ISSN: 2994-6875

Review Article

Journal of Emergency Medicine: Open Access

A Critical Genealogy of Punishment and Its Chilling Effect on Medical Practice

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Submitted: 2025, Oct 05; **Accepted:** 2025, Oct 30; **Published:** 2025, Nov 07

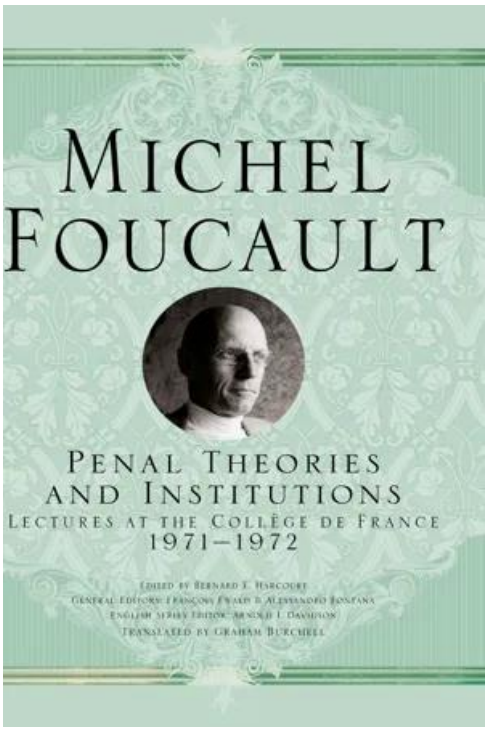
Citation: Ungar-Sargon, J. (2025). A Critical Genealogy of Punishment and Its Chilling Effect on Medical Practice. *J Emerg Med OA, 3*(2), 01-13.

How Carceral Surveillance Infiltrates the Physician's Inner Life

Abstract

This article examines how the evolution of punishment from public spectacle to bureaucratic surveillance has created a pervasive climate of internal fear within medical practice, fundamentally altering physicians' psychological states and clinical decision-making. Drawing on Foucault's genealogy of punishment, contemporary sociology of the carceral state (Simon's "governing through crime," Garland's "culture of control," Wacquant's analysis of neoliberal penality), and my work on heretical medical ethics, I argue that the threat of criminal prosecution for pain management, off-label prescribing, reproductive care, gender-affirming treatment, and alternative medicine has transformed physicians from autonomous healers into risk-averse bureaucratic functionaries. This "carceral consciousness" operates through internalized surveillance that restructures clinical reasoning from patient-centered benefit to organizational risk avoidance. The article traces four mechanisms—legal indeterminacy, surveillance infrastructures, professional discipline, and institutional co-production with law enforcement—showing how they generate chilling effects across pain medicine, reproductive care, gender-affirming treatment, dual-loyalty contexts, and sites where policing infiltrates clinical spaces. I conclude with safeguards to restore ethical primacy and call for heretical resistance to this colonization of medical consciousness.

Keywords: Foucault, Carceral State, Medical Fear, Chilling Effect, Physician Consciousness, Panopticism, Surveillance, Dual Loyalty, Opioid Policy, Reproductive Care, Gender-Affirming Care



1. Introduction: Punishment Migrates from Scaffold to Soul to Clinic

When Michel Foucault opened *Discipline and Punish* with the brutal spectacle of Damiens the regicide's 1757 torture and execution, he revealed something profound about the evolution of power: punishment had migrated from the body to the soul [1]. The shift from corporeal torture to disciplinary normalization represented not a humanization of punishment but its diffusion throughout society, operating through surveillance, timetables, record-keeping, and the production of "docile bodies" that internalize control and police themselves [1]. The modern penitentiary, the asylum, and the clinic share architectural and epistemic kinship—the gaze that observes, measures, and normalizes [1].

