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Preparing physicians to contend with the problem of dual loyalty

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ABSTRACT

Dual loyalty is defined as, particularly as it pertains to the field of medicine, a conflict or potential conflict between a healthcare professional's simultaneous obligations—expressed or implied—to a patient and to a third party. Dual loyalty situations often compromise physicians' ethical behavior, leading them to participate, either knowingly or unknowingly, in human rights violations perpetrated by a third party, often the state. Classic dual loyalty situations include the participation of physicians in state-sanctioned torture or the death penalty. However, there are a number of other dual loyalty scenarios that arise routinely in clinical practice in both closed institutions such as prisons, psychiatric facilities, and the military and in open societies promulgated by discriminatory practices, policies, and laws that can lead physicians and other health care professionals to contribute to the violation of individuals' human rights. Healthcare professionals are, for the most part, not formally trained to contend with these dual loyalty conflicts. While physicians routinely learn about bioethical frameworks to assist them in resolving difficult clinical dilemmas created, for example, by modern technology that extends life or by limited resources, few are taught a human rights framework that can assist them in protecting patients' human rights in cases of dual loyalty. This paper presents a case-based approach that utilizes a human rights framework for teaching dual loyalty in the undergraduate medical education curriculum. The medical profession is in dire need of training its workforce to grapple with the myriad dual loyalty issues that confront the profession today, and must institute curriculum reform to prepare future health care professionals to deal with dual loyalty scenarios that threaten individuals' human rights.

The problem of dual loyalty

The problem of dual loyalty (DL) abounds in medicine. DL is defined as a “clinical role conflict between professional duties to a patient and obligations, expressed or implied, to the interests of a third party such as an employer, an insurer, or the state” (Pont, Stover, and Wolff 2012: 475). DL dilemmas can compromise physicians' ethical behavior, leading them to participate, either knowingly or unknowingly, in human rights violations perpetrated by a third party, typically the state (International Dual Loyalty Working Group 2002). Classic DL conflicts include the participation of physicians in the force-feeding of hunger strikers (Nicholl, Atkinson, Kalk, Hopkins, Elias, Siddiqui, Cranford, and Sacks 2006; Annas 2006), in state-sanctioned torture (Lifton 2004),

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Multiple Interests Impact the Physician-Patient Relationship

Figure 1. In reality, the physician–patient relationship is subjected to ongoing third-parties interests, including interests of the state, hospitals and clinics, insurance companies, and the public at large, among others. Figure adapted from MacDonald, R. “Dual Loyalty and Correctional Health.” InFocus 3 Lecture, Mount Sinai, October 24, 2018.

Conflicting Interests Create Dual Loyalty Dilemmas

Figure 2. Dual loyalty dilemmas arise for physicians when their role as a healer conflicts with their obligations to or the demands of a third party. Figure adapted from MacDonald, R. “Dual Loyalty and Correctional Health.” InFocus 3 Lecture, Mount Sinai, October 24, 2018.

and in administration of the death penalty (Guwande 2006). These egregious role conflicts have received extensive coverage in the public sphere and are robustly debated in a variety of venues.

However, these are not the DL situations with which most physicians and other healthcare providers (HCPs) in practice today must grapple. Although the physician–patient relationship is often conceptualized as an isolated, pure dyad, the relationship is, in reality, subjected to a number of interests emanating from a variety of different parties on an ongoing basis (see Figure 1).

When physicians find their role as healers (Figure 2A) in conflict with their obligation to a third party (Figure 2B), a DL dilemma arises (Figure 2C).

There are a number of situations that routinely occur in clinical practice in both closed institutions (e.g., prisons, psychiatric facilities, the military) and open institutions (e.g., hospitals, clinics) that create dual loyalties in physicians. These DL dilemmas are, by nature, not easy to resolve. It is important to note that not every conflict or ethical dilemma presents a DL dilemma, and that not every DL dilemma potentially violates human rights. There are cases in which DL exists in which the state's interests should take priority over the individual's interest as it serves a greater social good and is deemed justifiable. Dual loyalties, however, pose particular challenges for HCPs when the subordination of the patient's interest to the state or another third party risks violating the patient's human rights.

Although medical students and physicians-in-training are routinely trained to use bioethics frameworks to assist them in resolving difficult clinical dilemmas created, for example, by modern technology that extends life or by limited resources that require rationing, few are taught a human rights framework that can assist them in resolving DL conflicts. As London and colleagues (2006: 386) stated,

Whereas ethical discourse provides tools for applying philosophical reasoning to moral dilemmas, an understanding of human rights protections and the obligations of health professionals to uphold human rights offers a different strategy for resolving these dilemmas, one we believe is more explicit both about the processes to resolve the dilemmas and about the fundamental justice of the outcomes achieved.

A rights-based approach is critical to resolving DL conflicts associated with human rights violations.

The medical profession remains in dire need of training its workforce to grapple with the myriad DL issues that confront the profession today. Medical educators must institute curriculum reform to assist HCPs, first, in clearly identifying DL situations, especially those that risk violating human rights, and then in evaluating the demands of the state or other third-parties to subordinate patients' interests and in determining appropriate responses. This article presents a pilot case-based educational approach that uses a human rights framework to introduce medical students to the problem of dual loyalty and offers a basic rubric for analyzing DL dilemmas.

