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### HEALTH LAW: PEER-REVIEWED ARTICLE

#### Health Professionals, Human Rights Violations at the US-Mexico Border, and Holocaust Legacy

Susannah Sirkin, MEd, Kathryn Hampton, MSt, and Ranit Mishori, MD, MHS

##### Abstract

Health professionals caring for asylum seekers face decisions about whether to participate in force-feeding hunger strikers, performing and reviewing unnecessary x-rays to assess detainees' ages, misusing detainees' health information, and discharging patients based on immigration officials' demands rather than patient safety. The latter action is a classic dual-loyalty dilemma reminiscent of some clinicians' actions during the Holocaust. This article investigates how professional organizations can support clinicians targeted by the state for resisting immigration officials' demands for their participation in human rights violations, opposing policies that compromise health professional values, and refusing to engage in unethical detention practices.

##### Dual Loyalty

For centuries, health professionals have pledged uncompromising devotion to patients' well-being. **Dual-loyalty conflicts** arise when clinicians' duties to public health or third parties (health care organizations, insurance companies, family members, and others) conflict with their duties to individuals, particularly patients. Failure to navigate dual loyalties well undermines the integrity of patient-clinician relationships and even entire health professions' trustworthiness. When individual clinicians succumb to pressure from states or state authorities to prioritize nonclinical factors (eg, national security, immigration enforcement, or customs policies) above the interests of patient-detainees, they compromise fidelity to vulnerable persons who have few to whom they can turn. Training clinicians to resist commission of or complicity in human rights violations is expected of health professions educators seeking to help prepare graduates of their programs to resist state-sanctioned abuse and neglect.<sup>1</sup>

Notorious examples of breaches of health professional ethics abound, from Nazi doctors' participation in "euthanasia" programs to US clinicians' participation in **state-administered torture** and executions.<sup>2,3,4,5</sup> Although international codes and professional society statements have been invoked to prevent violations and hold perpetrators accountable,<sup>6,7</sup> the possible role of medical ethics and dual loyalty has been neglected in investigations of US clinicians' involvement in asylum seekers' and migrants' traumatic custody experiences of indefinite detention, overcrowding, and squalor.

Clinicians in detention centers face dual-loyalty conflicts similar to those faced by some Nazi clinicians.<sup>8</sup> This article illuminates human rights violations that illustrate these similarities.

### **Violations Involving US Clinicians**

Physician hiring practices<sup>9</sup> for Immigration and Customs Enforcement (ICE) detention centers or their private contractors have come under scrutiny, as have challenges to clinicians' professional practice independence and lack of agency accountability.<sup>10</sup> Practices such as force-feeding hunger strikers,<sup>11</sup> withholding clinically indicated interventions,<sup>12</sup> and prescribing and administering psychotropic drugs (even to minors) without (parental) consent,<sup>13</sup> and other abuses<sup>14</sup> have happened under US health care professionals' watch in US detention centers.

*Force-feeding.* Since May 2015, at least 1600 individuals have undertaken hunger strikes at 20 US detention centers to protest their detention by ICE.<sup>15,16,17</sup> The World Medical Association (WMA) and other international and US-based organizations have expressed clear opposition to force-feeding of hunger-strikers.<sup>18,19,20</sup> The WMA's Declaration of Malta on Hunger Strikers states: "Physicians must respect the autonomy of competent individuals, even where this will predictably lead to harm."<sup>18</sup> Yet, according to civil society organizations,<sup>19</sup> some detainees have been and are being **forcibly fed**, a practice long considered to be inhumane and unjustifiable from a health care ethics standpoint, as it deprives competent individuals' rights to protest and to bodily autonomy.<sup>20,21</sup> Current and former detainees have reported not only being force-fed via nasogastric tube, but also being shackled and having intravenous (IV) lines placed by clinicians following invocation of court orders.<sup>17</sup>

