressed in ragged blankets and asked them, were there any problems. Most of them refused to speak or turned their back on you. My memory of it was that the doctors at that time didn't want to see the prisoners in the medical room in blankets and dirty, they wanted them to wash for the medical visit...

This is the enforced washing. A lot of the prisoners felt that the doctors were just picking out people for enforced washing, and even though they knew that when they came back they had probably been brushed really hard or with big brushes or beaten up.

I never saw that personally because I wasn't there really long enough, but I did hear a case where this doctor was told that you could order a medical bath. And he ordered one without understanding what the medical bath consisted of. It consisted of a lot of roughhouse and dropping somebody on tiles and scrubbing them with wire brushes. But what you have to see it against is that, in the period 1979–80/81 there was an assassination campaign matched against the prison staff, and quite a lot of prison officers were shot. There was a period in 1979 nearly every month [when] somebody was shot. (PS 62)

Another doctor remembered:

In 1971 or thereabout for about six months I think we worked. Our practice provided a service to Long Kesh...

Were there any procedures that were laid down that you had to follow?

Not at that time. These were the very early days just after internment. We were just acting as a GP outpost, as it were.

What was the attitude of the prisoners towards yourselves during that period?

It wasn't difficult at all, they were very easy to deal with.

Do you know of what the procedures were, how prisoners were able to see yourselves?

Yes, just put their name down on a list, and they did have huge numbers, about ten per cent per day. And to see the doctor they came out, got a bit of a walk and so on, met their colleagues and so on and so forth while they were sitting waiting. I know there were a lot of doctors who refused to provide the same service we did. They were just worried about the whole security because they were identified as part of the system. Curiously, as I saw it, the prisoners didn't identify it to the same extent that way because we never – I personally never or any of my colleagues never – experienced any antagonism; the prisoners were very, very easy to deal with, quite extraordinary. I mean, the reluctance wasn't just medical staff, it was the nursing staff as well.

Do you think that doctors were 'put in the middle' by both prison staff and prisoners: that is, caught in the middle of the conflict between the two in any way?

No.

Do you think you needed more guidance and support, and if so, of what kind?

Oh, I think there is no doubt about that. I mean it really was being thrown into the den initially, but to be fair to the authorities, the situation arose overnight.

How did the role of the medical service change during these times?

They changed quite dramatically, I think, because they appointed full-time staff. (PS 60)

Another doctor:

Did you at any time feel that there was a conflict between professional medical ethics and your role and duty in the prison service or interrogation centre?

There can be always that, there is the potential for that, but it is something that you have to be alert to, yes.

How do you think you coped, and how do you think other doctors coped with that?

I think it damaged me slightly over the years. Not so always at the time, but I think it damaged me slightly from a sort of post-traumatic sense, that I am a bit hypervigilant. (PS 4)

A former head of the prison service:

The medical service was in effect independent of me. I was head of the Prison Service. But when I arrived and during the time that I was there, it was organised through the Department of Health, provided directly by the Department of Health. Although of course I worked closely with the doctors, the doctors really did their own thing, as it were. (PS 61)

Discussion

Internment and interrogation

The character of the treatment meted out to prisoners has always been disputed. Whatever its description, if the allegation were true, doctors should not have acquiesced in what was happening. At least some of them protested. One resigned, and wrote to the Chief Constable that he “had been driven to two conclusions: results were expected and were to be obtained even if a certain degree of ill-treatment were necessary, and that a degree of ill-treatment was condoned at a very high level” (Taylor, 1980: 334). The police surgeons that examined prisoners who came to be charged following interrogation were

so concerned that the Association of Police Surgeons issued a memorandum in 1977 stating:

Early in 1977 there was a large increase in persons having significant bruising, contusions and abrasions of recent origin especially of the epigastrium and ribcage areas. There was evidence of hyper-extension and hyper-flexion of joints, especially of the wrist; of tenderness associated with hair-pulling and persistent jabbing. There was evidence of rupture of eardrums and other injuries. At the same time, there was evidence of increased metal agitation and excessive anxiety states. (Taylor, 1980: 178)

Prisons

The prisoners themselves recognised that there was individual variation among prison doctors. The general assessment by prisoners of doctors was that they concentrated on getting through the business; there was little criticism of the basic medical care that they received from doctors. They complained of delays by prison officers in calling doctors; this was confirmed by one of the prison doctors. There was not much resentment recorded by prisoners or doctors at the clumsiness of the administrative system, which meant that prisoners were shunted slowly, one-by-one, through security pockets to consultations.

There was criticism that doctors did not see prisoners routinely on their own. Not surprisingly, prisoners saw no problem that their seeing the doctor was subject to the approval of their internal command structure. Neither doctors nor prisoners commented on the observation by the former head of the Prison Service that prisoners were trying constantly to be manipulative; perhaps both recognised the problem and just took it for granted. There were serious episodes of threats to doctors and one physical attack that was frightening, if bogus. Several doctors were concerned about their safety; one left the Prison Service because of the security concern.

Some prisoners felt that the doctors were offhand and indifferent, lacking in feeling; they regarded them as part of the establishment. Some recognised that the doctors were working under difficulties; one even felt that the doctors would have liked to perform better than they were able to in the circumstances. A recognised difficulty was that prisoners were demanding, partly because they were suffering the effects of imprisonment, and partly because they needed to see a doctor even to get a sticking plaster. One doctor estimated that one in ten prisoners attended each day; one told of

the difficulty caused when prisoners in large numbers made medical attendance into a protest. Another spoke of the need to concentrate, lest a serious condition be missed in the midst of much trivia. Prisoners might have been surprised to learn that their doctors were giving much thought to their relationships, or at least some of them were.

The doctors were alert to the ethical requirement to treat patients, regardless of their crimes. One commented that, with time, it became possible to forget their crimes, but drew the line at “loving the sinner, not the sin”. He described the problems, not apparently perceived by prisoners, of maintaining neutrality against the pressure from the security forces when seeking evidence, and against the reluctance of governors to let prisoners out to general hospitals, even though the doctor thought it necessary. One prisoner acknowledged the insistence of a prison doctor that a prisoner with suspected appendicitis be sent out to hospital – not once, but twice. Others spoke warmly of the humanity of some doctors. These words of praise came in the context of sometimes scathing condemnation of other doctors in other circumstances. The participants alleged bad behaviour by doctors, such as the chaplain’s description of the treatment of the bereaved woman prisoner. One prisoner spoke of conduct by a doctor that led prisoners to demand his withdrawal.

