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FROM AN AMA JOURNAL OF ETHICS SPECIAL CONTRIBUTOR

Deciding Whether To Refer a Colleague to a Physician Health Program

J. Wesley Boyd, MD, PhD

When a physician is suspected of having a substance use disorder, the potential ramifications are far reaching, and the situation is rife with ethical considerations. Not only can any disciplinary action have a significant impact—for better or for worse—on the physician, but the effects on that physician's patients can be dramatic. Take action against a physician incorrectly suspected of being impaired, and many patients can lose their in fact competent physician and be deprived of needed access to health care. Fail to take action against a physician who in fact has a substance use disorder, and patients can lose their lives. Thus, navigating these waters as well as possible is vitally important, even though it can be difficult at best, given the competing and overlapping interests and needs of the physician and his or her patients.

In theory, the recommendations for a physician who suspects a colleague of misusing substances are straightforward. The American Medical Association's (AMA) *Code of Medical Ethics*, for example, outlines the [reporting responsibilities](#) of physicians who suspect that a colleague might be impaired:

Physicians' responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program (PHP)... Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program. The duty to report...may entail...reporting to the licensing authority [1].

Even with these guidelines, ascertaining exactly how and when to intervene with a colleague can be tricky. I focus here on two aspects of the AMA's position. First, I address the ethical and practical issues of physicians assessing impairment and deciding whether to approach a colleague they suspect of impairment or whether to report that physician to a board of medicine or some other credentialing entity. And secondly, I consider the nature and operation of the physician health programs (PHPs) that the AMA recommends referring our colleagues to. Most physicians do not know much about these programs, but given that they wield a lot of power and generally operate outside the scrutiny of the wider medical community, a closer examination is warranted.

How Can I Be Sure There is a Problem?

Although we have a duty to prevent harm to patients by impaired physicians, it can be difficult to know if there is actually a problem. For example, questions often arise about the causes of various unusual or unprofessional behaviors: is the physician [intoxicated](#) or sleep-deprived? Is she [snappy and irritable](#) because she is abusing stimulants or because she is merely stressed at home or overwhelmed at work? Was that car accident in the hospital parking lot due to alcohol abuse or uncontrolled diabetes, or was it not even the physician's fault? In these and other instances, it might not be clear how best to honor one's ethical duty to promote good and prevent harm for all parties involved.

To further complicate matters, when considering possible impairment in one of our colleagues, our objectivity might be compromised. There could be occasions when bringing a colleague down in some manner might serve to improve our own standing—by, for example, increasing our patient panel or improving our status within our medical institution. Thus, can we be certain about the purity of our motivations when confronting or deciding whether to report a colleague? Do we like him or her? Do we stand to gain something if he or she is found to be impaired? Will our own workload increase if this person has to take time off? If we are in the same practice, will our practice's reputation be stained? So, while drawing a line between casual, nonproblematic drug use and dependence is always difficult, it is especially complex when thinking about this distinction in a colleague.

Will Intervening Do Good?

In addition to the fact that we often might be uncertain about whether there is in fact a problem, it is not clear that intervention universally results in good. The potential downside of reporting is that merely reporting a physician for suspicious behavior can result in a board of medicine asking that the physician stop practicing medicine until the allegations are investigated. This can result in potentially unnecessary loss of income for the physician, patients being deprived of their physician, and the physician's colleagues being overwhelmed with extra patients. Additionally, merely being investigated, much less actually disciplined or cited, can result in public ignominy for the physician, strained personal and professional relationships, and possibly legal bills. So when physicians have had action taken against them, at times it can be difficult to conclude that, all things considered, good has been accomplished. On the other hand, inaction could cause not only direct harm to the family members and patients of the physician, but also harm to or perhaps even the death of the physician.

We have a *prima facie* duty to respect the autonomy of physicians, but this duty can and should get trumped by other more pressing needs if we suspect that a physician is actively misusing psychoactive substances. Our duty to promote both beneficence (defined as "doing good") and nonmaleficence (defined as "preventing harm" and "not

inflicting harm on others”) has to trump the physician’s right to autonomy. Patients’ autonomy—the right to make choices about who they see for health care based on as much relevant information as possible—is more important.

When to Intervene

If the warning signs observed in clinical practice are overt—erratic behavior, slurring words, poor clinical decision making, and so on—then taking immediate action by confronting the physician with follow-up reporting to a clinic chief or even to the board of medicine itself (if the physician does not self-report) might be imperative. Doing so might save a life, perhaps even multiple lives. Given the high stakes in both directions, if in doubt about how to proceed, seek expert guidance and confer with those knowledgeable about physician health and substance abuse to help determine whether your thoughts and concerns are justified and warrant action of some sort.

Potential Concerns about Physician Health Programs

In its statement about how to proceed when one suspects a colleague of a substance abuse problem, the AMA says that we might be ethically and legally obligated to refer that colleague to a state PHP [1]. Currently, 47 states in the US have one of these programs [2]. The purpose of PHPs is generally to promote the health and well-being of physicians—especially those with substance use and mental health issues—and also to protect the public from physicians who might be impaired. PHPs vary in their composition and funding sources. Some are arms of their state medical societies, some are housed within the state medical boards, and others are freestanding [3].

Physicians can end up at PHPs through various means. In some instances, they might self-refer, seeking help with a substance abuse or mental health issue. In others, colleagues, a departmental chair, or a chief medical officer might insist that they meet with the PHP. In still others, the state licensing board might insist that physicians do so. In the latter two instances, physicians generally have no choice but to comply with any and all PHP recommendations if they want to be able to continue practicing medicine [3]. PHP recommendations often include a several-day evaluation. Physicians deemed to have a substance use disorder are often required to enter a 30-to-90-day inpatient stay for treatment. Generally, neither the evaluation nor treatment is covered by insurance [3]. And once treatment is complete, physicians are generally required to sign a monitoring agreement and begin random drug testing, Alcoholics Anonymous or Narcotics Anonymous attendance, and regular meetings with a PHP representative. Failure to comply with any aspect of the contract can, and often does, result in being reported to the licensing board. The board then might ask the physician to suspend practice while it investigates matters or simply revoke the physician’s license [4].

Given the authority that PHPs often have over the ability of physicians to practice medicine, their power is enormous and not necessarily wielded appropriately. A recent

class action lawsuit filed in Michigan alleges a coercive, punitive process within the PHP in that state [5]. The suit states that health care professionals “are forced into extensive and unnecessary substance abuse/dependence treatment under the threat of the arbitrary application of pre-hearing deprivations,” which include suspension by the Michigan licensing board. In addition, I have known some PHPs to report low-level positive drug tests to their boards even when these tests might indicate incidental exposure to a substance instead of intentional use or relapse. (For example, a physician who uses ethanol-based hand sanitizer repeatedly over the course of the day might have a low-level positive test the following day for metabolites of ethanol.) This can create significant hardships for the physician who is reported. Furthermore, some PHPs use physician participant data for research and publication purposes [6]. Even if PHPs obtain signed consent forms, are these physicians actually able to give noncoerced, informed consent, given the power the PHP holds over them?

There are often significant financial ties in both directions between PHPs and the evaluation and treatment centers they use [3, 7]. Many of these centers are more or less dependent on such PHP referrals for their own viability and are often principal sponsors of state, regional, or national meetings of PHPs. Such relationships between the PHPs and the evaluation and treatment centers create financial incentives for each to act in ways that favor the other’s interests. All of this would suggest that oversight of PHPs is crucial for ensuring ethically acceptable practices. But, even though PHPs work closely with their state medical societies or licensing boards, they often receive very little scrutiny from either of these entities because of their origins as organizations of “doctors helping doctors,” which can lead to a presumption that they are benevolent organizations working solely for the benefit of their physician clients [3].

Physicians who object to state PHP recommendations are often not taken seriously. In 18 years of working with PHPs in various capacities, I have generally seen that the only people who register concerns about PHPs are those who have been referred to them for evaluation or their loved ones. As a result, their complaints—which might be valid and important—are generally seen as mere sour grapes and viewed skeptically by hospital or state authorities. (The same is true for at least one journal editor. Several years ago, when a colleague and I submitted a paper to a major medical journal about ethical and managerial concerns regarding PHPs, I received a call from the editor in chief of the journal two days after submission asking if either I or my co-author had been referred to one of these programs. Only after I confirmed that we had not did the editor say she would send the paper out for review.) Formally appealing these decisions can be difficult or actually impossible. In my state, Massachusetts, appealing a PHP recommendation requires filing a lawsuit in the state court system, which can cost thousands of dollars in legal fees and take months or years to adjudicate. In many states, there is no avenue of appeal at all. Consider the case of North Carolina. After receiving several complaints from physicians, the state auditor’s office, for which I served as a consultant, audited the

North Carolina Physicians Health Program (NCPHP) and found that it lacked objective, impartial due process procedures for physicians who disputed its conclusions [7]. The auditor's office stated that "the lack of objective and independent due process procedures could prevent physicians from successfully defending themselves against potentially erroneous accusations and evaluations" [8] and decried the appearance of conflict of interest between the NCPHP and the evaluation/treatment centers that it utilized. It will revisit the NCPHP soon to ensure its various recommendations have been implemented.

Conclusion

Although there are currently no national standards for or routine audits of state PHPs, implementing such standards and regularly inspecting programs for compliance would go a long way to ensure the fair and ethical treatment of physicians suspected of substance abuse. Great thoughtfulness and care must be exercised when dealing with a colleague who might have a substance use disorder. Falsely accuse a physician, and the damage to your colleague's career, family, and patients can be extreme. Allow an impaired colleague to continue to work out of fear of taking action, and the danger to the physician and to patients can be extreme. Thus, it is imperative for health care personnel to properly navigate a course that carefully considers competing ethical principles and steers between the rocky shoals on either side. Moreover, given PHPs' power and the potential costs to physicians—much less the inability in many states to effectively protest PHP recommendations—caution should be exercised when considering referring a colleague to a PHP.

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FROM THE EDITOR

Health and Social Justice: The Role of Today's Physician

As physicians (and trainees), we are often at the front lines, facing societies' ills with our patients as our windows into spaces and worlds we may not be living in. We are taught in medical school how to accurately classify the various types of cardio-renal syndrome or recognize diagnostic criteria for lupus or the side effects of digoxin, but discussions of civil and human rights issues are often lacking. Perhaps this is because these issues make us uncomfortable and the science of medicine feels more exact, or perhaps it is because we feel helpless against large social structures that make violations of rights possible.

In the context of health and health care, a commitment to social justice means believing that everyone ought to be able to avoid preventable disease and escape premature death. Far too often, gross inequities mean that some groups succumb to disease and death disproportionately, while others' advantages protect them, due to disparities in health care provision, political persecution, social strife, racial discrimination, and a plethora of other factors.

Therefore, this issue of the *AMA Journal of Ethics* was conceived to highlight the abuses of rights that some health care professionals have participated in, to underscore that vigilance is required to ensure that we are doing right by those whom we serve, and to propose an active, concrete role for physicians in the struggle for social justice.

Two powerful pieces by South African physicians highlight the systemic injustices of the apartheid era. Wendy Orr's [narrative](#) recounts her experience as a whistleblower physician alerting the public to the human rights abuses perpetrated in South African jails against black detainees. Keymanthri Moodley and Sharon Kling complement Dr. Orr's piece by [describing](#) the role of doctors and the Medical Association of South Africa in these apartheid-era prisoner abuses.

South Africa is not the only place where physicians have engaged in egregiously unethical conduct without dissuasion or punishment from medical societies or criminal courts. As Stephanie Bi and Tobin Klusty [explain](#), physicians in several countries forcibly sterilize HIV-positive women for spurious pseudomedical reasons not supported by science. Steven H. Miles [examines](#) medical societies' role in a worldwide lack of accountability for physicians who participate in torture and proposes steps to reverse it. And G. David Elkin and I [discuss](#) the American Psychological Association's failure to

prohibit members' involvement in torture. This month's excerpt from the *AMA Code of Medical Ethics* states in no uncertain terms that physicians should not participate in interrogations or developing interrogation methods.

The ethics cases in this issue highlight very real social justice issues that physicians face. J. Wesley Boyd [explores](#) the ethical implications of force-feeding prisoners; the Israeli medical establishment recently advised physicians not to participate in the force-feeding of Palestinian prisoners on hunger strike despite a recently passed law that allows it [1]. Although same-sex marriage was made the law of the land by a recent Supreme Court ruling, full social equality is another story. Judith Palfrey comments on [a case](#) of a physician who is reluctant to care for the child of two mothers, underscoring physicians' social responsibility to avoid discriminating against classes of people and to contribute to the expansion of access to care for marginalized people. And, in their [peer-reviewed piece](#), Aaron Wightman and Douglas Diekema urge readers to look past the assumption that undocumented immigrants are inappropriate candidates for organ transplantation.

Paradoxically, even attempts at humanitarian aid run the risk of ignoring the voices of the vulnerable people they intend to help. Amos Lichtman and Mohit Nair [identify](#) barriers to introducing drones and satellite imagery analysis—well known for their military applications—into humanitarian aid.

This issue also suggests ways physicians can be forces for good. Hanni Stoklosa, Aimee M. Grace, and Nicole Littenberg [describe](#) a human rights framework for educating physicians about how to identify, protect, and care for victims of human trafficking. The White Coats for Black Lives national working group [proposes](#) four actions the medical profession should take to strive toward racial equity in our health care system. Andrea S. Christopher and Dominic Caruso [provide](#) an update on the progress of the right to health movement in the US in the period after the passage of the Affordable Care Act and propose further reforms. Tobin Klusty and Stephanie Bi [describe](#) the Supreme Court's role in ensuring affordable care for citizens in states that did not create their own health insurance exchanges. Finally, in the podcast, Joia Mukherjee describes how Partners in Health seeks not merely to contain disease outbreaks but to bolster developing countries' health care systems through multilateral funding and cooperation.

Choosing not to see injustices does not mean they are not occurring. Structural violence exists. Racism exists. Homophobia exists. Human rights abuses exist. We are stewards of a profession that requires us to *do no harm*, but, beyond that, to help everyone live healthy and productive lives. We have to take our patients' biopsychosocial contexts—the neighborhoods they live in, the work they do, and the lives that they live—into account.

With that understanding, Dr. Martin Luther King Jr.'s words resonate: "Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly" [2]. Social justice is not merely a nice idea but a crucial part of our responsibility to promote health. We must participate in addressing inequalities and abuses so that all people are able to achieve health, defined by the World Health Organization as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [3]. We hope this issue challenges preconceived notions of the role physicians ought to play in safeguarding human and civil rights and sparks insight into how to join the struggle.

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ETHICS CASE

Conscientious Refusal or Discrimination against Gay Parents?

Commentary by Judith Palfrey, MD

Dr. Smith had been one of four members of a pediatric family practice for 19 years. Over the years, she had greatly enjoyed seeing her patients and getting to know their families, and she took pleasure in the routines of her practice, the cycles of back-to-school checkups and vaccination schedules, the Christmas cards from patients that accumulated on a bulletin board every December. She felt she'd long since found her rhythm as a pediatrician.

So it was with some surprise that she confronted a new situation when her 2 p.m. Wednesday appointment—expectant parents preparing for the birth of their first child—turned out to be not a mother and father but two women. What raced through her mind in the following second or two was the relationship that she formed with her patients' parents—often they shared other aspects of their lives with her and sought counsel on all sorts of matters. Dr. Smith knew she could not pretend to have that degree of comfort with and interest in this couple.

Dr. Smith regained her composure and shook their hands, hoping she was disguising her discomfort. She took notes, mustered up enough normalcy to give terse answers to the parents' questions, and saw them out the door with a tight smile. When they'd left, she looked back over her notes and thought, "I don't want to treat a patient with lesbian parents. Children should be raised by a mother and a father. And I don't think I should have to do this. Shouldn't this family be assigned to one of my partners?"

