Edmund Burke, the 18th Century British statesman, is credited with having said, “The only thing necessary for the triumph of evil is that good men do nothing.”

That is why the silence of military physicians at Afghanistan, Guantanamo, and Abu Ghraib is so distressing and why the failure of medical societies to condemn outright the violations of medical ethics is so appalling.

Our government has failed to acknowledge its responsibility for, and to repudiate its role in, these abuses, acts entirely foreign to the values of a democratic society and completely at odds with the traditions of our armed forces. The road to human rights violations began with President Bush’s unscripted remarks calling for a “crusade”, “a war on terrorism” to “rid the world of evil-doers” (Carroll 2004). Nothing is apparently impermissible in such a war: some argue that adhering to international conventions against torture ties the hands of democratic states in the fight against terrorism. Terrorists obey no such constraints. Yet, in the words of Michael Ignatieff (2004): “It is the very nature of a democracy that it not only
does, but should, fight with one hand tied behind its back. It is also in the nature of democracy that it prevails against its enemies precisely because it does.” To the extent that we employ torture against terrorists, we have become them. The battle will be lost by joining it on those terms.

The responsibility to protest against the abuse of human rights rests with every citizen. It applies with special force to physicians who uncover abuse in the course of patient care. The physician has a duty to treat the victim and a duty to report the circumstances that led to the need for treatment.

It is said that, as Khrushchev took his seat after his 1956 speech to the 20th USSR Party Congress detailing Stalin’s crimes, a voice called out: “And where were you, Comrade Khrushchev, when Comrade Stalin committed those atrocities?”

Khrushchev returned to the podium to ask: “Will the Comrade who put the question stand up and identify himself?”

And uneasy silence followed, Khrushchev ended the meeting by saying: “That is where I was.”

Is fear the reason American doctors went along with torture in Abu Ghraib? If it is, is it an acceptable reason? I hope to persuade you
that doctors should not only refuse to participate in or sanction torture, but that we are obliged to speak out against it. I will make five points:

- Torture and participation have been outlawed by the United Nations and by the United States Congress and are condemned by the ethical codes and policies of the relevant international medical bodies: the World Medical Association and the World Psychiatric Association, and by the relevant national bodies: the American Medical Association and the American Psychiatric Association.

- Despite these injunctions, there is unequivocal evidence that the U.S. military has employed torture and degrading treatment against detainees. Some physicians in the military had to have been aware of that torture; some advised torturers how to proceed.

- The absence of a medical voice of protest is all the more distressing in view of the reservations expressed within the military itself by the Judge Advocate Generals and other officers.

- The silence of American physicians and professional organizations stands in contrast to the courage
demonstrated in other countries where doctors were at far greater risk to their careers and personal freedoms.

• We must affirm that doctors serve health, not war, and give care to enemy and ally alike. In war, medical neutrality must be preserved.

The Universal Declaration of Human Rights, adopted by the UN in 1948, states that:

• “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment” (Article 5).

• Article II of the 1985 UN Convention Against Torture states that: “No exceptional circumstance whatsoever, whether a state of war or a threat of war, internal political instability, or any other public emergency, may be invoked as a justification for torture.”

• The United Nation’s Principles of Medical Ethics relevant o the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture (Resolution 37/104), was adopted by the General Assembly in 1982. The principles were prepared by the Council of International Organizations of Medical Sciences and approved by the Executive Committee of
the World Health Organization. They provide that “It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to, or attempts to commit torture.”

• The World Medical Association’s Declaration of Tokyo adopted in 1975, states in its preamble that: “the utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity”. The declaration prohibits the physician from being “present during any procedure during which torture or any other forms of cruel, inhuman, or degrading treatment is used or threatened.” It concludes with: “The World Medical Association will support…the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture…”

• The World Psychiatric Association, in its declaration of Hawaii, adopted in 1977 and revised in 1983, insists that: “The psychiatrist must never use his professional
possibilities to violate the dignity or human rights of any individual or group” and that: “Whatever the psychiatrist has been told by the patient, or has noted during examination or treatment, must be kept confidential.”

- The American Medical Association’s Code of Medical Ethics provides, “Physicians must oppose and must not participate in torture for any reasons.” As a matter of policy, “the AMA opposes torture in any country for any reason.”