What Foucault could not have fully anticipated was how this carceral logic would infiltrate one of medicine's most sacred spaces—the clinical encounter itself—and how the threat of prosecution would reshape not just physician behavior but physician consciousness. As Jonathan Simon argues, late twentieth-century American society increasingly addressed social problems through criminal justice mechanisms, embedding penal logics into institutions previously organized around care, education, or welfare [2]. David Garland describes this as a "culture of control" wherein the state outsources risk management to actuarial systems, private actors, and administrative law [3]. Loïc Wacquant links neoliberal retrenchment to penal expansion, arguing that the carceral state manages social marginality produced by economic restructuring [4]. These frameworks situate contemporary medicine within broader governance structures in which clinical judgment is re-coded as compliance with risk metrics [2–4].

The modern physician practices under a panopticon of potential criminal liability. Federal prosecutors target doctors for "overprescribing" opioids [5,6]. State legislatures threaten felony charges for providing abortions, gender-affirming care, or reproductive health services [7–9]. Medical boards revoke licenses for recommending "unproven" alternative therapies [10]. Insurance companies flag "suspicious" prescribing patterns [11]. Electronic health records create permanent audit trails accessible to law enforcement [12]. Prescription drug monitoring programs (PDMPs) track every controlled substance prescription [5,6]. In this environment, the physician internalizes the gaze of the law enforcement apparatus, and this internalization produces a fundamental transformation of clinical consciousness—what I term "carceral subjectivity" in medical practice. Drawing on my previous work on heretical medical ethics, Foucault's genealogy of punishment, contemporary sociological analysis of the carceral state, and the rich scholarship on dual loyalty and structural violence, this article examines how the threat of criminal prosecution creates an internal architecture of fear that fundamentally reshapes how physicians think, prescribe, and practice [1-4,13-16]. The focus here is not merely on external constraints but on the psychological mechanisms through which carceral power colonizes medical consciousness itself—what legal scholars call the "chilling effect" [17].

2. Genealogies of Punishment and the Medical-Penal Nexus

2.1 From Spectacle to Surveillance

Early European regimes emphasized corporal sanctions—branding, stocks, whipping, mutilation—enacted as public spectacle to display sovereign power [1]. Foucault reads the nineteenth-century prison as a paradigmatic shift: punishment relocates from the body to the soul, producing compliant subjects through surveillance, temporal regulation, and hierarchical observation [1]. The panopticon, Bentham's architectural fantasy of perfect visibility, became Foucault's paradigm for understanding how modern power functions: not through overt coercion but through the internalization of being watched [1]. The prisoner who might be observed at any moment comes to monitor his own behavior, making external force unnecessary. This disciplinary power spread beyond prisons to schools, factories, hospitals, and military barracks—what Foucault termed the "carceral archipelago" [1]. The modern penitentiary, the psychiatric asylum, and the medical clinic share not merely architectural similarities but epistemic kinship: all deploy "the gaze that observes, measures, and normalizes," producing knowledge about subjects while simultaneously subjecting them to control [1]. As Garland argues, late modernity extends this logic through "governing at a distance," outsourcing surveillance and risk management to private actors, administrative law, and actuarial systems [3].

2.2 Medicine's Entanglements with Penal Power

Historically, medicine has alternated between emancipation from and complicity with penal power. Nineteenth-century psychiatry helped define legal categories of insanity and dangerousness, while asylums blurred treatment and confinement [18,19]. As Andrew Scull and Roy Porter document, the asylum functioned simultaneously as therapeutic institution and carceral space, with "moral treatment" serving as both humanitarian reform and mechanism of social control [18,19]. Twentieth-century abuses exposed how thoroughly therapeutic rationales can be weaponized. Eugenic sterilization laws in the United States and Europe transformed reproductive medicine into an instrument of racial and class control [20]. Nazi medical crimes, culminating in the Nuremberg Code, revealed the depths of medical complicity with state violence [21,22]. Punitive psychiatry in the Soviet Union used diagnostic categories to pathologize political dissent [23]. Robert Jay Lifton's analysis of Nazi physicians showed how ordinary medical professionals became agents of genocide through processes of "doubling"—psychological splitting that allowed them to function simultaneously as healers and killers [24].

In the United States, the "war on drugs" initiated in the 1970s and intensified through subsequent decades transformed the medical-penal nexus [25]. Ernest Drucker's epidemiological analysis documents how mass incarceration became a public health crisis, with physicians increasingly encountering patients whose health problems resulted from carceral exposure [25]. Post-9/11 security regimes further intensified medical-penal entanglements through controversies over physician participation in interrogations, force-feeding of hunger strikers at Guantánamo, and the surveillance of immigrant and Muslim patients [26,27].