Commentary

The birth of a baby is one of the most beautiful moments in the life of any parent. It is also the sacred establishment of a family. With a child's entrance into the world, the parents take on the awesome responsibility of providing nurturance, nourishment, protection, love, education, and a future for the little new being entrusted to them. The transformation of a couple into a family is supported by the parents' own families, the community around them, and the larger society. A key member of the community in this transformation is the health care professional who delivers anticipatory guidance and preventive health care and is a backstop in case of illness and other emergencies.

In this case, a physician is considering "[turfing](#)" the expected newborn patient because her parents are [lesbians](#). From the case description, we do not know whether the

parents have experienced other rejections or discriminatory reactions from their own families, but here is a professional considering refusing to support the creation of this new family because of her personal belief and [bias](#). Since family, community, and societal support all bolster family formation, this refusal to provide professional health care needs to be examined.

This case raises a number of questions:

1. What does it mean for a physician to judge a patient or patient's family based on sexual orientation? Is this discrimination on the part of the physician? Will it have specific effects on the couple's child or children?
2. If a doctor questions the parenting abilities of individuals based on their sexual orientation and considers treating their children against her conscience, what other characteristics might a physician consider against her own conscience?
3. What would make people unfit or "wrong parents" and what actions would be appropriate for a physician to take "in good conscience"?

Physician Judgment as a Denial of Access to Care

The physician in this case has made the judgment that the parents are somehow different from other parents she cares for and is not willing to provide them medical care and advice. She wants to make provision for them to see someone else, but her view of the parents is clearly discriminatory—based solely on the information that they are a gay couple. Until recently, such a decision on the part of a doctor would have been unfortunate, but the parents would have had little societal or community recourse to improve the situation. In the wake of the passage of the Affordable Care Act (ACA) [1] in 2010 and the US Supreme Court decisions in *United States v. Windsor* (2013) and *Obergefell v. Hodges* (2015) [2, 3], the parents have official support that shines a new light on their dismissal by the doctor.

Provisions of the Affordable Care Act aim to lessen the de facto discrimination that has denied care to different classes of Americans. For instance, the elimination of the preexisting condition exclusion extended health care coverage to a whole class of sick and vulnerable people. The widening of Medicaid eligibility opens the health care door to people who cannot afford private health care premiums. The ACA has as its premise that *all* means *all*. In other words, no segment of the population should be denied care that other segments receive.

Within the American population, there is wide diversity of sexual identification. In 2014, the CDC's National Health Interview Survey [4] reported that, among American adults aged 18 and over, 2,000,000 American men (1.8 percent) and 1,729,000 American women (1.5 percent) identify as gay. In addition, 481,000 US men and 1,033,000 US women report their sexual orientation as bisexual. Many consider these figures an underestimate [5].

Following the 2013 Supreme Court decision that declared the Defense of Marriage Act unconstitutional [2], there were substantial changes in more than half the states regarding the legal status of gay marriage [6]. As of June 25, 2015 (the day prior to the *Obergefell v. Hodges* decision), 37 states recognized same-sex marriage [6]. In 8 of the 13 states with same-sex marriage bans, the bans had actually been overturned but were in the process of appeal [6]. As of June 26, 2015, based on the *Obergefell v. Hodges* decision, all states are now required to recognize same-sex marriage and afford gay couples all the rights that legal marriage carries with it [3]. The Centers for Medicare and Medicaid Services (CMS) have published extensive information about the coverage that legally married same-sex couples should expect in the medical marketplace, including services that same-sex spouses were denied in the past [7].

More than 15 professional organizations have strongly supported marriage equality, gay and lesbian parenting, or both [8]. In 2013, the American Academy of Pediatrics (AAP) published an unambiguous statement in support of gay parents based on a rigorously researched technical report [9]. The AAP Committee on Psychosocial Aspects of Child and Family Health demonstrated that children thrive best in homes with married parents. The central thesis of the AAP committee argument in support of gay marriage was that, historically, systematic discrimination against gay parents has denied their children the community and societal supports that promote health and child development.

If doctors can refuse to care for patients and families of certain types or classes, this is a health inequity. If insurance companies were still allowed to limit payment for the children or spouses of gay enrollees (including maternity benefits), that might prevent such enrollees from affording essential care. If one parent in a family cannot benefit from the provisions of federal laws such as the Family and Medical Leave Act, he or she may suffer unduly when a child or other loved one is sick and he or she cannot assist in care. If social service agencies can limit services, some children may not have access to the nurturance and nourishment other children receive. These community and societal discriminatory practices that can impact health are the basis for the new legal standards protecting gay married couples. In cases like the one presented here, the physician's bias is the first brick in the wall of barriers gay parents have traditionally found themselves confronting in the health care system.

Personal Conscience and Physician "Rights"?

In light of the health legislation, court cases, and professional statements, does a doctor have the "right" to refuse care to patients whose traits or behavior she does not approve of? All human beings have deeply held beliefs and biases [10], and physicians are no exception. The question is how does personal bias play out in professional settings? Should all Catholic internists decide that they cannot "in good conscience" take care of

ob-gyn physicians who perform terminations of pregnancy? Should all doctors who object to the taking of another human's life be allowed to refuse to care for members of the military, police, and the unfortunate individuals who must administer lethal injections? Should vegetarian physicians refuse to care for meat eaters? Should physicians who believe in divestment from fossil fuel companies refuse to care for parents who come to see them in cars? Should Democratic physicians ask all Republican patients to transfer to their Republican colleagues? And—a much-asked question—should physicians who provide immunizations refuse to care for vaccine-refusers?

While some of the examples above border on a *reductio ad absurdum*, it is critical to ask what rights physicians have regarding their beliefs. Should a Catholic physician be obligated to perform an abortion? Should a doctor ever be required to unhook a respirator or euthanize a patient? It may be fruitful to untangle attitudes from behaviors. The doctor's attitude is what is at stake in this case.

The doctor has made her decision not to care for this family because the parents have openly identified themselves to her as a lesbian couple. If one parent had come in, presenting herself as a single mother, Dr. Smith would have assumed she was straight and not considered refusing to treat her child. Is it fair to punish them for their honesty? She is not, and probably should not be, privy to the sexual practices of the vast majority of the families who come to see her. Moreover, within her practice there are doubtless parents who hold beliefs that are different from hers on a whole array of topics. She might, without her knowledge, be caring for some parents who behave in other ways she holds reprehensible—people who cheat on their spouses, evade their taxes, underpay their employees, or rob banks. Singling out this particular couple because she disapproves of their sexual orientation seems impossible to justify.

What Are “Wrong Parents”?

What if Dr. Smith does not object per se to interacting with gay people, but to (indirectly participating in) their parenting, because she believes it harms the children? There is [no evidence](#) that gay parents are less good at parenting than heterosexual parents, despite the challenges of community and societal bias against them [9]. The American Academy of Pediatrics (AAP) makes a strong point that the preponderance of research shows that two parents (whether they are straight or gay) are better equipped than single parents to provide a family structure, physical supports, discipline and guidance, education, and mental health promotion [8]. If we don't condemn single parents as harmful to children and unfit to parent, it is difficult to justify condemning partnered gay parents.

In this case, the physician has no reason to have concern that these parents will behave in anything but a loving and supportive way regarding their baby. In fact, she has proof that they are doing their best to follow the most up-to-date parenting recommendations. The evidence is right in front of her: the parents chose *her* as their

child's pediatrician and made a prenatal visit. These are metrics (crude though they may be) of "good parenting." In the face of this evidence, a dismissal would not appear justified.

Child health physicians unfortunately do sometimes encounter "wrong parents." Under extreme circumstances of major mental health or substance abuse disorders or in the presence of domestic violence, physicians may have to take action to protect children from the neglect or abuse of parents who are either temporarily or permanently incapable of giving support and sustenance to their children. This is often under circumstances in which the parents are extremely ill and overwhelmed. Pediatricians in these situations are mandated to report the family to the state social service agency, which determines the degree of neglect and abuse and makes a disposition that may include taking custody of the child away from the parent. Even in these circumstances, however, clinicians still have a moral obligation to try to ensure the best care and outcomes for both the children and the family.

Conclusion

As we probe the question of whether this case constitutes conscientious refusal or discrimination, we could reasonably ask if there is anyone a physician isn't obligated to care for. Or, stated another way, are all physicians personally responsible for all patients? Obviously, physicians as a group make decisions all the time about which patient is best cared for by which physician (generalist or specialist, pediatrician or geriatrician, mental health professional or surgeon). What is different in this case is that the decision to opt out of providing care is based on the doctor's disapproval of an entire social demographic group, rather than a moral objection to participating in a particular medical practice or treatment; it is a question of who the patient is, rather than what the doctor will do.

In the twenty-first century, we are in the middle of large sociopolitical shifts, including increasing rights for and acceptance of previously marginalized groups and increasing transparency about sexual orientation. We also are increasingly aware of the health outcome disparities that are associated with different socioeconomic, cultural, linguistic, and gender identities. A significant portion of our civil society is trying to eliminate discrimination in every segment of life. Medicine, too, is working to eliminate discrimination. The Accreditation Council for Graduate Medical Education (ACGME) considers "sensitivity and responsiveness to a diverse patient population" part of the core physician competency of professionalism [11]. The US Office of Disease Prevention and Health Promotion's goals for the nation, *Healthy People 2020*, specifically calls on the health care community and others to "improve the health, safety, and well-being of lesbian, gay, bi-sexual and transgender (LGBT) individuals" [12].

While physicians' rights to their own belief systems should be protected, the standards of the medical profession dictate that health care professionals not let discriminatory

views interfere with their duty to respond to the needs of their patients. Furthermore, to decide not to care for this family in this case would be sad for the doctor. She would be “turfing” her responsibility, but, more importantly, she would be losing the chance to engage personally with the valuable and enlivening diversity of the American community.

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ETHICS CASE

Force-Feeding Prisoners Is Wrong

Commentary by J. Wesley Boyd, MD, PhD

Dr. Johnson had worked within the California Department of Corrections and Rehabilitation (CDCR) since completing his residency. A passionate advocate for inmates' health, he saw the CDCR as a place for him to care for a vulnerable population. No day was ever the same.

Dr. Johnson knew that several prisoners at one of the state institutions had been on hunger strikes for three weeks, and he was being kept informed of the situation. One morning he received the report that they were extremely fatigued and lethargic, dizzy, bradycardic, and experiencing chills. As their conditions deteriorated, Dr. Johnson was told by his superiors that they needed to be given artificial nutrition.

The protestors were bringing attention to the experience of solitary confinement, a practice used in CDCR maximum-security prisons. Dr. Johnson had treated prisoners after they had been in solitary confinement and had seen the devastating psychological and physical sequelae of being locked in an isolation cell for 22 to 24 hours a day. In speaking with the prisoners, Dr. Johnson learned that they intended to refuse any form of nutrition until their demands—including an end to long-term solitary confinement, the provision of regular and meaningful social contact, adequate health care, access to sunlight, and adequate food—were met [1].

The prison administrator to whom Dr. Johnson reported asked that he oversee providing nutrition artificially to the inmates so they would not die. The prison warden said, "It's not like this is Guantanamo or anything, we won't be using NG tubes; we'll just give them TPN through an IV. They're wavering in and out of consciousness as it is. They won't even notice."

Commentary

In being asked to help provide nutrition for hunger-striking prisoners through an IV, prison physician Dr. Johnson is presented with a dilemma that can be viewed from several perspectives. Assuming he wants to keep his job, he presumably feels pressure to acquiesce to the warden's request. Additionally, although Dr. Johnson might respect the prisoners and their motivations for refusing nourishment, it could be very painful for him to stand by and watch the prisoners' physical suffering, knowing that relief was as close as an IV line. At the same time, and despite how difficult it might be for him to

witness, if he respects these prisoners, he probably supports their cause and thinks they have a right to refuse nutrition to press their case for reform within the prison.

Prior to addressing the other issues in this case, I want to comment on solitary confinement, which can consist of being locked in a cell, alone, for 22 to 24 hours a day. The Center for Constitutional Rights (CCR) writes that the “devastating psychological and physical effects of prolonged solitary confinement” place prisoners at even greater risk of “more devastating future psychological harm” [1]. After highlighting multiple negative psychological aspects of solitary confinement, CCR concludes that “solitary confinement is torture,” pointing out that it has been condemned as such by the international community, and constitutes cruel and unusual punishment in violation of the US Constitution [1]. Given the consensus opinion on the cruelty of solitary confinement, anyone looking from without would conclude that these prisoners’ demands are reasonable and that their fasting, while extreme, is rational and may be the only peaceful means available to them for calling attention to the cruel and punishing practice of solitary confinement.

Political Objections to Prisoners’ Fasting as a Form of Protest

Unless the prison warden accedes to the protestors’ demands or they call off their hunger strike at some point, the ultimate result of these hunger strikes will be death. And death is, *prima facie*, something to be avoided. Perhaps it is even more to be avoided from the perspective of a prison warden who fears that, if the hunger strikers do in fact die, their deaths could be cause for significant political repercussions and also stain the prison’s reputation.

The Israeli government recently authorized force-feeding of hunger-striking Palestinian prisoners who were deemed in danger of dying for just these kinds of reasons [2]. The legislators wanted “to prevent security detainees from trying to ‘blackmail the government’ or foment unrest among Palestinians in the event that a detainee dies in prison after a hunger strike” [2]. The Israeli Public Security minister is quoted as saying that “security prisoners are interested in turning a hunger strike into a new type of suicide terrorist attack through which they will threaten the State of Israel. We will not allow anyone to threaten us and we will not allow prisoners to die in our prisons” [2].

By recasting the hunger strike as a “suicide terrorist attack,” Israel is attempting to portray force-feeding of detainees as political self-protection. The Israeli Medical Association wasn’t buying this rationale; it promised that, if the policy were enacted, it would encourage doctors to refuse to participate [2].

Examination of the Ethical Dilemmas

Ethical dilemmas arise because basic ethical principles are competing with one another, and, with a hunger strike, the competing principles are in stark relief. On the one hand,

respecting prisoner human rights suggests that, all other things being equal, prisoners ought to be allowed to choose how to act, within the limits of those rights. Other basic bioethical principles are also at play, including beneficence, nonmaleficence, and justice. With respect to hunger-striking prisoners, beneficence could easily be interpreted to suggest that maintaining prisoner health and well-being should be prioritized and that the doctor is actually being asked to promote beneficence.

Although the warden might, in fact, be asking Dr. Johnson to adhere to principles of nonmaleficence and beneficence, he might also be acting out of professional self-interest. He might simply hope to protect himself and his prison from the negative publicity that can result from hunger-striking prisoner deaths or, should he acquiesce to their demands, from having the prison's solitary confinement policies and procedures exposed to the public.

In this instance, how to best promote the principle of justice could be argued in various ways. Working for greater justice could mean that any way of diminishing the use of solitary confinement should be promoted, but it also might—more superficially—mean that we ought to prioritize the health and welfare of individual prisoners and not permit them to starve themselves.

So, despite the doctor's dilemma, if the prisoners are making rational, informed, and uncoerced choices to continue their hunger strike, then every international code of ethics, including that of the World Medical Association (WMA), [supports](#) the prisoners' actions. The WMA Declaration of Tokyo states: "Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially" [3]. To ensure that the physician is making the correct determination, the WMA goes on to add, "the decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner" [3].

Given that the WMA rejects any artificial nourishment under these circumstances, it does not matter that in this scenario the warden tells Dr. Johnson that nasogastric tubes would not be used and that the artificial nourishment "would only" be given through an IV. Even though the cruelty associated with forced NG tube placement would be avoided, the prisoners' rights would nonetheless be trampled, and international ethical norms and mores ignored.

The short way of putting this is that, if the capacity of the striking prisoners to make rational choices has been medically confirmed, they should be allowed to refuse nourishment, even if that refusal means that they might die, and even though some

governments—including the US at Guantanamo and presumably at other “black sites” around the globe—have force-fed prisoners.

