

Medical Doctors in Torture Program. The Need for Virtue Ethics in Medical Conscience Formation

Anna Alichniewicz, Monika Michałowska (Uniwersytet Medyczny w Łodzi)¹

In December 2014, Physicians for Human Rights (PHR) released their analysis of the summary of the *Committee Report of the Central Intelligence Agency's Detention and Interrogation Program*. PHR focused on the involvement of health care professionals in the CIA torture program, concluding that the health professionals' commissions and omissions violated the prescriptions of many fundamental bioethical documents, including international declarations of bioethics and medical research ethics. The medical doctors' involvement evokes some thoughts concerning bioethical education. It seems that instead of developing virtues through practicing morally good habits, the experience of clinical training undermines the moral ideals that medical students identified themselves with at the commencement of their medical education. The hostile response they sometimes get from their mentors when trying to question morally troubling situations may shape the habit of 'turning a blind eye' to unethical behaviour, since the students do not want to jeopardize their grades and future medical career. Maybe it was the development of this habit and the failure to develop the habit of moral courage instead that prevented the medical doctors participating in torture programs from defending moral ideals of their profession more effectively.

In December 2014 Physicians for Human Rights (PHR) released their analysis of the summary of the *Committee Report of the Central Intelligence Agency's Detention and Interrogation Program*. PHR focused on the involvement of health care professionals in the CIA torture program, concluding that the program initiated after September 11, 2001 "relied on health professionals to a degree previously un-

¹ Anna Alichniewicz and Monika Michałowska have contributed equally to the manuscript.

known”.² The authors of the PHR study pointed out that the key role of psychologists and physicians was visible at all steps of the long term torture program and comprised designing, performing, self-justifying, and keeping secret individually tailored methods and tools of torture.

Torture is universally considered an outrageous practice that is morally wrong and should be also forbidden by the law. Nevertheless, against the background of the general moral condemnation of torture, one can encounter a view that although morally wrong, in some specific scenario known as “the ticking bomb case” (the case developed by Alan Dershowitz³), torture could be justified by the so-called necessity doctrine. The ticking bomb case refers to the circumstances “where it reasonably appears necessary to avert a greater and imminent harm”⁴ even at the cost of violation of the law and producing some harm. Thus the necessity doctrine refers to the special scenario where a net benefit to society (the greater good or the lesser evil) will result from inflicting some harm on an individual or individuals.⁵ Our point is not to discuss the problem whether torture should be absolutely banned or whether there is a scenario in which torture is justifiable. Noting this problem, we are not going to address it on a general level, because it would go beyond the scope of our paper, the goal of which is much more modest. We would only like to argue that, regardless of the fact whether it is ethically possible to recognize any scenario making torture allowable, the moral commitment of the physician to the values of autonomy and goodness of the patient should exclude them from any participation in such a practice.

Given a long history of medical regulations from the *Hippocratic Oath* to the *Declaration of Geneva* calling for fairness and impartiality of a medical doctor, it could be argued that declaratively medicine is politically neutral. Nevertheless, it would be naïve to claim that this is really the case. There is a long history of political impact on medicine, eloquently shown by Foucault, but also, as Engelhardt observes, “Political problems are medicalized, undoubtedly in part, because medicine offers an efficacious way of controlling free expression.”⁶ Nevertheless, the fact that

2 Physicians for Human Rights, *Doing Harm: Health Professionals’ Central Role in the CIA Torture Program*, December 2014, p. 2. https://s3.amazonaws.com/PHR_Reports/doing-harm-health-professionals-central-role-in-the-cia-torture-program.pdf [Accessed 3 May 2015].

3 A. Dershowitz, *Why Terrorism Works: Understanding the Threat, Responding to the Challenge*, Yale University Press 2002.

4 J. A. Cohan, *Torture and the Necessity Doctrine*, 41 Valparaiso University Law Review 1587 (2007), pp. 1605, 1607 <http://scholar.valpo.edu/cgi/viewcontent.cgi?article=1196&context=vulr> [Accessed 29 January 2016].

5 *Ibidem*, p. 1608.