Paul Farmer's concept of "structural violence" illuminates how poverty, racism, and punitive policies produce illness and constrain care, making the social determinants of health inseparable from carceral politics [16]. As Farmer argues, physicians cannot be neutral in contexts where state policies systematically harm patient populations; the question is whether medicine serves structures of violence or resists them [16].

3. The Psychological Architecture of Carceral Consciousness

3.1 Defining the Chilling Effect in Clinical Practice

A chilling effect occurs when actors refrain from otherwise lawful and ethical conduct due to fear of sanction [17]. In medicine, chill emerges when clinicians avoid indicated treatments, decline appropriate referrals, or alter documentation to reduce legal exposure or regulatory scrutiny—even when such care is both legal and clinically indicated [2,5,12,17]. The result is ethically suboptimal care and exacerbated health disparities. Legal scholars describe chilling effects primarily in First Amendment contexts—when fear of prosecution deters protected speech [17]. But the concept applies with devastating force to medical practice, where the stakes involve not merely expression but patient welfare. When a physician undertreats a patient's pain to avoid DEA scrutiny, delays necessary abortion care to ensure legal "justification," or refuses to recommend medical cannabis despite believing it might help—these represent chilling effects that directly harm patients.

3.2 Four Mechanisms of Carceral Chill

Drawing on the scholarship of Simon, Garland, and contemporary medical ethics literature, I identify four mechanisms through which penal logics produce chilling effects in clinical practice [2,3,5-9,12]:

• **Legal Indeterminacy:** Rapidly changing statutes, ambiguous legal standards, and conflicting guidance create environments where physicians cannot reliably determine what conduct is permitted [7–9,28]. When the law governing reproductive care, gender-affirming treatment, or controlled substance prescribing shifts unpredictably, physicians face impossible choices: either cease providing care or risk retrospective criminalization of previously lawful practice.

• **Surveillance Infrastructures:** PDMPs, electronic health records, insurance claim databases, and quality metric reporting create comprehensive audit trails that can be accessed by law enforcement [5,6,12,29]. These systems transform every clinical decision into potential evidence in future prosecutions. As one physician described: "I'm not just treating patients—I'm creating my own indictment" [30].

• **Professional Discipline and Reputational Risk:** Medical boards and hospital credentialing committees adopt conservative interpretations of clinical standards to limit institutional exposure, often going beyond legal requirements [9,11,31]. The threat of investigation—even if ultimately dismissed—carries enormous professional and psychological costs through what criminologists call "process as punishment" [32].

• **Institutional Co-Production:** Health systems increasingly partner with law enforcement through drug diversion task forces, hospital-based police units, and data-sharing agreements, embedding coercion directly into clinical spaces [33,34]. These partnerships compromise patient trust, deter care-seeking, and force clinicians into dual-loyalty conflicts between patient welfare and institutional security.

Each mechanism shifts clinical reasoning from patient-centered benefit to organizational risk avoidance, transforming the physician from healer to risk manager.

3.3 Cognitive Internalization of Surveillance

The transformation of physician consciousness under carceral pressure operates through several interrelated psychological mechanisms. First, there is what cognitive psychologists call "availability heuristic"—the tendency to assess risk based on the ease with which examples come to mind [35]. When physicians regularly encounter stories of colleagues prosecuted for prescribing decisions, investigated for offering alternative treatments, or disciplined for deviating from algorithmic protocols, these examples become cognitively available, inflating the perceived likelihood of similar outcomes. This availability bias interacts with what Kahneman and Tversky term "loss aversion"—the psychological tendency to weigh potential losses more heavily than equivalent gains [36]. For the physician, the potential loss—criminal prosecution, license revocation, professional ruin, imprisonment—is catastrophic and concrete. The potential gain—optimal patient care, fulfillment of healing vocation—is diffuse and abstract. Loss aversion thus systematically biases clinical decision-making toward defensive medicine.