*Age assessment.* Health professionals have also been implicated in administering and reviewing radiographs for purposes not clinically indicated—to determine detainees' ages.<sup>22</sup> Reports suggest that dozens, if not hundreds, of migrant children have been forced to undergo dental radiographs, which are used to determine whether they are adults who could be placed in adult detention.<sup>23</sup> This procedure has due process implications, as adults detainees are exempt from legal protections for migrant children, including protection of the right to nonadversarial asylum interview.<sup>24</sup> Many experts consider radiographic age assessments to be scientifically inaccurate and misleading because they fail to account for ethnicity, nutritional status, overall health, and development history, which are considerations especially relevant for people coming from low-resource backgrounds and environments.<sup>22</sup>

*Compromised patient safety.* Migrants' use of primary and even emergency care in community health settings has declined,<sup>25,26</sup> due to their fear of clinicians' and administrative staff members' complicity with immigration enforcement arrests and raids. Physicians for Human Rights (PHR) interviews with community health clinicians in border states have confirmed that, in some community health facilities, patients have experienced compromised access to care, compromised care quality, and racial, ethnic, and immigration status-based discrimination.<sup>27</sup> Although federal guidelines generally prohibit immigration enforcement activities at health care delivery sites,<sup>28</sup> critically ill patients have been shackled against medical advice and experienced delay in their transport by ambulance to emergency health services sites, which violates their right to nondiscriminatory emergent care and interferes with clinicians' execution of their ethical and legal duties to provide lifesaving treatment to patients.<sup>27</sup> Patients also have been denied attorney and family member visitation, have been profiled in waiting rooms, and have experienced **unauthorized disclosure** of their immigration status.<sup>27</sup>

*Unsafe discharge.* Routinization of abrupt discharge with no continuity of care plan has been reported to PHR.<sup>27</sup> Clinicians reported being intimidated by US agents to clear patients for release to detention centers or for deportation,<sup>27</sup> even though doing so would endanger patients' health or risk their death. In January 2020, an 18-month-old and her 6-year-old sibling became ill in Customs and Border Protection (CBP) detention and were hospitalized. Diagnosed with 2 infections, the toddler began receiving IV antibiotics, and an oxygen monitor was placed. Despite the lack of a plan for the toddler's continuing care, the 2 children were discharged and removed on the authority of the government and, in fewer than 12 hours, flown with their mother to Guatemala.<sup>29</sup>

*Misuse of patient information.* For the past decade, children's (allegedly confidential) therapy notes have been used as evidence against them in deportation proceedings.<sup>30</sup> One boy confided to his therapist that, under duress, he joined a gang, later refused to comply with gang demands, and then fled his country.<sup>31</sup> Without the child's or the therapist's consent, an ICE prosecutor used these notes to emphasize the child's gang membership and undermine his case for asylum. Although the extent to which this information is protected under the Health Insurance Portability and Accountability Act (HIPAA) is unclear,<sup>32</sup> violating the confidence of a vulnerable child seeking help neglects the child's dignity and undermines the therapist's capacity to execute professional caregiving duties.<sup>31</sup> Clinicians working with or for organizations such as CBP and ICE should learn about potential **misuses of information they record** about patients and perhaps even inform patients during consent processes of such potential misuses. The American Psychological Association has called for an end to government misuse of patient information and for Congress to investigate.<sup>33</sup> Clinicians should demand similar robust objections to these and other practices of health information misuse from their employers and professional organizations.

### Standing Up for Patients

The practices discussed above and the policies that support them can cause and exacerbate clinicians' moral distress. Clinicians also experience intimidation by armed agents' point-of-care interferences and by threats of demotion or dismissal for resisting or reporting state agents' actions.<sup>27</sup> Such pressure is not easy to resist. But standing up for patients and upholding ethics is a health professional requirement even when it's not easy to work within an unjust system, take legal action, blow a whistle, or resign. Responding to dual-loyalty conflicts usually means that clinicians need to clarify the nature and scope of their and their colleagues' responsibilities and then plan and execute actions to demand or promote change.<sup>1</sup> The following 10 guidelines can help (see Table).

**Table.** Guidelines to Help Clinicians Respond to Dual Loyalty Conflicts<sup>a</sup>

1. Enhance your awareness of human rights principles and "the implications of human rights for clinical practice through study and training in human rights."
2. "Develop skills to identify situations where dual loyalty conflicts threaten human rights and where independent professional judgment may be compromised."
3. Always "place the protection of the patient's human rights and well-being first," especially in situations in which "there exists a conflict between the patient's human rights and the state's interests; this responsibility includes affirmatively resisting demands or requests by the state or third party interests to subordinate patient human rights to state or third party interests."