DL issues abound in military and civilian life

DL situations involving physicians in the military have long been debated in the medical literature (Clark 2006; London, Rubenstein, Baldwin-Ragaven, and Van Es 2006; Benatar and Upshur 2008). Unlike their civilian counterparts, military physicians find themselves in two distinct professional roles—that of being both soldier and doctor (Gross 2010). Military DL dilemmas often involve tensions between “mission priority” concerns (securing victory over an adversary) and obligations to the welfare of individual patients, whether they are friend or foe. Some of the most ethically challenging DL scenarios arise when the state—the military, in particular—exerts pressure on physicians and other HCPs to participate in actions that either risk violations or constitute violations of an individual's human rights. Physicians who work in prisons routinely face DL dilemmas when prison administrators or state authorities make requests that compromise patient care. As MacDonald, Rosner, and Venters (2015: 1) noted, “In the case of health care in the jails and prisons, the conflict between the desires and needs of the patients and of the security authority comes to the surface in clinical interactions almost immediately and universally.” Medical activities not in the interest of the prisoners include activities such as forensic assessments, disclosure of patient-related medical data without patient consent, assisting in body searches or obtaining body fluids for analysis for safety and security reasons, or assisting in determining the safety of disciplinary measures, such as solitary confinement (Pont et al. 2012).

In civilian medical life, DL abounds as well, occurring under numerous scenarios, for example,

when a managed care plan or hospital exerts financial control over physicians' choices, when public health regulations require that a physician break patient confidentiality and report someone with a communicable disease, or when a psychiatrist is bound to report that her/his patient may be dangerous to a vulnerable third party. (Solomon 2005)

It is important to note that DL conflicts do not only arise in clinical situations that involve health professionals providing direct patient care (e.g., screening, diagnosis, and/or treatment to an individual patient); they can also arise in the context of various other roles. The International Dual Loyalty Working Group (IDLWG) described five other roles of health professionals, in addition to the one-on-one physician–patient relationship, that can potentially give rise to DL conflicts (IDLWG 2002):

- clinicians engaging in various types of medical evaluations for the state and state-approved purposes (e.g., refugee status determination, asylum applications, fitness to stand trial, pre-employment workplace examinations);
- health professionals undertaking the comprehensive healthcare of a definitive population with responsibility for the health outcomes (e.g., the community-oriented primary care approach that includes health promotion, prevention, diagnosis and treatment, rehabilitation, and palliation);
- public health workers (e.g., health inspectors, industrial hygienists, epidemiologists, monitoring and surveillance officers) providing nonclinical services such as health education, outreach, and promotion interventions;
- health policymakers (e.g., health systems planners and administrators) in either public or private settings developing policy that affects large groups of individuals, populations, communities, states, or the nation at large; and
- researchers engaging in investigations that involve human subjects.

When resolving DL situations, health professionals in these various roles can violate human rights through a number of practices or actions. These may include compromising their medical judgment (e.g., failing to record evidence of abuse or torture), imposing medical procedures to serve the state's interests (e.g., participating in the death penalty), accepting a lower standard of care or withholding care for certain groups (e.g., tolerating racial disparities regarding access to care or denying women reproductive healthcare), or remaining silent (e.g., abiding by gag rules promulgated by the state; Solomon, Miles, Rubenstein, and Lifton 2005).

For HCPs in their various healthcare roles, when resolving DL conflicts, the central question becomes this: Is the demand of the state or third party justifiable and consistent with human rights norms? Or should the demand be resisted? To be sure, although physicians are expected to uphold the central ethical standard—dating back to the Hippocratic oath (National Library of Medicine 2002) and reaffirmed by both the World Medical Association (WMA) Declaration of Geneva (WMA 1948) and the WMA International Code of Medical Ethics (WMA 1949)—that demands undivided loyalty to the patient, they are legitimately obligated, as noted previously, to resolve *some* ethical dilemmas in favor of society's greater good. For example, reporting suspected cases of child abuse, undertaking individual evaluations for adjudicative purposes, breaching patient confidentiality to protect a third party from harm, reporting an individual with a communicable disease to health authorities, or quarantining an individual with a contagious infection can be justified. What is the measure of justifiable? The IDLWG articulated it thus: "in all circumstances where departure from undivided loyalty takes place, what is critical to the moral acceptability of such departures is the fairness and transparency of the balancing of conflicting interests, and the way in which such balancing is, or is not, consistent with human rights.

(IDLWG 2002: 12)” The IDLWG went on to state, “subordinating loyalty to the patient to the interests of the state is only permissible to serve a higher social purpose. Violations of human rights cannot constitute permissible social purposes. Professional conduct that abets human rights abuse is thus illegitimate” (IDLWG 2002: 20).

By embracing a human rights analysis, HCPs attempting to resolve DL conflicts can turn to and use a set of universally accepted moral principles and human rights norms secured in various international instruments, conventions, and treaties to inform the resolution of the conflict. Educational instruction on the human rights framework, the problem of dual loyalty, and how to protect human rights can empower HCPs to make better decisions. It will help them answer the question of when they should resist the demands of the state or other third parties and when they should comply. Because they have not been adequately trained, HCPs fail to recognize the contributions a human right analysis can make to the resolution of difficult DL conflicts associated with human rights violations.

Human rights education and dual loyalty

Historically, the traditional medical school curriculum did not include instruction about the human rights framework—its ideals and principals, its history, its legal tenets and supporting documents, its ethical underpinnings, the commitment to advocacy, and especially the profound influence HR violations have on health outcomes. In the 1990s, a few medical schools began offering various health and human rights (HHR) educational opportunities for medical students—thanks primarily to the work of Physicians for Human Rights (PHR) and the students who were inspired by PHR’s initiatives. Students—along with supportive faculty—drove grassroots efforts to bring about curricular reform, demanding that deans of medical education and medical educators include HHR education in the undergraduate medical curriculum.