6 H.T. Engelhardt, Jr., *The Foundations of Bioethics*, New York, NY: Oxford University Press, 1996, p. 224.

politics and medicine have been intertwined does not imply that this phenomenon is something to be taken as such. To the contrary, given the power the doctors have, the intertwining between medicine and politics should be strictly controlled.

It should be admitted that it is possible to imagine a situation when somebody who is a medical doctor by training is involved in torture in the 'ticking bomb scenario' in which many human beings are at stake, and the doctor is not engaged in the doctor-patient relationship with the individual who undergoes torture. In that case, the doctor should not present herself/himself as a care-giver to the subject of the torture the doctor is involved in. However, given the professional commitment and the covenantal character of the doctor-patient relationship, it seems unacceptable that the doctor could be allowed or forced to combine the role of a healer with that of a torturer with regard to her/his patient. It should also be emphasized that because of the primordial nature of medicine as the art of healing the highest measures should be undertaken to prevent the usage of medical doctors' skills and knowledge in torture.

Claiming this, we also address the problem of a moral conflict faced by dual professionals. We are of the opinion that medicine is an inherently ethical enterprise and it is a unique doctor-patient relationship that should be given priority when a conflict of roles occurs. It should be noted that a military doctor is in a special position being both a physician and a military officer, which can lead to moral distress, that is a situation when somebody feels restrained from doing what he/she recognizes as morally right.⁷ The potential conflict created by dual loyalties has been recognized and led to formulating two opposite views. Nevertheless, no generally accepted solution of the dilemma has been achieved so far. Some authors, like Samuel Huntington⁸, Edward Colbach⁹ and Michael Gross¹⁰ give the priority to military duties, whereas others, for example Victor Sidel and Barry Levy¹¹ and

7 E. J. Gordon, A. B. Hamric, *The courage to stand up: The cultural politics of nurses' access to ethic consultation*, Journal of Clinical Ethics 17/3 2006, pp. 231-254; L. D. Wocial, *An Urgent Call for Ethics Education*, The American Journal of Bioethics 8/ 4 (2008), pp. 21-23; K. R. Lang, *The Professional Ills of Moral Distress and Nurse Retention: Is Ethics Education an Antidote?*, The American Journal of Bioethics 8/ 4 (2008), pp. 19-21.

8 S. P. Huntington, *The Soldier and the State: The Theory and Politics of Civil -Military Relations*, Cambridge, MA.: The Belknap Press of Harvard University Press, 1957.

9 E. Colbach, *Ethical Issues in Combat Psychiatry*, Military Medicine 150 (1985), pp. 256-264.

10 M. Gross, *Bioethics and Armed Conflict: Moral Dilemmas of Medicine and War*, Cambridge MA The MIT Press 2006.

11 W. Sidel, B. S. Levy, *Physician-Soldier: A Moral Dilemma*, Military Ethics, vol. 1. ed. T.E. Beam, L.R. Sparacino, *Textbooks of Military Medicine*, Washington, DC: Borden, 2003, pp. 295-305.

Edmond Howe¹², claim that medical obligations should override military duties. The ethical challenge “faced by military medical professionals in their dual-hatted positions as a military officer and a medical provider”¹³ has been also recognized by WMA Past President, Cecil B. Wilson, who says, “Tensions can arise if the demands of the mission or line command are at odds or in tension with the duties to attend to the health of those needing care.”¹⁴ The particular problem of their involvement in torture was addressed by Task Force Members of the Institute on Medicine as a Profession and Open Society Foundations, who commented on their report entitled *Ethics Abandoned: Medical Professionalism and Detainee Abuse in the War on Terror* saying: “By shining a light on misconduct, we hope to remind physicians of their ethical responsibilities.”¹⁵ It seems worth mentioning that although the title of the report referred to ‘the war on terror’, the question whether the self-declared war on terror invoked Geneva Conventions has become the subject of some legal controversies.¹⁶

Nevertheless, from the point of view shared by us, the fact that the health professionals involved in the CIA torture program not only failed to protect their patients from harm and brutality but they actually did harm to them seems extremely repulsive. Not only did they fail to prevent torture, but they actively participated in performing and monitoring it. Moreover, they got engaged in unethical research on human subjects.¹⁷ Against this background, the fact that they did not observe the rule of receiving informed consent from a patient before providing medical treatment may seem a lesser fault, but we should keep in mind that this requirement is nowadays universally recognized as a basic medico-moral rule.