Human beings have an overwhelmingly strong urge to continue living, even in the most deplorable and hideous conditions. As an example, almost everyone held captive in Nazi concentration camps chose not to end his or her own life, even though the circumstances were incomprehensibly horrible. Because of this primal urge to live, those who are deemed to have decision-making competency and are willing to sacrifice their lives—and only their own—for a cause must believe that their reasons are compelling, and therefore respecting their autonomous choice is paramount.

All things considered, the warden’s best course of action would be not to force-feed the prisoners but instead to accede to their demands, engaging in dialogue with them about solitary confinement policies and procedures, and enacting change. Although it likely would be uncomfortable for prison administrators to appear being “pushed around” or “manipulated” by prisoners, there are times when acceding to demands such as these is the proper course of action. Given the emerging consensus about the cruelty of solitary confinement and the long-standing consensus that force-feeding hunger-striking prisoners violates their basic human rights, this is one of those times.

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PEER REVIEW

Should an Undocumented Immigrant Receive a Heart Transplant?

Commentary by Aaron Wightman, MD, MA, and Douglas Diekema, MD, MPH

Sarah is a 17-year-old undocumented immigrant who has been followed at a regional pediatric heart center since age six for single-ventricle Fontan physiology. She lives with her parents and three siblings in a rural community, where her parents struggle to avoid deportation and support their four children by working as agricultural laborers. Although Sarah and two of her siblings immigrated in childhood and are eligible for the Deferred Action for Childhood Arrivals program (DACA), Sarah's youngest sibling was born in the United States and is an American citizen.

Sarah's heart condition is now complicated by protein-losing enteropathy, tricuspid regurgitation, and decreased cardiac function. Her cardiologists have diagnosed her with end-stage heart disease and believe she will require a cardiac transplant to survive to adulthood. Due to her anatomy, Sarah is at a higher risk of a poor outcome if transplantation is pursued, and this risk will increase as she gets sicker. She is not a candidate for a ventricular assist device. After a discussion of the risks and benefits of a transplant, Sarah and her parents have indicated that they would like to pursue heart transplantation.

The cardiac transplantation team considers Sarah an acceptable candidate for transplantation despite her increased risk, but it has raised concerns about whether her status as an undocumented immigrant will adversely affect her ability to obtain the health care and medications required to maintain her long-term health following the transplant. Her first surgery was performed in Mexico, but subsequent surgeries have been performed at the regional pediatric institution. The regional children's hospital has committed to providing care and medications until Sarah reaches age 21, but the team has expressed concern about whether she would be able to afford the necessary care and medications after that point.

Commentary

The published Organ Procurement Transplant Network (OPTN) policy [1] and the National Organ Transplantation Act [2] require that only medical criteria be used in organ allocation decisions once a patient has been listed for transplantation. Criteria such as race, citizenship, and celebrity status are not permitted to play a role in listing decisions. The transplant listing decision, however, may consider the ability to pay [3]. In 2011, the average billable charges for a cardiac transplant were \$997,700 in the first year and

\$30,300 in subsequent years [4]. In effect, the ability to pay—often tied to insurance status—has become a precondition for transplantation. A recent survey of adult heart transplant centers noted that 48 percent required candidate health insurance to initiate an evaluation, and 84 percent required the candidate to have health insurance in order to be listed for transplantation [5]. The same survey noted that only two percent of recipients were uninsured; for these patients, 81 percent of centers required substantial upfront payment (median \$200,000) [5]. Ability to pay, however, is not one of the evaluated listing criteria in the 2006 guidelines of the International Society for Heart and Lung Transplantation [6].

The Affordable Care Act expanded eligibility for Medicaid to include more low-income adults and eliminated the exclusion for preexisting conditions, thereby increasing the number of people who potentially could obtain health insurance. Sarah's immigration status requires her family to pay for her transplant because, in many states, including theirs, individuals with DACA status are excluded from qualifying for Medicaid or Medicare [7]. Rather than rationing organs based upon citizenship, this is rationing based upon ability to pay.

Ethical Analysis

The concern posed by the cardiac transplant team raises the questions of justice and fairness in the distribution of scarce organs for [transplant](#). Rationing organs by ability to pay is different than rationing other medical resources by ability to pay. Organs are a limited, national resource, donated by the population, that by law do not have a monetary value [8]. Simply having the ability to pay for an organ or a transplant procedure does not make more organs available in the way that paying for other medical resources can make the purchase or manufacture of more of that resource possible. Moreover, exclusion of patients based on ability to pay may lead to erosion of public trust in the transplant system and lower donation rates.

Justice and fairness. Undocumented immigrants [can and do donate organs](#) in the United States, accounting for 3.3 percent of total deceased donors from March 2012 to December 2013 [9]. Most of these organs are transplanted into US citizens. Similarly, a significant percentage of organ donors have historically been uninsured [3]. The principle of [solidarity](#) would suggest that if undocumented immigrants and the uninsured contribute to the donor pool, they should also be considered potential recipients of solid organs. Any system that uses the organs of individuals who would themselves not be considered eligible for a transplant because of inability to pay is clearly unjust. Contribution to the donor organ pool also means that undocumented immigrants do not count as "[transplant tourists](#)" by the definition of the Declaration of Istanbul [9].

Sarah's case. In Sarah's case, the hospital has committed to covering the costs of both the transplant and her posttransplant care until she reaches the age of 21 as part of its

mission to provide uncompensated care to those who reside within their referral area. Thus, the question about suitability for transplant is not based on her current inability to pay. Rather, the question has been raised due to concerns that graft survival would be jeopardized beyond the age of 21 because Sarah's DACA status disqualifies her from receiving Medicare or other federal and state aid or from purchasing private health insurance on the exchanges in her state [10]. Health care has a cost and this must be paid if it is to continue to remain available. The inability to pay for health care and medications or to obtain public assistance or insurance would significantly decrease the likelihood of a successful transplant over the average lifespan of a typical graft. Some might argue that Sarah's potential inability to afford medical care past the age of 21 makes her more likely than the average transplant recipient to lose the graft and that therefore the scarce organ should be allocated to someone with a higher likelihood of long-term graft survival. This argument reframes the reason for not listing Sarah from [financial considerations](#) to likelihood of success (compared to the average transplant recipient).

Although likelihood of success is generally regarded as a legitimate criterion for allocating scarce organs, we do not think undocumented immigrant status should be used as a proxy for likelihood of success, especially in this case. First, the hospital has made a commitment to Sarah's care for the next three to four years. Any potential negative impact of her immigrant status on her insurance coverage or ability to pay would occur after that time period. Second, concerns about how Sarah's current [immigrant status](#) might impact her future care are purely speculative. We have no way of knowing how Sarah's life might change in the next four years. She could successfully petition to become a United States citizen, or the state regulations regarding Medicaid and Medicare eligibility could change. She could qualify for medical aid from some unanticipated source. Finally, she might gain employment that offers insurance or allows her to absorb the costs of medication and clinic visits.

Denying a transplant to anyone requires compelling reasons. These reasons should not be based upon a worst-case prediction of what the future might hold for a particular person. Uncertainty about the future applies to almost every person who is listed for transplant. We can never be certain that a given patient's family will have insurance in the future, whether a given patient will become noncompliant with follow-up care and medications, or whether a transplant patient will develop habits or unrelated medical conditions that jeopardize the health of the graft.

Although Sarah's current situation may differ in important ways from that of other patients, we simply cannot predict with any degree of certainty that it will negatively impact her health in the future. If she is otherwise a candidate for a heart transplant, she should be listed without regard to her immigrant status or the possibility of her future insurance coverage or ability to pay.

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MEDICAL EDUCATION

Medical Education on Human Trafficking

Hanni Stoklosa, MD, MPH, Aimee M. Grace, MD, MPH, and Nicole Littenberg, MD, MPH

Human trafficking occurs in all 50 US states and in at least 124 countries worldwide [1, 2]. The US Trafficking Victims Protection Act (TVPA) of 2000 defines “severe forms of trafficking in persons” as

(A) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or (B) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion, for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery [3].

The physical and mental health impacts of human trafficking have been described widely [4-8]. They include infectious illnesses and their sequelae, such as HIV/AIDS, sexually transmitted infections (STIs), pelvic inflammatory disease (PID), viral hepatitis, respiratory illnesses, and dental infections; exacerbations of chronic conditions such as asthma, heart disease, and diabetes; noninfectious conditions such as head injuries, fractures, lacerations, malnutrition, hearing loss, and gastrointestinal illnesses; and mental health disorders such as depression, anxiety, posttraumatic stress disorder (PTSD), substance abuse, and suicidality.

Victims of human trafficking interact with the health care system before, during, and after the period of victimization [5, 9, 10]. These encounters provide health care professionals the opportunity and the responsibility to play a critical role in identifying and preventing human trafficking and treating conditions resulting from it. For these reasons, health care professionals must be trained about human trafficking from a human rights perspective.

Education on Human Trafficking in Medical Training: A Human Rights Framework

Human trafficking is a human rights issue [11]. International human rights law has declared the “fundamental immorality and unlawfulness of one person appropriating the legal personality, labour or humanity of another” [12]; arguably, there is no act more dehumanizing and exploitative than the trafficking of another human being. The particular human rights violated in cases of trafficking include the right to liberty and

security; the right not to be submitted to slavery, servitude, forced labor, or bonded labor; the right not to be subjected to torture, punishment, or cruel, inhumane, or degrading treatment; the right to be free from gendered violence; the right to freedom of movement; the right to the highest attainable standard of physical and mental health; and the right of children to special protection [11].

Accordingly, training for health care professionals on human trafficking should be informed by a [human rights-based framework](#). Fundamental to a rights-based approach is the core concept of “strengthening the capacities of rights holders [the trafficking survivors] to secure their rights” [13]. Therefore, the medical education of health care professionals should be grounded in a victim-centered, culturally relevant, evidence-based, gender-sensitive, trauma-informed perspective and include the essential components of prevention and identification of trafficking and treatment of trafficking-related health conditions.

Prevention. According to a US Department of Justice report, the majority (83 percent) of confirmed sex trafficking victims in the United States are US citizens [14]. Victims of sex or labor trafficking may be of any gender, age, or sexual orientation. Many victims have experienced prior trauma. Risk factors for future trafficking victimization include sexual abuse, physical abuse, emotional abuse and neglect, intimate partner violence, homelessness, and social marginalization [4, 15, 16]. Health care professionals who screen for and recognize these overlapping forms of violence and trauma have the opportunity to intervene and potentially prevent future trafficking victimization.

Identification. Studies have found that the percentage of victims in the United States who encounter health care professionals while under the control of the trafficker ranges from 28 percent [5] to 87.8 percent [17]. Traffickers may bring or allow the victims to obtain medical care either when their illnesses or injuries are interfering with their ability to work or for routine care such as STI testing and contraception [18]. In many of these cases, health care professionals may be the only professionals who interact with a victim while he or she is still being controlled. Even in the presence of a clinician, however, victims may not disclose their situation for numerous reasons, including language and cultural barriers, fear of the criminal justice system or of deportation, fear of repercussions from the trafficker (to themselves or to loved ones), distrust of health care professionals, and doubt that anyone can help them [9, 19]. Health care professionals must have an understanding of the “red flags” for trafficking and the barriers to disclosure in order to appropriately interview, identify, and assist victims [19]. Identifying and assisting trafficking victims brings trafficking survivors closer to the end of their cycle of violence.

Treatment. The wide range of acute and chronic medical and psychological conditions that affect trafficking survivors can be addressed through ongoing medical and psychiatric

care. Many will require months, years, or even decades of intensive care to recover from their traumas [8, 9].

In the care that survivors receive, a [trauma-informed approach](#) is crucial to avoid retraumatizing patients. Chronic trauma and its mental health sequelae can lead to somatization, distrust, and difficulty developing therapeutic relationships. Furthermore, lack of reliable housing, transportation, and employment, combined with frequent appointments with other social service providers and law enforcement personnel, can all contribute to medical noncompliance. If clinicians do not have an appropriate understanding of survivors' experiences and needs, the patients are at risk of being labeled "difficult," and clinicians risk burnout. Linking survivors to critical medical and psychological care, as well as to legal and social services, will provide them the protection and support they require for restoration and healing [6, 8, 9]. Because each interaction with a victim of trafficking is complex and critical, health care professionals must be thoroughly trained to engage in a multidisciplinary response that addresses the effects of trauma on victims' physical and mental health.

The Need for Education on Human Trafficking in Medical Training

Gaps in knowledge of human trafficking identification, care, and response are apparent among medical students, residents, physician assistants, attending physicians, nurses, and social workers [20-26]. For example, in a New York City-based study, only 4.8 percent of emergency medicine clinicians reported feeling confident about their ability to identify a victim of human trafficking [24]. A survey of survivors about their interactions with health care professionals demonstrated that, in addition to not being identified, they had been hurt, humiliated, and, in some cases, harmed by the actions of clinicians [27], highlighting the need for trauma-informed care training.

Several studies [20-21, 23-26], including a randomized controlled trial [22], have demonstrated that simple training can have a significant impact on clinicians' knowledge of trafficking and ability to recognize and care for trafficking victims. For example, prior to training, a majority of the students in a Michigan medical school either believed that the correct number to call to report a victim of human trafficking was 911 or were uncertain of whom to call. Following the presentation, a vast majority of students correctly identified the number 1-888-373-7888 (the National Human Trafficking Resource Center) [25]. Various modalities, including Grand Rounds-style didactics and online training, have shown promising results in increasing clinician knowledge of human trafficking for medical students and physicians. Core topics include definitions of trafficking; scope and scale of the problem; prevention; health consequences; a trauma-informed, multidisciplinary approach to identification based on trafficking indicators; and resources for response at the national level (i.e., the National Human Trafficking Resource Center hotline) and the local level (i.e., physical and psychological medical care,

hospital or clinic social work services, and other resources for shelter, substance abuse treatment, or legal services, based on survivor needs) [26, 28].

Progress and Resources

The state governments of Michigan and Illinois have recognized and addressed the lack of awareness of human trafficking among health care professionals by enacting laws that require or encourage training about trafficking [29, 30]. On the federal level, the US Department of Health and Human Services (HHS) launched the Stop, Observe, Ask, and Respond (SOAR) to Health and Wellness Training program in 2013 to provide human trafficking training to health care and other related professionals [31]. The training is part of the five-year Federal Strategic Action Plan on Services for Victims of Human Trafficking in the United States, 2013–2017 [32]. To inform the development and evaluation of the pilot training, HHS appointed a national technical working group comprising health professionals, survivors of human trafficking, and other subject matter experts. The trainings were held in September of 2014 in six cities across the United States. One hundred and eighty health care professionals, including physicians, nurses, dentists, and clinical social workers, were trained and received a three-month follow-up evaluation (results forthcoming) [31]. Recently introduced legislation in the US Senate would codify and further expand this training program on human trafficking [33].

The American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), the American Medical Women's Association (AMWA), the American Nurses Association (ANA), the American Psychological Association (APA), the American College of Emergency Physicians (ACEP), and other medical, nursing, and social welfare organizations have encouraged their members to receive training in and increase their awareness of human trafficking [34].

Additionally, a network of professionals called Health Professional Education, Advocacy, and Linkage (HEAL) Trafficking unifies and mobilizes interdisciplinary professionals in combating human trafficking and serves as a centralized resource on health care for the broader anti-trafficking community. HEAL Trafficking convenes multiple working groups that address various aspects of health and trafficking, including protocol development, education and training, direct services, prevention, and media and technology [35].

Conclusion

Human trafficking victims interface with the health care system every day and often leave undetected. Victims have numerous physical and psychological needs that require unique and compassionate care. A human rights framework should inform a medical education trafficking curriculum that is victim-centered, culturally relevant, evidence-based, gender-sensitive, and trauma-informed and that includes the essential components of prevention, identification, and treatment. By properly training health care

professionals, we can make our health care system a place of healing for victims of this egregious human rights abuse.

