



FASPE

Fellowships at
Auschwitz
for the Study of
Professional Ethics

2017 JOURNAL

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EDITOR

Thorin R. Tritter, Ph.D.

MANAGING EDITOR

Talia Bloch

DESIGN & LAYOUT

Trevor Messersmith

COVER PHOTO

FASPE 2017 Medical and Seminary Fellows on the grounds of the House of the Wannsee Conference in Berlin. **KATIE ZONI / FASPE**

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INTRODUCTION

Introduction

What does Germany from 1933 to 1945 have to do with today? Wasn't the Holocaust a singular act of malevolence perpetrated by a group of evil and deranged madmen?

What do professionals and the professions have to do with mass murder and genocide?

What do contemporary ethics have to do with Adolf Hitler?

These are the questions that underlie the FASPE mission.

In fact, it *was* the professionals in Germany and portions of occupied Europe who designed and enabled the actions that led to genocide. It *was* the professionals who executed the laws and policies that they designed. Lawyers wrote and enforced the Nuremberg Laws. Doctors designed and carried out the first murders of the handicapped and the opposition. Journalists became propagandists. Business executives used slave labor and entered into contracts with the Nazi regime to produce the weapons of genocide. Pastors and priests too often collaborated and condoned, even promoted, Nazi policies. And, to be sure, their actions were *voluntary*, not carried out at gunpoint.

FASPE begins by studying the *perpetrators*, the professionals who looked like, were educated in the same fashion as, and played the same leadership roles in their society as, today's professionals. How and why did *they* make the transition from ordinary professionals to becoming accessories to or enablers of mass murder? The answer is that it happened day by day, decision by decision, often in the service of ambition and prestige and not ideology.

In FASPE's focus on contemporary ethics in the professions, we do not seek analogies or equivalencies to Nazi Germany. Instead, we seek to display the importance of ethical behavior — even on the “little issues” — and to highlight the leadership role that professionals must play in their communities. We want our professionals to identify ethical issues and to develop tactics to address them.

We hope that the essays in this year's journal display the seriousness with which FASPE Fellows accept their responsibilities. Our Fellows give us reason for optimism as they become ethical leaders in their professions.

On behalf of FASPE, I congratulate the 2017 class of FASPE Fellows and welcome them to our community of over 430 alumni Fellows. We look forward to your leadership.

David Goldman
Chairman

FASPE

FASPE operates fellowship programs for graduate students in professional schools — business, journalism, law, medical and seminary — and early stage practitioners in those professions, which challenge its Fellows to become acutely aware of their responsibilities as respected professionals in their communities and to act in an ethical fashion.

FASPE fellowships are comprised of intense two-week study trips to Germany and Poland where Fellows study the actions and choices of their professional counterparts between 1933 and 1945. Through this examination of the ethical failures of the professions in what was a progressive, modern society, Fellows learn about the critical role that professionals play in society and the consequences of their actions — positive or negative — on the world around them.

FASPE offers a contemporary approach to the study of the Holocaust by focusing on the actions of the perpetrators rather than on the victims. Drawing on the powers of place, the study of history and a rich contextual education, FASPE creates a uniquely effective means for studying professional ethics — well beyond what is achieved by the rules-based approach often seen in the traditional university classroom.

Originally piloted in 2009 and launched in 2010, FASPE marked its eighth year of operation in 2017. A highly competitive program, FASPE accepts only 65 Fellows (12 - 15 in each of the five professions) from nearly 1,000 applications per year. Its faculty is drawn from international Holocaust historians, practicing professionals and leading academics.

FASPE seminars engage Fellows in thinking across several themes, including: defining professionalism; considering a professional's responsibility to the larger society; and the tactics of enacting an ethical decision. Seminars also focus on topics that are discipline specific, such as:

- **Business:** Are there products that simply should not be sold to particular consumers? What are the responsibilities of the C-Suite, or of the corporation, beyond formalistic legal compliance? What are appropriate penalties for corporate wrongdoing?
- **Journalism:** How do journalists balance the costs and benefits of access? What ethical issues arise in political reporting? What challenges arise in fact-checking a victim's story? Does advocacy fit into journalism?

- **Law:** How do attorneys manage duties of candor and confidentiality? What control do lawyers have over decisions that impact a client? Does the duty to a client supersede all other responsibilities?
- **Medical:** What are the ethical issues involved in medical research on human subjects? Should physicians participate in assisted suicide? How should doctors deal with resource limitations in making healthcare decisions?
- **Seminary:** What is the role of religious leaders as ethical, and not just religious, educators? When and how should they address political issues with a congregation? What are the challenges of pastoral care during times of crisis?

FASPE has far-reaching goals. On an individual basis, it seeks to instill participants with a sense of personal responsibility for the ethical and moral choices they make. By extension, it also seeks to have an impact on the professions at large, improving the practices of all business executives, clergy, doctors, journalists and lawyers.

MEDICAL
PAPERS

Introduction to Selected Medical Papers

The 2017 Medical cohort included a group of 15 caring and intelligent medical students from 13 different medical schools. Led by veteran FASPE faculty members Dr. Mark Mercurio and Dr. Jack Hughes, both from Yale Medical School, these Fellows engaged in a series of discussions and debates about specific ethical challenges faced by individual physicians and the broader ethical dilemmas confronting the medical profession as a whole.