The Blanket and Dirty Protests

The Blanket and Dirty Protests produced a distillate of all that prisoners saw was wrong with prison doctors. They were conducted in circumstances of public political intensity as sharp as any during the Troubles. The atmosphere within prisons was rancorous in the extreme and inevitably, doctors were sucked into the maelstrom. First, doctors were bound to be concerned that prisoners were in small cells on the walls of which they were smearing their faeces; the health hazards were no less because the prisoners had chosen to establish and maintain their situation. Second, there was the problem as to whether to expect the prisoners to come dressed to a medical consultation: acquiescence to their naked arrival would have seemed to be collusion in the protest. It was difficult to achieve the aim of checking prisoners regularly, given the squalor of the cell block and the prisoners’ deliberate stance of non-cooperation. The prisoners were unlikely to be giving much thought to the frustration and helplessness of the doctors, who were unable to help those who would not help themselves. Almost any action by a doctor in those circumstances would be capable of misinterpretation. A man ‘on the Blanket’ surely would resent another human being walking up to his cell door and peering in at him, with nothing to offer that he would accept. The

resentment would be heightened if the other person were perceived to be part of an oppressive establishment, which we know was the prisoners' considered view of prison doctors – just being there would be an insult. If the doctor were to convey any distaste, sneer or make unkind comments, the sense of insult would be strong. The prisoners certainly read disapproval in the attitudes, and sometimes the observations, of doctors.

Prisoners thought that the authorities were using forced washing to try to break the protest, and they thought that doctors were colluding by ordering them to be washed on the excuse, in their view, of hygienic requirement.

Doctors and the hunger strikes

The hunger strikes saw a clear change in the relationship between doctors and prisoners. One striking absence from two important dispassionate books on the hunger strikes – Beresford (1987) and O'Malley (1990) – is any criticism of the medical attention afforded to the hunger strikers. Unfortunately, the three doctors who attended the prisoners are now dead – their testimony would have been invaluable. However, their memories are to be honoured properly as exemplars in one of the most stressful experiences imaginable for members of the medical profession. Also to be honoured, in a connection other than the hunger strikes, is the anonymous army doctor who features in the account given by a republican ex-prisoner:

I was shot in the hand, left leg and stomach, and the person with me was shot dead. ...I was very serious. I had been shot three times in the stomach and obviously I had lost a lot of blood. I think some people were surprised I was still alive. Initially when I was found, I was found by the British army, and they said that they had a medical officer amongst their members, and that they would go and find the medical officer and give me attention.

Obviously [they] knew I was no threat, once they determined I was no threat. But in the meantime...the RUC [Royal Ulster Constabulary] came along and they started, there was no doubt that they began to brutalise me and kick me and... . The medical officer arrived about ten minutes later in the meantime, and this conversation which went on between the medical officer when he arrived – he then reprimanded the RUC... . His words were, "Would you like one of your men treated like this in that state?" And firmly said that you don't treat anyone like that, but the medical officer began to give me treatment, put me on a drip. Yes, right there in the field, he gave me field attention and my leg was broken, so he put me on a splint.

Also my whole intestines were starting to come out...and he put a bandage, rolled me up in a bandage. It was professional. I think that only that the army medical officer took charge that I wouldn't be sitting here today.

The medical officer demanded a helicopter to transfer me to hospital, but they said: "So we'll get an ambulance and he'll be DOA." This was the RUC was saying he will be dead on arrival. But he wasn't accepting this – he was demanding a helicopter. Finally a helicopter came from Omagh and I was transferred by helicopter to Enniskillen Hospital.

In the helicopter I was laid on the floor. I was lifted by the RUC and he told the RUC members there was no stretcher to lift me carefully and place me on the floor of the helicopter. That was fine, but when they were getting into the helicopter... [it] was like a wooded [area] where you put your feet on a wooded structure that you can take out and wash. Then one of them actually walked on my chest as he got in, and the medical officer wouldn't have seen this because he was outside the door... So the medical officer came with me down into the theatre...he had actually briefed the surgeon as to what he had done in the field. (P 110)

Conclusion

Individual variation in the attitudes and behaviour of doctors might be expected. One ex-prisoner used the term 'mixed bag'. Some doctors behaved in a humane way; others appeared more detached, even uninterested. Prisoners seeking explanation for what they perceived to be the shortcomings of doctors attributed them to social difference and to doctors working for authority. Interestingly, no prisoner referred to the fact that all of the doctors in the different scenarios were Protestant, so there was no attribution of shortcomings to religious bias. It is acknowledged that the doctors were operating under stress, that they were worried about their own safety and that of their families; the hunger strikes presented perhaps one of the severest test to medical professionals in Western Europe in recent memory. Also, it is acknowledged that the number of incarcerations – which increased fourfold in the 1970s from under 800 to 3,000 – did so at a challenging speed. It was extremely difficult to put coherent medical services in place so quickly in so many places, and in a politically charged atmosphere in which many doctors simply would not get involved. Doctors did protest about ill-treatment, and the Bennett recommendations were the consequences. Nevertheless, more doctors than those who spoke out were aware that prisoners were being abused.

It is clear that as time went on, the medical services were better organised and more professional, with the then Chief Medical Officer taking steps to supervise the doctors and provide ethical guidance and leadership, without which the care of the hunger strikers would have been even more challenging. Although some doctors underperformed, there was no suggestion that they had taken an active part in ill-treatment. This is, of course, the most important single point. The most frequent allegation was of collusion with the prison authorities' attempts to break the Blanket and Dirty Protests by ordering forced washing. The comment about "despatching" the "Hooded Man" was perhaps the most heartless remembered by an ex-prisoner. Underperforming doctors were at one end of the spectrum; the other was occupied by many doctors who did difficult jobs in difficult situations. It is right to recognise all of them: both those whose names have survived, as well as the anonymous army doctor who brought such credit to his profession in very demanding circumstances.

7. Conclusion

Physical and administrative questions

When civil conflict reaches a certain stage, whether briefly or, as in the case of Northern Ireland, over a long period of time, there can be no infallible way of protecting the health services from its effects. These effects are physical, moral and ethical. The physical effects are various. It is axiomatic that violence contaminates the whole community.

One deeply frustrating experience for many health professionals was having to sit for hours in static traffic, whether in a car or on public transport. For a time this occurred daily. The usual cause was a hoax bomb, which was almost as effective as the real thing in disrupting society. However, often enough the cause was a real bomb, for explosions in cities and towns became almost commonplace during the early 1970s. Parents were terrified for their children, and frequently unable to reach them because of traffic jams. The secondary effects of violence were everywhere. One could not be certain that a shop that supplied goods would be there if more were needed or a fault had developed.

Everywhere, businesses were the targets of bombers. A trip into the centre of Belfast for the population as a whole was an adventure. Security staff frisked the public at gated entry-points; others inspected handbags at the entrances to shops. The doormen at Harrods must have wondered at the antics of Northern Irish women who proffered their handbags for inspection; the unintentional raising of expectations may have led to some small disappointments.