- The American Psychiatric Association and the American Psychological Association issued a joint statement against torture in 1985, expressly supporting the UN Declaration and Convention Against Torture and the UN Principles of Medical Ethics relative to torture and ill-treatment.

Violations of the Geneva Conventions violate U.S. law because the Conventions were ratified by the U.S. Congress. Torture came to widespread attention when ordinary soldiers, some of whom provided pictures of themselves humiliating prisoners, posted explicit photographs on the Internet. No longer couple the U.S. Defense Department deny, though it continued to minimize, covert practices
including the systematic use of sleep deprivation, mock executions, painful physical restraints, prolonged isolation, hooding, severe sexual and cultural humiliation, forced nudity, use of threats and dogs to induce fear of injury or death, prolonged social isolation, threats of violence or death against detainees or their families (Physicians for Human Rights, 2005).

At various times, these acts have been explicitly authorized by U.S. commanders. An official inquiry led by Lt. Gen. Randall Schmidt, reviewing allegations by the FBI of abuse at Guantanamo, acknowledged the authorized use of sleep deprivation, long term isolation, sensory overstimulation (loud music), sexual humiliation, and military dogs against detainees (Physicians for Human Rights, 2005). FBI agents had witnessed harsh treatment of detainees at the Abu Ghraib prison in 2003. They were so troubled by what they saw that they raised the issue, both with their superiors and with the DoD, but to no avail (Lewis 2004). Army jailors in Iraq, acting at the Central Intelligence Agency’s request, kept many of the detainees at Abu Ghraib off official rosters to hide them from Red Cross inspectors. The number was “in the dozens, to perhaps up to 100”, according to General Kern, a senior officer who oversaw an Army inquiry (Schmitt and Jael 2004).
Miles (2004) and Bloch and Marks (2005) have documented the complicity of American military physicians in the torture of prisoners in Afghanistan, Guantanamo, and Abu Ghraib prison. “Medical personnel evaluated detainees for interrogation, monitored coercive interrogation, allowed interrogators to use medical records, falsified records and death certifications, and failed to provide basic health care” (Miles 2004). The military has notified the deaths of at least 28 detainees as confirmed or suspected homicides (Jehl 2005). Death certificates of detainees in Afghanistan and Iraq were falsified and corrected only after they were exposed. In one instance, soldiers tied a beaten detainee to the top of his cell door and gagged him. A pathologist prepared a certificate of his death stating that he died of “natural causes…during his sleep.” After public disclosure, the death certificate was revised to list the death as “homicide” resulting from blunt force injuries and asphyxia. In November 2003, Iraqi Major General Mowhoush was pushed into a sleeping bag while interrogators sat on his chest. He suffocated. Attempts to resuscitate him failed; a surgeon stated that he died of natural causes. Six months later, the death certificate was revised to list homicide by asphyxia (Moffeit 2004). The record leaves no doubt that pathologists have been willing to lie to suit the purposes of the DoD.
Accounts of ill-treatment of detainees have linked health personnel, including psychiatrists and psychologists serving on “Behavioral Science Consulting Teams” (“BSCTs”), to psychologically coercive and abusive interrogations. The Schmidt report cites an instance of a psychologist who was part of a BSCT in connection with the use of a military dog in an interrogation — and who may have been under pressure to participate based on the authorization and approval of such techniques. A comprehensive investigative report in the July 11 & 18 issue of The New Yorker, entitled “The Experiment,” provides a detailed picture of psychological coercion of detainees. Major General Geoffrey D. Miller, “who commanded the Guantanamo Bay detention center between November, 2002, and March, 2004, and who was then sent by Secretary of Defense Donald Rumsfeld to manage Abu Ghraib prison in Iraq,” described the BSCTs as “essential in developing integrated interrogation strategies and assessing interrogation intelligence production.” The article describes in detail several of the psychological stress techniques devised and implemented with the participation, consultation, and monitory of BSCT psychologists and psychiatrists and other health professionals.