The starting point for these discussions was the frightening fact that Nazi physicians were neither evil monsters nor a crazed minority, but had largely been trained in the German medical system, which was considered one of the foremost in the world at the time. If Nazi physicians could have lost their professional moorings, how can physicians today avoid doing so? This question was at the heart of many of the FASPE Medical discussions.

After the trip, Medical Fellows were asked to submit a short paper about a particular issue in medical ethics that interested them. The two essays that follow are examples of the approaches taken by the Fellows as they delved more deeply into some of the questions raised during the trip and represent the high quality of analysis done by this cohort of medical students.

The first essay is by Yuntong Ma, who explores the large role Nazi atrocities had in shaping post-war medical ethics, spurring an emphasis on the principles of patient autonomy, informed consent and preserving life at all costs. Yuntong goes on to argue, however, that adhering dogmatically to these principles today raises its own set of ethical concerns, particularly in the ICU setting. She concludes that doctors should be willing to offer more guidance in end-of-life situations and should consider more carefully how treatments can diminish the quality of life for the patients in their care.

The second essay is written by Alexa Kanbergs, who focuses on circumstances in which pressures from state authorities or institutions can lead doctors to prioritize third-party loyalties over the interests of their patients. In particular, Alexa examines the challenges faced by doctors working within the prison system, where their obligations to patients sometimes come into conflict with the requirements of a prison's security procedures. In the end, Alexa calls for improved ethics education, particularly for physicians who may be working in prisons or other contexts in which dual loyalty comes into play.

On behalf of FASPE, I am grateful for having had the privilege of traveling with this group of medical students, and I thank the faculty for all their efforts to enrich the journey for everyone.

Thorin Tritter
Executive Director

Life! End of Discussion

End-of-Life Discussions in the Intensive Care Setting

BY YUNTONG MA

On a cloudless day in June, I stood in front of a barrack at the Auschwitz I camp along with 30 other FASPE Fellows. This brick-red building has not been restored or reconstructed as part of the permanent exhibition of the Auschwitz-Birkenau Memorial and Museum, but instead, has been preserved in its original state. Here, women and children who were the subject of “scientific” experiments by Nazi physicians were once imprisoned. The walls were dusty and slate-colored. Slivers of afternoon sunlight filtered through and illuminated the emptiness of rooms once used for sterilization, freezing and other experiments by Nazi physicians, the most infamous of whom was Josef Mengele. These experiments were painful, often deadly, and performed on prisoners without their consent. In our FASPE seminar discussions, we discussed the step-by-step ideological distortions that led Nazi physicians to go from early sterilization experiments and euthanasia of the elderly and disabled — those deemed a burden to society — to the large-scale extermination of Jews and others termed “racial undesirables.”¹

Six weeks later, I was working a month-long rotation in a hospital intensive care unit (ICU). One of my patients was an elderly man, who had formerly been a professor of English literature at a prestigious university in India. After a fall leading to traumatic brain injury, he suffered severe neurologic damage and a prolonged hospital stay due to respiratory failure, bowel obstruction and repeated infections. During our latest meeting with the patient’s family to discuss the goals of care, the attending physician had stated that even after trying “everything possible,” the patient had still not improved, and he therefore recommended withdrawal of interventions and the start of comfort care. Upon hearing this, the patient’s wife became emotional and began hurling a series of accusations at us, stating that we had been “experimenting on him,” “not doing anything for him,” and now that we were done, we were “giving up on him.”

¹ Peter Fritzsche, *Life and Death in the Third Reich* (Cambridge, MA: Belknap Press of Harvard University Press, 2009).

Back in the workroom, the wife's accusations were dismissed easily by those at the meeting as an irrational, emotional outburst — a failure on her part to confront the reality of her husband's situation. But the incident disturbed me. How different, I thought, was the situation of patients being cared for in the ICU from that of prisoners being experimented upon in concentration camps? Why did I find that the wife's words made me think of how Nazi physicians had experimented on prisoners and carried out the involuntary euthanasia of those deemed "incurably sick" or labeled as "burdensome lives"?²

At a time when the right-to-die and death with dignity movements are evolving, when debates around the exorbitant costs of the American healthcare system and "rationing" are ongoing, end-of-life care remains a morally ambiguous landscape that physicians, especially in the intensive-care setting, are required to navigate on a regular basis. Physician recommendations for "do not resuscitate/do not intubate" (DNR/DNI) or non-escalation of interventions can stray dangerously close to the territory of determining for another person whether his or her life is "worthy of living." In the post-Holocaust world, this can evoke the awful legacy of the Nazi designation of "life unworthy of life" (in German: *lebensunwertes Leben*) for segments of the population targeted for "euthanasia."³ Patients who are nonverbal or severely disabled are even more vulnerable to these calculations of the value of a human life.

After FASPE, I have continued to grapple with how to navigate end-of-life care in the intensive care setting in a manner that is moral and sensitive and that is mindful of history and the many perspectives on the issues that arise in this context. Specifically, my questions are: What is our role and duty as physicians in counseling patients and their families regarding end-of-life medical care? And, on what basis do we make our recommendations?

In this paper, I will start by exploring how the reaction to Nazi atrocities has shaped post-Holocaust medical ethics in the United States, how it has led to an ethos that errs on the side of always preserving life and has been guided by principles of patient autonomy and informed consent. Second, I will examine how dogmatic adherence to these principles can become problematic in the ICU setting. Third, I propose that in order to provide better care to those at the end of their lives we must begin by challenging and reorienting ourselves around some of the existing orthodoxies and principles in medical ethics.