In 2009, Cotter and colleagues published the results of the first survey that sought to determine the nature and extent of health and human rights education among schools of medicine (SOMs) and schools of public health (SPHs). They surveyed deans of all accredited allopathic SOMs and SPHs and found that, overall, 40 percent of respondents indicated that their schools offered some form (course, seminar, or one or more modules in a course) of HHR education, with 32 percent of SOMs and 54 percent of SPHs having some form of HHR education. Overall, 22 percent of the schools offered one or more required or elective HHR courses or seminars, with offerings being three times more prevalent at SPHs compared with SOMs. Survey respondents put forth three primary reasons as to why HHR education was not more widespread: lack of time in the curriculum, lack of qualified faculty who could teach the discipline, and lack of funding. As time has passed and our understanding of the connection between health and human rights has deepened, as well as our continual witnessing of ongoing human rights violations the world over, it has become even more urgent to include HHR training in the core curriculum of undergraduate medical education. In her article “Human Rights Education in Patient Care,” Erdman (2017) argued that human rights education is expansive in its scope as it seeks to embed human rights norms into core social institutions in order to transform the institutions themselves.

Human rights education is envisioned as a site of knowledge, change, and justice. This is why human right education is “transformative” in its vision and practice. There is something radical at its roots—human rights education is an effort to realize human rights not in singular, heroic moments, but in systemic reform of the most basic and fundamental institutions of society. These institutions include the healthcare system, and the guardians of that system, the health professions, and there is no better place to begin their transformation than in the world of patient care. (IDLWG 2002: 12)

Table 1. General guidelines from the DLHR Report (IDLWG 2002).

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1. The health professional should become conversant with human rights and the implications of human rights for clinical practice through study and training in human rights.
  2. The health professional should develop skills to identify situations where dual loyalty conflicts threaten human rights and where independent professional judgment may be compromised.
  3. The health professional must place the protection of the patient's human rights and well-being first whenever there exists a conflict between the patient's human rights and the state's interests; this responsibility includes affirmatively resisting demands or requests by the state or third-party interests to subordinate patient human rights to state or third-party interests.
  4. In all clinical assessments, whether for therapeutic or evaluative purposes, the health professional should exercise judgment independent of the interests of the state or other third party.
  5. The health professional should recognize how his or her professional skills can be misused by state agents to violate the human rights of individuals—especially in settings where human rights violations are pervasive—and take appropriate steps to avoid this misuse.
  6. The health professional should recognize that passive participation, or acquiescence, in violations of a patient's human rights is a breach of loyalty to the patient.
  7. The health professional should only depart from loyalty to the patient within a framework of exceptions established by a standard-setting authority competent to define the human rights obligations of a health professional; any such departure should be disclosed to the patient.
  8. The health professional should maintain confidentiality of medical information except where the patient consents to disclosure or where an exception recognized by competent authorities in medical ethics permits disclosure.
  9. The health professional should take all possible steps to resist state demands to participation in a violation of the human rights of patients.
  10. The health professional should act with an understanding of health professionals' collective obligation to uphold and promote the human rights and well-being of the patient.
  11. The health professional should take advantage of opportunities for support from local, national, and international professional bodies to meet his or her ethical and human rights duties to the patient.
  12. The health professional should report violations of human rights that interfere with his or her ability to comply with his or her duty of loyalty to patients to appropriate authorities, both civil and medical.
  13. The health professional should act individually and collectively to bring an end to policies and practices that prevent the health professional from providing core health services to some or all patients in need. These practices include, among others, a state's failure to take steps needed to achieve the highest attainable standard of health for all; inequity in allocation of health resources or benefits; discrimination (or tolerance of discrimination) in health based on sex, race, ethnicity, class, sexual orientation, refugee and immigrant status, religion, language, caste or class, or disability; denial of health information (such as information about reproductive health). This guideline also applies in private settings where the state's obligations extend to ending discrimination and assuring the highest attainable standard of health.
  14. The health professional should support colleagues individually and collectively—through professional bodies—when the state acts to impede or threaten their ability to fulfill their duty of loyalty to patients.
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Bringing about systemic reform in healthcare systems is a powerful way to address issues of DL that deeply effect patient care. And yet, as HHR education has expanded and evolved over the last two decades,¹ training regarding DL has not been in the foreground. A scoping review of the medical literature reveals a dearth of publications regarding the pedagogy of DL, and no articles from schools of medicine reporting successful integration of DL training into their core curricula, despite calls for such DL training 15 years ago.

In 2002, the IDLWG—a multinational, interdisciplinary team with expertise in bioethics, medicine, human rights, and law—in response to the disturbing trend of health professionals putting their allegiance to their patients aside in deference to demands of powerful state actors, published a report entitled, “Dual Loyalty and Human Rights in Health Professional Practice” (DLHR Report). The DLHR Report called for widespread training of physicians and other HCPs and proposed a set of comprehensive general guidelines (see Table 1) to assist them in navigating a variety of dual loyalty scenarios (IDLWG 2002). It also called for strengthening institutions to assist healthcare providers in formulating and implementing appropriate responses. The DLHR Report states in its conclusions:

The situations where health professionals, wittingly or unwittingly, subordinate the human rights of their patients to the interests of the state are varied and wide-ranging. Nevertheless they share some common themes: lack of awareness among health professionals of the problem of dual loyalty and human rights, a

lack [of] guidance on how to evaluate dual loyalty problems in human rights terms, lack of institutional supports for those who seek to protect the human rights of their patients, employment and others structural arrangements that prevent professionals from resisting demands of the state or other third parties, and pressures to serve state interests. Each of these problems demands attention to address the serious and pervasive human rights violations that result. (IDLWG 2002:50)