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Related in the *AMA Journal of Ethics*

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THE CODE SAYS

The AMA *Code of Medical Ethics*' Opinion on Interrogation of Detainees

Opinion 2.068 - Physician Participation in Interrogation

Interrogation is defined as questioning related to law enforcement or to military and national security intelligence gathering, designed to prevent harm or danger to individuals, the public, or national security. Interrogations are distinct from questioning used by physicians to assess the physical or mental condition of an individual. To be appropriate, interrogations must avoid the use of coercion—that is, threatening or causing harm through physical injury or mental suffering. In this Opinion, “detainee” is defined as a criminal suspect, [prisoner of war](#), or any other individual who is being held involuntarily.

Physicians who engage in any activity that relies on their medical knowledge and skills must continue to uphold principles of medical ethics. Questions about the propriety of physician participation in interrogations and in the development of interrogation strategies may be addressed by balancing obligations to individuals with obligations to protect third parties and the public. The further removed the physician is from direct involvement with a detainee, the more justifiable is a role serving the public interest. Applying this general approach, physician involvement with interrogations during law enforcement or intelligence gathering should be guided by the following:

- (1) Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others have access to information included in medical records. Treatment must never be conditional on a patient's participation in an interrogation.
- (2) Physicians must neither [conduct](#) nor [directly participate](#) in an interrogation, because a role as physician-interrogator undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.
- (3) Physicians must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation.
- (4) Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must not threaten or cause physical injury or mental suffering and must be humane and respect the rights of individuals.

(5) When physicians have reason to believe that interrogations are coercive, they must [report](#) their observations to the appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations.

Issued November 2006 based on the report "Physician Participation in Interrogation," adopted June 2006.

Related in the *AMA Journal of Ethics*

[Medical Associations and Accountability for Physician Participation in Torture](#), October 2015

[Professionalism and Conflicting Interests: The American Psychological Association's Involvement in Torture](#), October 2015

[Dual Loyalties, Human Rights Violations, and Physician Complicity in Apartheid South Africa](#), October 2015

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IN THE LITERATURE

Professionalism and Conflicting Interests: The American Psychological Association's Involvement in Torture

Nikhil A. Patel, MS, and G. David Elkin, MD

Hoffman DH, Carter DJ, Viglucci Lopez CR, et al. *Report to the Special Committee of the Board of Directors of the American Psychological Association: Independent Review Relating to APA Ethics Guidelines, National Security Interrogations, and Torture*. Chicago, IL: Sidley Austin; July 2, 2015.

On July 2, 2015, a 542-page report, "Independent Review Relating to APA Ethics Guidelines, National Security Interrogations, and Torture," was submitted to the Special Committee of the Board of Directors of the American Psychological Association (APA) [1]. This review was commissioned after a decade of intense scrutiny, principally by journalists and activist groups such as the Coalition for an Ethical Psychology, of the APA's unethical involvement with governmental agencies, particularly the Department of Defense (DoD) and the Central Intelligence Agency (CIA) [2].

The review highlights that the ethical guidelines on interrogation issued by the APA were intentionally ambiguous in the interest of currying favor with the DoD and CIA [1]. Given that the APA represents the interests of professional psychology, its condoning psychologists' participation in "enhanced interrogation" or torture had significant consequences. The report details how an APA ethics task force obfuscated the language of its ethical guidelines and *de facto* allowed psychologists to play a role in "[enhanced interrogations](#)" and [torture](#).

The Context

The 2002 White House Office of Legal Counsel's "torture memos" [3-5] laid the groundwork for the Bush Administration's approval of the CIA's use of "enhanced interrogation" methods. Central to the memos was a narrow definition of "torture" as acts that cause pain and "serious physical injury such as organ failure, impairment of bodily function, or even death" [3]. The temporary or long-lasting mental distress and psychological harm that detainees faced would not be considered torture if the interrogators had not "specifically *intended* to cause severe...mental pain or suffering" [4]. The argument was that interrogators would safeguard against potential abuses by "consulting with experts or reviewing evidence gained in past experience" [3]. Because the [American Medical Association](#) [6] and American Psychiatric Association [7]

prohibited their members from participating in torture, “experts” meant psychologists. Thus the American Psychological Association’s statements on ethical matters are not merely abstract ideals, but instructions for psychologists, including those working in the government sector.

Conflicts of Interest at the APA

In 2005, the APA’s “Presidential Task Force on Ethics and National Security” (PENS) was convened by then-APA President Ronald F. Levant, EdD. The mandate of the task force, led by APA Ethics Director Stephen Behnke, PhD, JD, was to functionally define ethical practice for psychologists working in interrogation of detainees. There was a conflict of interest in the formation of the commission, inasmuch as six of ten participants were DoD psychologists and only three were not, and the report asserts that this was intentional [1].

Although the PENS Task Force was ostensibly responding to criticism of its involvement in intelligence activities in a serious manner [2], the report reveals that Dr. Behnke crafted much of the language ahead of time and kept it vague and nondescript [1]. A major objective was to produce guidelines that minimally constrained DoD psychologists [8].

As a profession that is involved in the provision of vital mental health care, why would the APA want to cooperate with the DoD? The principal motives, as outlined in the report, were twofold. First, the DoD has endowed psychologists with benefits such as grants and contracts, and there was even a small program in the 1990s that allowed DoD psychologists to have prescribing privileges—a contentious, long-standing scope-of-practice issue between psychologists and psychiatrists. The report surmised that APA officials wanted to ensure that psychology stayed relevant to DoD intelligence activities. While the 2005 PENS Task Force was also intended to demonstrate to the public that the APA was introspective and thoughtful about issues of professionalism and ethics, one of the motives behind it was to cultivate and support military psychologists’ work and avoid placing concrete constraints on what was “right” for its members to do.

The Task Force and the Creation of Dual Loyalties

“Safe, legal, ethical, effective” was the framework that the PENS task force approved to guide psychologist participation in interrogations [1]. Only two of the criteria created by a group formed to analyze “ethics” addressed ethical issues, and the criteria seem to be at odds with each other. “Enhanced interrogations” are purportedly intended to extract essential information to protect the homeland from nefarious elements. The torture memos argued that mental health professionals would prevent abuse by monitoring the interrogations and making them *safe*. But how can psychologists safeguard against torture when they have loyalties not only to their “patients,” the detainees, but to their superiors within the DoD and the goal of obtaining information? Can one be hired to help

exploit detainee psychological vulnerabilities, such as specific phobias, and at the same time ensure that the detainees are not tortured? The former makes interrogations more “effective,” but a more “effective” interrogation is probably not “safe” or in the best interests of the detainee. Standard 1.02 of the APA Ethics Code, revised the same year as the release of the torture memos, stated that, if there was conflict between a psychologist’s ethical obligations and legal authority, deference ought to be provided to the legal authority [9]. Such guidance disrupts the tenuous balance in the notion of [dual loyalties](#), instructing psychologists to put the government’s aims above those of the profession.

Even if there were not such extreme conflicts of interest, there is no evidence that psychologists or other professionals can prevent, or even remain immune to, abusive behavior in such a setting. The classic “Stanford Prison Experiment,” conducted by Philip Zimbardo (APA President in 2002) showed that, when college students were assigned to play the roles of “prisoners” receiving punishment and “guards” meting it out, the “prisoners” became passive and some of the “guards,” aggressive and dehumanizing [10]. The prison guards were said to be experiencing “behavioral drift.” The argument made in the torture memos that psychologists could prevent this from happening does not pass muster. No evidence has surfaced in the literature to suggest that certain professionals are immune to behavioral drift or that they could mitigate the outcomes of it.

Psychologist Involvement with Torture: A Violation of Multiple Norms

A violation of medical ethics. “Primum non nocere” (first, do no harm) is a central ethical tenet that applies to all health care professionals, including psychologists. Society trusts us to provide high-quality, ethical care to those who seek our help. While we may not be able to heal all of our patients, this principle of nonmaleficence is a pillar of bioethics that must be considered in deciding whether we are doing “right” by those under our care. As the United Nations (UN) declares: “It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health” [11]. The fact that the ethics leadership at the APA ensured that the ethical guidelines would be written with the operational interests of the DoD in mind is an affront to the independence and integrity of the profession of psychology.

The guidance that psychologists should defer to legal authority in conflict with professional norms has an alarming similarity to the “Nuremberg defense,” in which doctors on trial after the horrors of the Holocaust argued that they were simply following the orders of their commanding officers and that their actions were legal at the time [1]. An action’s being legal for citizens in general or military officers does not make it ethically acceptable for members of a healing profession.

A violation of international law. Furthermore, psychologists' and the US government's role in condoning torture ultimately contravenes international law, such as the UN Convention Against Torture which outlines in article 1 that "torture" is:

any act by which severe pain or suffering, *whether physical or mental*, is intentionally inflicted on a person for such purposes as obtaining from him, or a third person, information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity [12; italics added].

Article 2 states specifically that there are "no exceptional circumstances whatsoever" [12].

The Geneva Conventions, created in response to the brutality of war, were wantonly disregarded. The Third Geneva convention was written to protect prisoners of war, as stated in Common Article 3:

Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed *hors de combat* by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria [13].

It seems that, too easily, international law is perceived as a mere obstacle to ensuring national security. The United States position has been that those captured in combat are not prisoners of war but in fact detainees who are not entitled to the rights ensured by the Geneva Conventions. Arguments are often made that if we are following these codes and our enemy is not, we are leaving ourselves open for more brutal attacks. But, indeed, they are the codes and values we are fighting to protect.

The Way Forward: Individual Responsibility

As this piece was being written, the voting membership at the APA national meeting unanimously banned the involvement of psychologists in torture in no uncertain terms [14]. Although activists may argue that this is too little, too late, progress can be made, and without reports like that of the Hoffman et al., this positive step forward would not have been possible.

Although the Special Committee report concerns only the APA's involvement in torture, other professions have found themselves in similar positions or may do so in the future. The history of medicine is plagued with [violations of human rights](#). Psychiatric asylums in the era prior to antipsychotics often violated the basic human dignity of individuals with severe mental illness [15]. The Tuskegee experiments selectively targeted African American men and violated their human rights and dignity [16]. [Wartime abuses](#) by physicians have been well-documented. Having once violated society's trust, it may be difficult to regain it.

We must use critical thought to distinguish what is ethical from what is lawful and to consider what it means to be a professional. Therefore, we must continually [question and re-question authority](#), whether it is the law or a code of ethics, or else we may be doomed to serve the interests of those who crafted the code, not necessarily the interests of those who need to embody the code or use it to guide their practice. Just because a principle is codified does not make it ethical. Ethics is not an abstract exercise but one of importance and consequence, as the Hoffman et al. report illustrates. It is our individual responsibility to safeguard the values of the profession.

Organs of power do not move easily—inertia is often the default—but individuals also have power: power of conscience, power of knowledge, and power of organizing. Professional education needs to ensure that the history of professional participation in human rights abuses is not forgotten but discussed and grappled with. Cycles of abuse need not be repeated. As custodians of mental and physical health care, it is our obligation to ensure that they are not.

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STATE OF THE ART AND SCIENCE

Humanitarian Uses of Drones and Satellite Imagery Analysis: The Promises and Perils

Amos Lichtman, MPH, and Mohit Nair

Introduction

The pace of development of new technologies and their application to humanitarian purposes has outstripped careful, ethical consideration of the consequences of their use. Technologies that were once available only to governments and military have become affordable and within reach of individuals and humanitarian organizations. This diversification of uses from initial military applications brings with it questions that reflect [long-recognized challenges](#) of humanitarian work. When the international community responds to military conflict or natural disaster, how do we ensure that the voices and perspectives of members of the affected communities are heard? What threats to the core humanitarian principles of impartiality and respect for the independence of those being aided do these technologies bring with them? We consider here two examples of technologies that highlight these challenges: drone use in humanitarian disaster response, and satellite imagery analysis to document and prevent mass atrocities.

Military Use of Drones

The term “drone” refers to many different types of machines, some small enough to be handheld and some large enough to drop bombs and fly at higher altitudes than those being used for documenting the extent of earthquake damage [1]. Drones are better known outside of humanitarian aid, which might explain why the less sinister-sounding term “unmanned aerial vehicles” (UAVs) is used in most contexts that advocate for humanitarian applications [2, 3]. The US military has been conducting drone strikes in Pakistan for a decade, averaging one every three days in 2010 (a number which has since decreased) [4]. These strikes target people who are believed to be participating in terrorist organizations, but they have also killed large numbers of civilians—an estimated 3,000 in Pakistan [5, 6]. The effect of these continued strikes on Pakistani civilians has been documented in the report, *Living under Drones* [7]. In addition to causing death and injury, the repeated strikes and frequent hovering of drones has resulted in civilians’ becoming afraid to help injured victims, produced psychological trauma, and led to parents’ keeping their children home from school out of fear [7].

Drone Use in Humanitarian Response

Humanitarian efforts in response to wars and disasters have a long history of ethical [challenges](#) and [mistakes](#). Images of food aid being dropped off the backs of pick-up trucks are often used to illustrate past failures to respect the dignity of affected populations and to ensure equal access to aid for vulnerable groups. Increasing emphasis has been placed on the inclusion of affected communities and organizations in planning the response to a disaster. These principles cannot be abandoned when new technologies such as drones are introduced into humanitarian response.

The use of drones in humanitarian aid has a short history, but it has proliferated rapidly enough and generated enough interest that the United Nations (UN) Office of Coordination of Humanitarian Affairs (OCHA) produced a report on the topic in June of 2014 [8]. The potential uses are multifaceted and are likely to grow rapidly as technology and coordination improve. They include mapping of disaster-affected areas, search and rescue assistance, and procurement and delivery of aid materials. These applications, especially the mapping of damaged areas, already showed promise during the Haiti 2010 earthquake [9], and drones have been employed similarly in Nepal, producing powerful images of the devastation caused by the earthquake [10]. In addition to their use in mapping, these images received a great deal of media attention for possibly aiding in the location and rescue of trapped earthquake survivors [10]. With drones' cutting-edge technology and dramatic human rescue stories, it is easy to see why. It has also been suggested that drones could be used to deliver emergency supplies to hard-to-reach locations [11].

If mapping, surveying, and provision of food and non-food items are to be conducted by drones, however, already marginalized voices of disaster victims must be protected and the expectations of people accustomed to seeing military drones flying overhead must be recognized.

Is it fair to consider the connections between these two diametrically opposed uses of drone technology? After all, the use of drones is increasing rapidly, and they are being deployed for a wide range of purposes such as rainforest mapping and home delivery [12, 13]. In the technology-obsessed US, excitement over new toys for recording ski videos is far more salient than fear over big-brother style surveillance [14].

Yet it *is* crucial to consider the connection between humanitarian and military uses of drones. Civil-military cooperation is central to much of US humanitarian response in general, with the military possessing immense and unparalleled logistical capacity thanks to its \$520 billion budget (about 40 percent of the world's total military expenditure) [15, 16]. This capacity makes the necessity of military participation in humanitarian response inevitable for the foreseeable future. Because of its extensive involvement in wars across the world and widespread military bases, the US military is,

to some extent, the face of the US in many countries. Many of these countries also happen to be among the most vulnerable to natural disasters.

These considerations suggest that the actions and image of the US military have critical implications for humanitarian response. Two weeks after the April 25 earthquake in Nepal, the Nepalese government issued a ban on the use of drones in the humanitarian response without prior permission from the Civil Aviation Authority [17], due to concern over the gathering of sensitive information and the photographing of important cultural heritage sites. This demonstrates that cooperation with those who are receiving aid must be part of the introduction of drones in humanitarian response.