These cognitive biases are amplified by what sociologist Stanley Cohen called "moral panic"—the social process through which particular behaviors or groups become defined as existential threats requiring extraordinary response [37]. The "opioid epidemic," the "crisis" of abortion access, the "controversy" over gender-affirming care—each constitutes a moral panic that reconstructs previously routine medical practices as dangerous aberrations requiring carceral intervention.

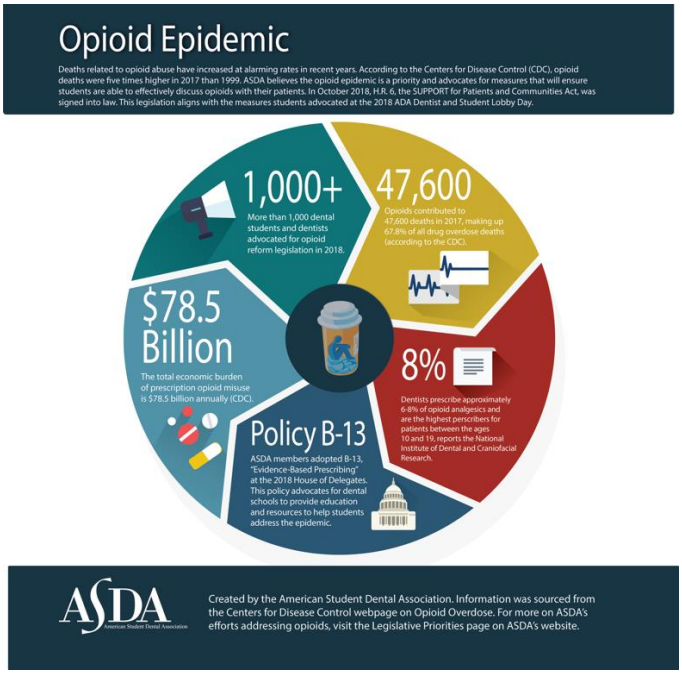
3.4 Anticipatory Obedience and Self-Censorship

Perhaps the most insidious effect of carceral consciousness is what Timothy Snyder calls "anticipatory obedience"—the tendency to comply with unstated demands, to self-censor before external censorship occurs [38]. The physician learns to avoid certain prescriptions, decline certain referrals, omit certain documentation—not because these actions are illegal but because they might attract unwanted attention, trigger an audit, or complicate future defense against potential charges. This anticipatory obedience operates through what Foucault termed "normalization"—the process by which power produces not merely obedience but subjects who desire what power demands [1]. The physician who initially reluctantly curtails pain prescriptions to avoid DEA scrutiny gradually comes to internalize this curtailment as proper medical practice. What began as defensive adaptation becomes experienced as ethical constraint. The carceral logic thus achieves its apotheosis: the physician polices herself in the name of good medicine, experiencing coercion as conscience.

3.5 Moral Injury and Professional Trauma

When physicians face investigation or prosecution—even when charges are ultimately dismissed—the psychological impact can be devastating [32]. The uncertainty of prolonged investigation, the financial cost of legal defense, the professional stigma of being investigated, the psychological burden of potential imprisonment—these constitute what criminologists term "process as punishment," where the investigative process itself functions as sanction independent of outcome [32]. Moreover, physicians forced to compromise patient care due to fear of prosecution experience what psychiatrists term "moral injury"—the psychological distress that results from actions or inactions that violate one's moral code [39]. The physician who undertreats pain, delays necessary abortion care, or refuses alternative treatment that might benefit

a patient experiences herself as complicit in harm, even as she recognizes the systemic pressures that constrain her choices. This moral injury manifests in increased rates of burnout, depression, substance abuse, and suicide among physicians [40,41].



4. Case Studies: How Carceral Logic Reshapes Clinical Domains

4.1 Pain Medicine and Opioid Surveillance

Following the opioid crisis, federal and state policies dramatically tightened control of opioid prescribing. While necessary to curb industry-driven overuse and diversion, criminal prosecutions of prescribers, aggressive use of PDMP data, and insurer audits created a climate of pervasive fear [5,6,42]. The DEA's interpretation of "legitimate medical purpose" has become increasingly restrictive, and physicians have been prosecuted not merely for illegal prescribing but for clinical judgment that prosecutors retrospectively deemed excessive [25]. Studies document the devastating consequences: abrupt tapering or discontinuation of long-term opioid therapy, closure of pain management practices, and patient abandonment—with increased harms including withdrawal, suicidality, and overdose [11,42,43]. The 2016 CDC guideline—later revised in 2022—was frequently misapplied as mandatory policy rather than clinical guidance, exemplifying how compliance regimes rather than individualized clinical judgment came to dictate care [5,6,11].