Unfortunately, in the intervening 15 years since its publication, we have not seen widespread training about or distribution of the DLHR general guidelines in either undergraduate or graduate medical education programs. A number of professional medical organizations have developed or strengthened their ethical statements and policies regarding specific DL conflicts—for example, physician participation in torture in the wake of the exposure of US medical personnel having participated in torture at Guantanamo Bay. There have also been some efforts to address the problems of DL that suffuse clinical interactions in correctional health. For example, MacDonald and colleagues (2015) described working to operationalize a human rights agenda in the New York City jail system that includes training the entire staff about the phenomenon of DL and providing them with tools to employ in difficult DL situations. Nevertheless, the vast majority of healthcare providers have never received formal training to contend with the pressing problem of DL, especially in regard to identifying those situations that violate an individual's human rights. The need for awareness, training, and a robust institutional response to DL in medicine is critical and demands a concerted response from the medical community, especially leaders in medical education.

Teaching DL

InFocus—A novel curriculum

In 2013, the Icahn School of Medicine at Mount Sinai (ISMMS) in New York City launched a new curricular initiative, called InFocus, as part of its formal medical school curriculum. InFocus is a longitudinal curriculum that comprises nine week-long mandatory courses interspersed across the eight semesters of the medical school education. Each week-long immersive educational experience provides medical students (~140) with the opportunity to learn about a topic area that is not traditionally included in the formal curriculum of medical school, such as health disparities (InFocus 1), global health (InFocus 2), human rights (InFocus 3), and physician advocacy (InFocus 4).

InFocus 3 and InFocus 4 are offered during the fall and early spring of the second year of the four-year medical school curriculum and include formal instruction on health and human rights and on physician advocacy, respectively. InFocus 3 and InFocus 4 are designed as a pair, in that the students' baseline knowledge and experience with human rights gained during InFocus 3 are used to develop subsequent programming for InFocus 4, which centers on advocacy as a strategy for addressing global health and human rights challenges. InFocus 3 and InFocus 4 comprise twelve hours each of curriculum, which are structured into three-hour blocks on four afternoons during the InFocus weeks. The DL training is part of InFocus 3.

InFocus 3: Health and human rights

Broadly speaking, the aim of InFocus 3 is to provide second-year medical students with the basic knowledge and skills to explore and analyze the ideas and conflicts surrounding the major health and human rights issues of our time. To achieve this aim, students are immersed in a series of didactic lectures, case-based breakout sessions, and skills-building workshops focusing on human rights issues both locally and globally. The conceptual design of InFocus 3 includes five broad areas:

1. The human rights framework: Students are introduced to human rights concepts, the legal framework, leading HR institutions, key stakeholders, and the critical intersection of health and human rights.
2. Current health and human rights issues: Students are exposed to several major human rights issues, such as violence against women, including female genital mutilation/cutting; mass incarceration; asylee and refugee health; gun violence; and racism, structural violence, and health disparities.
3. Research techniques for documenting HR abuses and health outcomes: Students are taught the role quantitative and qualitative research plays in documenting human rights abuses, with examples of contemporary research questions/cases from the field.
4. Clinical skills building: Students obtain tangible skills to work with human rights issues clinically, through basic training in performing medical evaluations for individuals who have been persecuted and suffered human right abuses.
5. The problem of dual loyalty: Students learn to identify situations of DL and are introduced to a systematic approach to analyze a DL dilemma and formulate an appropriate response.

Dual Loyalty Training within InFocus 3

The specific objectives of the InFocus 3 DL training are for students, by the end of the session, to be able to:

- define dual loyal and explain the foundational documents and key ethical principles involved in dual loyalty precepts;
- identify situations that present the problem of DL, clarify responsibilities of the healthcare professional in the situations, and respond appropriately to the DL conflict;
- appreciate and begin to use the DLHR general guidelines as a framework by which to assess, formulate, and implement appropriate responses to DL scenarios; and
- understand the ethical obligation to support colleagues, transform institutions, and address the problem of DL at a systemic level.

Ideally, at the end of the DL training portion of InFocus 3, students are expected to be able to recognize the myriad manifestations of dual loyalty in various medical settings and begin to use the framework to help them navigate these difficult situations. Further, students should also understand the need for physician advocacy aimed at both ending policies and practices that infringe upon patients' rights and strengthening the institutional responses to the problem of DL. It should be noted this is an introductory session to the problem of DL; we do not expect second-year medical students to come out of this learning experience as masters in resolving DL dilemmas. Far from it: These are challenging situations for even the most seasoned physicians who routinely work in environments, such as prisons, where DL dilemmas are common, and we have much to learn about the pedagogy of training HCPs about dual loyalty.

Given these objectives, the form and content of the training is as follows: The DL training comprises three sixty-minute foundational didactic lectures and one ninety-minute case-based breakout session. Lecture 1 provides an overview of the human rights framework, Lecture 2 covers current health and human rights issues, and Lecture 3 specifically lays out the issue of dual loyalty—its definition, historical antecedents, and examples of DL dilemmas. Students then break into small groups of about fifteen to grapple with a DL case. Each breakout session focuses on only one DL case, written from the perspective of a practicing physician. Cases involve DL dilemmas typically experienced by physicians in both closed institutions (prisons) and in open institutions (hospitals and clinics)—for example, physician participation in the death penalty, in torture, in the force feeding of prisoners, and in solitary confinement; compassionate release of inmates;

opioid management; quarantine of patients; upholding of state mandatory reporting laws; balancing state laws versus patients' rights (the shackling of pregnant inmates); and being a "good" physician in a complex medical system. Students choose the breakout group they prefer based on short descriptions of the cases.