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4. “Exercise judgment independent of the interests of the state or other third party” in all clinical assessments, whether for therapeutic or evaluative purposes.

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  5. Recognize how your “professional skills can be misused by state agents to violate the human rights of individuals—especially in settings where human rights violations are pervasive—and take appropriate steps to avoid this misuse.”

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  6. “Recognize that passive participation, or acquiescence, in violations of a patient’s human rights is a breach of loyalty to the patient.”

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  7. “Only depart from loyalty to the patient within a framework of exceptions established by a standard-setting authority competent to define the human rights obligations of a health professional; any such departure should be disclosed to the patient.”

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  8. “Maintain confidentiality of medical information except where the patient consents to disclosure or where an exception recognized by competent authorities in medical ethics permits disclosure.”

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  9. “Take all possible steps to resist state demands to participation in a violation of the human rights of patients.”

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  10. Always “act with an understanding of health professionals’ collective obligation to uphold and promote the human rights and well-being of the patient.”
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<sup>a</sup>Adapted from Physicians for Human Rights.<sup>1</sup>

### Organizational Responses

Health care organizations should develop, adopt—and train clinicians and staff in how to enact— policies<sup>34</sup> that protect patients’ health rights and human rights concerning nondiscriminatory care access, interactions with state agents, not permitting searches of hospital rooms without a court-ordered warrant, and maintaining confidentiality and HIPAA compliance. Several models exist,<sup>35,36,37,38,39</sup> and they can be adapted to meet local needs.

Health professional societies can also advocate for local, state, and federal policy changes and circulate guidance about how clinicians can safeguard patients’ rights and the quality of care they deliver. If such guidance is insufficient or not followed, clinicians can **advocate for patients** through petitioning, demonstrating, registering formal complaints, launching media campaigns, documenting human rights abuses, and supporting whistleblowers. Although such actions are not without personal risk, the risk of harm to patients from an absence of advocacy by individual clinicians and health professions organizations is severe. Psychiatrist Pamela K. McPherson and internist Scott A. Allen consulted for the US Department of Homeland Security (DHS), inspected detention centers, exposed conditions that threatened detainees’ health and safety, and wrote to the US Senate Whistleblower Protection Caucus in 2018.<sup>40</sup> PHR honored these clinicians’ standing up for human rights and health professional ethics. In response, McPherson stated: “No one needs a medical degree to know that the separation of families and the detention of toddlers are wrong.... It’s clear that traumatizing children is not a political issue but one of human dignity.”<sup>41</sup> More recently, during the COVID-19 pandemic, DHS experts wrote to Congress about the “imminent risk to the health and safety of immigrant detainees” and to local communities if people are not released from detention.<sup>42</sup>

Such individual and organizational responses underscore that recognizing and responding to dual-loyalty conflicts require more than clinical skill, even for experienced clinicians. The Holocaust illuminated how easily clinicians colluded with a state in barbarism. *De jure* cruelty threatens individuals’ health rights and human rights today



and still call for clinician advocacy. Humanity relies on clinicians' individual and collective conscience, and history has a way of holding us all accountable.

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**Susannah Sirkin, MEd** is the director of policy at Physicians for Human Rights, where she oversees international policy engagement, including with respect to organizations such as the United Nations, domestic and international justice systems, and human rights coalitions. She has organized health and human rights investigations on dozens of countries and has authored and edited numerous reports and articles on the medical consequences of human rights violations, physical evidence of human rights abuses, and physician complicity in violations

**Kathryn Hampton, MSt** is the senior officer of the Asylum Program at Physicians for Human Rights, where she coordinates an initiative that recruits, trains, and supports a network of clinicians to provide forensic evaluations for asylum seekers and advocate for human rights-based immigration policies.

**Ranit Mishori, MD, MHS** is a professor of family medicine at the Georgetown University School of Medicine in Washington DC and senior medical advisor at Physicians for Human Rights. Her areas of interest and expertise include clinical human rights, human rights education, women’s health, global health, and reproductive health justice.

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