The psychological impact on pain management practitioners has been catastrophic. Physicians report "opiate-phobia"—reluctance to prescribe appropriate analgesia even for severe pain [44]. Many describe experiencing pain management consultations as potential crime scenes, where every prescription might become prosecution evidence. The chilling effect turns pain itself into a legal risk, disproportionately affecting patients with chronic pain and marginalized populations who face additional barriers to care [5,11]. From a Foucauldian perspective, this represents the production of a new medical subjectivity: the pain physician who experiences her therapeutic role primarily through the lens of potential criminality. The patient's suffering becomes secondary to the physician's self-protection. The sacred obligation to relieve suffering—one of medicine's oldest ethical commitments—dissolves in the acid of carceral fear.

4.2 Reproductive Care After Changing Legal Regimes

The criminalization of abortion and reproductive healthcare exemplifies how carceral logic transforms clinical consciousness. Following recent legislative changes, physicians in multiple states face felony charges for providing abortion care, even in cases of medical emergency [7,8,45,46]. Legal criteria for exceptions—often requiring "imminent" rather than merely "serious" threat to maternal health—create impossible decision points where physicians must calculate legal defensibility rather than patient need. Clinicians report delaying miscarriage management until patients become septic, restricting counseling for fear of legal exposure, and reducing training opportunities [45–47]. Mandatory reporting statutes and fetal "personhood" provisions complicate documentation and referrals. One obstetrician described the psychological burden: "I found myself calculating whether I could legally justify intervening rather than what my patient needed. That's not medicine—that's defensive bureaucracy conducted on a patient's body" [48].

The internalization of this carceral logic transforms the physician from patient advocate to risk manager. Documentation becomes potential prosecution evidence. Clinical judgment about when a patient is "sick enough" to legally justify intervention creates paralyzing uncertainty that delays timely care—an inversion of the principle of beneficence [45,47]. As legal scholars note,

these chilling effects extend beyond contexts where abortion is criminalized, deterring even legal reproductive healthcare due to fear of investigation or the appearance of wrongdoing [17,46].

4.3 Gender-Affirming Care and Professional Risk

Legislative restrictions on gender-affirming care for transgender adolescents—and in some jurisdictions, adults—have produced pronounced chilling effects: health systems halt services, academic centers restrict clinical rotations, and clinicians reduce or cease prescribing despite consensus guidelines from major medical associations [8,9,49,50]. Threats of criminal penalties, loss of licensure, and civil liability shift practice from patient-centered to risk-averse, destabilizing continuity of care [8,9]. Physicians report experiencing gender medicine consultations as potential evidence in future prosecutions, leading to excessive documentation, reluctance to recommend indicated interventions, and out-of-state referrals that compromise care continuity [49,50]. The psychological impact extends beyond individual encounters. Gender medicine practitioners describe constant low-level anxiety—"waiting for the knock on the door"—that pervades their professional lives [50]. This chronic stress produces hypervigilance, a trauma response characterized by excessive monitoring of potential threats [51].

The physician practicing gender-affirming care under carceral threat develops split consciousness: attempting to provide affirming, patient-centered care while simultaneously monitoring for behaviors that might attract prosecution. This fragmentation of professional identity—what sociologists call "role strain"—produces psychological distress arising from incompatible role demands [52].

