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Caretakers and Collaborators

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Caretakers and Collaborators

M. GREGG BLOCHE

A chilling subplot in the twentieth-century saga of state-sponsored mass murder, torture, and other atrocities was the widespread incidence of medical complicity. Nazi doctors' human "experiments" and assistance in genocidal killing^{1,2} are the most oft-cited exemplar, but wartime Japanese physicians' human vivisection and other grotesque practices³ rivaled the Nazi medical horrors. Measured by these standards, Soviet psychiatrists' role in repressing dissent,⁴ Latin American⁵ and Turkish⁶ military doctors' complicity in torture, and even the South African medical profession's systematic involvement in apartheid⁷ may seem, to some, almost prosaic. Yet these and other reported cases of medical complicity in human rights abuse⁸ compel an inquiry into medicine's vulnerability to becoming an adjunct to illicit state purposes.

To many practicing physicians, the idea of such vulnerability may seem anathema. The Hippocratic Oath's pledge of undivided loyalty—"[i]n every house where I come, I will enter only for the good of my patients"⁹—and the oft-quoted maxim, "first do no harm," express the profession's ethical commitment to the sick people it primarily serves. Well-meaning practitioners might reasonably presume that this commitment safeguards the profession against involvement in illicit purposes and that physicians who collude in human rights abuses are a rogue element, not evidence of a deeper problem. But I shall argue here that the Hippocratic commitment of undivided loyalty to patients tells only part of the story of medicine's purposes, that clinical work in contemporary societies serves myriad state and social ends, and that physician complicity in state-sanctioned human rights abuse is a perverse corollary of this seldom-acknowledged reality. Were the ethic of undivided loyalty and the maxim, "first do no harm," the inviolate precepts many take them to be, then efforts to prevent such complicity could concentrate on the conceptually simple tasks of dissuading physicians from doing anything that serves state purposes at their patients' expense and pressing governments to respect the profession's adherence to these precepts. But the pervasive links between clinical work and state purposes—in the industrialized democracies no less than in repressive regimes—complicate the work of prevention and put physicians at risk for becoming collaborators when state purposes turn illicit. This risk is heightened by the near-absence of ethical guidance as to how to distinguish between acceptable and intolerable furtherance of state objectives.

I thank Daniel Wikler and the late Jonathan Mann for their comments, suggestions, and encouragement. This article is dedicated to the memory of Jonathan Mann.

Medicine and State Purposes

The Hippocratic ethic of undivided loyalty to patients occupies a central place in the medical profession's conception of itself. Yet the use of clinical methods and judgment for purposes other than diagnosing or treating the sick has an ancient history. Since recorded civilization began, those charged with caring for the sick have given clinical opinions to government authorities, employed medical techniques for religious and cultural purposes, and compromised the interests of individual patients in the face of pressing public health needs. More often than not, societies have accepted such professional conduct as a matter of course. Neither the Hippocratic corpus nor the contemporary bioethics movement have made a place, let alone prescribed rules, for the diverse services that physicians render to the state.

As I have suggested elsewhere,¹⁰ the use of medical skill and judgment for purposes other than the promotion of patients' well-being can be grouped into three categories: (1) pursuit of public health objectives, (2) advancement of nonmedical ends, and (3) ascription of rights, responsibility, and opportunity based on health status. These categories overlap, and each encompasses diverse professional activities—some broadly accepted, others controversial, and still others clearly beyond the ethical pale. Yet these categories are useful for the focus they bring to the social import of medical work and thus to the profession's susceptibility to becoming an adjunct to state purposes that are troubling or worse.