12 E. G. Howe, *Dilemmas in Military Medical Ethics Since 9/11*, Kennedy Institute of Ethics Journal 13, no. 2, pp. 175-188.

13 C. B. Wilson, Report on “Ethical Guidelines and Practices for U.S. Military Medical Professionals” http://www.wma.net/en/45blogs/01wilson/2015_pblog01/ [Accessed 29 January 2016].

14 *Ibidem*.

15 *Interrogation|Torture and Dual Loyalty*, <http://imapny.org/medicine-as-a-profession/interrogationtorture-and-dual-loyalty/> [Accessed 2 February 2016]; Task Force Report, *Ethics Abandoned: Medical Professionalism and Detainee Abuse in the War on Terror*. <http://imapny.org/wp-content/themes/imapny/File%20Library/Documents/IMAP-EthicsTextFinal2.pdf> [Accessed 2 February 2016].

16 Geneva Conventions comprise four international treaties and three additional protocols concluded in Geneva between 1864 and 1949. The documents establish the standards of the international humanitarian law for the wartime. <http://www.cfr.org/international-law/united-states-geneva-conventions/p11485> [Accessed 18 April 2016].

17 It seems parallel to the experiments on human subject performed by Scientific Intelligence Division of the CIA known as MK-Ultra Project, the purpose of which was to examine the method of mind control and to enhance interrogation techniques in the case of resistant subjects. We wish to thank the anonymous reviewer for drawing our attention to that fact.

The authors of the PHR analysis noted that the above described commissions and omissions violated the prescriptions of many fundamental bioethical documents, including international declarations of bioethics and medical research ethics. As one of the most eloquent examples can serve rectal rehydration and rectal force-feeding that were performed on the detainees who engaged in hunger strike. These procedures were described as allegedly medically indicated, but no consent was sought from the strikers who were not deemed incompetent. Breaking the will of a competent hunger striker is clearly forbidden by the World Medical Association (WMA) *Declaration of Malta on Hunger Strikers* adopted in 1991 (latest revision 2006) that states: "Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting."¹⁸ Also, the WMA *Declaration of Tokyo*, that is *Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment* adopted in 1975 (latest revision 2006) clearly obliges the physicians to respect competent strikers' refusal of nourishment, saying: "Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially."¹⁹ It could be argued that rectal rehydration and rectal force-feeding do not amount to torture. Thus, the question that arises is what actually is meant by the notion of torture. Although there have been several attempts to address this problem²⁰, "the boundaries of the concept of torture are undefined"²¹, so there is no *consensus* what level of intentionally inflicting physical or mental suffering constitutes torture. It is rather obvious that not every humiliating treatment should be qualified as torture, and one might say that although a harsh practice, neither rectal rehydration nor rectal force-feeding constitutes torture. Nevertheless, even if not torture, it is bad enough. In this very scenario, this was unquestion-

18 WMA *Declaration of Malta on Hunger Strikers*. <http://www.wma.net/en/30publications/10policies/h31/> [Accessed 3 May 2015].

19 WMA *Declaration of Tokyo - Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*, principle 6 <http://www.wma.net/en/30publications/10policies/c18/> [Accessed 3 May 2015].

20 See for example: United Nations Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment, G. A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No.51, U.N. Doc. A/39/51 (Dec. 10, 1984).