In a report, the UN Special Rapporteur on extrajudicial, summary or arbitrary executions raised concerns that the use of drones and other remote technologies in police work could remove protections against the unnecessary use of force and violate human rights. The report specifically brought up issues of accountability, stating “The decreased personal involvement of police officers in the deployment of force raises the question, among others, of who is responsible if things go wrong” [18]. The UN, however, has itself used unarmed drones for surveillance in the Democratic Republic of the Congo as a *deterrent* to violence against civilians [19]. While its purpose is distinct, this surveillance does not seem qualitatively different from military or police surveillance using drones. This contrast highlights that the humanitarian potential and military applications of drones are ethically linked. Surveillance in conflict areas for the purposes of deterrence and documentation is also performed using satellite imagery. Additional ethical issues arise with this technology, which we discuss below.

Humanitarian Use of Satellite Imagery Analysis

In 2012, the Harvard Humanitarian Initiative (HHI) officially launched the Signal Program on Human Security and Technology, which plans to “conduct participatory action research about how technology can prevent and document threats to human rights” and translate lessons learned into the “first-ever research and academic program for the practice, study and teaching of crisis mapping” [20]. The program builds on the pilot phase of the Satellite Sentinel Project (SSP), which monitored threats to human security along the Sudan-South Sudan border, galvanizing the practice of predicting threats to civilians living in conflict zones before they materialized. Since 2010, SSP has analyzed satellite imagery and built maps and software. The reports to which this information contributed confirmed the destruction of more than six villages in Sudan and provided evidence of eight mass grave sites and indiscriminate civilian bombardment in South Kordofan, and they were subsequently used by the International Criminal Court [21]. The promises of the technology are significant, ranging from, at best, effective tracking of warning signs of threats to human rights (such as an accumulation of troops or tanks in an area) before they occur to, at worst, documenting atrocities and gathering evidence for future investigations.

Ethical Ramifications of the Program

While imagery analysis is instrumental in bringing human rights violations to light, it is often insufficient evidence of human rights violations by itself. Corroborating evidence is required, and the ability to obtain direct evidence is often limited [22]. HHI has developed its own protocol for what constitutes an adequate level of certainty for analytic conclusions from the imagery and geo-coded data [23]. While this has improved the predictive capabilities of the research, it is not clear whether this is sufficient to justify action and decision-making at the policy level. Since the analysts of the program do not have access to classified government intelligence, the outcomes of the analysis cannot be compared and reassessed based on the totality of available evidence, making the relevance of the findings unclear [23].

An article in the *International Business Times* succinctly presented the crux of the ethical dilemmas surrounding the widespread adoption of this technology: there is no precedent for its use and the collaborative project is “making the rules as they go, albeit rules within the strictures of international law” [24]. Since the satellites are not technically in Sudan’s airspace (and hence not a violation of national sovereignty) and are owned by a private corporation rather than a government, there is no violation of international law [24]. In addition to legality, though, the lack of precedent makes a careful ethical appraisal crucial. When is it justified to act on incomplete evidence in order to prevent harm if the consequences of this action are difficult to predict? In answering this question, significant questions must be resolved about the potential for cross-collaboration between research analysts, governments, and international bodies and about the formulation of a new legal code for those countries that are being mapped.

Conclusion

It is inevitable that new technologies will be incorporated into the field of humanitarian response, and many will help to save lives. Each technology and each new application will bring with it unintended consequences that must be carefully considered, as we have shown in the cases of drones and satellite imagery analysis. There is a danger in ignoring these consequences in the midst of enthusiasm for revolutionary potential. As our methods of providing care after disasters and protecting civilians during conflict evolve, we must always strive to do better in working with and respecting the dignity of those affected.

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HEALTH LAW

***King v. Burwell*: US Supreme Court Extends Tax Credits for Health Insurance Coverage to All 50 States**

Tobin Klusty and Stephanie Bi

On the morning of June 25, 2015, the Supreme Court decided *King v. Burwell*, a landmark case regarding the [Patient Protection and Affordable Care Act \(ACA\)](#). At the heart of the case is the statutory interpretation of a phrase in a provision dealing with the distribution of tax credits for the purchase of health insurance on the health insurance marketplaces known as “[exchanges](#)” [1-3]. The extension of federal tax credits to lower-income citizens for the purchase of health care is one of three major reforms mandated by the ACA [4]. The plaintiffs argued that those who bought insurance on federal exchanges were not eligible for tax credits because the states in which they resided had not created their own exchanges, and the ACA only provided tax credits to citizens who used “an Exchange established by the State” [5]. The defendants, several government agencies, claimed that exchanges created by the federal Department of Health and Human Services (HHS) qualified as exchanges “established by the State” [6]. After much testimony, the Supreme Court interpreted the phrase to include the federal HHS exchanges [7], thereby making users of HHS exchanges eligible to receive tax credits [7].

As mentioned, the ACA contains three reforms for extending health insurance coverage to all United States citizens. First, Congress created [insurance market regulations](#) that prohibit insurers from raising premiums or denying coverage to anyone because of a preexisting health condition [8]. Second, Congress required that all citizens purchase health insurance or pay a tax [8]. This “coverage mandate” is essential to the insurance market reforms because it prevents people from waiting until they are sick to purchase coverage, which would lead to dramatic rises in premium costs for those who are continuously insured [8]. Lastly and most relevantly, Congress offered “tax credits to individuals with household incomes between 100 percent and 400 percent of the federal poverty line” [9]. So an individual purchaser with an income between \$11,770 and \$47,080 or a family of four with an income between \$24,250 and \$97,000 would qualify for tax credits to purchase insurance [10]. The tax credits prevent the coverage mandate from causing unfair financial hardship to lower- and middle-income citizens.

The Case

The phrase at issue concerns this last provision—the disbursement of tax credits. The ACA sets forth a framework for each state to create a health insurance marketplace, called an “exchange,” through which individuals can compare and purchase coverage

plans [11]. The ACA explains that “[e]ach State shall...establish an...Exchange [12],” but provides that the Secretary of Health and Human Services will create “such Exchange” if a state chooses not to do so itself [13]. Further, section 36B of the Internal Revenue Code (part of the ACA) states that citizens are only eligible for tax credits if they find coverage through “an Exchange established by the State under” 42 USC section 18031 [14], but an Internal Revenue Service (IRS) regulation claimed tax credits were available to users of all exchanges, including those created by the federal HHS [15, 16]. The question addressed by the court was whether HHS exchanges qualified as exchanges “established by the State.”

Arguments

The plaintiffs argued that the plain meaning of the phrase “established by the State” precludes citizens in states with HHS exchanges from receiving federal tax credits [5]. The plaintiffs were Virginian citizens who filed claims against US Secretary of Health and Human Services Sylvia Burwell, US Secretary of the Treasury Jacob Lew, Commissioner of Internal Revenue John Koskinen, and their respective departments [17]. The plaintiffs alleged that the IRS rule altered a clear and unambiguous portion of the ACA [18].

Virginia was one of the 34 states that did not establish its own exchange [19]. According to the IRS rule, people must comply with the ACA’s coverage mandate when the annual cost of coverage amounts to less than 8 percent of their projected income, including the eligible tax credits [20]. When the IRS rule proclaimed that tax credits were available not only to users of state exchanges but also to users of HHS exchanges, the plaintiffs were held to the coverage mandate because the tax credits pushed the cost of coverage just below 8 percent of the their incomes [19]. The plaintiffs claimed that they should not have been subjected to the coverage mandate because the language of the ACA restricted tax credits to state-created exchanges and Virginia had not created a state exchange [21]. If the ACA clearly and unambiguously restricted tax credits to users of state exchanges, the plaintiffs argued, the IRS could not change the law’s meaning [22]. The plaintiffs also argued that Congress’s intention was to restrict tax credits to users of state exchanges to encourage states to create and operate their own exchanges [23].

The defendants—the government—argued that the text and structure of the ACA make tax credits available in all states [24]. They claimed that “established by the state” is a “term of art” that encompasses both an exchange created by a state and an exchange created by HHS on behalf of a state [25] and that, when HHS is directed to “establish and operate *such Exchange* within the State” if the state does not do so itself, the term “such Exchange” conveys that the HHS is acting as a surrogate for the state [26].

The defendants maintained that giving the phrase the limited reading the plaintiffs requested would change the meaning of other ACA provisions. For example, the definition of a “qualified individual” as a person “who resides in the State that

established the Exchange,” would mean there are no “qualified individuals” in states with HHS exchanges [27]. Secondly, they contended that the coverage mandate “could not perform its market-stabilizing function” without the tax credits [28]. Also, the alleged implication of loss of subsidies to residents of a state choosing not to develop and maintain its own exchange is located in “isolated phrases” of the tax code that discuss the calculations for an individual’s tax credit. On the plaintiffs’ reading, according to the defendants, this easy-to-miss qualification would not give clear notice to states of the drastic implication of utilizing an HHS exchange [29].

Much of the defendants’ argument focused on the validity of the IRS interpretation of the rule rather than the validity of the rule itself, but it also claimed that the IRS rule should be given deference if the court still found ambiguity about whether an HHS exchange qualified as “an Exchange established by the State” [30]. Under *Chevron* deference—a framework established in *Chevron USA Inc. v. Natural Resources Defense Council, Inc.*—the Supreme Court is required to give deference to a government agency’s interpretation of a federal statute when the “statute’s ambiguity constitutes an implicit delegation from Congress to the agency to fill the statutory gaps” [31]. The Supreme Court had to decide whether to give deference to the act’s Congressional purpose when reading the phrase or simply apply the plain meaning of the words contained in the phrase.

On March 4, 2015, the Supreme Court heard argument from both parties to the case. The oral arguments foreshadowed the Supreme Court’s decision on the matter. Michael A. Carvin, representing the plaintiffs, submitted that the specific wording in provision 36B eliminated ambiguity created by previous definitional sections [32], that Congress “was not agnostic as between State and Federal Exchanges” [33], and that, although considering context was important, providing tax credits to federal exchanges would have “essentially gutted Section 1311’s strong preference for State Exchanges” [34].

Solicitor General Donald B. Verrili, Jr. represented the US government. He argued that the context of the law must be taken into account in interpreting provision 36B, citing the 2000 case *FDA v. Brown & Williamson* [35]. Verrili argued further that, according to section 18041 of the ACA, the federal government would be acting on a state’s behalf by creating an exchange that would function in the same manner as a state-established exchange [35]. Finally, he argued that, during the public hearing about rulemaking “covered by C-SPAN,” the states were not aware of the alleged state exchange-only tax credit stipulation, which would have been pointed out conspicuously had the plaintiffs’ reading been the one intended by Congress [36].

Decision

On the morning of June 25, 2015, the Supreme Court issued a 5-4 decision in favor of the US government, finding that the ACA provides tax credits to buyers on both federal and

state exchanges [3]. The decision addressed three matters: whether the IRS's interpretation should be given deference according to the "*Chevron* deference" framework; whether the language of provision 36B is ambiguous; and how it should be interpreted in light of the rest of the document and Congress's intentions.

As for deference to the IRS's interpretation, the court declared that Congress would not implicitly leave the IRS, a body that lacks expertise in dealing with health insurance policies, to interpret a question of "deep 'economic and political significance'" [22] involving billions of dollars of federal tax money and the health care of millions of people. Hence, if the IRS were intended to interpret such a question, Congress would have explicitly stated so. Without deference to the IRS's interpretation, the Supreme Court had to interpret the statute for itself.

Per Supreme Court precedent, "[i]f the statutory language is plain, [the court] must enforce it according to its terms" [37]. To determine whether the language was plain, the court interpreted the words "in their context and with a view to their place in the overall statutory scheme" [38]. First, the court looked to section 18041, which states that the Secretary "shall...establish and operate such exchange within the State" if the state chooses not to do so, deeming that "such exchange" denotatively means "State Exchanges and Federal Exchanges are equivalent—they must meet the same requirements, perform the same functions, and serve the same purposes" [22]. Next, the court looked to another part of the act, which required "all Exchanges to make available qualified health plans to qualified individuals," with "qualified individual" defined as an individual who "resides in the State that established the Exchange" [39]. In this context, if "State" were given its most "natural" (that is, most commonly understood) meaning, then there would be no qualified individuals on federal exchanges,—clearly not the intended meaning [40]. The court concluded that the provision "established by the State" does not always convey its most natural meaning and is, therefore, ambiguous [39]. Supporting its conclusion, the court cited examples of "inartful drafting" within the ACA attributed to the methods Congress used to pass the act, which provided evidence that "established by the State" was used as a "surplusage construction" rather than as a phrase limiting application to state exchanges [41].

Having established the ambiguity of the phrase "established by the State," the court further explained that, because "a provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme" and "only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law," it was the duty of the court to interpret provision 36B under the "broader structure" of the document [42]. The court noted that if the tax credits were not given to all "individuals with household incomes between 100 percent and 400 percent of the federal poverty line," the "tax credit" arm of the ACA's reforms would be ineffective and thereby cause the collapse of the other two reforms—the individual coverage mandate

and the insurance market regulations [43]. The court reasoned that this surely could not have been the intention of Congress [44]. From the court's perspective, Congress had created section 18041 as a fallback option for states' citizens to receive tax credits regardless of whether the state chose to set up its own exchange, not as a means of coercing states to create them [44]. Further, the court reasoned that Congress would not have buried such a potentially deal-breaking provision deep within an esoteric "sub-sub section of the Tax Code" [45].

It also restated that, if a state fails to establish an exchange, HHS is required to do so in its place and that, therefore, a federal exchange qualifies as an exchange [39]. It pronounced that, based on Congressional intent and the structure of the document, the only permissible interpretation was that tax credits were available to citizens who purchased insurance through both federal and state exchanges [45].

The Supreme Court's decision prevented the collapse of the ACA and upheld the ability of millions of Americans to afford health insurance coverage. If the Supreme Court had ruled in favor of the plaintiffs, about 6.4 million people would have lost the tax credits that helped them afford coverage [46]. In addition, the decision would have affected all purchasers of insurance because insurance pools would become older and sicker, driving premiums upwards [46]. Applying the plain meaning of six words would have had [severe consequences](#) for individuals and for the health insurance market.

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POLICY FORUM

Medical Associations and Accountability for Physician Participation in Torture

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Doctors are integral to the practice of modern [torture](#). Some devise torture techniques (like rectal water infusions) in order to minimize incriminating scars. Some monitor and treat prisoners undergoing torture in order to prevent them from unintentionally dying. Some falsify medical records and death certificates to assist regimes in concealing [injuries or deaths from torture](#). Many claim to act under duress, but the example set by the majority of their national colleagues who either fight against torture or [refuse to collaborate](#) with the practice belies such claims [1].

Torture doctors work for fascist dictatorships such as China, Uzbekistan, and North Korea. They also work for democracies such as the United States, Portugal, and Spain. Some see and ignore torture victims who are brought by police or soldiers to public clinics or hospitals. Others hold military rank or contracts with police and see tortured persons in government prisons.

Torturing with Impunity

After World War II, only a few of the several hundred Nazi torture doctors and none of the Japanese torture doctors were punished [2, 3]. In 1947, the new World Medical Association (WMA) endorsed a British Medical Association working paper that asserted that doctors who participated in torture were personally responsible and should be individually punished to deter such acts [4]. The WMA called on the German medical associations to expel such doctors, thereby revoking their medical licenses, and endorsed criminal “judicial punishment of such crimes” [5].

But doctors’ torturing with impunity remained the rule for decades. A fair amount is known about Soviet-era psychiatric abuse of dissidents; none of the doctors involved were punished. Germany ignored Stasi torture doctors. Great Britain gave a free pass to physician participation in torture during decolonialization and the more recent “troubles” in Northern Ireland [6]. Although, in 1992, the British Medical Association recommended that alleged torture doctors be “fully and fairly investigated and that those found culpable [be] barred from medical practice and from membership in *professional associations*” [7], it explicitly said in 2009 that it would not investigate allegations against physicians [8]. The United States and its professional associations have allowed medicalized torture in “war-on-terror” prisons to pass without punishment or censure [9-11]. There is sketchy knowledge of physician complicity with penal amputations and

flogging across the Arab and Asian world, and the commonplace medical collaboration with torture in the world's prisons and police stations (for example, in India) is only dimly outlined [11-18]. The Doctors Who Torture Accountability Project lists 89 countries where it is confirmed that doctors have collaborated with torture with complete impunity [19]. (The site is unable to assess whether physicians have collaborated with torture in 49 additional countries, even though many of these countries are known to torture.) A huge amount of work is needed to discover the full extent of medical complicity with torture.