Faculty preceptors who are experts in the topics under discussion lead the breakout sessions. Given our three years of experience, when early on the quality of the sessions varied greatly, we found it necessary to engage in faculty development in order to meet the session's learning objectives. We have instituted a faculty preceptor training session that comprises review of the breakout session objectives, review of a facilitator's guide (which includes his or her individual case with exploratory questions, the DLHR general guidelines for students, the full DLHR Report, and tips for running small group discussions), and a discussion among the group of "lessons learned" from previous sessions in managing the breakout groups.

At the start of the ninety-minute breakout session, the DLHR Report general guidelines are distributed to the students to help them begin to frame an approach to the challenges of dual loyalty (IDLWG 2002). As noted in the DLHR, the general guidelines are specifically designed to address how physicians and other health professionals can

identify situations where subordination of patient interests to those of the state or other third party implicates human rights; *clarify the responsibilities* of the health professional in these situations; and in conjunction with the institutional mechanisms that follow, enable the health professional to *respond appropriately*, especially where the health professional faces personal or professional risks by adhering to obligations to the patient. (IDLWG 2002, italics added)

In designing the breakout sessions, we have used these three overarching concepts—identifying DL situations, clarifying responsibilities, and responding appropriately—to structure the analysis of the cases. After reviewing the DLHR general guidelines, students read the case and then, under the guidance of the faculty preceptor, discuss a series of questions under the identify, clarify, and respond (ICR) rubric to help them explore the central tensions presented by and formulate appropriate responses to each dual loyalty case.

Case example: Shackling of pregnant incarcerated women

The following case is an example of one of the DL scenarios used in the InFocus 3 breakout sessions. This case illustrates to medical students how easy it is to acquiesce to state demands and passively participate in the violation of a patient's human rights. It demonstrates the need to identify the DL situation, clarify one's responsibilities and seek information to enable one to respond appropriately, and then take action, advocating for the individual patient as well as advocating for institutional change at various levels. In the following case, the prompts are questions for the students to discuss, followed by key points to be brought out by the facilitator. The structure below gives an overview of how DL cases can be approached.

Case

You are the "in-house" Ob/Gyn doctor at a hospital and are made aware of an urgent transfer of a female inmate in active labor from the nearby prison. (Note: She is a nonviolent offender and incarcerated for a drug offense.) The patient presents wearing a one-piece prison jumpsuit, shackled at the wrists and ankles, and accompanied by an armed guard. Her wrists are shackled across the front of her body attached to a black box, causing her great discomfort. She reports having received minimal prenatal care in prison, but no medical records are available. She is having painful contractions, and the one-piece jump suit and the restraints prohibit proper examination of your patient.

After some negotiation with the guard, your patient is able to change into a hospital gown and is then reshackled to the labor bed at one wrist and one ankle. She is 5 cm. dilated and her blood pressure is noted to be 170/120. She is started on magnesium sulfate for preeclampsia. Shortly after admission, your patient reports sudden onset of severe abdominal pain, worse and different from that of the contractions. On examination, she is noted to have active vaginal bleeding and abruptio placentae (placental detachment from the uterine wall) is suspected. The fetal tracing shows significant heart rate abnormalities. A STAT cesarean section is called, but the patient remains shackled. What do you do?

Identify the DL issue (DLHR general guidelines 1 and 2)

Prompt: Why is this a DL case? Identify the dual loyalties.

Key Point: This case involves a conflict between providing best medical treatment and dignified care to mother and child versus abiding by the demands of the state/local authority, who has placed the woman in restraints.

Prompt: Do you think pregnant incarcerated women should ever be shackled? If so when, and under what circumstances (transport/waiting room/delivery/postpartum, etc.)?

Key Point: Explore with the students the reasons why they think it is appropriate/not appropriate to restrain pregnant women and under what circumstances it might be justified. Draw in the two questions below—the health effects of restraining on mother and infant as well as claims by the state for the need for the use of restraints, especially in the case of a violent offender.

Prompt: What are the justifications on the state side for using restraints on pregnant incarcerated women?

Key Point: Correctional officers shackle pregnant women for alleged security reasons—either to prevent flight or to prevent the inmate from harming others, her infant, or herself. Of note, about two-thirds of women in prison are convicted for nonviolent offenses, and there have been no reported escape attempts in the United States among pregnant incarcerated women who were not shackled during childbirth.

Prompt: Are there any laws or policies around the use of restraints? Federal, state, facility?

Key Point: Yes. Knowing the law and policies around any given issue is imperative for determining appropriate responses to a DL situation. The shackling of pregnant incarcerated women is widely considered a human rights violation and an affront to human dignity. The federal government has adopted an antishackling policy, and to date 24 states have passed laws or created policies restricting shackling. However, the laws and policies vary and have exception clauses, are poorly enforced, and are often flouted. A 2015 New York State law stipulates that women cannot be shackled during pregnancy or for eight weeks after pregnancy ends, except in the rare case that a woman poses a risk of harm to herself or others. The New York law also bars correctional staff from being in the delivery room unless the woman or medical staff requests their presence. Despite existing laws and policies, shackling still occurs across the country with disturbing frequency.

Clarify responsibilities (DLHR general guidelines 3 through 7)

Prompt: What is your primary responsibility?

Key Point: The physician's primary responsibility is to the patient and her infant. In this case, given the emergent nature of the situation, the ideal situation is for shackles to be removed so anesthesia can be safely administered and a C-section can be performed immediately.

