

MEDICINE AND SOCIETY

Groupthink: How Should Clinicians Respond to Human Trafficking?

William Polk Cheshire, Jr., MD, MA

Abstract

Human trafficking is a pervasive problem that exceeds the capacity of social and organizational resources to restrain and for which guidelines are inadequate to assist medical professionals in responding to the special needs of victims when they present as patients. One obstacle to appropriate disagreement with an inadequate status quo is the lure of group cohesion. "Groupthink" is a social psychological phenomenon in which presumed group consensus prevails despite potentially adverse consequences. In the context of the medical response to human trafficking, groupthink may foster complacency, rationalize acquiescence with inaction on the basis of perceived futility, create an illusion of unanimity, and accommodate negative stereotyping. Despite these inhibiting influences, even in apparently futile situations, medical professionals have unique opportunities to be a force for good.

Introduction

An estimated 18,000 people are trafficked into the United States each year and forced into commercial sex work or hard labor [1]. These persons are subject to physical, sexual, and emotional violence and suffer from neglected health conditions [2]. Their abuse often remains hidden from mainstream society. Rarely do they self-identify in health care settings, whether out of fear, intimidation, shame, language barriers, or limited interaction with medical personnel [1]. A majority of them encounter a health care professional and receive episodic medical care while under traffickers' control and yet frequently go unrecognized as victims of human trafficking [3]. In some cases, clinicians may not consider the possibility that the patient is a victim and thus may unknowingly miss relevant clinical clues.

Studies of human trafficking victims in health care settings have identified the need for health care professionals' increased [education](#) about and awareness of the phenomenon of human trafficking and how to identify and treat its victims [1, 2]. This need is real, yet factual knowledge alone is insufficient to address the problem. Health care professionals must also reflect on the ethical aspects of responding to human trafficking. Education should include more than information, because mere facts do not compel action. A robust moral response also requires the prompting of conscience, the stirring of

empathy, willingness to act, prudential judgment, and confrontation of complacency where it exists.

Complacency is easily overlooked. One may probe for it by inquiring whether, in response to a problem as widespread as human trafficking, society is appropriately outraged and committed to taking all actions necessary to address the problem. A greater cultural response is needed, but, until then, the medical profession should be among the forces that are stepping out and leading the response. One of the barriers to such initiative can be psychological cohesiveness around an inadequate status quo.

The Dangers of Groupthink

Among the factors that may limit the medical response to human trafficking is the psychological phenomenon of conformity to group norms. There are many types of groups, which in general may be defined as collections of people who interact with one another; share interests, goals, and norms; and are unified in identity and purpose [4]. From the perspective of sociology, the medical community is a group comprising people who may work together as teams or may not interact directly but who share a common identity, base of knowledge, set of ethical principles, and commitment to medical service. Medical professionals constitute a specific type of a medical community that encompasses mastery of a complex body of knowledge and skills as well as a social contract with society that includes adherence to a code of ethics; self-regulation; and a commitment to competence, integrity, altruism, and service in the public good [5, 6]. A group's success depends in part on each member's loyalty to the group's mission.

Although group unity is essential for effectiveness, it can become excessive. Too much cohesiveness within a group's attitudes or behaviors can be a symptom of "groupthink," a term coined in 1971 by Irving Janis [7] to describe the "nondeliberate suppression of critical thoughts as a result of internalization of the group's norms" [8]. When groupthink occurs, social conformity shapes the group's dynamics such that members of the group continue the policies and actions to which the group has committed itself, even when the results have negative outcomes or a group member's conscience is troubled. The inclination to seek concurrence with other group members overrides reappraisal and consideration of alternative courses of action [7].

Janis identified eight symptoms of groupthink—invulnerability, rationale, morality, stereotyping, pressure, self-censorship, unanimity, and mindguards [7, 9]—some of which may apply in particular (but not all) instances of the medical evaluation of potential victims of human trafficking. For the purpose of this discussion of the symptoms of groupthink and their ethical implications, the in-group refers to members of the medical community who are not well-educated in human trafficking.

Invulnerability. Most or all members of the in-group share an illusion of invulnerability that leads to an attitude of overconfidence. Groupthinkers tend to feel falsely optimistic in the face of danger and willing to take excessive risks or ignore warnings [7]. This is not to suggest that the health care professional encountering a patient who is a victim of human trafficking is likely to subject the patient to excessive medical risks. Rather, even well-intentioned clinicians who are concerned about victims of human trafficking should ask themselves whether they might be subject to an unconscious bias from social insulation from the patient's plight that might lead them to underestimate the dangers that a potentially trafficked patient faces or ignore clinical clues that ought to warn of ongoing risks to the patient. Although not direct evidence of health care professionals' social insulation, disparities between their awareness of the prevalence of human trafficking and their belief that it impacts their own medical practice suggest a possible cognitive sequestration. For example, a survey of 180 emergency medicine staff in the US found that though 79.4 percent knew what human trafficking was, only 26.7 percent thought it affected their patient population, while 59.4 percent were uncertain [10]. Health care professionals who feel safe and secure in their own communities should make an effort to be intentional in empathizing with their patients' vulnerabilities in order to avoid underappreciating that human trafficking ultimately endangers all communities, including their own—for example, through the spread of sexually transmitted infections and the tolerance of human abuse.