Public Health

Clinical practitioners routinely incorporate population-wide health concerns into their diagnostic, therapeutic, and other decisions. Classic examples, all involving compromise of patients' medical interests in pursuit of public health goals, include reporting of contagious diseases to state authorities and selection of antibiotics with an eye toward preventing the emergence of resistant bacterial strains. Vaccination is another example: when immunization rates are high and the incidence of a feared disease is low, vaccination of any one person can hold more medical risk than benefit for that person. To the extent that the human subjects of medical research bear risk for the sake of future patients, such research can be understood as a variation on this theme. More controversially, American courts have looked to such thinking as a basis for requiring psychiatrists to warn public authorities and potential victims when they believe their patients pose homicidal risk.¹¹

Public health ideals are potent as political metaphor. Redescription of the problem of gun violence as a public health crisis in the 1990s helped to shift American public sentiment toward gun control measures. Public health, broadly conceived, has animated progressive physicians' activism against nuclear weapons and in favor of world peace, international human rights, and aid to less-developed nations. Yet the power of public-health thinking as ethical justification for physicians to sacrifice individuals' interests gives it a political double edge. Christian Pross's penetrating examination of the roots of the Nazi medical horrors in Weimar-era thinking about medical ethics¹² points to the prominence of duty to the health of the people and the nation in Weimar ethics sources. When, in the 1930s, Hitler and his architects of mass killing framed the

campaign against Jews and other undesirables in biological terms, as a battle against social “bacillus” and “bubonic plague,”¹³ Nazi physician-collaborators drew, perversely, on Weimar conceptions of public duty. Transformed rhetorically into “plague,” people became objects, not subjects, of a program of eradication cognizable to its collaborators in biomedical terms.¹⁴

Nonmedical Ends

Among the non-health-related purposes that medical methods serve are military readiness, criminal justice and punishment, control of violence, and religious and cultural observance. Long-standing examples that we widely treat as legitimate include care that returns wounded soldiers to combat and male circumcision within the Jewish and Muslim traditions. Female genital cutting, on the other hand, is now generally seen as a brutal, sexually repressive practice, dangerous to women’s health.¹⁵ Technical advances and the growing cultural authority of medicine have multiplied the uses of medical methods for nontherapeutic purposes. Twentieth-century examples, all controversial and some widely condemned, include execution by lethal injection,¹⁶ punitive amputation of limbs, chemical castration of sex offenders, medication of mentally healthy detainees to quell physical resistance,¹⁷ and medication of prisoners with psychotic symptoms to render them competent for criminal trial¹⁸ or execution.¹⁹ Some of these practices, such as the psychopharmacologic treatment of disturbed prisoners, yield arguable health benefits that in turn further state purposes, sometimes raising the question of therapeutic pretext. Other practices, such as execution by lethal injection, entail frank use of clinical methods to achieve nontherapeutic ends.

Rights, Responsibility, and Opportunity

Health status, actual and perceived, plays a protean role in state assignment of rights and responsibility, as well as distribution of opportunities. As arbiters of health status, physicians thus exercise enormous gate-keeping authority. Most medical practitioners have at some point been asked to opine on a patient’s fitness for work or school or eligibility for disability benefits. Criminal justice systems in many nations defer to psychiatric testimony when a defendant’s competence to stand trial or a mentally impaired perpetrator’s responsibility for his conduct is at stake. Clinical judgment plays an even larger role in civil law matters, including competence to make contracts, wills, and medical treatment decisions, access to abortion on the basis of medical need, and assessment of damages in personal injury cases. Increasingly, medical assessment, on behalf of both government and private healthcare payers, determines patients’ access to costly technologies and courses of treatment.

Medical Complicity and Moral Regard

The medical examination that determines whether torture will continue in a clandestine detention center in Uruguay or Argentina circa 1980 or in Turkey today is of a conceptual piece with these other forms of clinical gatekeeping. It differs in its social context and implications—in the nature of the extraclinical consequences that ensue for the examinee—not in the nature of the clinical

skills and judgment employed. And to the extent that physicians in any society are inclined to perform their myriad gatekeeping functions unreflectively, without moral regard for the extraclinical consequences of their gatekeeping activities, the medical profession is at risk for complicity in virtually any form of human rights abuse that a society or government might perpetrate. The same is true of other exercises of medical skill without moral regard for social context and consequences. Pursuit of public health purposes without the habit of self-critical reflection on potential harms to individuals risks involving physicians in all manner of infringements on personal rights. Unreflective expression of an expanding range of social objectives in public-health terms invites physicians to compromise the interests and rights of patients for an expanding set of reasons. Application of medical techniques toward nonmedical ends without moral regard for harms suffered by the human objects of such applications makes physicians into accomplices, unrestrained by the profession's ethical commitment to patient well-being.

