Humanitarian medicine: up the garden path and down the slippery slope

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Doctors dealing with asylum seekers need clearer direction on how to manage human rights issues and avoid being drawn into abuses

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Twelve years ago, I joined an International Committee of the Red Cross mission to visit detainees in South African police stations under apartheid. As I was leaving, a colleague gave me *Medicine Betrayed*, the BMA's pioneering report on the participation of doctors in human rights abuses.¹ It seemed so relevant to the issues with which I was confronted as a "humanitarian" doctor. My missions with the Red Cross and then with Médecins Sans Frontières took me to countries at war such as Liberia, Tajikistan, Rwanda, Burundi, and Kosovo. These experiences reinforced my conviction that humanitarian medicine was a powerful antidote to the violations I had read about in *Medicine Betrayed*. I now worry that it can also become an unsuspecting accomplice of these same violations.

Asylum seekers and migrants

In 1995, I joined the International Organisation of Migration (IOM), another organisation with a humanitarian mandate. As its occupational health officer, I followed the work of IOM staff in over 70 countries, many of which I visited, including Afghanistan and East Timor. My work has slowly made me realise how easy it is to be absorbed in a system and to slide down the slippery slope of failing to perceive human rights abuses when dealing with migrants and asylum seekers. This issue was mentioned only briefly in *Medicine Betrayed*.

The politicisation of migration has meant that doctors are under increasing pressure to participate in actions to prevent people seeking asylum in rich countries. Doctors can thus become involved in actions that are at the limit of international humanitarian law and human rights.

Some doctors have acted courageously. Dr Ginette Marchant was employed as a doctor in the Vottem centre for asylum seekers in Belgium in 1999.² Eleven months later she resigned. She realised that she was being used as an alibi to give the centre a caring social image. She found it impossible to provide adequate medical care to detainees subjected to psychological violence and to ensure that confidentiality was respected. She tried to inform detainees of their rights, incurring the wrath of officials. Finally, she became convinced that the detention was totally unjustified and that she had been drawn unwittingly into supporting a system that violated human rights.

Nauru

Dr Maarten Dormaar left after four months working for the IOM. He was employed as a psychiatrist to work on the Pacific island of Nauru, where hundreds of asylum seekers (men, women, and children) had been detained since September 2001—condemned to idleness and

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constantly guarded by more than 100 security guards. Some of the asylum seekers had been rescued at sea by the Norwegian ship *Tampa*; others had tried to enter Australia.³ They were kept on Nauru as part of the Australian government's "Pacific solution," designed to prevent asylum seekers reaching its territory. Dr Dormaar witnessed worsening mental health problems, including depression and acute stress reactions, and claims that IOM did not act on his reports.⁴

Since his return Dr Dormaar has tried to mobilise public opinion in the Netherlands and Australia (with some success). In December 2002 riots broke out in a Nauru camp. IOM staff, including nurses and doctors, were threatened by asylum seekers, who could no longer tolerate indeterminate detention and constant pressure to return to their countries of origin, which included Iraq, Afghanistan, and Iran.

The Australian government finances the whole Nauru operation. IOM is the main contractor. Thus even a well established organisation like IOM, which has repeatedly proved its value in difficult situations, becomes compromised as the de facto detaining authority. Its medical staff thus face ethical dilemmas for which they do not receive clear guidance. An internet advertisement for an obstetrician and gynaecologist to be contracted by IOM reads, "Working in Nauru will give you a flavour for the 'Pacific Way.' You will be able to experience the relaxed lifestyle and savour some of what the Pacific has to offer with the sea, sand and smiling faces."⁵ It does not mention the complex human rights and ethical issues facing doctors who have to deal with refugees who have become prisoners.

Vigilance to abuse

Last summer I visited the Hiroshima Peace Museum, the Kyoto Museum for World Peace, and London's Imperial War Museum (where I saw the Holocaust

Summary points

Political action to control migration to richer countries makes asylum seekers vulnerable

Doctors working with asylum seekers may find tension between professional values and the policies of their employers

Stronger guidelines are needed on human rights and ethical issues

exhibition). All three showed how easily doctors can become involved in abuses. The risk is that we remember the most grotesque cases—the collusion of the German medical profession with the Nazis, the active involvement of Japanese doctors in experiments on humans, and the Allies' inadequate care for the victims of the Hiroshima bomb—while failing to react in a timely way to new potential abuses.