One of the most significant lessons that I took away from the history of Nazi medical atrocities is that they resulted, not from a breakdown of morality or a sinister dive into evil, but rather that they grew out of a progressive, stepwise ideological distortion of what

² Henry Friedlander, *The Origins of the Nazi Genocide: From Euthanasia to the Final Solution* (Chapel Hill: University of North Carolina Press, 1996).

³ Robert Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Harper Collins, 1986).

it means to heal. They represented a “transmutation of values”⁴ that enabled medicalized killing to be seen as a therapeutic cleansing of the body politic, and that allowed daily, bureaucratic medical tasks to be cut off from ethical reasoning.

Over time, the Nazi classification of “life unworthy of life” was extended. Initially used to characterize and label the physically disabled and mentally ill in order to justify their coerced sterilization and murder,⁵ it was later extended to people who were considered “racially impure” according to Nazi racial policy, culminating in the mass killings at extermination camps.

Furthermore, central to Nazi grassroots health propaganda was one of Hitler’s maxims: “What is useful for the community has priority over what is useful for the individual” (in German: *Gemeinnutz geht vor Eigennutz*). This led to a medical ethos that not only favored paternalism, but also, eventually, a total disregard for the individual as an individual.⁶

The medical experiments performed by Nazi physicians on concentration camp prisoners over the course of World War II, as well as other abuses perpetrated by the medical profession, such as the Tuskegee Syphilis Experiment (in which treatment for syphilis was withheld from rural African-American men without their knowledge over a 40-year period), have left a legacy of distrust of the medical profession, especially when it comes to its treatment of the poor and other vulnerable populations.

Many aspects of the principles of modern American medical care may be viewed as a corrective to 20th-century abuses in the medical profession. The historical experience of Nazi atrocities, some have argued, provides post-Holocaust physicians with an “absolute and infinite moral obligation to care for severely, chronically and non-rehabilitable sick individuals,”⁷ giving rise to a medico-legal system that protects life sedulously. In the arenas of cardiopulmonary resuscitation and intensive care, this sedulous protection of life has come to be called “erring on the side of life,” i.e. any chance to prolong a life tips the scale towards intervention.⁸

In the decades following the Holocaust, medical care in the US has also evolved from one that took a paternalistic approach to one that emphasizes patient autonomy and patient-centered care. The principle of patient autonomy is generally understood to mean that

⁴ Lifton.

⁵ Lifton.

⁶ Warren Reich, “The Care-Based Ethic of Nazi Medicine and the Moral Importance of What We Care About,” *American Journal of Bioethics*, 1 (2001): 64-74.

⁷ Alan Jotkowitz, S. Glick and B. Gesundheit, “A Case Against Justified Non-Voluntary Active Euthanasia (The Groningen Protocol),” *American Journal of Bioethics*, 8(11) (2008): 23-26.

⁸ Arthur Derse, “‘Erring on the Side of Life’ Is Sometimes an Error: Physicians Have the Primary Responsibility to Correct This,” *American Journal of Bioethics*, 17(2) (2017): 39-41.

physicians allow patients to make their own decisions regarding what interventions they will or will not receive.

Closely tied to patient autonomy is the principle of informed consent, according to which a physician informs the patient of the nature of the intervention, its risks and benefits and reasonable alternatives, but then leaves the burden of the final decision to the patient (or their surrogate decision-makers). Those participating in medical research must similarly be adequately informed of the nature of the experiment in which they are participating and, if they are ill, their options for treatment.

Starting in the mid-20th century, therefore, “erring on the side of life” became medical dogma, and patient autonomy, informed consent and the overarching theme of “patient-centered care” became fundamental, unquestioned tenets of the practice of modern medicine.

The history of medical abuse perpetrated by the Nazis certainly serves as a humbling reminder to remain thoughtful and to engage in a constant reevaluation of our actions as moral agents in our daily work. But it also serves as a cautionary tale to take the crucial step that Nazi physicians failed to do, which is to question the prevailing medical orthodoxies and ideologies when we sense that they may be wrong. In the context of modern-day medicine, therefore, it would mean continuously reanalyzing and reorienting ourselves as to what the concepts of patient autonomy, patient-centered care and, more broadly, “the sanctity of life” and “death with dignity” should actually mean.

I would like to argue that a dogmatic adherence to these principles is not unlike the blind obedience of Nazi physicians to the distorted ideologies of “healing” the *Volk* or people at the expense of the individual, and that the tenets of modern medicine, when adopted without a more thoughtful consideration of their consequences, may ultimately lead to more harm than good. Evidence for this may be especially salient in the ICU setting, where physicians may be unwilling to make strong recommendations regarding end-of-life care for fear that it will cause depression, take away hope or approach the slippery slope of assigning value to a person’s life.

Fifty percent of patients with lung cancer, for example, live to within two months prior to death before being presented with hospice care as an option.⁹ Sixty percent of oncologists prefer not to discuss advanced medical directives, code status or even hospice until all treatments have been exhausted.¹⁰ As a result, patients with terminal or life-threatening conditions lose time with their families, or for reflection, because they spend more time in

⁹ Haiden Huskamp, Nancy Keating, Jennifer Malin, et al., “Discussions with Physicians About Hospice Among Patients with Metastatic Lung Cancer,” *Archives of Internal Medicine*, 169(10) (2009): 954.