Medical practitioners in the United States and other industrialized democracies who take pride in their noninvolvement in human rights abuse may well be congratulating themselves on their blind luck. Were abuses of the sort we typically identify with authoritarian government endemic in their countries, would they be less prone toward complicity than their medical colleagues in, say, Latin America or Turkey? The unreflective willingness of most Western physicians to employ clinical skills for myriad state purposes suggests that their ethical sensitivity to the problem of extraclinical consequences does not greatly exceed that of their colleagues in countries where gross human rights abuse is endemic. If so, then their ability to avert complicity when state purposes turn troublesome or worse would likewise not differ greatly from that of their peers in more problematic settings. This is hardly to say that cooperation with legitimate state purposes is comparable to complicity in torture or other human rights abuses. But it is to caution that the medical profession's main tool for avoiding such complicity—an active, self-critical concern about harms to people that might ensue from putting clinical skills at the state's disposal—may be dysfunctional on a worldwide scale.

Complicity with state and social purposes, licit or otherwise, can be subtle to the point of near-invisibility. Definitions of illness, especially psychiatric, are informed by cultural and social norms of desirable and troublesome conduct. Therapies that benefit patients also support these norms. One need not embrace Thomas Szasz's claim that mental illness is a "myth" to acknowledge that such norms influence diagnosis and treatment in ways that shade, from a human rights perspective, from benign to problematic to pernicious. Diagnostic concepts like schizophrenia and bipolar disorder mark, for medical intervention, behaviors that both tear at the social fabric and bring misery to the afflicted. Other constructs, like narcissistic personality disorder,²⁰ mark character styles often noxious for their disregard of others' feelings (and disruptive in settings that call for interpersonal cooperation) but at times empowering of creative accomplishment that threatens ossified authority. Some disease concepts sit on the cusp of social controversy. To what extent does the increasing diagnosis and drug treatment of attention deficit disorder in children, especially boys, represent benevolent intervention to keep troubled youths on track toward educational and career opportunity and to what extent is it a repressive substitute for individualized efforts to engage children on their own, sometimes raucous

terms? Are we more prone today than, say, a century ago, when large organizations were less pervasive in economic and social life, to medicalize behaviors that interfere with cooperative endeavor?

The connection between social norms and clinical diagnosis and intervention became pernicious from a human rights perspective in the former Soviet Union. Diagnostic constructs that incorporated persistent political nonconformity as symptoms of mental illness were engrafted in the 1960s onto Western models of schizophrenia as a spectrum of biologically related illnesses. These constructs flourished when such nonconformity was so rare that the typical Soviet citizen considered it mad. Lay prejudice and professional practice reinforced each other, making it easier for Soviet psychiatrists to believe in these diagnoses' legitimacy and for laypeople to see political dissent as beyond the pale. When, in the 1960s and 1970s, post-Stalin reformers sought to render the repressive apparatus of the Soviet state less arbitrary and more legalistic, they seized on psychiatric diagnosis and internment, based on these disease constructs, as a way to silence dissidents and discredit their ideas.²¹

The connection between diagnosis and social expectations has engendered similar abuses elsewhere. For a time, South African psychiatrists issued diagnoses to blacks who repeatedly ventured into whites-only areas in violation of apartheid-era "pass" laws, and these diagnoses sometimes became the basis for internment. Benjamin Rush, a signer of the Declaration of Independence and a founder of the American Psychiatric Association, developed his own diagnostic categories for supporters of the British during the American Revolution, although there is no evidence that these diagnoses in themselves triggered hospitalization or imprisonment. Well into the 1970s, the American Psychiatric Association officially recognized homosexuality as an illness, fostering many forms of discrimination by state and private actors.