Anxiety was generated by the need to stop vehicles at checkpoints: these could be legal or illegal. Throughout the worst years of the Troubles, the security forces had a variety of checkpoints, some permanent, at places such as border crossings. Many were temporary and therefore unpredictable, thrown up as a result of a recent violent episode or an attempt to interrupt illegal activity. Legal checkpoints were tolerated, if not with lightheartedness, but if the delay was long – as it sometimes was – irritation might be

experienced by even the most equable citizen. Illegal checkpoints were worrying, and at times they were legion. At the very start of the Troubles, they often reflected real fear, with vigilantes genuinely trying to prevent malign incursions into vulnerable ghettos. Later, they often represented the arrogance of paramilitaries declaring their strength. Health professionals have given testimony of their negative experience of this.

All these factors had an impact on the ability of health service professionals to get to and from work or, if working within a community setting, to go about their business. Some examples of how dramatic this situation could become have been given in the narrative. Also illustrated has been the widespread community feeling that, whatever the situation, health service staff should receive some protection from the effects of civil disturbance. Thus ad hoc arrangements were developed with both the army and paramilitaries in different areas, but so swift and unexpected were the development of tensions at any particular point in time that these were not altogether effective in insulating the health service from the effects of disruption. In addition, neither could the wearing effects and feelings of insecurity be assuaged totally. After all, the health service professionals were trained to go towards danger – particularly in the case of the ambulance service – and were expected to turn up at work or reach the patient, whatever the situation on the ground.

Within the Health Service there were conventional strikes arising from normal industrial disputes, some unofficial. However, there was also the added burden of political strikes. Perhaps the most widely felt effects arose from the loyalist Ulster Workers' Council (UWC) strike in May 1974. This began with the establishment of a few barricades and rapidly escalated to the shutdown of the electricity supply, which was available unpredictably and only for a few hours at a time during the 24-hour period. Households were disrupted: when supplies were resumed for a few hours at night, women leapt from their beds to run their washing machines or do some family cooking. Although petrol supply lines were blocked, the fact that petrol pumps were powered by electricity was equally important in paralysing traffic, even in those areas without barricades. Strike leaders took to issuing dockets authorising the supply of a couple of gallons of fuel. Many ordinary citizens resented this extension of illicit authority. One senior officer of the Northern Health and Social Services Board listed the employees for whom a group application was to be made for 'licences' from the paramilitaries enforcing the strike, in order to allow the purchase of fuel and passage through barricades. However necessary, this was felt by many to be demeaning and unacceptable.

Another widely-felt event was the disruption of the water supply, caused by the detonation of an important water main. Thousands of houses were affected, and until

this is experienced, there can be little appreciation of the devastation it causes to modern living. One consultant recounted with repugnance the need to use the lavatory ‘en famille’, and he left Northern Ireland to take up a post in London shortly afterwards.

From the viewpoint of the health services, there are specific problems that went beyond the sporadic difficulties of ordinary living in a period of civil disruption: maintaining the security of hospitals and GP practices; protecting staff; keeping transport to and from medical services running, particularly for medical staff, and maintaining access to all patients regardless of their community. This meant an inevitable intrusion of the security forces into health provision: if, as in Northern Ireland, their legitimacy was contested, regardless of the inevitability of their involvement, a further set of problems arose associated with this. The conclusion that follows is that, once the extent and nature of the problems became apparent and a response evolved, the health care situation improved. In this respect, the story of the impact of the civil conflict in Northern Ireland can give reflection to those who may be faced at some point in the future with similar, if not identical, problems.

From the standpoint of medicine, novel forms of injury arising from the Troubles presented themselves. Expertise in treating gunshot and bomb wounds emerged. So too did experience in running a hospital under pressure of an influx of severely wounded and dying. This was learned the hard way. The impact of bombs on hospital procedure in the early part of the Troubles was dramatic and unexpected. On some occasions, inexperience led to difficulties. This was particularly true in the wake of the Abercorn bombing, where one nurse gave a graphic account of the organisational problems:

Well, normally when the ambulances came down towards that doorway, they turned off their klaxons because once you came under the covered way they were unbearably loud. They didn't turn them off and there were three of them. And I never forget those two things; the ambulances coming in, not turning their klaxons off – when they didn't turn their klaxons off you knew it was bad, the ambulanceman was panicking, you always knew that. I could hear three and I could hear the screams of the girls in the ambulances over the noise of those klaxons under cover. Now that's one of the abiding – when I think [about it] – I think it was a moment of hell, really. And at the same time she's [the nursing administrator] saying to me, “I have no nurses to give you!” (N 15)

Eventually clear lines of responsibility and action plans were laid down:

Each hospital had a disaster plan. Ours was rewritten in 1969. Yes, this was the second edition in 1969. And everybody has their own duty to do and there is a chapter for everybody. Security men, receptionists – switchboard was very important – and casualty doctors, consultants, nurses and social workers. Everybody had a chapter and they knew exactly what to do. (N 13)

The importance of this lay primarily in their value in saving lives, but secondarily in supporting staff and creating a sense of communal effort:

As a result of the whole thing a lot of rules were made...lessons were learned, and I know this, we became extremely slick. And any subsequent bombings and shootings with big numbers of casualties, we were very, very slick. ...I remember when I went back there later on, after a two-year gap when there was less activity, real numbers coming in, that phase went... It was because people very quickly forget, plus new staff come, old staff like myself had gone, and they hadn't had to learn that 'clickety click – everybody in place'. (N 15)

Much of the responsibility for the delivery of health care during the Troubles rested on the shoulders of health administrators. On the whole, they succeeded. Health care continued to be delivered without standards falling seriously below those that would have been expected in normal times, and both the administrative staff and the medical professionals deserve credit for this. However, in spite of this great achievement, there were occasions when not all problems were addressed. The location of hospitals cannot be changed, but management perhaps should have done more to deal with the concerns of patients and relatives. (The Royal Victoria Hospital, to its credit, provided a bus link with the neutral centre of Belfast.) The serious aversion of some of the public to attendance at particular hospitals was not picked up and addressed properly by management on the ground, or by those who had responsibility higher up in the management chain. Embarrassment and reluctance to raise these questions added to the problem but, nonetheless, there could have been more open public challenge of the misconceptions about hospitals. It would have been useful for Health Service policy-makers, management, staff, staff associations, unions and public representatives to have met to discuss such a major issue. This might have served the function of reminding staff, from whatever part of the health service, of their general obligation. In hindsight, there should have been some attempt to persuade politicians and others dealing with the public to cooperate in improving perceptions. The result of this might only have been partially effective, for there were real difficulties that the public would

pick up on, regardless of official statements. However, the sense would have been conveyed that the authorities were eager to address the problem and offer practical solutions. Indeed, this has all the appearance of unfinished business that would still benefit from attention.