21 J.A. Cohan, *Torture and the Necessity Doctrine*, p. 1594.

ably a degrading and inhuman treatment, given that the medical officers involved in these procedures were fully aware of the fact that from a medical point of view, it is intravenous infusion that is 'safe and effective'. They admitted, however, that they "were impressed with the ancillary effectiveness of rectal infusion on ending the water refusal in a similar case". It could be stated, therefore, that they intentionally participated in inflicting physical and mental suffering and sexual assault, and this means that they intentionally violated the first principle of the WMA *Declaration of Tokyo*, which stipulates that "The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife."²²

Furthermore, the fact that the data from the interrogation techniques were collected and analyzed by the health professionals to provide grounds for torture legitimization suggests that the physicians took part in illegal research on human subjects, which was a violation of the provisions of the *Nuremberg Code* of 1947²³ and the WMA *Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects* adopted in 1964 (latest revision 2013).²⁴

Last but not least, the physicians participating in brutal, carefully planned, and systematically executed torture revealed the utmost disrespect for the WMA *Declaration of Geneva* adopted in 1948 (latest revision 2006), which is generally acknowledged as the international oath of medical doctors.²⁵ It seems worth mentioning that art. 10/2 of *Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II)* from 8 June 1977 states that no medical professional can be compelled to engage in acts contrary to the rules of medical ethics, but the US is

22 WMA *Declaration of Tokyo - Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*, principle 1 <http://www.wma.net/en/30publications/10policies/c18/> [Accessed 3 May 2015].

23 *Nuremberg Code* <http://www.hhs.gov/ohrp/archive/nurcode.html> [Accessed 3 May 2015].

24 WMA *Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects* <http://www.wma.net/en/30publications/10policies/b3/> [Accessed 3 May 2015].

25 WMA *Declaration of Geneva* <http://www.wma.net/en/30publications/10policies/g1/> [Accessed 3 May 2015].

not a party to this *Protocol*.²⁶

The medical doctors' involvement in outrageous practices evokes some disturbing thoughts. One of the most important international documents concerning human rights, *The Universal Declaration of Human Rights* (1948), was developed in response to the horrendous crimes committed during the Second World War.²⁷ Medical atrocities of that period also triggered some international documents, for instance the already mentioned *Nuremberg Code* and the *WMA Declaration of Geneva*. These documents have been generally viewed as safeguards to prevent such heinous acts in the future. Although no doubt should be cast on the value of the observance of general as well as bioethical documents, both national and international ones, it seems rather obvious that ethical training in the faculties of medicine requires much more than just making students acquainted with the rules set by national and international ethical codes, declarations and conventions. The ethical formation of medical students and young doctors cannot be based solely upon the recognition of deontological and legal frameworks of their profession.

It can be argued that the spectacular technological progress in modern medicine gave rise to two noticeable tendencies. On the one hand, in medical education a great emphasis has been placed on the cognitive aspect of the profession, as well as on the excellence in medical skills rather than on the development of medico-moral awareness. On the other hand, there is some general acknowledgement that due to complexity of modern technological medicine generating many ethical doubts and dilemmas, bioethical education on both undergraduate and postgraduate levels has become an indispensable part of medical curricula.

There has also been a widespread agreement that although ethical education in medical faculties should provide some general knowledge of ethical theories, it should be focused especially on bioethical concepts and principles. As to the objectives of bioethical training, it seems that it is aiming mostly at conceptual clarity and analytical skills, which are essential intellectual competencies, but it can be argued that some other professionally important virtues should also be nur-

26 *Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II)*, 8 June, art. 10/2: "Persons engaged in medical activities shall neither be compelled to perform acts or to carry out work contrary to, nor be compelled to refrain from acts required by, the rules of medical ethics or other rules designed for the benefit of the wounded and sick, or this Protocol." <https://www.icrc.org/applic/ihl/ihl.nsf/Article.xsp?action=openDocument&documentId=D321BEBD-8192C5E0C12563CD0051E85A> [Accessed 16 April 2016]. As to the US not being a party of the Protocol, see: http://www.britannica.com/event/Geneva-Conventions#_comments [Accessed 18 April 2016]

27 *The Universal Declaration of Human Rights* <http://www.un.org/en/documents/udhr/> [Accessed 3 May 2015].