To be sure, the connection between clinical diagnosis and social norms is more often unimportant. Diagnosis and treatment of cancer or bacterial infection express and reinforce social norms only in a trivial sense. Leninist, fascist, Republican, and Democrat agree that bacteria are "bad" and that killing them is socially desirable, although some biologists might theorize about their ecological or evolutionary virtues. But when matters are not so simple—when inattention to the norms and values underlying clinical judgment extends to diagnostic constructs with social consequences that potentially infringe on personal rights—then such inattention puts physicians at risk for complicity in abuses of human rights.

Western critics who portrayed Soviet psychiatric diagnosis of dissidents as a consciously duplicitous adjunct of KGB repression²² failed to see the extent to which these diagnoses embodied social norms adhered to unreflectively, even unconsciously, by Soviet clinicians. This unawareness enabled psychiatric evaluators to see their work with dissidents as the mere exercise of medical judgment, without political purpose. Western critics' inability to discern this unawareness made their advocacy on behalf of Soviet psychiatry's victims less incisive—and perhaps less effective than it might otherwise have been.

Unawareness, even unconsciousness, of connections between clinical practices, social norms, and state purposes is, I submit, pervasive among medical practitioners. It helps to explain why physicians in the former Soviet Union, South Africa, Latin America, Turkey, and elsewhere have taken much umbrage at charges that they intentionally misused their medical skills on behalf of agents of state repression. A recent example is the reaction of some Turkish

forensic practitioners to allegations that their failure to document and draw reasonable inferences from evidence of torture and other brutality abetted the Turkish military's coverup of its atrocities in Kurdish areas. At a 1995 conference in Istanbul on physician complicity in these abuses, American pathologist Robert Kirschner, who led forensic medical teams that investigated mass graves in Bosnia-Herzegovina and Rwanda for the U.N. War Crimes Tribunal, criticized Turkish forensic doctors for failing to inquire into what occurred at the time and place of death and to report on likely causes of wounds they observed when they were called on to investigate deaths in detention.²³ Kirschner contended that the Turkish forensic practice of examining and reporting on only the condition of the body, without probing the circumstances of death, yielded unrevealing autopsy results that helped authorities to cover up state-sanctioned murder and torture.

In the audience were some of Turkey's senior forensic physicians. Several rebuked Kirschner for pressing them to extend their inquiries beyond the scope of their technical expertise. Kirschner answered, in essence, that all medical practice requires judgment, which is best exercised by reference to the totality of the circumstances. In later conversation, many of the forensic physicians present took umbrage at the notion that their approach abetted the coverup of killings and torture. What they did not acknowledge, and seemed sincerely unaware of, was the close fit between these features of Turkish forensic practice and avoidance of confrontation with state authority. Without conscious intent, it appeared, they had evolved practice norms that made it easier for the security forces to get away with murder. Lacking such duplicitous intent, these physicians were stunned by the suggestion that they collaborated in human rights abuse.

Some Challenges for Human Rights Activism

To be sure, medical participation in human rights abuse has at times been hands-on and purposeful. But the more subtle complicity of Turkish forensic doctors, Soviet and South African psychiatrists, and others whose clinical judgment and actions have indirectly supported state-sanctioned brutality and repression abets human rights abuse on a much larger scale. Ironically, this more subtle complicity is a byproduct of the human rights movement's global success. Torture and other crudely repressive measures have become a matter of international embarrassment to states that engage in them, and medical skills and judgment have therefore become useful to these states as means of concealment, sanitization, and even justification. Human rights activism that effectively targets such complicity has the potential to make a large difference in people's lives, by stripping perpetrators of their medical cover and thereby exposing state torture and terror to the full, harsh light of international judgment.