Rationale. Groupthinkers not only ignore warning signs but also construct rationalizations to discount negative feedback that, if accepted, might cause them to reconsider their assumptions [7]. An especially potent rationalization is in the futility of action. In the first ethics case in this issue, Kathy, a medical student practicing in Kathmandu, is told that there is nothing she can do to stop the abuse of her patient. Kathy has no recourse in her desire to remove her patient from an [abusive environment](#) or to change the social hierarchy in Nepal—conditions causing her patient's medical problems. If Kathy or her team were to fall into groupthink, they might acquiesce in the rationalization that offering further medical care would be futile because their patients would inevitably return with reinfections and repeated injuries. However, the medical care they provide at that moment is itself not futile, in that it achieves its intended immediate physiological goal to improve health and extend life. And deeds of compassion are never futile. Over time, the dedication of Kathy's medical team to caring for all kinds of people, including victims of human trafficking, might even inspire and spur the conscience of the local community and, in unforeseen ways, contribute to initiatives that could reorder that society from within.

Morality. Groupthink reinforces belief in the inherent morality of the in-group and makes it easier to overlook the ethical consequences of decisions while inconvenient ethical concerns are left unspoken or are even suppressed [7]. This attitude, which affects all of us at one time or another, is illustrated in the second case in this issue, in which Dr. W

considers disregarding ethical and legal requirements for [medical record documentation](#) out of a belief in the inherent morality of providing gynecological care to a vulnerable and underserved patient population.

In the health care professions in general, a bias toward the inherent morality of existing, praiseworthy, already time-consuming medical projects could potentially relegate efforts to educate ourselves or others about human trafficking to a lower priority. Time and resources are limited, and there may be a bias to continuing what one is already doing. Such a bias in many cases may be appropriate. The point to derive from the groupthink phenomenon is that priorities should periodically be reassessed.

Stereotypes. Groupthink mentality stereotypes anyone who disagrees with the group [7]. The problem for human trafficking, by contrast, is not that medical practitioners necessarily disagree with others who approach the issue differently, but that they may at times unconsciously stereotype trafficking victims as less important than other patients. Such stereotyping can be a form of groupthink insofar as attitudes toward people from similar backgrounds can be shaped by television portrayals or political rhetoric suggesting, for example, that undocumented aliens are a threat to society. Such unconscious social biases are a potential threat to the provision of compassionate care and should be resisted.

A professional approach to caring for trafficked persons bears in mind that they are victims, and as such their injuries or sexually transmitted infections are not the result of self-neglect or moral failure. Human trafficking victims are marginalized and may be subject to repeated physical assault or sexual violence and, therefore, merit our care and concern. In most US states, adolescents can be prosecuted for prostitution [11]; young people who are trafficked for sexual exploitation—which may be unknown to clinicians—may be viewed as criminals, although in fact they are victims coerced into servitude [11, 12]. The very conditions of confinement and abusive treatment can produce psychological symptoms and behaviors that can be mistaken for personality disorders [13], which are stigmatic [14].

Pressure and self-censorship. Groupthink mentality may apply pressure to conform to any member who expresses doubt or challenges the group's direction [7]. This aspect may not apply so much to medicine, where the in-group is dispersed, although self-censorship may quell dissent.

Those who are caught up in groupthink may self-censor by avoiding deviation from the perceived group consensus [7]. One form of medical consensus might be a detail in the patient's case history that, although unexplored or even known to be erroneous, has been repeatedly documented in the medical record. During a medical encounter it may be easier—and, for the moment, safer for the patient—to go along with incorrect

information already established in a medical record. For example, a clinician might avoid investigating further and documenting whether the man claiming to be the patient's uncle is actually her pimp or that the patient who registered as age 19 is actually 16. Rectifying the omitted or incorrect information could endanger the patient by exposing him or her to retaliatory abuse. Clear guidelines for clinicians are needed because, if the clinician is aware that the patient is being trafficked, in some states the law may require the clinician to notify authorities [15]. A compelling case can be made for judiciously engaging, within legal boundaries, in this aspect of intentional self-censorship (not groupthink), which places the safety of the patient before other considerations. By self-censoring, an immediate crisis is averted, although dealing with other issues is postponed.

Unanimity. Because dissent is discouraged, groupthink creates an illusion of unanimity within the in-group. Statements that accord with the majority view are encouraged and freely expressed, whereas silence from those who think differently may be misinterpreted as assent. Each member may then conclude that the majority opinion is true and the current course of action correct [7]. The group might come to the premature conclusion that, because dissenting views are not being expressed, all that might reasonably be done is already being done and further efforts would be futile.

In resisting the groupthink that gravitates toward complacency in accepting the status quo, health care professionals should take the initiative to speak out more about the problem of human trafficking and partner with organizations and agencies that are developing helpful interventions.