Similarly, relationships with the security forces affected both the public and the professionals and, with hindsight, more should have been done to establish protocols to help those at the workplace to resolve operational problems. To take a simple example, whether or not prisoners should be handcuffed in hospital seemed to depend on the intervention of care staff in individual cases. Too much was left to be sorted out by people on the ground, often when pressures were the greatest. Of course, it would be fatuous not to acknowledge that operations on the ground needed initiative at that level, and equally so to pretend that operational staff (health or security) did not overreact at times. However, the situations were repeated often enough to have made it possible to anticipate demands and work out general solutions. It is difficult to see what disadvantage would have attached to open discussion at all levels of responsibility. One lesson learned personally was that cross-institutional agreements needed to be renewed regularly, especially where staff changed often, as occurs with the security forces and hospital junior medical staff.

Staff behaviour towards patients and their relatives is a direct responsibility of the professionals themselves and their management. In any clinical setting, as in any working group, personalities have great effect on relationships, but it is not acceptable that some should show less sympathy – even if it is ‘equal opportunity’ sympathy – to patients. Patients and relatives are entitled to politeness and respect. Neither management nor professional groups can assume that all will be well without effort. There is need for specific discussion and training. If this is true in all clinical settings, how much more does it apply in a divided society?

The problem was that, even when new routines for coping were developed, there was no possibility of absolute certainty as to the outcome of pre-planning. A sudden unanticipated turn of events could throw all plans back into confusion. Therefore, one lesson is that there was no absolute guarantee of control possible, and that events can test all plans to destruction. One impact of this was that although lines of authority, responsibility and routine responses need to be clear and worked out in advance, improvisation was sometimes necessary, blurring the usual protocols. One nurse recalled an offer of help in an emergency from a staff member who outranked her:

Now she had been the ward sister who trained me when I first came, but she was a proper nurse and she realised this was not a time for rank. And she said, “Tell me what you want me to do – I’ll do anything. If you want

me to mop a floor or do clothes.” I said, “If you could make sure the patients all have their belongings on their trolley because everything is going to get lost,” and she did, and she did it immaculately, because she was a very efficient woman. (N 15)

However, at other times, leadership had to insist on this. This incident occurred during the UWC strike:

So while the younger medical staff were waiting for the consultant to arrive, I asked them if they would physically like to assist because I wasn't going to do ward round until the patients were washed, bathroomed and fed, and they laughed at me. The consultant arrived and told them that there would be no ward round until they got off their butts and physically helped the nurses to look after the basic care of the patients. The consultant told them that the next morning he also expected that. The staff objected: “We are doctors – we don't wash patients.” And the consultant told them that, basically, their patients required care first and foremost. And in fact he actually came and sat in the ward for the three or four days of the strike and physically assisted, and made sure the medical staff did...the medical staff, the most of them, laughed at us and would not give us physical assistance. It was a social class thing – it was atrocious, and relatives even came in to help. (N 17)

A certain pride emerges from the testimonies about the willingness to cope arising from the ability to meet challenges, improvise and lend a helping hand outside conventional boundaries. It also comes from the administrative strategies that were developed eventually, often after discussions before and after events. As one nurse recalled:

Our disaster plan was the best one in 1969 and it worked. So everybody...wanted it. I think we should have sold it, and we were giving it all over England, and we could have made a fortune. But everybody wanted our disaster plan, so I would say lots of people, our disaster plan replaced theirs, because they knew it worked. (N 13)

This in turn reinforces the sense of professionalism which, as will be described below, was an important factor in sustaining ethical values.

The professional community

Relationships between doctors from the two communities in Northern Ireland were not always easy. Their members came from a divided background. Most are Queen's University Belfast graduates; many came to the university never having formed a friendship with a member of the other community, perhaps never even having met one. The Medical School attracted loyalty from them all, and provided a meeting place where it was impossible to avoid close proximity. There is an unavoidable closeness among people clustered around a patient in a bed or in an outpatients department; living in at the hospital puts students in situations of social intimacy. People learned to pull together and support one another. However, until the 1980s, it was the custom for students to divide up for their main clinical teaching. The university certainly did not set the dividing line, and it was not invariable, but most Catholic students attended the Mater Infirmorium, and most Protestants attended the Royal Victoria Hospital. The Mater's separateness from the Health Service did not help.

After graduation, hospitals presented a pool of training posts, and the majority of postgraduate qualifications were obtained from UK colleges. Another separation appeared at this stage. Catholics were more likely than Protestants to forge additional links with Irish medical colleges. However, there were exceptions: Northern Ireland anaesthetists were very active in their Irish faculty (Faculty of Anaesthetists of the Royal College of Surgeons). There were efforts to smooth over these cracks. One notable achievement was the joint creation in 1959 by two physicians, one from Northern Ireland and the other from the Republic of Ireland, of the Corrigan Club, which had as its remit "the promotion of friendship among physicians in Ireland and the advancement of clinical medicine".

None of this is to say that relationships between Protestant and Catholic doctors were not good. In particular, clinical referrals between consultants and between GPs and consultants were not affected in any way. Patients' access to the most appropriate care was unrestricted. However, to some extent, collegiality had to be striven for, and one senior Protestant consultant reflected regretfully that the Troubles had sharpened the invisible divisions and reduced collegiality. There is no known calculus to test his thesis, but the experience of the Troubles was that, where fractures appeared in the community at large, they were likely to affect the medical community at all levels.

Generally it was assumed that, as the Troubles unfolded, these fractures were felt particularly among ancillary and nursing staff. However, overt expressions of support for one community or another in their quarrel was not unknown at the highest level. Union flags were often a bone of contention on public buildings connected to the health service,

and one doctor referred to “an episode in the RVH [Royal Victoria Hospital], where a consultant inappropriately put a flag in a ward” (D 51). On the other side there were consultants in the hospitals who acquired a reputation (whether deservedly or not) for being sympathetic to the Irish Republican Army (IRA). This account alleges one as:

well known to run an underground hospital for the IRA. There was equipment disappeared from his ward and from ours for that hospital...and at one of the houseman's concerts where, of course, anything was up for grabs, people were lampooned and so on. They were discussing at one point, saying something about, where is the headquarters of the IRA? And they said, “That's Ward [X] and [Y].” Now that was a houseman's concert, so you can imagine that's how open it was, no secret. (N 15)

The intrusion of political views into professional life was rare, but not unknown. It was not approved of and generally seen to impede the maintenance of a community dedicated to professional values and working for a set of common goals: the health and safety of the patient. There are dramatic incidences of the re-establishment of these values when under attack. One consultant recounted that he was the only Catholic houseman in the Royal Victoria at the start of the Troubles. After a major outbreak of trouble in east Belfast involving loyalists, several were admitted. This necessitated the houseman and his consultant to work well into the early hours of the following morning. The next day, the houseman became aware of a rumour that he had deliberately failed to sedate Protestants during treatment. He reported this to his consultant, a Protestant who, despite his long commitment the night before, remained in the hospital until 9pm to confront the member of staff who had allegedly started the rumour. (D 41).