Prompt: What are the health effects of use of restraints on mother and child?

Key Point: There is a consensus among professional groups (e.g., American Medical Association, The American College of Obstetricians and Gynecologists) that there are numerous health effects from the use of restraints, including increased risk of injury from falls, delays in

diagnosis, injury from seizures secondary to preeclampsia, increased risk of venous thrombosis, interference with labor and delivery in numerous ways, interference with bonding of mother and child, and interference with the mother's ability to care for the child. The use of restraints not only compromises healthcare; it is emotionally traumatizing, and it is considered degrading and a violation of a woman's human rights and civil rights.

Prompt: What about documentation: What should you further document in this case? What about reporting responsibilities?

Key Point: Use of restraints should be documented, including the reasons for using them and the type of restraint and how it was used. Know your state law (if there is one) and/or correctional facility's policies, and if there are any concerns about breaches in protocol, determine reporting procedures and report violations to the appropriate authorities.

Respond appropriately (DLHR general guidelines 8 through 14)

Prompt: What can you do directly for the patient in this case? Remind students that she is a nonviolent offender and incarcerated for a drug offense.

Key Point: Challenge the use of shackles; use the chain of command to do so. Call the correctional facility immediately and speak to the individual (warden, superintendent, or shift commander) who has the authority to authorize the officer to remove the restraints. If the authorizing officer refuses, you may be able to negotiate a different type of restraint and/or less time in restraints at certain junctures. Treat the patient with the utmost dignity and respect, and let her know you are advocating on her behalf.

Prompt: What if the patient is a high-security inmate who is incarcerated for a violent crime and has been known to be violent while in prison?

Key Point: Explore the issue of compliance with justified state demands versus unjustified state demands and the difficulty in deciding the right approach in some DL dilemmas. Underscore how a human rights analysis can provide norms that can help determine how to resolve DL conflicts that threaten human rights.

Prompt: What can you do to get support from other colleagues and/or your institution?

Key Point: You could involve the senior attending, head nurse, hospital patient advocates, and hospital lawyers, if you have time. Try to anticipate problems and plan in advance.

Prompt: What are some activities you could engage in to decrease the likelihood that other patients are shackled during labor and delivery?

Key Point: Become involved in efforts on the local level to strengthen institutional support for clinicians (develop hospital policies if they do not exist, clarify chain of command, and develop a rapid response plan) and become involved in advocacy campaigns on the state or national level to support antishackling legislation, enforcement of existing laws, and improved policies. It has been the advocacy work on the part of women who have experienced shackling, integral to a coalition of more than eighteen hundred individuals—including medical professionals—and one hundred organizations that won the campaign against shackling in New York.

Student feedback and future plans

To date, this introductory session to the problem of DL has been offered four times as an integral part of the InFocus 3 curriculum over the course of four years, 2015–2018. Students provide course feedback regarding InFocus 3 via an anonymous electronic evaluation form sent to the entire class. Students rated the overall quality of the *entire* InFocus 3 course (which includes substantially more content than the DL sessions) on a scale of 1 to 5 (1 = strongly disagree; 5 = strongly agree): IF 3 received a 3.5 in 2015, 3.5 in 2016, 3.4 in 2017, and 3.7 in 2018. Students also rated on a five-point scale whether the instructional methods (lectures and small groups)

facilitated learning. The average rating was 3.5 in 2015, 3.8 in 2016, 3.8 in 2017, and 3.8 in 2018. In 2018, students were specifically asked to rate the quality of the DL small group breakout sessions; ratings for the eight sessions ranged from 3.5 to 4.3, with four of the sessions rated above 4.0. Open-field questions solicited input from students on how to improve any and all aspects of the InFocus 3 course. Students have consistently indicated they prefer small group discussions to lectures; for example, in 2016, 48 percent of the 85 students who wrote in comments suggested reducing the number of lectures and increasing the number of breakout sessions. The most recent cohort of students in 2018 reiterated a desire for more small groups and more interactive sessions. Students have also consistently over the four years indicated on their evaluations that the DL breakout session was among their favorite sessions of the entire InFocus 3 course. Most students appreciated being introduced to the concept of DL, and criticism was typically focused on the quality of group facilitation by individual preceptors. Comments regarding the specific breakout sessions included these:

Incredible discussion, extremely inspiring, and thought-provoking.

I loved my small group on dual loyalty based on the topic of mandatory reporting. I felt our preceptor led the discussion very well and we were all able to discuss very interesting points.

Really interesting topics and discussion. Great small group leader who asked thought-provoking questions and got everyone participating.

This was one of the most interesting small groups I've attended during medical school. Dr. B was engaging and got me thinking more about situations of dual loyalty jail physicians face.

[The preceptor] really challenged us and made us think hard about the dual loyal issues faced by physicians regarding state laws and difficult working environments.

[The preceptor] did not answer any of our questions ... and also dismissed many of our claims as "that's not what would happen in the real world."

Prompted very interesting and heated discussion on a topic that will most likely be very relevant to our practice in the future.

For the first time, we had to establish our own opinions on complex human rights cases rather than just see which complex patients we're [assigned to]. It was a very important learning experience for me.

We had a very interesting ethical discussion, but I didn't feel like I had any solutions. This might just be the nature of the problem.

Based on student feedback over the previous three years, improvements in the DL sessions have included formalizing the training session for the faculty preceptors, disinviting a number of preceptors who were poorly rated by students in previous years, increasing the number of breakout sessions to allow for smaller groups, making the sessions more interactive, distributing handouts with the DLHR guidelines and ICR rubric, and expanding the DL topics available from which the students could choose. For example, as part of the most recent InFocus 3 course, a new DL case was added that addressed how to be a "good" physician in a complex medical system, a common DL dilemma for HCPs practicing in the current medical environment. The case involves balancing the needs of hospitalized complex patients with the drive for "productivity" as measured through relative value units (RVUs).