¹⁰ Nancy Keating et al., “Cancer Patients’ Roles in Treatment Decisions: Do Characteristics of the Decision Influence Roles?” *Journal of Clinical Oncology*, 28(28) (2010): 4364-4370.

the hospital and the ICU.¹¹ For physicians, performing resuscitative interventions on terminally-ill patients or those likely to have a poor prognosis also presents a significant source of moral distress.¹²

Moreover, despite the great strides that have been made in increasing referrals to hospice facilities and palliative care and in formalizing patient-physician discussions around end-of-life care wishes and advanced directives, end-of-life care continues to be characterized by aggressive medical intervention as well as runaway costs. Of the close to \$554 billion spent by Medicare in the year 2011, 28 percent (about \$170 billion) was spent on patients in the last six months of life.¹³

With this data in mind, my question is: What is our role and what can we do to become better at caring for patients at the end-of-life?

In the ICU setting, concepts of autonomy and informed consent become problematic when the physician-patient discussions focus on specific interventions rather than on the overarching goals of care. These discussions most often take the form of asking patients questions, such as “Do you want me to pound on your chest or put a tube down your throat to help you breathe?” Observational studies have documented physicians asking very specific questions, such as: “Do you want an insulin drip?” “If we turn off the insulin drip, are you OK if we don’t check blood sugars?” and “Do you still want antibiotics even if we’re not drawing labs?”¹⁴ Even when patients decline heroic or invasive resuscitative measures, they find it challenging to make decisions about the bewildering array of other medical interventions available. Although it adheres to the rules of informed consent and patient autonomy, this approach fails to recognize that most patients and families have no basis on which to make these decisions, and it leaves them shouldering the responsibility for end results that would have occurred regardless of their decisions.

In the transformation of medicine from a paternalistic practice to a patient-centered one, physicians have struggled to define the boundary between where their clinical decision-making ends and patient autonomy begins. In an essay published posthumously in the *New England Journal of Medicine* (NEJM), Franz Ingelfinger, a former editor of the NEJM who died from esophageal cancer, described what he sought from his own physicians at the end of his life that may help us to begin to better approach the issues surrounding this. He wrote, “A physician who merely spreads an array of vendibles in

¹¹ Sarah Harrington and Thomas Smith, “The Role of Chemotherapy at the End of Life: ‘When Is Enough, Enough?’” *The Journal of the American Medical Association*, 299(22) (2008): 2667.

¹² Elizabeth Dzenz, Alessandra Colaianni, Martin Roland, et al., “Moral Distress Amongst American Physician Trainees Regarding Futile Treatments at the End of Life: A Qualitative Study,” *Journal of General Internal Medicine*, 31(1) (2015): 93-99.

¹³ “End-of-Life Care: A Challenge in Terms of Costs and Quality,” *KHN Morning Briefing*, June 4, 2013.

¹⁴ Daniela Lamas and Lisa Rosenbaum, “Freedom from the Tyranny of Choice — Teaching the End-of-Life Conversation,” *New England Journal of Medicine*, 366(18) (2012): 1655-1657.

front of the patient and then says, 'Go ahead and choose, it's your life,' . . . does not warrant the somewhat tarnished but still distinguished title of doctor."¹⁵

We, as physicians, should challenge ourselves to recognize that patient autonomy is not synonymous with endless choice, and, moreover, that shifting the burden of decision-making from us to our patients or their families is not patient-centered care. Especially when it pertains to end-of-life care, the data suggests that some patients prefer a more physician-driven decision-making process.¹⁶ A meaningful in-road towards becoming better physicians for patients at the end-of-life may start with actively eliciting the preferences of patients and their families about whether they wish to receive recommendations concerning life support. This is not an abnegation of responsibility, but rather an approach that is likely to engender trust.

Moreover, while prolonging life is clearly one of the main goals of medicine, I would argue that doing so should not be the *sine qua non* of what it means to care for a patient. The path of least resistance may be to follow the hemodynamic parameters and serological markers as surrogates for preserving life for patients who are intubated, on a ventilator and being fed through a gastrostomy tube in the ICU, but more fundamental to the idea of recognizing and protecting the sanctity of life is the need to understand a patient's unique perspective on what gives his or her life meaning in a setting replete with depersonalizing devices. Rather than responding to the Nazi legacy of "life unworthy of life" with "life for the sake of life," we should always attempt to recognize the intrinsic, unconditional quality of human life and to consider each patient's goals and values when we offer our interventions. And we should understand the choice to die with dignity over living too long a life deprived of meaning.

Conversely, we should also be careful not to hold onto or fetishize an ideal of the good death or death with dignity that is held by many who work in end-of-life care. Many times in the ICU, when we encounter patients or families who resist a change in code status to DNR/DNI or who continue to desire a full-court press of medical interventions despite our judgment that this will not alter the disease course or the prognosis, their insistence is met with exasperated sighs and the unspoken assumption that they are unreasonable, deluded, religious or some combination of the three. Oftentimes, once they are labeled as such, we stop listening to or eliciting their concerns. But this is wrong. We must be understanding of the fact that not everyone meets the end-of-life period with peace and acceptance and that almost all balk at deception and desire clear and compassionate communication from their physicians. As Leah Rosenberg and David Doolittle, palliative care physicians at Massachusetts General Hospital write, "We must be willing to tolerate and support the

¹⁵ Franz Ingelfinger, "Arrogance," *New England Journal of Medicine*, 303(26) (1980): 1507-1511.