Attempts to Hold Doctors Accountable for Participation in Torture

In 1975, a Greek physician, Dimitrios Kofas, one of many government officials who tortured for the military junta, was prosecuted [20, 21]. He was court martialed, sentenced to jail, served at least part of his time, and is apparently now practicing medicine again.

A broader effort to systematically punish torture doctors arose during the years of crumbling juntas in Argentina, Brazil, Chile, and Uruguay [7]. The human rights movement supplies the energy that spurs medical boards or courts to pursue these physicians. In Brazil, Chile, and Uruguay, medical associations, in collaboration with local and international human rights groups, took the lead. The Medical Association of Argentina took no action; courts punished torture doctors as criminals, sending ten to jail, and several trials are still ongoing [19]. Since Kofas's punishment, the cases worldwide have continued to accelerate—12 physicians were punished by medical groups or courts in the '80s and 20 in the '90s, and there have been 51 more cases since the turn of the century [19]. By 2015, the number of countries in which torture doctors had been punished had risen to 16 [19]. In sum, since 1975, 85 physicians from 16 countries (Argentina, Brazil, Chile, Egypt, Great Britain, Greece, Guyana, India, Italy, Pakistan, Rwanda, Sri Lanka, Serbia, South Africa, Turkey, and Uruguay) have been punished for abetting torture or war crimes [19].

I note from personal review of public and private primary sources that this period has also witnessed an accelerating number of failed prosecutions, which are only partially countable because of rules and laws regarding confidentiality. These prosecutions, although unsuccessful, are nevertheless a sign of the increasing strength of the movement to hold physicians accountable for torture, as they are part of the expanding base of prosecutions upon which successful prosecutions rest.

Why Punish Torture Doctors?

Although courts, medical licensing boards, and medical societies have different purposes and powers, it is worthwhile for any of them to hold torture doctors accountable. Courts punish crimes and may impose prison terms or fines or order restitution. Licensing boards are stewards of medical professionalism; they often revoke or suspend the

licenses of physicians who have violated trust in the profession. The loss of a medical license is a serious punishment. Punishments may be levied for dishonorable conduct, such as sex with a patient, even when such acts are not illegal. In this sense, the discretionary power of medical boards extends beyond the law and does not require conviction of a crime. Medical societies are also stewards of medical professionalism, although their punishments are limited to censure and expulsion.

Some argue that physicians' institutions should not press for accountability [22]. According to this view, since it is governments that authorize torture, responsibility for reform and accountability is a political or judicial responsibility. The problem with this argument is that regimes, including their courts, are loath to act against physicians who tortured in the course of their government service. Demurral by medical institutions comes at a high price, however.

- It [violates the public trust](#) that doctors will advance and preserve the health of all persons.
- It offers a welcome cover to doctors who abet torture or are considering doing so and puts medical institutions in the position of being tacitly complicit with violating and undermining international law.
- It encourages officials in torturing regimes to believe that they can safely trust doctors to abet and conceal their crimes.
- It deprives tortured prisoners and their relatives of solidarity from a respected element of civil society that has important connections to human rights advocates.
- It undermines international solidarity. Physicians protesting torture and tortured persons in other nations need global support.

In its most fundamental sense, accountability is less about punishment than about driving a wedge between torturing governments and the doctors whose help, fraud, and silence they condone. Accountability for doctors' behavior allows light to shine on a nation's darkest places.

How to Promote Accountability for Torture Doctors

Several steps are required to advance holding torture doctors accountable.

First, national medical associations must endorse strong standards against physician complicity, such as the WMA's "Declaration of Tokyo—Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment" [23]. The World Medical Association, founded in response to the abuses of Nazi medicine, should require national medical associations to endorse such standards as a condition of membership. In response to the 1997 flight of several African and Asian doctors to Europe to avoid prosecution for war crimes, the WMA passed "Statement on the Licensing of Physicians Fleeing Prosecution for Serious

Criminal Offences,” which asserts that “a physician who perpetrates such crimes [torture, war crimes, or crimes against humanity] is unfit to practice medicine” [24]. It urged national medical associations

to ensure that physicians against whom serious allegations of participation in torture, war crimes or crimes against humanity have been made are not able to obtain licenses to practice until they have satisfactorily answered these allegations. National medical associations that do not have licensing powers should inform the appropriate licensing authorities of information they receive regarding physicians against whom serious allegations of participation in torture, war crimes or crimes against humanity have been made, and should encourage the licensing authorities to take appropriate actions to ensure that such physicians have satisfactorily answered these allegations before granting them licenses to practice [24].

Such a standard should apply not only to immigrant physicians but also to physicians in their own countries.

Second, the WMA should compile and endorse procedural guidelines and casebooks to show courts and medical boards how to convene and conduct cases against doctors who are alleged to have tortured. The WMA should also publish a comprehensive online index of cases of physicians who have been punished by a court or licensing board for torture or other war crimes. These two steps would show that prosecution and punishment of torture physicians is possible.

Third, the WMA should establish a secure web portal to enable persons to report allegations of physician complicity with torture to the United Nations Rapporteur on Torture and/or other human rights groups for investigation.

Fourth, national medical associations should support legislation and policies to ensure that state licensing boards may restrict or revoke licenses for war crimes and torture even without a criminal conviction because they constitute unprofessional conduct. Licensing boards should inform their practitioners of this position, as happened in California [25].

Fifth, national medical associations and the WMA should perform and publish audits to assess whether courts and licensing boards are holding torture doctors accountable. Such audits should assess the *general* performance of accountability rather than oversee individual cases. For example, a finding that there is ample evidence that physicians in the United States, Portugal, Israel, Russia, and Singapore have abetted torture and that no censure or sanctions have been levied would suffice.

Conclusion

The partnership between torturers and physicians can be summarized as follows:

- Physician involvement in torture coextends with the global practice of torture.
- Physicians play key roles in designing, implementing, monitoring, and concealing torture.
- Lack of accountability for physician torturers is the norm. Licensing boards rarely revoke or suspend licenses, medical associations rarely censure, and courts rarely convict torture doctors.
- Major medical associations do not offer standards or model procedures for holding torture doctors accountable.
- Accountability, although rare, is becoming more common because of pressure arising outside of the medical profession [26].

Torture, although global, is decreasing. The end of chattel slavery, ecclesiastical torture, and the illegalization of state torture had the most dramatic impact [27]. It is past time for the medical community to firmly place itself against impunity for its torture doctors.

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POLICY FORUM

Forced Sterilizations of HIV-Positive Women: A Global Ethics and Policy Failure

Stephanie Bi and Tobin Klusty

In an attempt to combat mother-to-child HIV transmission, there has been a preponderance of forced sterilizations of HIV-positive women in countries around the world, especially those with high HIV rates [1, 2]. "Forced sterilization" is a sterilization procedure, such as tubal ligation, performed without informed consent from the patient [3]. Forced sterilization violates the human right to autonomy and the principle of informed consent. Although the practice conflicts with their ethical duties, many physicians still forcibly sterilize HIV-positive women in an attempt to limit mother-to-child transmission of the virus [4-7]. This practice further marginalizes these women, who can already face discrimination due to the [stigmas](#) associated with womanhood and HIV [8]. South Africa, Namibia, and Chile all provide examples of the widespread use of and legal advocacy against this marginalizing practice [1, 2, 4, 9-17]. This is clearly a pressing ethical problem that reflects global discrimination against women with HIV. All nations must restrict forced sterilization by implementing and enforcing appropriate policy.

Forced Sterilization in South Africa, Namibia, and Chile

The country that has perhaps received the most attention for forced sterilization from the media and researchers is South Africa, due to the irony of its highly progressive laws concerning women's sexual and reproductive rights [9]. South Africa was the first country to grant the right to "health care, including reproductive health services" in its national constitution [10]. In addition, a 1998 South African law prohibited sterilization without informed consent [11]. Despite the promise of these progressive laws, enforcement is sorely lacking. For example, a South African study for the Her Rights Initiative interviewed 22 women who were sterilized and given no legal justice [4]. Eighteen of these women were coerced into signing consent waivers, which protected the medical staff from liability [4].

A neighboring country, Namibia, is facing the same problem [12], although, to some degree, Namibia has addressed the issue in its courts. In 2014, the Namibian Supreme Court upheld the High Court's ruling that medical personnel at public hospitals had sterilized three HIV-positive women without their consent [13]. The Court ruled that "individual autonomy and self-determination are the overriding principles towards which our jurisprudence should move in this area of the law" [13] and declared that "[t]hese

principles require that in deciding whether or not to undergo an elective procedure, the patient must have the final word" [14].

In Chile, forced sterilization of HIV-positive women is widespread, and legal advocacy has been less effective. A 2004 study showed that 12.9 percent of sterilized HIV-positive women had been sterilized without consent and 29 percent had consented under coercion [15]. In *F. S. v. Chile*, the advocacy groups Vivo Positivo and Center for Reproductive Rights sued on behalf of a 27-year-old HIV-positive woman who was sterilized during a cesarean section without her knowledge [15]. Following several years of unsuccessful litigation, the advocacy groups filed a complaint with the Inter-American Commission on Human Rights (IACHR) in 2009 [16]. Four years later, the commission announced it would hear the case—the first it has admitted related to HIV-positive women's sexual and reproductive rights [17]—which is still pending.

Forced Sterilization as a Violation of Medical Duty

Physicians performing forced sterilizations are violating not only internationally-recognized human rights, but also their duties as medical professionals. Autonomy, as recognized by Amnesty International, is the right to make "choices free from outside pressure or violence, whether mental or physical" [18]. According to the American Medical Association's (AMA) *Code of Ethics*, a "patient should make his or her own determination about treatment" [19]. Such determination includes a woman's decision regarding what happens to her body [18]. Her ability to do so is diminished, and thus her right to autonomy is lost, if she is coerced into accepting a medical procedure.

The World Medical Association's (WMA) International Code of Medical Ethics lists several duties that physicians are expected to uphold regardless of the geographic locations of their practices: to "respect a competent patient's right to accept or refuse treatment," "not allow [clinical] judgment to be influenced by...unfair discrimination," "respect the rights and preferences of patients," "act in the patient's best interest when providing medical care" and "owe his/her patients complete loyalty and all the scientific resources available to him/her" [20].

Forcing sterilization upon women diagnosed with HIV conflicts with all of these duties. Firstly, it is a violation of their right to autonomy and the doctrine of informed consent. Many HIV-positive women in South Africa, Namibia, and Chile are sterilized without their knowledge or are compelled to accept the procedure to receive food or necessary medical treatment [1, 2, 4]. Lindsey McLaughlin reports that women in South Africa were threatened with halting of life-sustaining antiretroviral medication if they did not sign a consent form for sterilization [21]. HIV-positive women often succumb to sterilization due to this kind of duress and coercion, as well as to fear of disappointing or inconveniencing health care professionals or lack of knowledge of their right to autonomy [4]. One South African survey participant explained, "Today, I would have said

no, I would have taken my own decision. But in those days we did not know much about our rights. One was simply told, and to say to a doctor, 'I do not want' was unheard of. You were just told to do this or else you had to leave the clinic or hospital" [22].

Furthermore, this procedure violates the medical ethics principle of beneficence, that treatments must benefit the patient. The main medical rationale for these sterilizations, that HIV-positive-women should be sterilized to reduce mother-to-child HIV transmission [5], is flawed. Sterilization is not necessary for this purpose; consistent antiretroviral treatment has been shown to reduce risk of mother-to-child HIV transmission to less than 2 percent in nonbreastfeeding populations [7]. These medications, developed in the 1990s, are available inexpensively even in countries without fully developed health care systems [23]. And if the justification for sterilization is not medical benefit but the public good, as can be the case [7], the duty of loyalty to the patient is violated.

Forced Sterilization and Intersectional Discrimination

Intersectional discrimination is defined as "the phenomenon of multiple and compounded forms of discrimination" [24]. According to Ronli Sifris, separate marginalized qualities may overlap and eventually compound the degree of discrimination a person faces [8].

In South Africa, for example, "being part of a group of people who are [already] structurally and systematically discriminated against [increases](#) one's chances of contracting HIV" [25]. Consequently, the prevalence of HIV is disproportionately high among already marginalized groups, such as women, members of sexual and racial minorities, those in poverty, and drug users, due to the lack of access to essential health care and social resources among these groups [25]. Specifically, the subordinate social status of South African women hinders their ability to "negotiate safer sex" or participate in the workforce, factors that may make a woman feel compelled to remain in a relationship with an HIV-positive partner and that heighten vulnerability to HIV [25]. After an HIV diagnosis, women are further stigmatized by the cultural assumption that they have engaged in deviant behavior [26]. As a result, South African women with HIV are viewed as irresponsible and promiscuous, leading to social isolation [27] and, in some cases, sterilization. In South African medical culture, an imbalanced physician-patient power dynamic disproportionately affects women [6]. Exemplifying this power imbalance, physicians judge women with HIV to be irresponsible and thus "unworthy" of having children, and sterilize them to prevent public harm [28].

Sterilization leads to even more cultural stigma due to the great emphasis in South African culture on marriage and motherhood for women [29]. Because a husband must pay a "lobola" (bride price), married women are expected to be fertile and experience pressure from their husbands to have children for financial reasons [30]. After

sterilization, women sometimes become social outcasts who are banned from family activities, weddings, and funerals [29]. To evade this extreme stigma, many sterilized women avoid telling their families and partners about their sterilization [31]. In this sense, HIV-positive status can be likened to having a history of mental illness or sexual assault: it constitutes a “concealable stigmatized identity,” the strain of which can manifest as depression, anxiety, and/or self-reported illness symptoms [31]. Sterilization thus harms already marginalized HIV-positive women.

The use of forced sterilization is a widespread violation of internationally recognized human rights. As Lindsay McLaughlin has recommended, laws must be created or amended to prohibit sterilization without informed consent, and the punishments for violating these laws should be made more stringent [32]. She recommends that, in addition to fines and incarceration, the medical license of health care workers be suspended or revoked if they perform sterilization without informed consent [32]. The laws should be strictly enforced to provide a sufficient deterrent through such means as reducing barriers to women’s accessing adequate legal representation, using a special court to address these cases in order to reduce the formality and intimidation of a traditional courtroom, requiring all-female adjudicators, and allowing anonymous testimony [33]. In addition, medical staff should be educated on the issue and trained to provide adequate information for the patient to give informed consent [32]. Lastly, she argues, women who have been forcefully sterilized should be granted reparations to mitigate social and psychological damage, perhaps in the form of not only monetary compensation, but also free trauma counseling and mental health care [34].

Conclusion

Forced sterilization of HIV-positive women is a global problem of great ethical importance. Sterilization without informed consent is a violation of women’s right to autonomy, and sterilization to prevent transmission to children is medically unnecessary. To help achieve reproductive justice, there needs to be a global call to end forced sterilizations through well-implemented and enforced policy.

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MEDICINE AND SOCIETY

Promoting Health as a Human Right in the Post-ACA United States

Andrea S. Christopher, MD, and Dominic Caruso

The World Health Organization (WHO) Constitution of 1946 declared that the “enjoyment of the highest attainable standard of health”—defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”—“is one of the fundamental rights of every human being” [1]. The constitution added that “governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures” [2]. With these statements the WHO achieved two important milestones: defining health in the context of social determinants and codifying the right to health as international law [3]. The international community furthered the right to health movement in the 1948 United Nations (UN) Declaration of Human Rights [4] and multiple subsequent international treaties [5-7]. In the upcoming UN summit on the new Sustainable Development Goals, the United States (US) is one of the member states expected to adopt the proposed goal to “ensure healthy lives and promote well-being for all at all ages,” which enshrines the universality of safeguarding health [8]. In the US, the right to health and health care movement is experiencing renewed relevance with the political debate surrounding the passage of the [Patient Protection and Affordable Care Act](#) (ACA) in 2010 [9] and the ensuing Supreme Court rulings of 2012 and [2015](#) [10, 11]. Although the ACA does much to expand access to health insurance coverage, it falls short of the goals espoused by the right to health movement. We will examine the limitations of the ACA and propose steps for furthering the goal of health as a human right.