The issue here is not how the Belgian authorities, IOM, or the Australian government deal with asylum seekers. It is about how doctors find themselves torn between the policies of their employers and their professional values, thus allowing projects to get into tight corners. We lack a strong system of standards and ethical guidelines for doctors dealing with migrants and especially with asylum seekers. There are several settings where this lack of directives makes doctors vulnerable:

- Working in detention facilities for asylum seekers or in holding areas at airports for illegal migrants
- Assessing the medical consequences of torture and more generally providing reports which can influence the destiny of migrants and their families
- Treating seriously ill patients who face expulsion to countries with inadequate health facilities
- Coping with the psychological disturbances of children of illegal migrants facing constant uncertainty about the future
- Being directly involved in expulsion procedures.

The rhetoric about human rights and humanitarian law at the level of international organisations, congresses, and medical journals does little to help such doctors. Perhaps the discourse about health and human rights and humanitarian action should concentrate more on failures in enforcement and a patchy setting of standards. In the past 12 years, I have learnt how medicine can be betrayed in many ways and how we need to be especially vigilant when cloaked in a humanitarian mantle.

Competing interests: DH-P worked for the International Organisation of Migration from 1995 to 2003.

- 1 British Medical Association. *Medicine betrayed*. London: Zed Books, 1992.
- 2 Collectif Contre Les Expulsions. *Centre fermé de Vottem : un médecin démissionne et accuse*. <http://ccle.collectifs.net/article39.html> (accessed 22 Jul 2004).
- 3 Zinn C. Australia accused of blocking doctors' visits to asylum seekers. *BMJ* 2004;328:186.
- 4 Fickler D. Australia "as bad as Taliban" say hunger strikers. *Observer* 2003 Dec 21. <http://observer.guardian.co.uk/international/story/0,1111167,00.html> (accessed 22 Jul 2004).
- 5 Royal Australian and New Zealand College of Obstetricians and Gynaecologists Asia and Oceania Affairs Committee. *Volunteer e-News* 2002;1:4. www.ranzcog.edu.au/Open/asia-oceania/pdfs/volunteers-emews-may2002.pdf (accessed 5 April 2004).

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Commentary: ethical pitfalls can be hard to avoid

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Many clinicians will have memories of slightly disturbing encounters—perhaps while in training—when they felt that a patient was suffering unnecessarily thoughtless, humiliating, or frankly brutal treatment. It is difficult for junior doctors to make a complaint. Perhaps it becomes slightly easier with growing experience and seniority, but it is never straightforward and many encounters go by without protest. Although ethical norms have improved in recent years, there are still many working environments where doctors daily witness doubtful practices and have to decide whether to confront or ignore them.¹ When should you blow the whistle?

Doctors whose work involves divided loyalties, such as police surgeons, prison doctors, or medical officers in the armed forces, are most likely to encounter these ethical problems. Of course, in countries where torture is practised, doctors in such jobs face more serious choices and risks than doctors in the NHS. If they do not cooperate with their employers, they can risk dismissal or even physical danger to themselves or their families. Some have been seduced not only into compliance but complicity or actual participation in torture. Similar dangers must also exist in countries that practise "moderate physical pressure"² or "torture-

lite."³ We can only wonder what the doctors in the US detention centre in Guantanamo Bay or Abu Ghraib prison in Iraq have seen.

Reasons for collusion

It is easy for those of us who do not work in these environments to be critical, but in some circumstances vulnerable doctors are in danger of being drawn in. In 1990, Amnesty International produced a report that identified some reasons for medical participation in torture.⁴ Doctors rarely talk about their role in human rights violations, and the reasons behind it are therefore mostly speculative. However, those participating in torture or other abuses will probably be doing so for one or more of the following reasons:

Identification with the cause of the torturers—Doctors working with security forces may absorb (or fundamentally identify with) the values of those carrying out torture, particularly in countries with sharp political, social, or racial divisions

Fear of the consequences of refusal—In some countries doctors have been forced to serve a period of military service and may believe that opposition to military

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