Former interrogators at Guantanamo Bay report that military doctors aided them in refining coercive interrogations by providing
advice on how to increase stress levels and exploit fears. In one case they reported that a detainee’s medical files showed he had a severe phobia of the dark and suggested ways to manipulate that to induce him to cooperate. Brian Whitman, a senior Pentagon spokesperson, insists that doctors advising interrogators were not covered by ethics strictures because they were not “treating patients” but rather acting as “behavioral scientists”. A recent report issued by the Surgeon General of the U.S. Army acknowledged the involvement of BSCT psychologists and psychiatrists in designing and monitoring interrogations, including help for interrogators in deciding “when to push or not push harder in pursuit of intelligence information.” As part of the Taguba investigation, Colonel Thomas M. Pappas, chief of military intelligence at Abu Ghraib, provided documents showing physicians’ systematic role in interrogation, including “dietary manipulation,” “environmental manipulation” (raising and lowering room temperature), “sleep management” (for up to 72 hours), “isolation” (for more than 30 days). “Since late 2002, psychiatrists and psychologists [at Guantanamo] have been part of a strategy that employs extreme stress, combined with behavior-shaping rewards” in interrogations, and that medical records were made available to facilitate interrogators’ efforts to exploit detainees’ conditions” (Bloche and Marks 2005).
The International committee of the Red Cross (ICRC) termed these activities “tantamount to torture” and “a flagrant violation of medical ethics” (Lewis 2004). What makes this indictment of American military physicians all the more bitter is that the collaboration of physicians in torture was a hallmark of the dictatorship of Saddam Hussein, the very regime we invaded to depose.

Although we have as yet no record of protest by physicians, the Judge Advocate Generals (JAGs) for the U.S. Army, Air Force, and Marines expressed concern about the interrogation tactics being developed in the Pentagon because they not only “contravened longstanding military doctrine but would also cause widespread public outrage if they became known.” The three JAGs were overruled by the General Counsel’s office for the Pentagon on the grounds that the “President’s inherent Constitutional authority to manage a military campaign” made a prohibition against torture “inapplicable to interrogations undertaken pursuant to his Commander-In-Chief authority” (White 2005). The JAGs did not go public.

Maj. Gen. Lester Martinez-Lopez recommended that the Defense Department stop using physicians and psychiatrists to aid interrogations, criticizing the lack of … “policy defining the role of “behavioral science consultation teams” (referred to as “biscuit
teams”) which have access to medical records on the detainees. However, Lt. Gen. Kevin C. Kiley, the Army Surgeon General, acknowledging only “isolated cases” of detainee abuse involving medical personnel, refused to exclude physicians from the biscuit teams. Military physicians, according to the Pentagon, are acting as combatants, not as physicians, when they put their knowledge to use for military end. The tactics unequivocally violate the Third Geneva Convention, which rules out physical or mental torture being inflicted on prisoners of war. Dr. David Tornberg, Deputy Assistant Secretary of Defense, defended these practices on the grounds that “physicians assigned to military intelligence have no doctor-patient relationship with detainees and, in the absence of life-threatening emergency, have no obligation to offer medical aid” (Bloche and Marks 2005). Colonel Thomas M. Pappas, Chief of Military Intelligence at Abu Ghraib, emphasized that there is a systematic role for physicians in devising individualized plans for detainees. In its defense, he stated that “a physician and a psychiatrist are on-hand to monitor what we are doing”, as if that assured a humane interrogation! This claim is difficult to accept at face value. The history of physician participation in torture is that they are employed to “titrate” the dose to avoid too premature a death (a dead “informant” has lost his or her value) and to revive victims who lose consciousness, with the result that their misery is prolonged.
Indeed, reservations were expressed even with the CIA. Johnm Helgerson, the CIA Inspector General, warned in a classified report that the interrogation proceedings approved by the CUIA in the wake of 9/11 “might violate provisions of the International Convention Against Torture” to which the United States is a signatory. The IG’s findings were vigorously disputed” by the agency’s General Counsel. The issue continues to roil the agency. (Jehl 2005).

An Army Captain, Ian Fishback, has waged an unsuccessful 17-month struggle to “get clear, consistent answers from my leadership about what constitutes lawful and humane treatment of detainees…” “I am certain,” he stated, “that this confusion contributed to a wide range of abuses including death threats, beatings, broken bones, murder, exposure to elements, extreme forced physical exertion, hostage-taking, stripping, sleep deprivation and degrading treatment” (White 2005). It is altogether bizarre that the Criminal Investigation Command, rather than looking into the ubiquity of torture at Forward Operating Base Mercury in Iraq (Human Rights Watch 2005), “pressed Captain Fishback to divulge the names of the two sergeants who also gave accounts of abuse.” A West Point graduate, the Captain found himself deeply troubled by the Army’s response. He has been warned he may face criminal prosecution if he disobeys its “lawful order” to disclose their names. Yet he reports no regrets about having
come forward because “It’s the right thing to do” (Schmitt 2005 a and b). Fishback’s testimony before the McCain Committee helped persuade the Senator to introduce a resolution to regulate the detention, interrogation, and treatment of prisoners held by the American military. It passed overwhelmingly in the Senate (90 to 9). The American College of Physicians, the American Psychiatric Association, and the American Psychological Association have gone on record endorsing the McCain Proposal (Hedberg et al 2005). The McCain amendment awaits final action by the House-Senate Conference Committee, a venue at which aides to Vice President Cheney are trying to gut the amendment by exempting clandestine CIA activities from its provisions (Golden and Schmitt 2005).