Context of the Right to Health Movement in the US

We will begin by clarifying the major ethical, economic, and political arguments and forces that shape discussions about health care in the US. Internationally, the most often cited argument for pursuing universal health care is protection of human rights, a premise based in ethical theories about equity [12]. The major philosophical theories about justice, namely, libertarianism, utilitarianism, and liberal egalitarianism, generally accept that a society must in some way provide for its least advantaged members [13-16]. Yet there is not complete accord because health as a human right differs from most other human rights. Most widely recognized human rights are framed as “negative rights,” i.e., rights with which society cannot interfere; the right to health, on the other hand, is a “positive right,” i.e., something society has an obligation to provide [17]. The main challenges to the right to health movement thus stems from the difficulties in

defining health and its minimum entitlements as positive rights and determining who is responsible for ensuring their provision [18].

Although the ethical basis of the right to health has received acceptance internationally, it is often avoided in discussions about federal provision of health care in the US. Instead, the economic and political perspectives on health care as a human right predominate, and discussion centers on the tension between the financial burden of providing universal health care and the primacy of the free market in the US. Mainstream political ideologies agree that the disadvantaged in society require assistance to level the playing field. However, the political parties differ on how much social service to provide. Conservatives generally argue that medical care is a commodity and therefore “able-bodied individuals” should earn the ability to afford it [19]. In contrast, liberals frequently view health insurance and access to care as basic entitlements that should be available to all [20].

We should also consider the powerful influence of health care stakeholders in the national dialogue about a right to health. Health care lobbyists spent an estimated \$380 million dollars during the drafting of ACA legislation, with six registered health industry lobbyists for every member of Congress [21]. Despite a lack of transparency with regard to the specific legislation promoted by this health industry spending, we can infer that most lobbyists probably did not advocate for health care as a human right. Additionally, we must acknowledge the role that physician groups have historically played in petitioning against expanding coverage. For example, the American Medical Association sponsored “Operation Coffee Cup,” in which a recording of Ronald Reagan introduced the term “socialized medicine” into our public lexicon during congressional debate about expanding health insurance coverage for the elderly in 1961 [22, 23].

The Affordable Care Act: A Step toward Health Care as a Human Right

The ACA represents the biggest change to the US health care system since the creation of Medicaid and Medicare in 1965 [24]. Evaluations of the ACA five years after its enactment have focused on the increase in numbers of people with health insurance coverage, because it is still too soon to fully evaluate the law’s effects on costs of care or care quality [25]. Most notably, the number of uninsured Americans who have gained health insurance coverage under the ACA is estimated to be between 9.3 and 16.4 million [26–30], a sizeable reduction in the pre-ACA uninsured population of 57 million Americans [31]. The ACA was also intended to reduce the financial burden of health care through measures such as the Patient’s Bill of Rights, which includes coverage of preventive services [32]. With regard to gender parity, the ACA takes important steps with coverage of reproductive health and maternity services as well as banning of the practice of charging women higher premiums than men for health insurance [33].

But these valuable gains do not absolve the ACA of shortcomings regarding the goals of health as a human right. The focus in the US on health care financing and insurance is reflected in the ACA's silence on a human right to health and health care. Although the ACA makes strides in reducing the number of uninsured people, it was never designed to guarantee access to health care for everyone in the US—thus neglecting a basic premise of the right to health movement. Much of the political debate around health care reform during the greater part of the last century centered on the push for [universal health coverage by political liberals](#), but the ACA's individual mandate arose from the Heritage Foundation, a conservative think tank seeking to [preserve the free market](#) in health care [34]. Augmenting a complex private health insurance structure to increase coverage rather than approaching health care as a human right [18] preserves the notion of health care as a commodity in the US. Additionally, much of the research evaluating the impact of the ACA highlights a few percentage point improvements in preventive screening rates as evidence of the ACA's success [27, 35, 36]. These incremental increases, however, fall far short of meaningful improvements in population-level health outcomes. Thus, many opportunities remain for further reforms aimed at improving health and achieving the rights to health and health care.

Proposals for Enshrining the Right to Health Care in the US

We must acknowledge that the movement promoting the right to health in the United States is actually a movement for universal health care, which is not an unreasonable or even particularly remarkable goal. Nearly all other member nations of the Organization for Economic Cooperation and Development (OECD) provide for the health of all citizens as a fundamental responsibility, not as a condition of employment, income, disability status, or some other criterion [37]. The upcoming UN agreement represents both an opportunity and an imperative for the US to provide health care that is truly universally available to all Americans.

What would universal coverage and access to health care services look like in the US? In their seminal 2000 paper, Eisenberg and Power [38] laid out a framework for achieving quality health care, listing seven key tenets: (1) access to health insurance; (2) enrollment in an insurance plan; (3) coverage of services and clinicians; (4) choice of services and clinicians; (5) access to consistent primary care; (6) access to referral services; and (7) delivery of high-quality services. The first four items depend on the availability of comprehensive health insurance. In the US, a patient's access to any of these benefits is severely limited without such coverage.

Evidence from countries with universal health care systems suggests that a universal scheme may lead to enhanced access to care, improved efficiency and equity, and better health outcomes. A recent Commonwealth Fund study of health systems in 11 industrialized nations ranked the US, the only country without universal health care, at the bottom, noting particular deficiencies with regard to cost, efficiency, equity, and

healthy lives [39]. A 2013 report completed under the auspices of the National Research Council and the Institute of Medicine looked at mortality and health across the lifespan in 17 affluent nations, including the US. The report consistently found higher rates of mortality and worse health outcomes in the US than in the other 16 nations in the report, all of which have universal systems of health care [40]. Based on these observations, Americans could reasonably expect that adoption of a universal system of health care would be a significant step toward improving health care and health equity.

Beyond Health Care

In the US, we tend to conflate health with health care. As clinicians, we necessarily focus on the provision of health care and its role in providing for the health of populations. However, a right to health care is only one aspect of a larger right to health, particularly as described previously in the WHO definition of health [1] and as enshrined in the UN's Sustainable Development Goals [7]. A right to health encompasses a right to provision of social measures (in WHO terms) such as sufficient food and drinking water, adequate housing and working conditions, satisfactory education, racial and gender equality, and freedom from cruel or inhumane treatment [4]. Compared to other OECD members, the United States gives limited attention to social programs and continues to outspend its peers on medical care [41]. Social spending arguably has a greater aggregate impact on population health than medical care. A 2011 analysis of 30 OECD nations found an association between social service spending and better outcomes in three of five indicators of health [39]. Acknowledging a genuine right to health means addressing social determinants of health as well as working toward universal health care.

Conclusion

As current and future US clinicians, we share the professional responsibility to advocate for the health and well-being of our patients. Thus, we find the lack of universal health care in the world's wealthiest country to be both an embarrassment and a touchstone for action among medical and public health practitioners. While we acknowledge the achievements of the ACA in improving health insurance coverage, we advocate for universal health coverage as a necessary component in the drive toward broad recognition of the right to health. In addition, we have a responsibility to advocate for policies that improve population health regardless of whether they pertain to medical care. In advocating for the health of our patients, we must broaden our focus beyond the medical system and examine the social foundations that determine health on a population scale.

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HISTORY OF MEDICINE

Dual Loyalties, Human Rights Violations, and Physician Complicity in Apartheid South Africa

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Introduction

From 1948 to 1994, South Africans were subjected to a period of sociopolitical segregation and discrimination based on race, a social experiment known as apartheid. South African history was tainted by a minority Afrikaner Nationalist Party that sought to plunder, exploit, divide, and rule. When that party took power in 1948, human rights abuses permeated all levels of society, including the medical profession, which was to a large extent complicit in various human rights violations.

These discriminatory practices had a negative impact on the medical education of black students, the care of black patients in private as well as public institutions, and the careers of black medical doctors. Medical student training programs at most universities ensured that white patients were not examined by black medical students either in life or after death. Postmortems on white patients were conducted in the presence of white students only; students of color were permitted to view the organs only after they were removed from the corpse [1]. Public and private hospitals reflected the mores of apartheid South Africa. Ambulance services were segregated, and even in emergencies a designated "white ambulance" could not treat and transport critically ill or injured patients of color [2]. Public hospitals had separate wings for white and black patients and medical staff. Many private practices had separate entrances and waiting rooms for patients with medical insurance and those paying cash, effectively segregating white and black [1, 2]. Doctors treating political prisoners faced dual loyalties on a regular basis. Some, like [Dr. Wendy Orr](#), resisted the gross human rights violations, while many were complicit [2]. In particular, the abhorrent treatment of medical student and political activist Steve Biko received international attention [2].

The Case of Steve Biko

Steve Biko was a political activist, founder of the Black Consciousness Movement in South Africa, and a fierce opponent of the apartheid regime. As a medical student at the University of Natal, he established the South African Students Organisation (SASO) for "nonwhite" students in 1968. He was instrumental in encouraging self-respect and a desire for liberation among black youth in particular and black people more generally in South Africa. In 1973, he was "banned" by the South African government, that is, his

freedom of movement and freedom of speech were curtailed, and there was a severe restriction on his political activities with the intent to silence his opposition to the apartheid regime. Steve Biko was hence restricted to a single magisterial district, his birthplace, King Williams Town in the Eastern Cape [3]. On August 19, 1977, he was detained by the security police in the Eastern Cape Province; Section 6 of the Terrorism Act of 1967 permitted his detention for an unspecified time period. Nineteen days later, he was moved to security police headquarters in Port Elizabeth for interrogation, and the following day, Dr. Ivor Lang, the district surgeon, was asked to examine Biko because he was acting strangely and refused to respond to questions [2, 4]. Examining Biko in the presence of the security police, Dr. Lang found him to be ataxic, with slurred speech, a swollen upper lip, and various bruises. Nevertheless, he issued a medical certificate, stating, "I have found no evidence of any abnormality or pathology on the patient" [5].

The following day, Dr. Lang, accompanied by his superior, Dr. Benjamin Tucker, the chief district surgeon in Port Elizabeth, examined Biko again. Biko complained of "a vague pain in his head and back" [5], and this time Dr. Lang found signs suggesting a possible brain injury. A neurologist in private practice saw Biko at the prison hospital the next day and found signs of left-sided weakness and difficult speech; a lumbar puncture (LP) revealed blood-stained cerebrospinal fluid (CSF). His report did not refer to any brain injury, but he told the security police that there were signs of nervous system damage and recommended referral to a neurosurgeon. Dr. Lang's recommendation that Biko be transferred to another hospital was refused by the security police. Dr. Lang informed Dr. Tucker of the neurologist's findings, but nothing further was done and no treatment was initiated [4].

On September 10, a neurosurgeon was consulted and agreed that the neurological findings and bloody CSF were indications of brain damage and recommended close observation. Dr. Lang visited Biko and found his physical condition unchanged. Consistent with the medical certificate he had issued, he made a note in the medical record that he and the neurologist had not found any pathology and that the LP was normal. Despite the neurosurgeon's recommendation that Biko required observation in hospital—and his own previous recommendation that he be transferred to another hospital—Dr. Lang permitted Biko to be transferred back to the police cells, where he was left lying on a mat on the floor [4]. Although Dr. Lang consistently found pathology, he repeatedly acted in contradiction to his findings. It seems unlikely that such behavior could be explained by simple incompetence. Rather, what appears evident is a total violation of the most basic rules of medical professionalism and a complete disregard for the life of a black political prisoner.

The following afternoon, Biko was found "collapsed, glassy-eyed, hyperventilating, and frothing at the mouth" [5]. Dr. Tucker examined him and opined that his condition was unchanged. He recommended transfer to the local provincial hospital, but, when the

security police refused to allow this, he agreed to Biko's being transferred to Pretoria, 1,100 kilometers away, by motor vehicle. Biko was transported to Central Pretoria Prison—a twelve-hour journey—without medical escort, handcuffed, and lying naked on the floor in the back of a police Land Rover [4].

Many hours later Biko was examined by the district surgeon in Pretoria, who had not been given any medical information regarding him, and the only treatment he received was intravenous fluids and vitamins. Six hours after arriving in Pretoria, Biko, who was left completely unattended, died on the floor of an empty cell on the evening of September 12, 1977 [4]. It was in this way that South Africa was robbed of one of its foremost political thinkers.

Medical Professionalism and Dual Loyalties

The conduct of Drs. Lang and Tucker was indefensible. They failed to examine Biko adequately, did not attempt to elicit even a basic history from him, and did not provide adequate care or treatment. Instead they acquiesced to the instructions of the security police, neglecting to place the best interests of their patient above all other considerations. Dr. Lang wrote a false medical certificate on September 6 and inaccurate notes in the medical record on September 10. He also made no effort to ensure Biko's safety and allowed him to be transferred back to the prison cells. Dr. Tucker allowed Biko's transfer to Pretoria to occur in a police vehicle rather than an ambulance and without an accompanying medical report to the receiving doctor.

This unprofessional conduct may be explained by the conflict of the doctors caught in a classical "dual-loyalty" situation—one in which their duty to their patient, Steve Biko, conflicted with their (perceived) duty to the state. In fact, Dr. Tucker subsequently admitted, "I had become too closely identified with the interest of the organs of the State, especially the police force, with which I dealt practically on a daily basis.... I have come to realise that a medical practitioner's primary consideration is the well-being of his patient" [6].

G. R. McLean and Trefor Jenkins make the point that the Biko case is an example of a difficult ethics case not because it is difficult to know what the morally correct course of action is, but "because it is hard *to do* what one ought to do" [7]. The duty of the doctors involved in Steve Biko's case was clear, but *performing* that duty was difficult. They had become so accustomed to working with the security police and regarding the detainees as dangerous terrorists rather than patients that they had disengaged from the duties and the responsibilities of their profession.

The Role of the Medical Association of South Africa (MASA)

The Medical Association of South Africa (MASA) was originally linked to the British Medical Association. It became known as the South African Medical Association (SAMA)

in 1998 and was a voluntary association of doctors. The South African Medical and Dental Council (SAMDC) was the regulatory body controlling the medical and dental professions at the time Biko was imprisoned [8]. Surprisingly, neither MASA nor SAMDC supported charges of misconduct or unethical conduct against the doctors involved in the Biko case. The [professional organizations](#) were derelict in their duty to uphold professional standards because they too allowed state security issues to subvert the profession's responsibilities and ethical obligations to its patients. As N. Barney Pitso writes,

the Biko affair marked a moral threshold in public life in South Africa. The reputation of the medical profession had never sunk as low. Confidence had evaporated. It was no longer just a matter of moral wrongdoing by a few medical practitioners. Through the actions of MASA and the SAMDC, the whole organised medical profession became implicated in that wrongdoing [9].

It was only after a small group of doctors (Frances Ames, Edward Barker, Trefor Jenkins, Leslie Robertson, and Phillip Tobias) successfully obtained a Supreme Court ruling to force the SAMDC to re-open the case against the Biko doctors that the council did so in 1985 [10]. Ultimately, Dr. Lang was found guilty of improper conduct and received a caution and a reprimand; Dr. Tucker was found guilty of improper and disgraceful conduct and was later struck from the medical roll [8].

Other Ethical Violations

Other human rights violations occurred at the hands of physicians, many of them in [prisons](#) and the military.

