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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superiors is impossible. Doctors sometimes face contradictory obligations—for example, to medical ethics and to legal strictures against the public exposure of abuses occurring in government service.

“Bureaucratisation” of the medical role—Some doctors seem to have been able to distance themselves from the abuses being inflicted on prisoners by adopting the role of uninvolved technician, carrying out a purely technical function.

Inadequate understanding of medical ethics—Doctors may see their role as that of a healer, minimising the pain resulting from torture or ill treatment. This may be particularly so in the case of capital and corporal punishments, where there is a legal framework for the medical role.^{5–7}

Most doctors will not come into contact with these serious problems, but there are more subtle and insidious areas where doctors who think they are working in a humanitarian field may fall into the trap of conniving with unethical practices. Harding-Pink draws attention to the problems for doctors working with asylum seekers.¹ Clearly, asylum seekers need special protection. Individuals who have had their basic human rights violated in their country of origin are the least able to withstand further abuse in the country where they seek refuge. Yet by its nature, this work carries the possibility that human rights violations may occur when the care of refugees falls into the hands of staff who are not bound by the ethical principles that bind doctors.

Supporting doctors

The BMA's updated publication on human rights gives more attention to the rising problems related to immigrants and asylum seekers.⁸ This, together with *Medical Ethics Today*,⁹ should be a regular reference for all clinicians. Further specific guidance and detailed commentary are given in a publication by Physicians for Human Rights.¹⁰ However, those looking for a “recipe

book” approach may be disappointed. The examples Harding-Pink poses are difficult to resolve in practice even if some might find them clear in theory.

The teaching of medical ethics in medical schools has improved immeasurably in recent years, but all practising clinicians have a responsibility to keep up to date as new situations arise and new ethical pitfalls appear. Nevertheless, as Harding-Pink shows, health professionals can be isolated and left to make difficult decisions under pressure by those not committed to ethics. Professional bodies need to give ethical leadership and to constantly review the transparency and accountability of those authorities employing medical staff. The extraordinary turn around in public opinion after revelations of US torture at Abu Ghraib shows the effect of just a small amount of involuntary *glasnost*. We should be calling on governments and international agencies to account for their policies and practices, including those situations where they use medical staff.

Competing interests: None declared.

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- 2 Ziv H. *Physicians and torture—the case of Israel*. Tel Aviv: Physicians for Human Rights Israel, 1999.
- 3 Campbell D. US interrogators turn to “torture-lite.” *Guardian* 2003 Jan 25.
- 4 Amnesty International. *Involvement of medical personnel in abuses against detainees and prisoners (revised and updated)*. <http://web.amnesty.org/library/index/engact750081990> (accessed 19 Jul 2004).
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- 7 Lifton RJ. *The Nazi doctors*. London: Papermac, 1987.
- 8 British Medical Association. *The medical profession and human rights: handbook for a changing agenda*. London: Zed Books, 2001.
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A memorable patient

The longest weekend

It was late February, and I was working at a busy seaport hospital that often accepts patients from docking ships. A man in his early 30s was one such arrival, admitted to the infectious diseases unit with suspected chickenpox. In basic English, he complained of a rash over his face, trunk, and thighs, with pain on swallowing preventing him from eating or drinking.

On examination, he was feverish with generalised lymphadenopathy and widespread crusting papulopustular lesions. He also had painful aphthous ulceration of his oral mucosa and genitalia. A chest radiograph was suggestive of right basal pneumonic changes, and he was given both antiviral and antibiotic treatment.

Several days passed, and he neither deteriorated nor improved, with a diagnosis proving elusive. After much debate, we suspected that he might be immunocompromised, and on the Thursday afternoon the genitourinary specialist nurse was asked to counsel him and perform an HIV test. The result would be available within 24 hours, and we assumed that he would be told of the result before the weekend.

It was a bank holiday, and I enjoyed the long weekend away at a theme park near Paris; *Pirates of the Caribbean* in the snow is a real must-see. Returning refreshed on the Tuesday morning, I was

pleased to find the test had proved negative—but unfortunately no one had told the patient. I strode into his room to convey the good news only to find a broken man.

He had spent those four days in isolation, unable to eat, sleep, or defecate through fear. The thoughts had gone round and round in his head. Were we avoiding breaking the bad news? Were his wife and children infected? Would he lose everything he cherished? Emerging from his room an hour later, I had listened to him trying to make sense of it all: while I had been enjoying myself with friends, he had been suffering alone in a foreign land. Overwhelmed by relief, he could not comprehend why he had been so tortured.

He was subsequently discharged with a diagnosis of Behçet's syndrome, but I still think of how he was so cruelly let down by circumstance and our lack of foresight. His plight reminds me that clinical practice is not just about deciding which tests to perform, but checking the results and acting on them appropriately, and not presuming that someone else will do it.

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