To have maximal effect, though, such activism should, in general, eschew black-and-white condemnations of unreflective physician-collaborators in favor of efforts to engage, sensitize, and thereby transform them. Turkey's forensic doctors offer a powerful example. After the above-mentioned conference, the U.S.-based group Physicians for Human Rights (PHR) began a process of engagement with the Turkish medical community that continues to this day. In conjunction with Turkish human rights activists and sympathetic medical leaders, PHR conducted a series of conferences for Turkish forensic physicians, attorneys, and even judges and prosecutors on basic international human rights

law and the medical and pathological evaluation of suspicious injuries and deaths. Turkish physicians were encouraged to discuss their fears of punitive state reaction to more thorough forensic investigation and more revealing forensic reporting. They were also encouraged, in a nonconfrontational manner, to give greater thought to the ways by which shoddy, unrevealing reporting facilitates systemic torture and murder. Some, moreover, joined with colleagues from around the world, under the auspices of PHR, the U.N. Special Rapporteur on Torture, and a consortium of nongovernmental human rights organizations, to develop a set of guidelines for medical investigation of injuries in detention that became known as the Istanbul Protocol.²⁴

By late 1999, medical leaders and human rights monitors in Turkey were reporting large changes in forensic medical practice, toward more robust inquiry and more revealing reporting in cases of suspicious injury or death in detention (personal communication from Vincent Iacopino, Senior Medical Consultant, PHR). This apparent shift has occurred despite continuing harassment by state security authorities, including periodic arrests and detention of physicians who report evidence of state-sanctioned torture and murder. International support for these physicians has sustained their morale and made their moral example tenable to less courageous colleagues. Analogous collaborative efforts by health-and-human-rights activists have shown similar promise in other areas. U.S.-based Mental Disability Rights International (MDRI), which has documented systemic cruelty and appalling conditions in institutions for adults and children in Russia, Eastern Europe, Mexico, and Uruguay, launched a sustained effort several years ago to work with Hungarian mental disability rights activists, mental health professionals, and government officials to achieve better conditions for that country's mentally disabled and orphaned children. MDRI's mix of support for local activism, educational programs, and engagement and negotiation with government officials (abetted, to be sure, by international embarrassment and the threat of litigation in European Community forums) has already catalyzed changes in Hungarian mental disabilities law, although the impact on institutional practice remains to be seen (personal communication from Eric Rosenthal, Executive Director, MDRI). Such efforts merit a shift in the health-and-human-rights movement's focus and resources, away from the paradigm of one-shot investigation, public criticism, and disengagement that characterized the movement's early years.

The kind of activism I am urging also demands an eye for moral paradox and ambiguity. Physicians who work in detention settings where torture and other abuses are endemic are a case in point. Does thorough clinical evaluation and accurate reporting on a detainee's physical condition after beating, suffocation, or electric shock represent responsible professional conduct or complicity in torture when prison or camp authorities use the results of such evaluation to plan follow-up torture sessions? Is medical *treatment* in such settings an ethical duty or an act of complicity when successful, even life-saving therapeutic intervention enables the torturer to resume his efforts? What are the responsibilities, in such circumstances, of individual clinicians and of the medical profession as a whole?

The public health sphere represents another area of moral paradox for the health and human rights movement. We know now, from empirical studies, that social and economic well-being are much more important determinants of population-wide health status than is per capita spending on medical care. A

series of studies tie health status to social class,²⁵ wealth,²⁶ education,²⁷ environmental exposure, and patterns of racial subordination. Jonathan Mann, Robert Lawrence, and others have built on this work in arguing for an expansive conception of the relation between health and human rights—a conception that emphasizes the import of respect for civil/political and social/economic rights as means for ensuring the health of populations, while also pointing to population-wide health as a prerequisite for respect for individual rights. Yet as many, including Mann and Lawrence, have recognized, there are indissoluble tensions between the goals of maximizing the health of populations and protecting personal rights. Accommodation between these ends is a central task for the health-and-human-rights movement. It is critical to resolution of such diverse matters as the acceptability of personally intrusive public health campaigns against communicable diseases; the ethics of clinical trials of less-effective, low-cost treatments for HIV and other illnesses; and the acceptability of putting the third world poor into inexpensive, prevention-oriented managed health plans that restrict personal choice and deny access to “first world” clinical technology.