No doctor has seen fit to protest because “it is the right thing to do.” At least there is no record of such. Perhaps some did and their protests were suppressed. But no such incident has been revealed. Court martial for revealing what this Administration decides to classify as a “military secret” is no trivial threat. Yet Article II of the United Nations 1985 Convention Against Torture states that: “An order from the Superior Officer or a public authority may not be invoked as a justification of torture.” (Article II, Number ).

The claim that he was “following orders” did not exculpate Adolph Eichmann. The language of the Universal Declaration of
Human Rights is unequivocal: “The doctor’s fundamental role is to alleviate the distress of his or her fellow man. No motive, whether personal, collective, or political, shall prevail against this higher purpose.”

The World Medical Association Tokyo Declaration demands that: “The utmost respect for human life is to be maintained, even under threat.”

Have doctors ever lived up to these lofty goals? Under far more daunting circumstances, physicians and medical organizations in South Africa, Chile, and Turkey have spoken out in defense of human rights.

A courageous doctor made public the violations of medical ethics in the death of Steve Biko, a militant leader of the Black consciousness movement in South Africa (Richmond 2003). Biko was arrested in 1977 under the Terrorism Act. He was beaten so badly during prolonged interrogation in the Headquarters of the Security Police in Port Elizabeth that the security forces summoned Dr. Ivor Lang, the District Surgeon. Although Lang saw lip lacerations, bruises on the sternum, and edema of the hands and ankles and noted that Biko’s speech was slurred, he wrote for the medical record: “I have found no evidence of any abnormality or pathology on the patient.”
The following day, accompanied by Dr. Benjamin Tucker, the Chief District Surgeon, Lang found neurological damage. On lumbar punctures, blood-stained cerebrospinal fluid was obtained. Nevertheless, Lang certified that the lumbar puncture was “normal”.

A day later, Biko was in total collapse. Lang recommended transfer to a nearby provincial hospital. When the security forces refused, Tucker authorized trucking Biko in manacles 750 miles to Pretoria Central Prison without an ambulance, a medical attendant, or a referral letter. He died the following night. Lang and Tucker had provided a medical cover-up for rampant brutality and torture. They ignored their duty to Biko as their patient, a duty that should have trumped all other considerations (McLean & Jenkins 2003).

Frances Ames, Chair of the Department of Neurology at the University of Cape Town, was so disgusted by the doctors’ behavior that she lodged a complaint with the South Africa Medical and Dental Council (SAMDC) charging the doctors with violating medical ethics. In the words of a former student (McCarthy 2003): “For anyone recently widowed with four sons, the responsibility of running a neurology department in a prestigious hospital would have been onerous enough. She found herself surrounded by bewildered male colleagues, too afraid to speak out against the horror that was enveloping this country for fear of having their government subsidies
cut…She was confronted with open hostility by her apparently liberal colleagues…She was begged to drop the case.” In the event, the SAMDC summarily rejected the complaint without convening a full hearing. Race, “state security”, and politics were allowed to obfuscate the one question that mattered: did Biko receive the level of medical care that any patient was entitled to receive (McLean and Jenkins 2003)?

Dr. Ames and five physicians from the Witwatersrand University took the case to the South African Supreme Court to force the Council to hold a hearing into the conduct of the doctors. It took eight years, but the Court finally ordered the SAMDS to examine the charges (Izindaba 2003). Once the evidence was considered, the Council struck Tucker off the register and cautioned Lang. Frances Ames and two colleagues had received donations to help cover court costs (in the event they lost the Supreme Court appeal). They used those funds to initiate a Medical Faculty Ethics Committees at the University of Cape Town: Witwatersrand already had one. Wits and Capetown were “the only universities that would do so in the mid-1980s, a time of nationwide intimidation, states of emergency, and human rights violations on a grand scale” (McCarthy 2003). In June 1999, she received the Star of South Africa from the hands of President Nelson Mandela for standing up for humanity in a time of
legislated cruelty and dehumanization. “What Francis taught us through personal example was that ethics is about what happens on the ground, in our daily practice, when we are alone” — and not in lofty declarations (McCarthy 2005).