tured, since, as Henry Beecher emphasized, the most reliable safeguard is always “an intelligent, informed, conscientious, compassionate, responsible” physician.²⁸ Thus, from the very beginning of their education medical students should be made aware of the high ethical standards and “ideals for the person of a good doctor, which a medical student should learn and a physician should incorporate”.²⁹ These standards and ideals are involved in bioethical considerations that often refer to the ancient tradition of medical profession expressed in medical documents from the *Hippocratic Oath* onwards where virtues like empathy, compassion, care, benevolence, responsibility, and fidelity to trust were deemed crucial to the doctor.³⁰ Some authors explicitly stress that virtues like compassion are regarded as a core element needed for a proper fulfilment of professional tasks, as essential as technical competencies.³¹ Indeed, That demanding moral ideal of a good doctor is very appealing, but the question arises how these noble traits can be embedded in medical students so that they can flourish in full-fledged medical doctors.

According to the Aristotelian theory of virtues that has been revived in contemporary virtue ethics, good moral choices enabled by practical wisdom and repeated over time become habits.³² The model of acquiring virtues as habits of morally good conduct has also been approved of by authors dealing with medical ethics as the most effective way of fostering a morally good doctor.³³ It seems rather obvious that the only opportunities for medical students to develop and practice professional virtues are clinical encounters with patients and medical teams. Many students enter the medical school with quite an idealistic view on their future profession. Although their initial attitude is usually strengthened by a course of medical ethics they are obliged to take during the first years of medical curriculum, their further education in the clinical setting may cause some moral erosion. This deterioration

28 H. K. Beecher, *Ethics and Clinical Research*, in: *Bioethics: An Introduction to the History, Methods, and Practice*, ed. N.S. Jecker, A.R. Jonsen, R.A. Pearlman, Sudbury, MA: Jones and Bartlett Publishers 1997, pp. 29-41.

29 P. Gelhaus, *The desired moral attitude of the physician: (III) care*, *Medicine, Health Care and Philosophy* 2013, 16, no.2, p. 126.

30 P. Gelhaus, *The desired moral attitude of the physician: (I) empathy*, *Medicine, Health Care and Philosophy* 2012, 15, no.2, pp. 103-113; P. Gelhaus, *The desired moral attitude of the physician: (II) compassion*, *Medicine, Health Care and Philosophy* 2012, 15, no.4, pp. 397-410; E. D. Pellegrino, *Towards virtue-based normative ethics for the health professions*, *Kennedy Institute of Ethics Journal* 1995, 5, pp. 263-277.

31 J. Adams, et al. *Virtue in emergency medicine*, *Academic Emergency Medicine* 1996, 3, p. 961-966.

32 S. Broadie, *Ethics with Aristotle*, New York/Oxford: Oxford University Press 1991.

33 S. Bolsin, et al. *Practical virtue ethics: healthcare whistleblowing and portable digital technology*, *Journal of Medical Ethics* 2005, 31, pp. 612-618.

has been recognized for at least twenty years³⁴. Two major facets of this deterioration have been pointed out in the studies as a tendency to reduce a patient to her/his diseases and the inability of speaking up while witnessing ethically troubling situations.

Being trained in the system of month-long rotations, which is a common form of introduction to major clinical disciplines, students meet patients for a very limited time which makes any genuine training of the patient-doctor relationship impossible. At the beginning of their clinical training medical students generally consider it a weakness of the system, but with time many of them change their minds and take it as an advantage that can spare them lengthy conversations. Consequently, medical students cease seeing their patients as persons and start noticing only medical conditions. Gradually, they develop a habit of reducing their patients to diseases or even medical procedures: "I also got a Whipple" as one of the students said "referring to a patient with pancreatic cancer who needed that potentially complicated surgery. «That», he continued without flinching, «was awesome»."³⁵

Nevertheless, even fleeting clinical encounters give them opportunity to notice the so-called hidden curriculum, that is "a powerful institutional culture, which, in practice, subverted and contradicted, the fundamental ideals of medical ethics."³⁶ Students can witness behavior, attitudes, language, which remain in utter discrepancy with what was taught to them at their medical ethics courses. The moral ideals collide with medical reality. In the beginning students are frustrated and disappointed and usually feel that they should react somewhat. Here, the next factor enters the scene. In teaching hospitals students find themselves in an unfriendly, strictly hierarchical, army-like environment ruled by a pro-guild mentality. Their attempts to react or even their posing questions about the ethically troubling situations meet with hostile response from their mentors. The lesson the students get is that they should keep quiet. "K.M.S. [KEEP MOUTH SHUT] was from then on not only easy but second nature to me (...) I rarely if ever spoke unless I had been directly addressed. *This is the army*, I thought. *Every time you open your mouth you create complications for yourself*. It was a rule I followed throughout the rest of my medical training."³⁷