The importance of professional communities in this situation was immense. The professions represent historic bodies of practice with clear, well-outlined ethical boundaries and a common set of objectives. They provide one of the means by which individuals can be insulated from outside pressures and they focus on loyalty that cuts across all sectarian and political divisions. They were the basis of the discipline, and above all self-discipline, which guided individuals faced with ethical and moral dilemmas as well as physical difficulties. One's behaviour was judged by the point of reference provided by professionalism. This did not eliminate conflict, but where, for example, a sense of moral revulsion might affect attitudes towards some patients, professional ethics reasserted the primacy of patient equality as regards treatment and care. The significance of this is mentioned frequently in the testimonies of health professionals as the ultimate guide when ethical difficulties arose in certain situations. Professional ethical values were not always honoured, but in the overwhelming majority of cases they were. The proof of

that is that, whereas this narrative has looked at the rough edge of the medical practice in the Troubles, the majority of testimonies from patients would have allowed us to construct, legitimately, a long hymn of praise from all sides of the conflict for the work of health professionals during the Troubles.

Professionalism also helped a sense of collective identity to emerge that was separate from, and transcended, the major political divisions in society. It kept in check the divisions of religion, politics and culture. Although identification with one community or another was inevitable for most of the population, countervailing groups and communities originating from outside the political history created a different set of perspectives. Often, major occupational bodies, trade unions, professional organisations, voluntary clubs and societies are affected by political and religious segregation, but many are not. They provide a set of referents and values outside of traditional antagonisms, and often they are potent in day-to-day life. Of these, the medical profession was one of the most powerful, because it built upon notions of equality of treatment and inclusivity.

Political effects

All health systems exist in political contexts and the HS, which receives government funding, has had to negotiate relationships with government and politicians for a long time. However, civil disorder adds new challenges. In the case of Northern Ireland, this included the issue of how to coexist with security in hospitals, and in particular in the wider community. First, this was made all the more fraught as a division of opinion existed within society as to the legitimacy or otherwise of the security forces. It was one that did not arise so much earlier in the Troubles, but more after the emergence of the IRA. Second, it was particularly fraught in the case of the treatment of prisoners on remand or sentenced. Two of the chapters in the preceding narrative deal with this, because medical care became a battleground in which these issues were particularly crucial and difficult.

In the case of hospitals, the acceptance of a security presence was inevitable. Staff were murdered on the Royal Victoria site, which also witnessed a gunfight in the main corridor. Musgrave Park Hospital was bombed. Three hospitals in Belfast, the City, the Mater Infirmorium and the Royal Victoria, suffered the ultimate insult of having patients shot in their beds. Certain categories of patient brought specific problems. The security forces, prisoners and politicians generally required guarding. The presumption among paramilitaries was they too needed their own minders against the other side or the established forces of law and order. Security force presence deterred attacks on staff and

patients, but it made life difficult for medical professionals, requiring the establishment of boundaries of authority in clinical situations and in running the hospital. These, at first, were not clear.

The securing of hospital sites was a problem that required the presence of security forces and this kind of normal policing, albeit in a sectarian situation, never caused difficulty to professionals. However, the work of the security forces did not always fit comfortably with hospital care. According to one doctor: “One time there was a new officer and three or four soldiers walking round the place. We didn’t need guards parading around the place. I spoke to him and he adopted a low profile” (D 45). One difficulty in maintaining a balance between the authority of the doctor and nurse and the job of security was that the security personnel changed often – this was the case for the army more than the police, so that when personnel changed, a process of negotiation would have to open up *ab initio*. There was apparently little effort to resolve the problems by discussion between the security forces and professional bodies, and there was only a slow evolution of protocols to ease the tensions. Eventually, areas were identified that could be secured away from the normal wards of hospitals, and a secure unit was opened in Musgrave Park Hospital. However, there were always occasions when patients were in regular hospital accommodation because they needed specialist services. Also, patients who needed to be guarded often were referred to the intensive care unit of the Royal Victoria Hospital along with ordinary patients.

A more serious dilemma for the medical professions emerges when the state requires them to go beyond their normal duty as citizens to use, for example, the information gained during treatment or consultation for the purposes of combating terrorism. This occurred in 1971 when a Statutory Rule and Order was issued under the Special Powers Act. Doctors did not greet this warmly and representatives – two Protestants and a Catholic – went to the Ministry to convey their concern. They presented a pragmatic view, pointing out that in addition to the breach of confidentiality which arose from the measure, any practitioner obeying the law would be at serious personal risk. One of the Protestants, a consultant at the Royal Victoria, said that he would not obstruct the police, but that he would not do their job for them. This led to higher level discussions involving the Health Service authorities, and a compromise was reached.

The concern with which doctors in Northern Ireland confronted the government over the Statutory Rule and Order contrasts with the silence that apparently greeted the guidance for doctors on reporting gunshot wounds issued by the General Medical Council (GMC) in September 2003. This was developed with the Association of Chief Police Officers and supported by the British Association of Accident and Emergency

Medicine. While stating that “Patients have a right to expect that information about them will be held in confidence by their doctors” – this is an important element of a relationship of trust between doctors and patients – the guidance advises that all gunshot injuries should be reported on the grounds of public interest, even though the patient refuses or cannot give consent. The difference is that, in England, gunshot injuries are a mounting cause of concern in a society that is at one in wanting to stop a small minority of criminals from murdering their neighbours. In Northern Ireland, the concern was that the state was using its authority at that time to strengthen its hand against legitimate civil rights activists, among other more questionable participants in civil disturbance. Another important difference was that the GMC’s advice came from a professional source, and had been negotiated with the profession. This was not the case with the Northern Ireland Order, incredible as that approach may seem today.

Recently the GMC has given, by implication, an affirmative answer to the question: do changes in civil conditions change ethical requirements? Faced with an unwelcome legal imposition, doctors in Northern Ireland took a different view and an administrative solution emerged to the problem perceived by government. One lesson to be learned from the experience is that consultation is mandatory in such a matter. Nowadays, consultation probably would take place. However, even now a problem might result from an arm of government wishing to legislate, without realising that a profession with which it is unfamiliar has an ethical position on the matter under consideration. The interface between government and the professions leaves much scope for future debate.

A delicate balance was needed to insulate staff from the appearance of being government instruments while not colluding in wrongdoing. The necessary balance appears to have been misjudged on occasions, leaving it up to the initiative of local doctors on the ground to raise these questions with government and their professional bodies. There was no doubt about the sympathy of professional colleagues from elsewhere in the UK and Ireland for the vicissitudes of their colleagues in Northern Ireland. They showed practical support by coming to Northern Ireland for professional meetings at times when they would have felt at personal risk. When appealed to from medical professionals on the ground in Northern Ireland, they responded fully and generously. Yet there were no formal or concerted efforts by colleges (or the GMC) to examine the difficulties of their colleagues in Northern Ireland. Would this have been the case if those colleagues had been serving populations in London or Dublin? It was certain that help was not refused when the issues were raised, and it is reasonable to ask why support was not sought more often. It is possible that ‘outsiders’ felt reluctant to intrude in a problem that was seen as quintessentially local, and which was complex and dangerously controversial.