After Pinochet’s military coup in 1973, doctors associated with the Vicaría de la Solidaridad, the social service and human rights arm of the Catholic Church in Santiago, were arrested, harassed, and threatened with death for providing care to “subversives”. Its Medical Director, Dr. Ramiro Olivares, was held in prison for more than a year under an “anti-terrorist” statute which allowed no bail. Pinochet’s functionaries usurped the governance of the Collegio Medico (the Chilean Medical Society) by appointing its officers. When the regime attempted to soften its public image in the mid-1980s by allowing members of the Collegio to choose their own officers, the democratically-elected slate initiated an investigation of doctors who had supervised the systematic torture of prisoners. The tribunal identified six and voted to expel them. Supporters of the regime organized their own medical society to accommodate the expelled physicians. Dr. Juan Luis Gonzalez, President of the Collegio Medico, and Dr. Francisco Rivas, its Secretary General, were imprisoned for supporting a two-day general strike on behalf of health workers (Physicians for Human Rights 1988).
Physicians for Human Rights, an organization founded in 1986 by five Boston physicians to mobilize health professionals to advance health, dignity, and justice in defense of human rights sent a delegation to Santiago in October 1986. Drs. Carola Eisenberg and Robert Lawrence of Harvard Medical School, founding members of PHR, went to Gonzales and Rivas in prison and held a tightly-publicized press conference in Santiago. The PHR delegation drew international attention to the gross violations of medical neutrality by the Pinochet regime. The President and the Secretary General of the Collegio were released several weeks later.

My third illustration of medical conscience is the courage of the physicians in Turkey, who were imprisoned for “endangering the public order” when they testified to torture on prisoners (Physicians for Human Rights 1996). Dr. Cumhar Akpınar was arrested for providing forensic reports. The Central Council of the Turkish Medical Association and the Ankara Medical Chamber actively protested imprisoning a doctor for having “performed his duties in line with the ethical principles for the profession.” Even though they were under police surveillance, more than 100 Turkish physicians attended his trial in solidarity with Dr. Akpınar (Committee on Human Rights Correspondence 1996). After a long legal process, he was found not guilty on 30 December 1999.
Doctor Alb Ayan, a Turkish psychiatrist who helped to found the Human Rights Foundation of Turkey, worked at its treatment and rehabilitation center in Izmir. He was harassed repeatedly by the Turkish authorities for documenting the stigmata of torture on the prisoners he examined. He has been a defendant in 41 cases during the past decade. The Committee on Human Rights of the U.S. National Academy of Sciences wrote to Turkish authorities in defense of Dr. Ayan. After lengthy trials, periods of imprisonment, and numerous costly court appearances, Dr. Ayan has been acquitted of all but two cases. For the academic year 2005-2006, Dr. Ayan has been appointed a “Scholar at Risk” at Harvard University.

The official response to the horrors at Abu Ghraib, Afghanistan, and Guantanamo has been to dismiss them as aberrations by a small number of rogue military police soldiers. The role of the DoD, the Administration, and the military command has been denied. Yet, a memorandum from Alberto Gonzales, presently the Attorney General, advised the White House that the “war on terrorism” makes some elements of the Geneva Conventions “obsolete”. The Schlesinger Panel (2004), appointed to review DoD detention operations, recommended that: “All personnel who may be engaged in detention operations, from point of capture to final disposition, should participate in a professional ethics program that would equip them
with a sharp moral compass for guidance in situations often riven with conflicting moral duties.” Can we trust the very people whose policies led to the violation of ethics to prepare a new code? Who will guard the guardians? A top level commission, not beholden to this administration, should be appointed to review all of the evidence, assign responsibility for dereliction of duty, and propose a system of public accountability to prevent recurrence.

What of the complicity of behavior health personnel? The American Psychological Association appointed a Presidential Task Force to study the matter. To my dismay, it has concluded that psychologists can “support an interrogation and make use of confidential information in medical records…as long as it is not used to the detriment of the individual’s safety and well-being” (Evans 2005). The caveat “as long as” defies belief” the interrogations in question have been designed to place intolerable stress on the detainee threatening his “safety and well-being”!