¹⁶ Daren Heyland, Joan Tranmer, C.J. O'Callaghan and Amiram Gafni, "The Seriously Ill Hospitalized Patient: Preferred Role in End-of-Life Decision Making?" *Journal of Critical Care*, 18(1) (2003): 3-10.

varied end-of-life choices and experiences of our patients, which are often as fraught and unique as the lives that they led.”¹⁷

Leo Alexander, who investigated crimes committed by German physicians under Nazi rule and who served as an advisor at the Nuremberg trials, writes about the subtle shifts in the attitude of physicians that arose from “small beginnings” but resulted in the mass extermination of millions of people:

Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually, the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the non-rehabilitable sick.¹⁸

Alexander is a cogent proponent of the slippery slope argument, but his explanation should challenge those of us who live in the world after Nuremberg not to throw out the slope altogether in fear of our sliding down it uncontrollably, but rather to remember the relative ease with which commitments to “care” and to “heal” were manipulated and betrayed due to a failure on the part of medical professionals to recognize and act upon their own moral agency. As one German nurse wrote, “I sensed that the killings were wrong ... I carried out the deeds as prescribed, because I viewed it as my duty, inasmuch as my superior told me to.”¹⁹ The small, incremental steps towards the commitment of atrocities, taken unwaveringly in the name of “duty” to their profession, is one of the biggest reminders to me of the dangers of dogmatic, unreflective adherence to the guidelines and protocols that underpin the modern medical profession. Even principles as wholesome and routinely unquestioned as patient autonomy, informed consent and patient-centered care can become harmful if we stop evaluating whether our actions in service of these principles are causing good or harm.

One of the key personal responsibilities impressed upon me as a new physician is the development of powers of discernment and judgment regarding the task of aligning my actions and interventions as a medical professional with medicine’s overarching goals. In

¹⁷ Leah Rosenberg and David Doolittle, “Learn and Live?: Understanding the Cultural Focus on Nonbeneficial Cardiopulmonary Resuscitation (CPR) as a Response to Existential Distress About Death and Dying,” *American Journal of Bioethics*, 17(2) (2017): 54-55.

¹⁸ Leo Alexander, “Medical Science Under Dictatorship,” *New England Journal of Medicine*, 241 (1949): 39–47.

¹⁹ Derse, “Erring on the Side of Life.”

the intensive care setting, Hippocrates' enjoiner — to “cure sometimes, treat often, comfort always” — becomes especially salient. Through thoughtful, continuous evaluation of our actions as moral agents, we can begin to understand how our backgrounds both inform and obscure our values and beliefs about life, death and dying, and our role as doctors to care and heal even in the face of terminal illness.

Practically speaking, the current medical education system needs to improve by providing the requisite medical education to prepare physicians to lead compassionate and effective end-of-life conversations. Medical education needs to treat it like any other core competency, such as placing a central line or choosing appropriate sedation.²⁰ On a wider policy level, we need to develop standards for patient-physician communication about end-of-life preferences that are actionable, scalable and evidence-based, and we need to establish the structures necessary to support whatever decisions are made.²¹

During my second week of working in the ICU, my patient, the former English professor, died. His wife and children were present. On the wall above his hospital bed, someone had taped a quote from his favorite poet, Rabindranath Tagore: “Clouds come floating into my life, no longer to carry rain or usher storm, but to add color to my sunset sky.”

Yuntong Ma is currently in her first year of residency at Santa Clara Valley Medical Center. She graduated from the Washington University School of Medicine in St. Louis in 2017.

²⁰ Daniela Lamas, Robert Owens, Rachelle Bernacki, et al., “Palliative Care: A Core Competency for Intensive Care Unit Doctors,” *American Journal of Respiratory and Critical Care Medicine*, 189(12) (2014): 1569-1569.

²¹ Justin Sanders, “Finding the Right Words at the Right Time — High-Value Advance Care Planning,” *New England Journal of Medicine*, 372(7) (2015): 598-599.

The Challenge of Dual Loyalty in Correctional Health Care

BY ALEXA KANBERGS

This organization is not only a professional organization of physicians, but a military one too. Our members are first and foremost Nazis and then only are they doctors. They represent the nation as a whole and should put aside their own personal interests and become leaders who strive for the interests of the whole German nation.¹

These words, written by Dr. Hans Deuschel, director of the National Socialists Physician's League and head of the Fuhrer School of German Medicine, should alarm any physician. Dating back to the time of Hippocrates, physicians have recognized the importance of the physician-patient relationship and the primacy of their responsibility to help and not harm their patients. The Hippocratic Oath states, "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice." More modern versions of medical professional oaths also highlight the duty of a physician to his patients. The Declaration of Geneva, which was born out of the medical crimes perpetrated by the Nazis during World War II, states for example, that "The health of my patient will be my first consideration."² Such declarations of a physician's loyalty to his or her patients stand in stark contrast to Deuschel's words, which illustrate the thinking of a physician with dual loyalties. A physician with loyalties to something other than his or her patient can end up violating the patient-physician relationship and often in a very egregious manner, as has been amply demonstrated by the history of physicians in Nazi Germany.

This paper focuses on how pressure from a state authority or institution can lead a health professional (or professionals) to prioritize third party loyalties over the interests of their patients, identifies the most pressing examples of dual loyalties and the ethical dilemmas within the United States prison system, and offers suggestions of how to mitigate these ethical dilemmas.

¹ Tessa Chelouche and Geoffrey Brahmer, *Casebook on Bioethics and the Holocaust* (Haifa, Israel: University of Haifa, 2013), 48.