In particular, Dr. Wouter Basson joined the South African Defence Force as head of Project Coast—the chemical and biological warfare program of the apartheid government [11–14]. It was only in 1998, during the Truth and Reconciliation Commission (TRC) hearings, that the details of the activities of Project Coast emerged: the manufacture of poisoned weapons, secret stockpiles of lethal bacteria to selectively kill people with pigmented skin, and chemicals and drugs developed specifically for use against enemies of the apartheid South African government [14]. Although Basson gave evidence at the TRC hearings for 12 hours in 1998, he did not apologize, he did not show remorse, and he did not request amnesty [2].

Finally, after a 13-year-long case with the Health Professions Council of South Africa (HPCSA), Basson was found guilty of unethical conduct in December of 2013. Although he argued that he had acted as a soldier and not a doctor, that medical ethics were different for military doctors, and that he had no doctor-patient relationship with those he harmed, among other arguments [15, 16], a long-awaited guilty verdict was reached.

Although the SAMA issued a statement in support of this verdict [17], Basson retains his membership in the organization [18].

Conclusion

Apartheid seriously corrupted the moral fiber of South African society in a manner that permeated and broke the core ethical covenants of the medical profession. Separation between the profession and the state became opaque and ambiguous. Through this dense veil of confusion, a minority of health professionals were able to see their way clear and rebel against injustices in health care in the prisons and security forces. However, the stance of many was one of indifference or, worse still, complicity.

The TRC Hearings in 1998 played a pivotal role in reversing the tide of discrimination and human rights abuses. Public hospitals are now fully integrated. The Health Professions Council of South Africa mandated that ethics training for all registered professionals become compulsory. All medical schools in South Africa are now compelled to provide training in ethics, law, and human rights as a compulsory part of their curricula [19, 20]. Medical undergraduate training ensures equity in student intake and training, except for a minority of apartheid institutions that continue to use language as a barrier to entry, thereby denying access to non-Afrikaans-speaking students, who are typically black. We fervently hope that this bleak chapter of medical history will never be repeated.

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MEDICAL NARRATIVE

Uncompromised Professional Responsibility in Apartheid South Africa

Wendy Orr, MBChB

In September of 1985, 30 years ago this year, I became the first (and to date still the only) district surgeon to reveal evidence of police torture and abuse of political detainees in South Africa. In that year, I was appointed as a medical officer in the District Surgeon's Office in the magisterial district of Port Elizabeth. In those days a district surgeon was a medical doctor employed by the National Department of Health to provide (among other things) health services to prisoners and detainees and forensic services to the police. The larger part of my job consisted of conducting autopsies at the police mortuary in New Brighton (a black township just outside Port Elizabeth) and providing clinical services to sentenced and awaiting-trial prisoners in two prisons—St. Alban's and North End (the latter was known by its inmates as "rooi hel," which means "red hell" in Afrikaans).

Two months earlier, in July of 1985, a state of emergency (SoE) had been declared across a number of magisterial districts in South Africa—Port Elizabeth being one of them. This allowed police to detain, without charge and without trial, anyone who they believed constituted a "threat to the safety and security" of the state. Within days dozens of people had been detained in Port Elizabeth, and over the next few weeks that number rose to hundreds. Although political detainees were usually kept in police cells, the sheer number of people being detained during the 1985 SoE meant that they had to be sent to prisons—white and female detainees to North End and black men to St. Albans. This meant that, as part of my daily prison sick parades, I started to see SoE detainees as well.

From the outset it was evident that very many of the detainees displayed signs of having been assaulted—bruising, whip marks, lacerations, periorbital hematomas—and when I asked them how the injuries had been sustained, they said that the police had assaulted them. There appeared to be two sets of circumstances under which the assaults occurred.

The first such circumstance was at the time that the person was detained. It seemed as if the police tended to round up large groups of people, take them to a police station for "processing" (fingerprinting, recording of personal details), and, while the detainees were in the station precinct, randomly assault, beat, and brutalize them. These people would display injuries on their admission to the prison.

One example of this type of assault was a young man called Mbulelo Joseph Sogoni. He was brought to see me the day after his admission to prison. In my affidavit to the Supreme Court [1], I described his condition as follows:

He had weals from his shoulders to his buttocks. There were so many weals that I could not count them. They were superimposed upon each other. His wounds were fresh and he was in great pain. He was brought to me in a wheelchair. He could not speak, but his friends who brought him told me that he had been assaulted by the police [2].

I learned later that Mbulelo had been detained with a large group of men (about 150) on August 15. They had been taken to Kempston Road police station for processing. While they were there, Mbulelo had been made to strip down to his underpants and stand in front of the other detainees with his arms and legs spread apart. Every time his arms or legs sagged from fatigue, he was whipped across the back with a sjambok (a thick rubber whip).

The second set of circumstances during which detainees would be injured was when they were removed from the prison and taken to police headquarters for interrogation. During this interrogation they would be tortured. So, on admission, they would be injury-free, but at some stage during their detention they would be brought to me with complaints and, very often, horrific injuries.

One such torture victim was Ernest Singqokwana Malgas, whom I described thus:

I had not examined him on admission. However, according to the prison's record, he did not have any complaint on his admission. When I saw him, he was severely injured. His injuries included large areas of severe and deep bruising on the lower back and buttocks. The bruising was not merely sub-epidermal, but intra-muscular. The muscles were very swollen and very tender. The bruises were prominently purple and red, and consistent with a particularly violent assault with a blunt instrument. His condition was such that I was unable to take a history from him. I asked the nursing sister, a Sister Prins, whether she knew what had happened to the man.... She told me that the South African Police had taken the detainee to the Louis le Grange Building [the police headquarters in Port Elizabeth] for interrogation the previous day. Upon his return, he was severely injured and complained that he had been assaulted by the police [3].

In the first Truth and Reconciliation Commission hearings, in 1996, Mr. Malgas gave evidence that he had been subjected to "helicopter torture" the day before I saw him. He

had had the inner tube of a tire wrapped around his face to suffocate him. He was then handcuffed with his hands in front of him and a stick was passed over his left wrist, behind his knees and over his right wrist. The stick was then lifted, thus suspending Mr. Malgas upside down, hanging by his wrists and the tender spot behind his knees, and balanced between two tables. In this hanging position, he was repeatedly hit with a baton across his lower back and buttocks.

By late August I simply could not contemplate the thought of continuing to see the daily litany of pain and injury and do nothing about it. I had advised my superiors in the District Surgeon's Office in Port Elizabeth of what was happening (and indeed, they themselves conducted sick parades in the prisons, so they were fully aware of the situation); their response was simply that I should record the injuries and prescribe appropriate treatment. There was no acknowledgement on their part that our [role as physicians](#) went beyond this blinkered and narrow approach. It was therefore apparent that if any action was going to be taken, I would have to act independently and outside of usual "escalation" procedures.

Through a remarkable confluence of events, I was contacted by a human rights lawyer from Johannesburg who offered the option of seeking relief through the courts, if I was prepared to "go public" and reveal full details of my daily experience in the prisons. I concluded my affidavit to the Supreme Court of South Africa with the following words:

It ultimately became clear to that, unless I made a stand and did something about the plight of the detainees, I would be compromising my moral beliefs and my perception of my professional responsibility. My conscience told me that I could no longer stand by and do nothing.... I respectfully submit that this application is very urgent. The police are apparently engaged in a pattern of daily assaults upon detainees. For every day that goes by those apparently unrestrained assaults continue [4].

The rest, I suppose, is history—the interdict was granted and did, for a while, inhibit police from assaulting and torturing detainees. Unfortunately, because the court order only applied to the magisterial district of Port Elizabeth, it had little impact outside of that area. In addition, it only applied to people detained under the particular SoE declared in July 1985, not to detainees held under different legislation or after the SoE was lifted in early 1986.

Although I received huge support from a number of [medical associations](#) outside South Africa (most notably the British Medical Association), and from health professionals and many ordinary citizens in South Africa, the Medical Association of South Africa (MASA—

the predecessor to the South African Medical Association) did nothing to reach out to me or support me during that period.

Ten years later, towards the end of 1995, I was appointed as a commissioner for the Truth and Reconciliation Commission of South Africa. One of the things I did in that role, with my commission colleagues, was organize a hearing on the role of the health profession in human rights abuses during the period under review (1960 to 1994). One of the watershed cases in the sorry history of the medical profession during those years was the death of [Steve Biko](#) while in detention in 1977. He had been assaulted by police and, as a result of gross negligence on the part of the district surgeons responsible for his care, had died of head injuries sustained in the assault. I was given access to Steve Biko's file from that final period of detention, and I read through the reports that were regularly completed (and filed and apparently not acted on) by the district surgeons who visited him [5]. The doctor did nothing, the magistrate who was also required to make regular visits did nothing, and Steve Biko died a few weeks later because the people who were supposed to take care of him, who were meant to protect his human rights and put his needs first, saw him as less than a human being and undeserving of any kind of dignity or respect.

One of the first witnesses in the first Human Rights Violations hearings was Mr. Malgas, who gave evidence of the "helicopter" torture to which he had been subjected in 1985, before I examined him. During his testimony he broke down, which also brought Archbishop Desmond Tutu to tears, and iconic pictures of the Archbishop hunched over and weeping were flashed around the world [2].

As I watched this play out, I recalled what had happened when Mr. Malgas was brought to see me, an incident which I also referred to in my affidavit:

When he (Mr. Malgas) was brought in for me to examine him at the St Albans Prison, a number of prison officials came in to look at him because he was so severely injured. One of the warders commented that "Hy het dit seker nodig gehad" [*he probably had it coming to him*]. The others agreed. No one suggested that anything be done about the fact that this man had obviously very seriously been assaulted by the police [4].

For me this sums up the damage done to all of us by apartheid: it treated black people as something less than human, and it dehumanized white people because they came to believe that. A terrible chapter in our history is over, but the sequelae will be with us for generations to come.

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SECOND THOUGHTS

#BlackLivesMatter: Physicians Must Stand for Racial Justice

White Coats for Black Lives (WC4BL) National Working Group

Racism is one of the major causes of health problems in the United States. Between 1970 and 2004, the Black-white mortality gap resulted in more than 2.7 million excess Black deaths [1], making [racism](#) a more potent killer than prostate, breast, or colon cancer [2]. Physicians are intimately involved with institutions that contribute to the victimization of Black people and other people of color. As is widely documented, Black and Latino patients are less likely to receive the care they need, including adequate [analgesia](#), cancer screening, and organ transplants [3-6]. This is due both to physician bias and to the health care payment structure's financial disincentives for the care of people of color [7]—clinicians are paid less to care for patients who are uninsured, underinsured, or publicly insured, and these patients are disproportionately people of color. As a consequence, people of color are often denied access to the health care they need [8, 9].

These disparities in access to health care exacerbate the harm that social structures and policies cause to the health of people of color. Black and Latino people are disproportionately victimized by police violence, mass incarceration, and poverty [10-12]. Moreover, despite perceived improvements, rates of racial segregation across the country remain comparable to levels in the 1940s, and people of color face discrimination in their efforts to access adequate housing, quality education, and meaningful employment [13-16]. The harmful effects of structural inequity are augmented by the subjective experience of racism: for example, [awareness of one's race](#) is correlated with increased diastolic blood pressure among Black patients [17].

Addressing racism and its consequences, therefore, should be a central task of American medicine; physicians must work both within and outside the health care system to eliminate inequities in access to and delivery of care. Health professionals and community organizations ranging from the Black Panther Party to the National Latina Institute for Reproductive Health have long proposed effective strategies for addressing racism to improve the health of people of color, including expansion of free clinics, increased [research](#) on diseases affecting people of color, and legislative establishment of paid parental leave [18, 19]. Recent incidents and protests in Charleston, Baltimore, New York, and other cities across the country have reminded us of the urgency of acting on these and other proposals to address racism in medicine.

In particular, we, as members of the National Working Group of the medical student organization White Coats for Black Lives, suggest four ways that physicians and other health professionals can immediately pursue racial justice. The first is to more aggressively [recruit](#), support, and promote Black, Latino, and Native American people in medicine to ensure that the physician workforce reflects the diversity of the United States. Black and Latino people represent roughly 30 percent of our nation's population but make up only 8.5 percent of the physician workforce [20]. Physicians of color are more likely to provide care for America's underserved communities, and patients of color report higher satisfaction when their doctor shares their racial background [21-23]. Despite the Association of American Medical Colleges' Project 3000 by 2000 [24], the past three decades have witnessed little growth in the population of Latino, Black, and Native American physicians [20]. Increasing the numbers of Black, Latino, and Native American doctors is a key step in eliminating health inequities.

Secondly, hospitals and practices must take action to eliminate the significant impact of implicit racial biases on the care of patients of color [7]. To counteract these subtle forms of racism, institutions must routinely administer implicit association tests to their medical staffs to make them cognizant of their unconscious biases and then [train](#) their medical staffs to consciously overcome those biases when delivering care [25]. Furthermore, hospitals should create formal and informal structures to encourage accountability for incidents that may have involved racism. This can be done by fostering a work environment that makes it safe for colleagues to question each other's biased actions and by using structured venues such as morbidity and mortality conferences to discuss ways that racism may have impacted the quality of patient care.

Thirdly, physicians should join community members in advocating for a [single-payer health care system](#) as a means of eliminating cost-associated barriers to care. In addition to improving access for all patients, a single-payer system would eliminate insurance-status discrimination and ensure that reimbursements for services provided to white patients and patients of color are equal.

Finally, health care workers must recognize that our [responsibility](#) to our patients goes beyond physical exams, prescriptions, and surgical interventions; we must [work to alter](#) socioeconomic and environmental factors, including [structural racism](#), that directly affect our patients' health. The manifestations of structural racism are varied and ubiquitous; addressing them will require joining movements to increase the minimum wage, end criminalizing school discipline practices, and develop mixed-income housing, among many others. In doing so, physicians will need to partner with and take direction from community members who have experienced systemic oppression and are dedicated to working to dismantle it. We will not be able to solve the problems of racism in our society and in our health care system without the input of those most affected by it. In working to combat structural racism, physicians must not only listen to people of color in their

practices and communities, but also amplify those voices while [advocating](#) for equitable social structures. The [privilege](#) that physicians possess within society and within the professional hierarchy of medicine provides them with power that can be used to spearhead policy changes to advance racial justice locally and nationally. Using this “physician privilege” to advocate for social change is necessary if we are to eradicate the systemic illness that is racism.

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White Coats for Black Lives (WC4BL) is a national medical student organization devoted to safeguarding the lives of patients through the elimination of racism. The WC4BL National Working Group endeavors to raise awareness of racism as a public health concern that threatens the lives and health of people of color, end racial discrimination in the delivery of health care, and prepare future physicians to be advocates for racial justice. WC4BL encourages medical professionals to create a physician workforce that reflects the diversity of our nation by actively recruiting and supporting Black, Latino, and Native American people through medical school and into their careers.

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Suggested Readings and Resources

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Contributors

Stephanie Bi attends the University of Chicago, where she is majoring in biological sciences and English language and literature. In the summer of 2015, she was an Ethics Group intern at the American Medical Association. Stephanie is interested in health policy and aspires to become a physician-writer.

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Douglas Diekema, MD, MPH, is director of education at the Treuman Katz Center for Pediatric Bioethics at Seattle Children's Hospital. He serves on the Ethics Committee of the American Board of Pediatrics and is a past chair of the American Academy of Pediatrics Committee on Bioethics. His research interests include pediatric bioethics and pediatric wilderness medicine.

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Aaron Wightman, MD, MA, is a bioethicist and pediatric nephrologist at the University of Wisconsin School of Medicine and Public Health in Madison. His research focuses on decision making for children with complex, chronic medical conditions.

White Coats for Black Lives (WC4BL) is a national medical student organization devoted to safeguarding the lives of patients through the elimination of racism. The WC4BL National Working Group endeavors to raise awareness of racism as a public health concern that threatens the lives and health of people of color, end racial discrimination in the delivery of health care, and prepare future physicians to be advocates for racial justice. WC4BL encourages medical professionals to create a physician workforce that reflects the diversity of our nation by actively recruiting and supporting Black, Latino, and Native American people through medical school and into their careers.

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