Mindguards. Those entangled in groupthink will sometimes protect other members of the in-group from adverse information that would challenge the direction of the group, bring into question the morality of its past decisions, or undermine confidence in its leadership [7]. Combining and expanding upon the first and second ethics cases in this issue, suppose Kathy, a medical student, rotated next with Dr. W. Kathy might be reluctant to follow the law and accurately document the girls' medical details, because doing so could expose Dr. W's ethical compromise—if she did decide to treat the girls—which could have adverse consequences for her mentor Dr. W and for the continued provision of health care to the population of sexually trafficked women in the area. In a case of divided obligations such as this, loyalty to the group influences ethical decisions.

Conclusion

The framework of groupthink helps to explain how even well-intentioned medical professionals can, by going along with consensus, become participants in unnecessarily ineffective responses to serious health needs. Participation in groups, whether by actions, by attitudes, or by adopting uncritical habits of thought such as groupthink, entails personal moral responsibility. Analysis of the contours of ethical complicity must

consider acts of commission and omission as well as timing, proximity, certitude, knowledge, and intent [16-18].

Medical history is replete with unsettling reminders that it is possible for clinicians insufficiently to resist the ineffective or, in some instances, ethically questionable directions of a group. Medical history is also a story of health care professionals who have stood apart from their group, resisted an inadequate or complacent consensus, and led society in the direction of moral progress. The most appropriate ethical path is not always easily discerned. When moral matters are unclear, a valid guiding principle is to focus our care and compassion foremost on all our patients.

References

1. Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. Identification of human trafficking victims in health care settings. *Health Hum Rights*. 2011;13(1):e36-e49. <https://www.hhrjournal.org/2013/08/identification-of-human-trafficking-victims-in-health-care-setting/>. Accessed November 17, 2016.
2. Shandro J, Chisolm-Straker M, Duber HC, et al. Human trafficking: a guide to identification and approach for the emergency physician. *Ann Emerg Med*. 2016;768(4):501-508.
3. Sherif M, Sherif CW. *An Outline of Social Psychology*. New York, NY: Harper; 1956.
4. Cruess SR, Johnston S, Cruess RL. "Profession": a working definition for medical educators. *Teach Learn Med*. 2004;16(1):74-76.
5. Cheshire WP. The robot will see you now: can medical technology be professional? *Ethics Med*. 2016;32(3):135-141.
6. Chisolm-Straker M, Baldwin S, Gaigbé-Togbé B, Ndukew N, Johnson PN, Richardson LD. Health care and human trafficking: we are seeing the unseen. *J Health Care Poor Underserved*. 2016;27(3):1220-1233.
7. Janis IL. Groupthink. *Psychol Today*. 1971;5(6):43-46, 74-76.
8. Janis, 44.
9. Rosenblum EH. Groupthink: one peril of group cohesiveness. *J Nurs Adm*. 1982;12(4):27-31.
10. Chisolm-Straker M, Richardson LD, Cossio T. Combating slavery in the 21st century: the role of emergency medicine. *J Health Care Poor Underserved*. 2012;23(3):980-987.
11. Chung RJ, English A. Commercial sexual exploitation and sex trafficking of adolescents. *Curr Opin Pediatr*. 2015;27(4):427-433.
12. Greenbaum J, Crawford-Jakubiak JE. Child sex trafficking and commercial sexual exploitation: health care needs of victims. *Pediatrics*. 2015;135(3):566-574.
13. Iacopino V, Xenakis SN. Neglect of medical evidence of torture in Guantánamo Bay: a case series. *PLoS Med*. 2011;8(4):e1001027. <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001027>. Accessed September 19, 2016.

14. Sheehan L, Nieweglowski K, Corrigan P. The stigma of personality disorders. *Curr Psychiatry Rep.* 2016;18(1):11. doi:10.1007/s11920-015-0654-1.
15. Todres J. Can mandatory reporting laws help child survivors of human trafficking? *Wis L Rev Forward.* 2016: 69-78. <http://wisconsinlawreview.org/wp-content/uploads/2016/04/Todres-Final.pdf>. Accessed November 8, 2016.
16. Cheshire WP. Turning a blind eye: an ethical assessment. *Ethics Med.* 2011;27(1):7-11.
17. Post JM, Panis LK. Crimes of obedience: "groupthink" at Abu Ghraib. *Int J Group Psychother.* 2011;61(1):48-66.
18. Orr RD. The role of moral complicity in issues of conscience. *Am J Bioeth.* 2007;7(12):23-24.

William Polk Cheshire, Jr., MD, MA, is a professor of neurology at the Mayo Clinic College of Medicine in Jacksonville, Florida, where he chairs the Medical Ethics Committee and leads the Program in Professionalism & Values.

Related in the *AMA Journal of Ethics*

[Medical Education on Human Trafficking](#), October 2015

[Physician Encounters with Human Trafficking: Legal Consequences and Ethical Considerations](#), January 2017

[Saving the Starfish: Physicians' Roles in Responding to Human Rights Abuses in Global Health Practice](#), January 2017

[Taking Up the Mantle of Human Trafficking Education: Who Should Be Responsible?](#), January 2017

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

**Copyright 2017 American Medical Association. All rights reserved.
ISSN 2376-6980**