² General Assembly of the World Medical Association at Geneva Switzerland, *Declaration of Geneva*, September 1948.

Defining Dual Loyalty

Dual loyalty conflicts arise in situations in which a health professional has simultaneous obligations to a patient and a third party, generally a private employer or government body. In prison settings, apart from loyalty to their patients and their employers or administrative systems, “multiple loyalties” can arise for physicians as they can also have loyalties to others, including other prisoners, the public and the health care provider’s own self. Ethical dilemmas due to these multiple loyalties occur when a physician or other health care provider finds him or herself caught between the competing interests of different parties. Determining which party’s interest should win out over another or where one’s loyalties should lie is ethically challenging. This paper will examine how work with a specific population, the prison population, creates ethical issues for the treating physician.

Many professional societies and government agencies, including the US Department of Justice, the National Commission on Correctional Health Care and the American Correctional Health Services Association, provide recommendations for best practices for prison health care. The general conclusion reached by these organizations is that regardless of the environment in which health care providers work, they are bound by the ethics codes of their profession. Global organizations, such as the World Medical Association, have also made multiple statements regarding ethical conflicts resulting from multiple loyalties in which they come down on the side of loyalty to the patient.³

There are professional and societal expectations that a clinician conduct him or herself in a way that 1) prevents harm to patients, 2) benefits the patient and 3) maintains the patient’s confidentiality. The notion of clinician loyalty to patients is a necessary precondition for patient trust, and it is a patient’s trust in the clinician that allows a patient to disclose information that may be needed to administer proper care, such as substance abuse, infidelity or mental illness. Violations of loyalty to a patient do irreparable damage to the patient-physician relationship, and, historically, those that suffer the most are the most vulnerable members of society.⁴

The prison population in the United States consists predominantly of non-white individuals from low-income backgrounds with a high likelihood of having been medically underserved.⁵ As prison may be an individual’s first point of contact with professional health care providers, the therapeutic nature of the patient-physician relationship becomes especially critical here. In order to ensure prisoners receive the best possible health care, a physician must create an environment in which the patient feels comfortable

³ Nancy Dubler and Margaret Wishart, “The Inmate as Patient: An Inmate’s Rights in the Context of Health Care Services,” *Correctional Psychiatry*, eds. Richard Rosner and Ronnie Harmon (New York: Plenum Press, 1989): 157-16.

⁴ Seena Fazel, Parveen Bains and Helen Doll, “Substance Abuse and Dependence in Prisoners: A Systematic Review,” *Addiction*, 101(2) (2006): 181.

⁵ Dora Dumont, Brad Brockmann, Samuel Dickman, et al., “Public Health and the Epidemic of Incarceration,” *Annual Review of Public Health*, 33 (2012): 325.

enough to truthfully disclose his health history, including any drug or alcohol use or any history of physical or mental abuse, circumstances which are more prevalent among the prison population.⁶ Furthermore, prioritizing patient loyalty is not only important for promoting individual health, but to a large extent public health as well, as it will encourage our prison population to trust the medical community and to continue to seek care once released from prison.

When Loyalty to Others Displaces Loyalty to One's Patient

In his paper on clinical loyalties and the social purposes of medicine, physician and Georgetown Law professor M. Gregg Bloche describes three categories of interests that may be incongruent with patient loyalty: 1) pursuit of public health; 2) non-medical reasons that further social aims; and 3) medical assessment for the ascription of rights, responsibility and opportunity. Bloche's categories offer an organized approach to discussing some of the circumstances in which dual loyalty impacts prison health providers.⁷

Pursuit of Public Health

The use of technical physician expertise for the good of the prison population's health (public health) is one of the more palatable examples of dual loyalty. Instances arise in which it is ethically permissible to consider one's duties to a patient as secondary to those of the public, and in some instances, it is not only ethically permissible to elevate population interests over personal interests, it is a legal duty to do so. However, in other circumstances, the ethically permissible action is not as clear cut.

In two cases decided by the California Supreme Court in 1974 and 1976, respectively now known as *Tarasoff I* and *Tarasoff II*, the court found that providers have a duty to protect individuals who face a serious threat of physical harm. *Tarasoff II* concluded:

When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps. Thus, it may call for him to warn the intended victim, to notify the police, or to take whatever steps are reasonably necessary under the circumstances.⁸

⁶ Dumont, Brockmann, Dickman, et al., "Public Health and the Epidemic of Incarceration."

⁷ M. Gregg Bloche, "Clinical Loyalties and the Social Purposes of Medicine," *Journal of the American Medical Association*, 281 (January 20, 1999): 268-74.

⁸ *Tarasoff v. Regents of the University of California* (*Tarasoff II*), 17 Cal. 3D 425 (1976).

As a result of the Tarasoff cases, the law is clear: health care providers do not just have the ability to breach confidentiality, but may have a duty to breach confidentiality in certain instances. However, “Tarasoff Duties,” or the duty to report, can become more ethically and legally unclear when dealing with an incarcerated patient who makes a threat directed at a person residing outside the prison. While in many instances the fact that a prisoner is behind bars eliminates any imminent danger to an individual outside the prison targeted by the prisoner, credible threats in which a prisoner has a means of contacting and organizing actions to carry out his threat should be taken seriously and a provider would be ethically and legally justified in breaking confidentiality and putting the public’s interests over that of the patient’s. Furthermore, putting the interests of the public at the forefront may actually be a beneficent act for the patient as the physician’s action may prevent consequential punishment directed toward the patient down the line.⁹

One of the more ethically challenging situations for health care providers occurs when they learn that a patient is breaking prison rules. For example, what is a provider’s obligation if in a confidential exchange with a patient the provider learns that the patient has been using or smuggling drugs onto prison premises or has come into possession of a cell phone? A confidentiality breach in this instance generally has no direct therapeutic value for the patient and could cause irreparable harm to the provider-patient relationship. Further, it could even harm the prison population’s view of health care providers in general.