Perhaps it never occurred to the professionals from Northern Ireland that they would have benefited from outside intervention. However, attitudes have changed in recent years. Those with responsibilities are not expected to be too delicate to raise these questions, and generally, proper and useful interference is tolerated.

In the case of prisoners on remand, accusations have been made of poor compliance with the existing rules. Occasionally, in patients' perception at least and sometimes in reality, doctors were drawn into excessive identification with the security forces, and therefore a failure to exert their authority, even under the rules. This was not put right except by government inquiry. It provides a lesson in the need for clear support for, and the enforcement of, medical protocols at all levels. Above all, it requires an understanding of the extreme tensions, frustration and emotional disturbance felt by all sides at times such as the early 1970s, when the Troubles began to assume more serious and deadly forms. Better monitoring and leadership at all government levels would have made a difference to the medical staff placed in these conditions.

It is also the case that the state was not the only direction from which political manipulation could come. The 'Dirty Protest' and the subsequent hunger strike convulsed the prisons of Northern Ireland, playing a significant part in the electoral rise of Sinn Fein. Flouting and testing the prison rules, including medical ones, was part of the republican prisoners' campaign. Hygiene was being put at risk, but the only means available to avoid health problems sometimes involved intrusive and brutal action. Pressure on the prison medical service emanated from both prison staff and prisoners, and prison medical staff found themselves in a middle of a battle. Complicating this were perceptions of their loyalty to their colleagues, who were often in danger of physical attack outside the prison.

However, the events of the hunger strike showed the possibility, through forward thinking, discussion and consultation, of how the situation could be handled without pitching medical staff into confrontation. All the medical care during this period of this intensely stressful situation was based on worked-out protocols. The medical profession emerged from the hunger strikes with its professional and humanitarian reputation intact, even enhanced. Even so, the tactics adopted demanded that the medical staff work to alleviate suffering, but not to intervene to save life. Much of the conflict within the prisons which had been experienced during the Dirty Protest was avoided. However, this was at the cost of surrendering one key component of traditional medical ethics: the duty to preserve life.

Personal effects

Stress

One recurring theme in the interviews conducted during this study was the general neglect of the psychological effects of the conflict: this included the community at large, and comment was made on this by medical professionals. They pointed to the use of tranquilisers rather than counselling and support, which might have played a more constructive role. A considerable number of people from all sides felt that, such was the pressure of immediate events on the health service, mental health in the population at large tended to be neglected. The accounts also refer to the recurrent nature of these problems, feelings and emotions, which often were not recognised fully at the time but persisted long after the incidents that gave rise to them.

This was also a problem for health service professionals. Service management had a duty to provide help and support, but there were few, if any, management programmes to support staff. Several non-professional observers commented on the lack of support. One clergyman was quite explicit:

Does nobody want to ask the question: “What did the Troubles do to the health care people?” Because they are supposed to come out of that and get on with their ordinary work, and nobody is taking on board what they went through – and we all came through an awful lot. I am only speaking as a chaplain, but the medical personnel, what they had to go through in those days was terrible, and has nobody asked the question: “Why there wasn’t more help?” (C 132)

It is also remarkable that local professionals did not air the problems of working in an abnormal environment for so many years. Perhaps their success in finding a *modus vivendi* was enough to satisfy them. There may have been – and there may be yet – a feeling that the events should not be revisited, but left well alone. Nonetheless, one conclusion from this study is that the greater support and involvement of management all the way to the top in airing the problems faced by medical staff in the Troubles – and from time to time, in working out joint approaches – would have alleviated some of the problems encountered. One feeling was perhaps that the ongoing day-to-day stress of dealing with casualties arising from terrorism was invisible to those on the mainland. As one nurse recounts:

There had been a bomb in Birmingham – I don't know if you remember, they had everything, they had had an awful time. And [a representative for a British medical firm] said his or some firm were sending all the staff...to Paris for the weekend. And he said to his boss, "You know those staff in that hospital in Belfast? Nobody ever says to them, "You're great." So he squeezed enough money out of his firm to take all of us...out two different nights to stagger the cover.

We didn't get to Paris. One group went to the Europa [hotel in Belfast] and my group went to the Culloden. I had snails for the first time in my life because somebody else was paying, but that was it. (N 15)

Irreducible ethical dilemmas

In the end, the health service is delivered by individuals and teams of individuals working together. Ultimately, the delivery of medical care according to the best standards of medical ethics was the responsibility of individuals: this meant moral choices at crucial moments. These were to give the best medical care one could to everyone in whatever circumstances and, in the case of Northern Ireland, to put aside identification with community, distaste at the actions of some individual patients, or resentment of the political role of others. For the most part this was done, and often, because as many averred, there was the constant pressure of work and no time to reflect on the particularities of the situation that presented itself. "We were just too busy" was often the response. However, there are honest accounts of the dilemmas and pressures which did surface from time to time. These do not discredit the individual: in fact, they are testimony to the central importance of the code of ethics and to its actual working in framing individual responses. The most worrying outcome would have been denial that any conflicting feelings ever arose.

Similarly, the other dilemma was in working as a medical team in a community where divisions were deepening as a result of the Troubles. Out of this came natural suspicion, uneasiness, hypersensitivity from time to time and again, the need to question and evaluate one's behaviour. Irritation with, and suspicion of, others in the team was rare, but it did surface. This led to coping behaviour which ranged from the careful and strong reassertion of the communal ethical context of joint work towards caring for patients, to strategies for releasing tensions.

A team working together which had built up a rapport in difficult circumstances might do this by humour. One nurse recounted:

With my own friends we always went on like that, “Only a Catholic would think like that, ‘I trust you.’” “It’s only because you’re a Protestant you don’t know this.” Or things like “God Bless all Fenians in this house.” It was a lot of...a lot of jokes. I always used to say, you know, there is an old saying about the war: “As long as war is considered an evil it will continue, but when it becomes ridiculous it will stop.” ...So I personally always joked relentlessly about it and I know a lot of my friends would have been the same... But at times it was very good for morale, and after a big bomb some of the student nurses, some of the young girls would have been crying and that. So we used to have parties, nonsense and jokes and whatever. (N 15)

The patients were overwhelmingly of the opinion that health care had been delivered efficiently and fairly, often at a considerable cost to the medical professional. They went further: medical care and the action of professionals in the Troubles were praised and the medical service is one of the institutions in Northern Ireland that emerged with most credit among all sections of the community. There were tense incidents quoted, but much of the time they arose from suspicions about the medical profession ‘coming from the other side’, and how this might influence attitudes to the patient. However, there was also honesty among patients in admitting that sometimes this was based upon perception rather than reality. Suspicion is a legacy of the Troubles and, at times of crisis, enters into all social and professional encounters with people not known to the individual. However, alongside this goes a willingness to suspend judgement until things become clearer. Medical professionals were subject to this scrutiny, just like anyone else, and came through it well, so more cases are quoted of suspicion than of actual, evidentially-based events. As one individual described it:

Yes, there would be a bit of an anecdote... . You would hear people locally in Derry maybe say that the “So and so’s a bit frosty.” But then other people might say to you that “That person, that’s just their manner anyway”. It’s not as though the manner varies...their manner isn’t different to different people. (M 97)

The code of ethics governing the medical profession was one of the most important factors in the delivery of medical care during the Troubles. It provided a reference point, a guide and support. This code was put under strain, but it proved durable. Its influence

over individual actions was immense; it was the basis of all self-questioning and determined efforts not to bring the Troubles into the doctor's surgery or the hospital ward. At the extreme cutting edge – in the prisons – it came under the most strain. This illustrates the fact that the Troubles gave rise to new ethical dilemmas and problems not normally anticipated in the situation of giving health care. The code had to be interpreted in novel situations: for example, what authority can the doctor or nurse legitimately assert over the medical environment when challenged by the state or paramilitary? How can a prison be kept clean without embroiling the professional in political disputes? In the case of the hunger strikes, should preserving life or finding a *modus vivendi* which avoids exacerbating conflict be the priority?

The existence of professional ethics indicates a community united over certain objectives by training and experience. The role of such groups, which cut across the sectarian division and asserted the primacy of certain moral and professional values, was a significant contribution to keeping Northern Ireland society from descent into further chaos and conflict. Professional bonds uniting those from different religious and political views around a common professional objective and underpinned by an ethical code survived, grew in strength and were a triumph. As well as guiding conduct, they also instilled *esprit de corps* and a rallying point for medical professionals. Therefore, they contributed to general efficiency as well as a constant discipline upon the staff.

It might have been easier if more overt political acknowledgement had been given to the problems of political geography, stress and negotiation of boundaries which plagued the Health Service during these years. Perhaps the professional organisations could have been more involved, as could the health administration. More emphasis upon the roles and duties of ancillary staff might have helped; although to be fair, all parties in the delivery of health care were caught by constant new and unexpected challenges. It is hard to make policy while bedlam reigns. However, as acquaintance with the outcomes of the conflict developed, so there is clear evidence that the responses from all sides became more thought out and clearer. Hopefully, the reflections arising from this study might make a contribution to understanding the dilemmas that occur in the health service in a society in conflict.

Appendix 1:

Methodology

In order to help answer the question of how medical ethics withstood the stresses of the Troubles, the decision was taken to conduct recorded interviews with those persons who, it was thought, had considerable knowledge and experience of the period under examination. Permission to undertake the research was granted by a medical ethics committee. The safeguards accompanying the research were the prior information given to possible participants by letter, setting out the terms of the research. If, as a result of the letters, an interview was arranged, the participant was sent beforehand a list of the questions to be asked and also informed that, with their permission, a more free-ranging interview involving a tape recording might occur. All the participants were asked to sign a permission form which set out how and in what circumstances the material would be used. Anonymity was vouchsafed, as was a pledge to use the material only for the purposes of the study. Finally, the participant was told that they were free to withdraw at any time in the process. In most cases, the interviews were of health professionals, and counselling services were available to the participants in cases when recall of the events was distressing.

The logistics of setting up interviews were often time-consuming. The process began in 2002 and ended in 2005. More than 200 people were interviewed, although the nature of the testimonies differed in that some were very brief, while others were wide-ranging and lengthy testimonies.

The process of collecting testimonies was not easy. Persistence is the most important quality needed at this stage. First, there was the problem of locating suitable participants with no guarantee that the people whom the researcher most wanted to interview would actually agree to participate. In a number of cases, they agreed at the outset, but were then unavailable or difficult to contact to arrange times. If all of the above obstacles are

overcome, difficulties can still arise regarding how the interviews are conducted. As with research into other sensitive topics, some participants may prefer to respond only to the written questions which they have had the opportunity to study beforehand.

The categories of people sought for interview was wide, and recruiting from the different categories posed different problems. In the case of the medical professions, the unique knowledge and experience of Dr McKenna from his years as chief medical officer allowed the process to begin of recruiting identified individuals known to have had experience of the Troubles in their professional work. From these, further names were obtained. Thus a considerable dossier of testimony from nurses, doctors and other medical personnel was built up. These formed the bulk of the testimonies obtained – and rightly so, since the research was concentrated upon how they coped with the sometimes conflicting feelings provoked by the situation in which they found themselves.

However, a decision was made at an early stage that the testimonies of health professionals should be complemented by those who were in receipt of medical care. One particular and very sensitive category was ex-prisoners and the medical staff working in prisons. They are small in number but, given that the prisons became a battleground often involving medical staff, they represent cases of particular strain and significance in the problems of delivering medical care according to agreed ethical standards.

The problems of recruiting from this section of society are formidable. For research purposes it is much easier to gain access to ex-prisoners than those currently imprisoned, and since much of the research related to key historical events in the past, most of those interviewed were ex-prisoners. However, because many of the former are reinvolved in political activity on the outside, they very often regard research and researchers with suspicion. They are generally reluctant to speak openly about their past experiences and, in certain cases, wish to conceal the fact that they were once imprisoned. Because of the nature of their politics and the organisations to which they belong, any outsider approaching them for research purposes has to go to a higher authority for clearance. In the case of republicans, one has to go to the Republican Movement for clearance. Should the Movement advise against participation in the research, this can become problematic. In those instances where approval is given, the researcher is usually directed towards a number of pre-selected prisoners or ex-prisoners.

Even if all of the above obstacles are overcome, difficulties can still arise regarding the way in which the interviews are conducted. Participants may refuse to speak on tape or be identified in any way. They can be guarded when speaking about events and activities.

They may enquire as to who will own the results of the study, and whether the latter will be published in the media. They might demand that certain conditions be agreed to before speaking, or request that the transcripts of their contributions be screened by them. In some instances this means that the researcher receives an 'agreed narrative' generated from the organisation rather than individual responses. Awareness of this, and measuring the testimony against other and often opposed accounts, reduces the problems. However, even within general, broadly held political positions, individual experiences, nuances and a great deal of reflection on events from the perspective of time come through.

Hospital chaplains have considerable access to patients in hospital due to their religious duties. It is quite likely that patients would confide in them about any problems that they may encounter with health professionals during their stay in hospital. Letters were sent to chaplains who had worked in hospitals during the Troubles belonging to the Catholic Church, the Church of Ireland, the Presbyterians and the Methodist Church. Since the decision was made to begin this research at 1968, all hospital chaplains from this year were contacted. The letters were dispatched during November and December 2002. The response rate was very low – around five replies were received in all. The decision was made to call using religious directories and through word of mouth. This garnered a considerably more satisfactory response rate. The calls were made in June 2003 and the interviews conducted in June and July. The testimony from hospital chaplains was striking: it encompassed a wide range of reactions and opinions. Many significant episodes were witnessed by them during the Troubles, and they had almost constant contact with hospitals, the medical professionals there and the patients.