Contract this position with that of psychiatrist Stephen N. Xenakis (2005), a retired Medical Corps Brigadier General, who directed major medical programs during the 1991 Gulf War. He has stated forcefully that health workers in the military “have a common duty…to provide care according to high standards of medical practice…and…to report any signs of physical or psychological
abuse…Unlike soldiers, doctors have a duty to patients as well as to country. That is what separates U.S. military physicians from the German doctors who aided the Nazis in concentration camps and…the prison doctors who examined anti-apartheid leader Steve Biko.”

This September, my wife enlisted a group of colleagues (Eisenberg 2005) to cosign a letter to the American Psychiatric Association urging it to condemn the use of highly coercive interrogation techniques by the United States, techniques that amount to torture and cruel, inhuman and degrading treatment; to enjoin the participation of psychiatrists in any of these activities; and to insist that the military provide specific operational ethical guidelines to protect the integrity of the psychiatric profession and the stability of military medical services. This September, The Board of Trustees of the APA adopted those principles: psychiatrists should not play any role in providing guidance, support, advice, monitory, or prisoner evaluation for interrogations, nor should they provide interrogators with any knowledge gained from observing detainees who are undergoing interrogation. To become official policy, the statement awaits action by the APA Assembly in November (Hausman 2005).

Health professionals who wish to affirm their opposition to torture can do so by signing on to The Call to Prevent Torture and Abuse of Detainees in U.S. Custody already endorsed by more than
1,000 physicians and other health workers. Log onto www.PHRUSA.org and click on the “Torture” link in the left column (on the home page).

If Physicians in the military have been silent for fear of court martial, that doesn’t explain why civilian medical organizations have equivocated or remained silent. Have we been afraid to criticize government policy lest we appear “unpatriotic”? Have we created a professional culture in which one gets along by going along? A survey of students in six medical schools indicated that more than half report having seen and participated in unethical acts that put patients at risk (Feudtner et al 1994(. Almost all students in the survey had heard physicians refer to patients in a derogatory way; two-thirds had witnessed unethical behavior by other team members; half felt themselves to be accomplices. Why had they gone along with what they knew to be wrong The reasons they gave included wanting to “fit in” and their fear of poor evaluations. What did being accomplices do to them? They reported feeling that their ethical principles had been eroded. Agreed, faking a lab result or keeping silent when a house officer saves face by lying is not the same as acquiescing in torture; but it is no exaggeration to suggest that it is a precursor to the conspiracy of silence that covers up for medical malpractice.
From the time students enter medical school, they need to understand that, while their responsibility begins with maintaining high ethical standards in their own work, it includes confronting unethical behavior wherever it occurs. Silence in the face of malfeasance is unacceptable (Dwyer 1994). We need to create an academic climate in which students challenge the missteps they see, despite personal risk (Eisenberg 1994). Fifty years on medical school faculties have taught me that the student who suppresses dismay at the mistreatment of a patient in a first-year clinic is no longer dismayed when he or she observes a similar event as a third year clerk and will be guilty of it as a house officer. (obligation to recognize) The house officer who tolerates unethical behavior will become the Assistant Professor who delays taking a stand until tenure is acquired. Sadly, the moral habits acquired on the way to tenure will guarantee having become so inured to ethical lapses that the new Professor will be bold only in defending space, salary, and parking privileges. Conscience atrophies without exercise.

If medical schools and teaching hospitals fail to instill in graduates a commitment to the human rights of their patients, the source is not far to find: lapses among the Faculty that pass unchallenged. We must construct an academic environment that fosters confrontation of problem behavior wherever it occurs. The
medical curriculum should engage students and house officers explicitly from the first year in addressing the day-to-day dilemmas they face when peers or superiors mistreat patients or put them at risk. We need a clinical ethos in which lying — or remaining silent — to cover up a lapse in patient care becomes as reprehensible as the lapse itself (Bosk 1979).

When Elie Wiesel (1986) accepted the Nobel Peace Prize, he said: “I swore never to be silent whenever wherever human beings endure suffering and humiliation…Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented…” It is time to add a codicil to the Hippocratic Oath: “I swear never to be silent whenever wherever human beings endure suffering and humiliation.”