In situations like these, in which providers face the need to weigh the risk to the public vs. loyalty to the patient, the decision should be based on 1) the degree of danger, 2) guidance provided by the law and 3) consideration of what would be done under circumstances free of pressures from the prison authority. It is legally and ethically justifiable to commit breaches of the patient-physician relationship when there is imminent harm to the patient, a fellow inmate or prison personnel, but as a rule, it is harder to legally and ethically justify breaches that are purely driven by a prison’s security procedures.

To ensure informed consent and to operate with transparency, a physician has a responsibility to inform patients that there are limits to the patient-provider relationship in a prison setting; a patient in the prison context needs to be aware that not all information he or she shares with a provider can remain confidential, especially if it involves harm to oneself or another. When a breach of confidentiality is necessary, it must be done in the most limited manner possible. For example, if a health care provider feels it necessary to share a prisoner’s personal health information, he or she may only share the least amount of information possible to the smallest number of parties necessary.

⁹ Emil Pinta, “Tarasoff Duties in Prisons: Community Standards with Certain Twists,” *Psychiatric Quarterly*, 81(2) (2010): 177-182.

Ascribing Rights

State and federal health care systems within prisons, like those of the country at large, face budget constraints and physicians are often the key authority in determining which patients are to receive various items or services. For example:

- Providers make decisions about what diet a prisoner can be on, which can put pressure on kitchen staff and create extra work.
- Items such as night guards, or lumbar support pillows or double mattresses are considered medical items and must be linked to a current diagnosis in order for a patient to receive them.
- Providers determine when an inmate may receive specialty care, such as transport out of the prison for a dermatology appointment or treatment for hepatitis C.

According to the concepts of patient loyalty and the medical ethical principle of beneficence, a determination of what services a patient should receive would be made purely based on what would best serve the interest of the patient. However, this way of reasoning is not always practical and, in the context of the prison system, a patient or the prison administration may have ulterior, often financial, motives for requesting or denying a particular course of care.

As Dr. Kim Marie Thorburn writes in *Western Journal of Medicine*, providers serving in a prison are vulnerable to malingering from patient's, leaving providers torn between their duty to a patient and the potential for being manipulated by the patient. Conversely, prison administrations may pressure health care professionals not to provide evidence-based treatments, widely available to the community outside the prison, for financial reasons; for example, such as treatment for hepatitis C. If a physician denies care solely based on pressure from the prison administration or budgets, he or she runs the risk of violating the principle of "equivalence of health care."¹⁰

Non-Medical Aims

There exist many examples in which prison physicians employ their clinical skills to achieve non-medical aims because of a perceived or real dual loyalty to patients and prison authorities. Examples include, subduing patients with sedatives out of convenience, participating in state or federal sponsored executions, or involvement in any other type of punishment. However, these practices are much less widely accepted among the public, health care providers in general and the community of ethics professionals at large and may, moreover, be considered to be violations of the legal protections of prisoners.

¹⁰ Kim Marie Thorburn, "Croaker's Dilemma: Should Prison Physicians Serve Prisons or Prisoners?" *Western Journal of Medicine*, 134(5) (1981): 457; Jörg Pont, Heino Stöver and Hans Wolff, "Dual Loyalty in Prison Health Care," *American Journal of Public Health*, 102(3) (2012): 475-480.

Mitigating the Challenge of Dual Loyalty

While some argue that ethical principles represent absolutes that should be upheld no matter the circumstances,¹¹ the law and a significant portion of the bioethics community believe that circumstances may arise that justify confidentiality breaches within the patient-physician relationship. Thus, there is a need to train physicians to recognize when such a breach is justified and to draft a set of regulations to help in assessing such circumstances so that physicians can more confidently navigate situations in which they are being pulled in different directions due to multiple loyalties.

Standardized Training

In a study titled “Correctional Health Curriculum Enhancement through Focus Groups” published in *Teaching and Learning in Medicine*, researchers conducted a qualitative analysis of the results of focus groups composed of correctional health clinicians. The results of this analysis suggest that the “successful provision of health care in correctional settings requires specialized knowledge, skills, and awareness not typically available in other health care training settings.” Despite the existence of guidelines from professional societies, an education component is critical for preparing prison health providers for the nuances and complexities of the environment in which they will work. While multiple programs exist for training correctional physicians, no national standards have been established and training for correctional health care workers varies dramatically from program to program. To ensure continuity and quality of health care delivery in prisons, providers should undertake a standard number of courses and rotations to prepare them for prison health care, with one of those requirements being bioethics training.¹²

Ethics Education

While all medical schools must provide a minimum of bioethics training as required by the Liaison Committee on Medical Education, a strong bioethics background is particularly necessary for those working in the prison health care system. When confronted with ethical dilemmas regarding loyalty to patients, physicians need a thorough understanding of bioethics principles in order to be able to make these principles the basis for their deliberations in situations in which they must make case-by-case value judgments.