Political representatives had less immediate experience of the situation in hospitals than the chaplains. However, they were able to recount their individual experiences as patients, episodes when they represented a patient, and give a generally longer overview of the achievements or failures, as they saw it, of the health care system during the years of conflict. A proportion of the political representatives were health professionals themselves, and their testimony was often a straightforward account of their experience. The political representatives interviewed were from both local and central government. On 12 November 2002, 93 letters were sent to Members of the Legislative Assembly (MLAs) of the different political parties in Northern Ireland. In addition, letters were sent to all the Westminster MPs since 1968 that were still available to be contacted. In mid-January, due to the low response rate, it was decided to send reminder letters to MLAs, MPs and Local Representatives. The response from MLAs was extremely slow, even after reminder letters had been sent. With this in mind, calls were made to

constituency offices. Even with phone calls, many of the MLAs were difficult to contact or they were said to be busy. By June 2003 there were a large number still to interview; nonetheless, by the end of the process, considerable numbers of their testimonies had been obtained.

Only local councils operating since 1974 were approached. The reason that this date was chosen instead of 1968 was due to the fact that local councils were reorganised in 1974. Given the subsequent reorganisation, tracing councillors before that date would have been difficult and time-consuming. It was decided to write only to certain councils: this was due to the fact that, due to time restraints and cost, it was not possible to write to all councillors in Northern Ireland. With these difficulties in mind, the decision was made to write only to those councillors in those areas which were 'hotspots': that is, where most of the Troubles took place, and to omit those areas which were mostly conflict-free. However, the response rate from these councillors was very low and thus a further round of letters was sent.

In addition, letters of introduction were distributed to certain organisations with paramilitary contacts. It was felt that they would be in a position to pass them on to individuals who might want to contribute to the research, but who would be difficult to contact on a face-to-face basis. Since a majority of them belong to organisations on different political sides, some thought was given to getting a representative sample of these organisations, including: North Belfast Prisoners Aid, East Belfast Prisoners Aid, Prisoners Aid Lisburn, Prisoners Enterprise Project South Belfast and North Belfast Prisoners Aid. To contact victims of the Troubles, the WAVE Trauma Centre was approached. The centre manager agreed to pass the letters on to members of its group and to encourage people to contact the researchers. The Greater Shankill Alternatives Programme, a voluntary organisation for victims of the Troubles, was contacted on 6 December 2002, but informed the researchers that it did not feel it could offer any help with the project.

Accessing members of the public unconnected to particular groups or churches proved most difficult of all. In order to access the general public and get their views and opinions, the researchers decided to send a letter to the 'Letter to Editors' section of all the newspapers in Northern Ireland. This was done on 2 February 2003. In addition, church publications were requested to print a letter asking for contributions to the research. The churches asked were the Presbyterian Church and the Church of Ireland (the Catholic Church does not have a publication in Northern Ireland). The response rate from this action was also very low and in all, only five letters were received.

Low response rates from the general public could be due to a number of factors. First, the Northern Ireland community is one of the most interviewed in the UK and, after a while, weariness sets in. Second, time constraints, and a desire not to revisit constantly what are painful experiences in many cases, play a part. Third, the investigation did not fall into the usual categories, and many of the general public concluded they did not have the kind of information that the study was seeking. This is illustrated by the fact that those who were interviewed expressed surprise at the kinds of experiences they were asked about, and the significance the researchers felt that they had. The general public often demurred unnecessarily about what they could contribute. Fourth, another point emerging from the interviews regarded how much of the experiences they were asked about had been 'forgotten', or were on topics that they thought would have no interest.

Also very influential in affecting low response rates among the public was suspicion about the researchers' motives. There is a widespread feeling that narrative oral history of the Troubles has been hijacked by politics and become part of the dynamic contributing to the depth of misunderstanding and division in Northern Ireland society. Thus the feeling that an individual does not have much to say is exacerbated, in other instances, by hostility to the whole programme of 'recall' and suspicion about the political motives of those engaged in it.

This brings us to the particular problems of oral history in the case of Northern Ireland. First, one must be aware of the existing 'narratives' of each opposed community: they often isolate different events, as well as show a wide gulf between them on the meaning of the events themselves. Talking about their experiences is seen frequently as a form of participating in the 'ongoing' struggle against the other side, and therefore emphasising and interpreting events structured by these communal narratives. However, in the case of this research, there were some important differences: it was not concentrated on political events, and it used the characteristics which united individuals across the political divide. This was not true of political representatives or paramilitaries, but it was true of the category of health professional. Second, it stepped outside the normal political narrative to ask about problems at work. This produced a rather salutary corrective to much history of the Troubles in that, however difficult this became from time to time, the professions, trade unions and the workplace presented shared spaces and often places that established collegial relationships across the political divide.

Nonetheless, in recognition of the difficulties that a divided society gives rise to, the researchers were aware that the study should be balanced by a cross-section of individuals from across the divide. In the event, political attitudes were shown to be pertinent, not to the practice of medicine, but more to the emotional attitudes which

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both sides of the divide felt obliged to bring under control. Of course, the dimensions of the problems that they encountered were frequently the outcome of the political and religious divisions in society, but often this elucidated a united front by the health professionals interviewed.

Appendix 2:

Consent Form A

Enduring Values Research Project

Name of Researcher:

I confirm that I have read and understand the information sheet for the above project and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. I agree to be involved by responding to questions about my experience.

I understand that my contribution will remain confidential if I so wish. I understand that my permission will be obtained if it is proposed to quote me.

Name

Date

Signature

Appendix 3:

Consent Form B

Enduring Values Research Project

Name of Researcher:

I agree that I may be identified by name with any information that I have given or any opinions that I have expressed.¹

Name

Date

Signature

¹ For the purposes of this publication, all participants' contributions have been anonymised.

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CANDLES IN THE DARK

MEDICAL ETHICAL ISSUES IN NORTHERN IRELAND DURING THE TROUBLES

This report tells the story of how medical care was dispensed during the period of the recent civil conflict in Northern Ireland. Based on interviews with medical professionals who lived and worked through the Troubles as well those with whom they came into contact, it highlights the strains and ethical tensions that the Troubles in Northern Ireland placed on the medical profession. Based on the experiences of those in hospitals, surgeries and prisons within the province, *Candles in the Dark* is both a significant record of the issues faced and a testament to the integrity and dedication of the vast majority the medical professionals involved.

This report is based on the Nuffield Trust's 2002 Rock Carling lecture by Dr James McKenna, former Chief Medical Officer for Northern Ireland, and is augmented by additional research and interviews carried out by Farhat Manzoor and Greta Jones of the University of Ulster. It will be of interest to health leaders, researchers and all those interested in medical ethics or the recent social history of Britain and Ireland.

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