In the most recent (2018) InFocus 3, we attempted to align each breakout session more closely with the Kolb cycle of experiential learning (Kolb 1984). A session run according to the Kolb cycle includes a concrete experience, reflective observation, abstract conceptualization, and active experimentation. Small-group DL facilitators were asked to begin their sessions by asking the students if they had had any previous personal experience with a DL situation while in medical school. Students were invited to share their DL experience(s) with the group and then self-reflect on the dilemma, including any action(s) they had taken or had contemplated, but did not take.

This was designed to ground the students' learning in their concrete lived experiences and engage in reflective observation. Facilitators then aided abstract conceptualization by presenting the DLHR guidelines explicitly within the context of the ICR rubric. Students participated in active experimentation by progressing through the discussion focused on their assigned DL case, with prompts from the faculty preceptors.

The small-group DL facilitators of the most recent InFocus 3 course indicated that, for the most part, the Kolb cycle provided a good framework for the overall discussion. The facilitators were asked to rate on a scale of 1 to 5 (1 = not at all; 5 = very well) how well the ICR rubric worked in providing a framework to discuss their specific DL case. Eight of the nine said the ICR rubric worked "well" (five facilitators rated it a 4) or "very well" (three facilitators rated it a 5) in discussing the case, with only one facilitator indicating that the ICR rubric was not that useful (rating it a 2). One of the facilitators summed up the experience by saying, "I found the addition of the Kolb cycle and the ICR framework very helpful in aiding me to guide the students in their case analysis as well as for myself ... keeping the dialog focused."

In the future, we plan to further increase the number of small groups, reducing the number of students in each and thereby making them more interactive and inclusive, as well as expanding the range of DL cases offered. We also plan to develop and integrate subsequent longitudinal sessions at various other points in the curriculum to deepen students' familiarity with the problems of DL and the potential for human rights violations, and to improve their ability to contend with DL dilemmas when they arise in their work environments. This includes honing their ability to determine when and how to resist the demands of third parties and when they should comply. Currently, we have no follow-up data regarding the effectiveness of this basic DL training on clinical behavior, and we look to initiate evaluations to measure long-term impact.

Advocacy for institutional change

In grappling with the DL cases, our students, in their discussions, often move from a "micro" to a "macro" view of the issues. In other words, they understand that lasting solutions to many DL dilemmas often do not lie with the individual physician but that change on a systemic level can be a more powerful and comprehensive approach. They see the need to engage with power structures and to advocate for institutional transformation, through changes in legislation, policy, practice, or communal responses to pressing issues. The DLHR Report (IDLWG 2002: 81) addresses directly the role that institutions play in creating or mitigating dual loyalty dilemmas: "Institutional mechanisms may serve either to protect the practitioner from being placed in the conflict in the first place or to help the practitioner address it effectively once it arises."

Institutional mechanisms, according to the DLHR Report, include activities and policies of professional medical organizations. The DLHR Report went on to state,

[I]n many cases individual practitioners are not in a strong position to resolve conflicts on their own – and in some cases put themselves in serious jeopardy if they try. Under these circumstances, only collective action will enable individual health professionals to fulfill their human rights obligations towards their patients. (IDLWG 2002: 82)

The DLHR Report called for professionals to engage in collective action, highlighting the role advocacy should play in changing laws and regulations that prevent or impede health professionals from meeting their human rights obligations to their patients, to end state policies and practices that prevent HPs from providing healthcare to some or all patients in needs, and for policies to promote, protect, and fulfill human rights that avoid dual loyalty conflicts.

Myriad examples of medical professionals engaging in transformative advocacy work exist in the medical literature, and they are highlighted in the lay media as modern-day heroes. Examples include Mona Hanna-Attisha, the pediatrician who exposed the Flint water crisis and led a movement to ensure action was taken; Alex Wubbels, a nurse who was arrested in 2017 for refusing a

police order to draw blood from an unconscious patient in her care at a Utah hospital and now leads #EndNurseAbuse; and Mariposa McCall, a psychiatrist who has witnessed first-hand the harm of placing prisoners in solitary confinement and has launched a petition calling on professional medical organizations to work to end prolonged solitary confinement in American jails, prisons, and detention centers.

Physicians, nurses, and other HCPs who have participated in advocacy campaigns coordinated by nongovernmental organizations have also had a profound impact around the globe. For example, International Physicians for the Prevention of Nuclear War has worked to abolish nuclear weapons and prevent war, and Physicians for Human Rights was one of the founding organizations of the International Campaign to Ban Landmines (both have been recognized for their work with the Nobel Peace Prize). The examples set by HCPs who engage in advocacy serve as inspirational role models for young rising healthcare professionals, and the success they have achieved through specific campaigns also serves as models of how to bring about change.

For several years, there has been debate in the medical literature about whether advocacy should be considered a core component of medical professionalism, or whether it should remain aspirational on the part of the individual physician (Earnest, Wong, and Federico 2010; Croft 2012; Dobson, Voyer, and Reghr 2012). With the increased focus on the social determinants of health (SDH) and increased awareness of the role that social structures, power hierarchies, and structural violence play in determining SDH—and, consequently, health outcomes—the commitment to the idea that the professional role of physician should include advocacy has solidified. There is now widespread acceptance throughout the medical community that physicians have a professional obligation to engage in evidence-based advocacy to improve health and address health disparities as part of their social contract. A number of professional organizations have articulated this obligation in their code of ethics; for example, the American Medical Association (AMA) endorsed the idea that physicians must engage in advocacy, stating the physicians should, “Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being” (AMA 2001). Many schools now include advocacy as a fundamental competency and consequently include training of some sort in the core curriculum, in support of the belief that young physicians should develop a range of skills that support their ability to be agents of social change (Hubinette, Dobson, Scott, and Sherbino 2017).