Consultation Service

In their article titled “Bioethics in Corrections,” published in *Correctional Health Today* authors David Thomas and Nicholas Thomas argue that the best way to address ethical

¹¹ David L. Thomas and Nicholas Thomas, “Bioethics in Corrections,” *Correctional Health Today* 1 (2009).

¹² Heather-Lyn Haley, Warren Ferguson, Arthur Brewer, et al., “Correctional Health Curriculum Enhancement Through Focus Groups,” *Teaching and Learning in Medicine*, 21(4) (2009): 317; I. Min, Dana Schonberg and Matthew Anderson, “A Review of Primary Care Training Programs in Correctional Health for Physicians,” *Teaching and Learning in Medicine*, 24(1) (2012): 89.

dilemmas in prison health care is through a bioethics forum, similar to those found in hospitals, run by a private national organization.¹³ Even without a national umbrella organization, ensuring that each prison facility has access to an outside consultation service that could provide input when ethical conflicts arise would be incredibly useful for practitioners in the prison health care setting. Having either a national or more locally-based established service would allow a casuistry method of bioethics to emerge in which trends and cases could be tracked and established to solve future ethical dilemmas. Attention to ethics standards and reform in the prison health care system is relatively new and not well documented; therefore, establishing a database of cases with proposed resolutions would be a helpful step toward providing a framework for responding when prison health care workers are challenged with similar dilemmas. However, despite the many potential benefits that would result from a consultation service, there are an equal number of challenges that may arise should one be developed. It may be difficult to support a service financially given the strained budgets at federal and state prisons, and a volunteer-based ethics committee could face quality control challenges. Additionally, given the wide degree of variation in state and federal laws regulating prison health care, a large-scale or national consultation service could be logistically difficult to manage.¹⁴

Standardizing the Allocation of Scarce Medical Resources

In an article on justice, autonomy and cost containment in the *New England Journal of Medicine*, Harvard University bioethicist Norman Daniels examines why it is so difficult for physicians in the United States to say “no” to patients, by comparing medical care in the US and Great Britain. Daniels finds that what distinguishes Britain is that the allocation of health care there occurs under two unique constraints: 1) Britain provides universal access to health care and 2) turning down a patient’s requests takes place within the context of a closed system with a regionally centralized budget.¹⁵ One could argue that health care in the US prison system — as opposed to American society overall — operates with many similarities to the British health care system. All individuals within the penal system have access to care, and there is rationing that occurs on a facility, state and federal level. Standardizing health care service distribution across prisons could help 1) prevent provider subjectivity in determining who should receive resources and 2) shield providers from bureaucratic pressure to make the consideration of the financial needs of the prison a priority when assessing what services to provide which patients.

Separation of Roles

Finally, and most importantly, a strong argument should be made for the complete separation of the role of provider from the role of an agent of the corrections department.

¹³ Thomas and Thomas, “Bioethics in Corrections.”

¹⁴ Solomon R. Benatar and Ross E. G. Upshur, “Dual Loyalty of Physicians in the Military and in Civilian Life,” *American Journal of Public Health*, 98(12) (2008): 2161.

¹⁵ Norman Daniels, “Why Saying No to Patients in the United States Is So Hard,” *New England Journal of Medicine*, 314 (1986): 1380-1383.

As British medical ethicist Margaret Brazier has noted, “No individual, however skilled and compassionate a doctor, can maintain a normal doctor-patient relationship with a man who the next day he may acquiesce in subjection to solitary confinement.”¹⁶ However, by acknowledging the damage that competing loyalties may do to the provider-patient relationship and mitigating that damage by preventing dual loyalties from arising in the first place — as proposed above — some semblance of normalcy can be maintained.

As much as there is an emphasis on maintaining traditional physician duties in a prison setting, it is naive to believe that the practice of medicine can be the same in an environment in which a physician finds himself pulled in multiple directions by loyalties and obligations to parties other than his patient. Physician-patient confidentiality, as the concept is traditionally understood, does not exist in the prison context. That reality must be acknowledged and corrected for by arming physicians and other health professionals with the necessary knowledge and tools to navigate the ethical dilemmas that will therefore arise. Physicians in this setting must receive proper training and would benefit from access to ethics consultation services. Furthermore, creating a clear separation between a provider’s role as a healer and as an agent of the corrections system must be made a priority across the federal and state penal systems. Only through awareness of the complexities of confidentiality can a physician strive to meet the standards of health care, while conforming to the guidelines of bioethics and correctional health care organizations.

Conclusion

Dual loyalty has troubled the medical profession from its beginnings, leaving physicians vulnerable to abandoning their duty to the individual patient. Physicians must be vigilant in recognizing the external forces that drive medical decision-making, including the pressure to use technical expertise or medical privilege in a manner that is incongruent with undivided loyalty to the patient and which perpetuates exploitation of our most vulnerable populations. This is not to suggest that there are never circumstances in which a provider must place the interests of a patient secondary to another entity, but given the fragility and importance of the patient-physician relationship, especially in the prison setting, it must be done in a thoughtful manner.

Alexa Kanbergs is currently a student at Brown University’s Warren Alpert Medical School. She will receive her medical degree in 2019.

¹⁶ Quoted in William Rold, “Legal Considerations in the Delivery of Health Care Services in Prison and Jails,” *Correctional Health Care: Guidelines for the Management of an Adequate Delivery System*, ed. B. Jaye Anno (Washington, DC: US Department of Justice National Institute of Corrections, 2001): 55.