34 J. Goldie, et al. *Students' attitudes and potential behaviour with regard to whistleblowing as they pass through a modern medical curriculum*, Medical Education 2003, 37, pp. 368-375.

35 P.W. Chen, *Reinventing the third-year medical student*, NYTimes 2012/04/19 <http://well.blogs.nytimes.com/2012/04/19/reinventing-the-third-year-medical-student/> [Accessed 3 May 2015].

36 S. Bolsin, et al. *Practical virtue ethics: healthcare whistleblowing and portable digital technology*, Journal of Medical Ethics 2005, 31, p. 614.

37 J. Dwyer, *Primum non tacere: an ethics of speaking up*, Hastings Center Report 1994, 24, p. 14.

Paradoxically, instead of developing virtues through practicing morally good habits, the experience of clinical training can undermine the moral ideals the students identified themselves with in the commencement of their medical education. To make matters worse, it may shape the habit of turning a blind eye to unethical behavior, so that their grades and future medical career are not jeopardized. Finally, it is not an emphatic compassionate care attitude, but the “K.M.S.” attitude that may become their nature. If so, it can be argued that the habit of “K.M.S.” may make some physicians incapable of defending the moral principles of their profession and reacting against moral wrongfulness, even if the most fundamental medico-moral values are endangered, because instead of boosting their courage the medical training has suppressed it.

It may seem rather surprising that we are invoking courage in the context of bioethical education, as it is not usually mentioned as one of the virtues the ideal of a medical doctor is composed of. Amélie Oksenberg Rorty pointed out that although Aristotle “retains physical courage as the primary case”, he “extends its exercise to political and moral contexts”.³⁸ She describes moral courage as “the capacities and traits that enable us to persist in acting well under stress, to endure hardships when following our judgments about what is best is difficult or dangerous”.³⁹ It seems that this is the kind of courage that should be considered an important virtue of a medical doctor, because facing conflict situations is not a rare occurrence in his/her professional life. On the contrary, since medicine is nowadays practiced in a complex social and political framework, the duties towards patients may be incompatible with the obligations towards medical institutions or research teams, or the demands of the policy makers, etc.

As Petra Gelhaus observed, “personal virtues are what defend the internal moral goals of clinical medicine against other incentives and influences that are incompatible with these goals.”⁴⁰ To act virtuously in a hostile environment, medical doctors should develop courage as a general condition for any action since “Without courage, there is no active virtue”, as Oksenberg Rorty says.⁴¹

The challenge faced by the physicians who took part in the torture program was extreme, given that they were military doctors. The conflict of duties they were confronted was really tough and it might seem even insoluble. As it is known from

38 A. Oksenberg Rorty, *Mind in Action*, Boston, MA: Beacon Press 1988, p. 305.

39 *Ibidem*, p. 299.

40 P. Gelhaus, *The desired moral attitude of the physician: (III) care*, *Medicine, Health Care and Philosophy* 2013, 16, no. 2, pp. 126.

41 A. Oksenberg Rorty, *Mind in Action*, Boston, MA: Beacon Press 1988, p. 302.

the report, some of them tried to express their doubts and hesitations concerning their involvement in the program, but eventually condoned it. Maybe it was the “K.M.S.” habit they had developed –

instead of the one of moral courage – that prevented them from defending the moral ideals of their profession more effectively. We wish to argue, however, that by that time the entire process of medical education should have shaped their awareness not only of who they are, but also of who they are not. Surely, medical doctors are not torturers.⁴²

42 L. V. Monrouxe. *Identity, identification and medical education: why should we care?*, Medical Education 44 (2010), pp. 42.