As noted above, InFocus 4 focuses on physician advocacy. Students are introduced to a range of physician-advocates/activists through presentations that focus on real advocacy campaigns. They also interact in a small-group breakout sessions with representatives of local organizations, brainstorming on how the medical profession can play a role in advancing various health advocacy agendas. For example, staff from the Women in Prison Project of the Correctional Association of New York have run breakout sessions as part of InFocus 4 on their continuing advocacy to end the shackling of women prisoners who are pregnant, in labor and delivery, or postpartum. Students have the opportunity to move from analyzing a specific clinical DL case during InFocus 3 to exploring how advocacy initiatives can promote systemic change, either in the medical field itself or in the broader community, during InFocus 4. In addition, students begin to develop—or, in the case of students who have already been advocates, expand—their advocacy skills by participating in skills-building workshops. In this way, by setting expectations early on in the undergraduate preclinical years, students, for the most part, feel both the responsibility to act and empowered to bring about changes in institutional structures that will mitigate problems of DL and promote, protect, and fulfill human rights overall.

However, it should be noted that physician involvement in advocacy is not without controversy, even among our students. Although consensus often does develop around certain health advocacy initiatives, students sometimes strongly disagree, particularly about many of the controversial issues that currently confront our society at large. In InFocus 4, we do not instruct students on *which* positions they should take (for example, there are, as expected, disagreements

among students over abortion rights and gun control). Rather, we expose them to the central public health and human rights challenges of our time, invite them to engage with a number of local organizations with clear advocacy agendas, ask them to analyze data to inform evidence-based advocacy positions, and assist them in developing skills that support them in becoming change agent themselves.

Moving forward

Dual loyalty is inherent to the practice of medicine; it is unavoidable. Although DL dilemmas do not always contribute to the violation of human rights, a variety of DL conflicts have the capacity to significantly infringe on individuals' rights, including the right to life and the right to the highest attainable standard of health. Physicians and other healthcare professionals who fail to understand DL are at particular risk of becoming enablers of human rights violations. The failure to understand the ubiquitous nature of DL in medicine and the inability to formulate an appropriate response to any given situation are primarily due to a lack of training during both the undergraduate medical education (UME) and graduate medical educations (GME), as well as an insufficient response on the part of professional organizations and other bodies to create robust institutional mechanisms to assist HCPs to respond appropriately.

Currently, DL training is not considered part of the core medical curriculum, even within the domains of human rights training or medical ethics instruction. The Icahn School of Medicine at Mount Sinai is unusual in this regard, as it has formalized basic DL training for all medical students, a preliminary step in the right direction. But much work remains to be done. Medical educators should work to raise awareness among all healthcare professionals, particularly physicians, on the issue of DL. We need to develop a pedagogy of DL education—that is, to determine what educational guidance is most efficient and effective in protecting human rights in DL conflicts and how to best train HCPs in discerning when and how to resist the demands of the state or other third parties and when to comply. This will, no doubt, entail the development of longitudinal educational interventions that can be integrated into the core curriculum in both the undergraduate and graduate medical education years. However, training medical students, resident physicians, and other HCPs about DL will be challenging, as both UME and GME curricula are already overburdened by full agendas, and faculty who are experienced in teaching DL are few and far between. There is a need to develop innovative approaches to DL training that take these barriers into account. The full range of educational techniques should be experimented with, including seminars, case-based instruction, simulations, and shadowing experts to model behavior—as well as combinations thereof. Furthermore, technology needs to be employed creatively to maximize distribution, minimize cost, and leverage the expertise that is available.

We also need, as the DLHR Report called for in 2002, more involvement of national professional bodies and boards of healthcare professionals in supporting individual colleagues who are mired in DL conflicts by making changes at the systems level. Physicians who are in administrative leadership positions within policy, public health, and healthcare organizations can influence how DL conflicts ultimately play out in various settings by developing, implementing, and monitoring guidelines to support policies that uphold medical ethics and human rights, and by holding professionals accountable for violations of such policies. If DL training promotes reflective practice among young trainees during their formative clinical years, it could promote such needed systems change when these physicians advance into leadership roles in various organizations. Physician leaders with a framework for understanding DL conflicts will be better positioned than nonclinician administrators or physicians who are not trained in DL to understand how policy changes might mitigate a range of DL dilemmas with which individual physicians must contend. Finally, as originally envisioned by the IDLWG, we need to engage in a robust, inclusive conversation that involves a multitude of stakeholders—healthcare providers, attorneys, human rights

scholars, bioethicists, and members of civil society, government, and professional healthcare organizations, among others—about the larger social context that gives rise to the problems of DL in medicine today.

Arming physicians and other HCPs with a solid foundation regarding DL and offering them collegial support, advocacy initiatives, and institutional backing are powerful ways to prevent many of the abuses of human rights that occur within the realm of medicine today.

Note

1. The study conducted by Cotter, Chevrier, El-Nachef, Radhakrishna, Rahangdale, Weiser, and Iacopino (2009) has not been repeated, thus updated figures regarding the prevalence of HHR training in schools of medicine and public health today are not available.

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