More generally, the growing emphasis on population-wide health in progressive thinking about the relations between international human rights and medicine risks anesthetizing clinicians to the moral problem of departure from the ethic of undivided commitment to individuals. This commitment—so central to medicine’s ministerial functions of comfort and support, explanation, and reassurance against fear of abandonment—fits awkwardly with population-wide thinking. My point is not that the profession should refrain from robust advocacy of public policies that would clearly enhance the health and well-being of populations. When such advocacy draws on medical expertise, it can be a credible, even powerful force for good. Professional activism in the United States against cigarette advertising aimed at children and on behalf of programs targeting child poverty is illustrative. Internationally, efforts to highlight and better understand the connections between education, nutrition, family and social stability, economic growth and opportunity, morbidity and mortality, and the building and preservation of rights-respecting political institutions hold much promise. Yet the broader the range of social objectives that we place under the rubric of public health—and thus within the medical sphere—the wider the scope of our summons to physicians to put social purposes ahead of Hippocratic loyalty when tensions between the two arise. Whether, as Christian Pross suggests, Weimar-era German emphasis on the physician’s responsibility for the health of the “body politic” helped to set the stage for Nazi medical atrocities, or whether Pross makes too much of a macabre coincidence, the Nazi physicians’ embrace of public health metaphor as rationale stands as warning of the risk of excess. Against this risk, the physician’s principal protective tool is an unflinching moral alertness—a habit of self-conscious reflection on the legitimacy of social purposes and on the ethical tensions between public obligation and Hippocratic fidelity.

International human-rights activism aimed at health professionals should seek foremost to inculcate such moral alertness. Advocacy and teaching of codes of conduct are helpful up to a point, but they cannot substitute for development of reflective, independent habits of mind. Human rights investigative missions can both enrich our understanding of the varieties of medical complicity and help to establish culpability in particular cases, but they are in

the main an after-the-fact response, not a prophylactic tool. To wage a proactive, high-impact campaign against medical complicity in human rights abuse, deeper, sustained engagement with professionals and institutions at risk is essential. This engagement should encompass, in addition to the teaching of international human rights and ethics norms, consideration of the ways in which clinical work can unwittingly abet human rights abuse. It should also include collaborative efforts to distinguish between acceptable and unacceptable uses of medicine for state purposes. Such efforts are important at least as much for their contribution toward the inculcation of independent, deliberative habits of mind as they are for the line-drawing that ensues.

Such habits of mind are essential to the medical profession's ability to resist when state authorities and social forces pull it toward systemic complicity in human rights abuse. Also vital to physicians' capacity to resist are institutional mechanisms that nurture sufficient professional autonomy to empower physicians to say no and to speak out, without fear of retribution, when they are called on to conceal, sanitize, or otherwise abet torture and other abuses.²⁸ Separate lines of administrative authority for clinical work in military, prison, and other at-risk environments; rotation of physicians in and out of such settings to forestall acculturation to their ethos; and institutionalized professional interaction (e.g., clinical conferences, continuing education programs) with peers in civilian practice are among the most promising mechanisms for achieving this. Almost equally important is international support—from professional bodies, human rights organizations, and governments—for physicians who put their lives, families, liberty, or careers at risk by exposing or refusing to collaborate in abuse.

In comparison to the enormity of state-sponsored brutality during the century now behind us, the problem of medical complicity can pale into seeming insignificance. Yet physician involvement, more often indirect—and sometimes unwitting—than hands-on or purposeful, played a large role in making torture, murder, and less brutal forms of repression less visible and more palatable. Ironically, the human rights movement's success at winning over world opinion during the second half of the twentieth century²⁹ has made such involvement more appealing than ever to repressive governments. The central human-rights paradox at the dawn of the twenty-first century is the survival and proliferation of regimes that rule through torture and terror despite global agreement that such conduct is unacceptable. These regimes' incentives to disguise their behavior so as to avoid international embarrassment make medical concealment and sanitization of atrocities and repression attractive in proportion to this embarrassment's economic and political consequences. In the coming years, physicians and other health professionals who work in settings where human rights abuse is endemic will face sustained, perhaps growing pressure to collude at least tacitly in its concealment. International activism aimed at stripping the medical veil from the architects and perpetrators of abuse promises to harness the deterrent power of the global consensus that is the human rights revolution's greatest achievement.

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