4.4 Dual Loyalty in Prisons and Detention

In carceral settings, clinicians confront "dual loyalty"—obligations to patient wellbeing versus institutional security [14,15,53–55]. Constraints on confidentiality, security-driven shackling and taser use during clinical encounters, and formulary austerity can severely compromise care. COVID-19 exposed systemic neglect, where decarceration was resisted despite epidemiological evidence that prisons functioned as viral amplifiers [54]. Ethical frameworks from Physicians for Human Rights and the World Medical Association emphasize the primacy of patient interests over institutional demands, yet enforcement remains weak [14,53]. Physicians working in prisons describe intense pressure to prioritize security over health, to participate in coercive practices (restraints during labor, strip searches before medical visits), and to share confidential information with custody staff [15,53,55].

The dual-loyalty dilemma operates not merely as external constraint but as internal psychological conflict. Prison physicians experience moral distress from forced complicity in practices they recognize as harmful yet feel unable to resist without jeopardizing their positions or facing retaliation [15,55]. This chilling effect discourages thorough documentation of abuse, deters advocacy for improved conditions, and produces what Atul Gawande termed the "hellhole" of prolonged solitary confinement facilitated by medical acquiescence [56].

4.5 Policing at the Bedside: Hospitals as Carceral Spaces

The presence of law enforcement in emergency departments—bedside questioning, patient restraints, vehicle searches in hospital parking lots—can deter patients from seeking care, especially undocumented individuals, those with substance use disorders, or people with outstanding warrants [33,34,57]. Unclear boundaries between clinical information and law-enforcement access to records fundamentally undermine trust [29,33,34]. Empirical work links fear of policing with delayed care and worse health outcomes [33,57]. Patients who fear immigration enforcement avoid prenatal care, delay treatment for injuries, and forgo mental health services [57]. Clinicians uncertain about HIPAA exceptions may over-share information with police (violating patient confidentiality) or over-restrict it (interfering with appropriate care)—both responses reflecting the chilling effect of legal ambiguity [29,34]. The psychological impact on clinicians is profound. Physicians describe experiencing emergency departments as contested spaces where therapeutic and carceral logics collide [33,34]. The presence of police transforms clinical encounters into potential arrest scenarios, forcing physicians into impossible positions: cooperate with law enforcement and betray patient trust, or protect patients and risk obstruction charges. This ambient threat restructures clinical consciousness, making physicians constantly aware of surveillance and potential coercion.

4.6 Executions, Force-Feeding, and Interrogations

Professional bodies prohibit physician participation in executions, torture, and force-feeding of competent hunger strikers [58–61]. Nonetheless, states have sought medical involvement, and some clinicians have participated, prompting disciplinary debates and legal shields protecting physicians who cooperate with executions [58,60]. The ambiguity around "monitoring" versus "participation" creates chilling effects that extend beyond direct involvement [58,61]. Physicians working in correctional settings describe pressure to cooperate with practices they view as unethical, fear of retaliation if they refuse, and uncertainty about where to draw lines [15,61]. This uncertainty deters physicians from working in carceral settings entirely—potentially worsening healthcare quality for incarcerated populations—or from engaging in advocacy that could be construed as policy interference [58,60]. The post-9/11 controversies over physician involvement in "enhanced interrogation" at Guantánamo and other detention sites revealed how national security imperatives can override professional ethics [26,27]. Vincent Iacopino's analysis documented systematic neglect of medical evidence of torture, showing how institutional pressures silenced physicians who might otherwise have documented abuse [27].

5. From External Threat to Internal Colonization

5.1 The Internalization Process

The most profound impact of carceral surveillance is not the external constraint it imposes but the internal colonization it achieves. Foucault's analysis of discipline emphasized that modern power works most efficiently when subjects internalize surveillance and police themselves [1]. This internalization occurs through what I call "carceral subjectification." The process operates through several stages. Initially, physicians respond to external threats with conscious defensive adaptation: avoiding certain prescriptions, documenting excessively, declining high-risk patients. This represents behavioral compliance motivated by fear of sanction [62].

But over time, these defensive behaviors become habitual, then normative, then incorporated into professional identity. The physician who initially reluctantly undertreated pain to avoid DEA scrutiny gradually comes to view aggressive pain management as inappropriate. The obstetrician who initially resented being forced to delay abortion care for legal cover gradually incorporates this delay into her conception of proper clinical practice. The psychiatrist who avoided recommending medical cannabis eventually comes to view such recommendations as ethically questionable. This represents what Foucault called "subjectification"—the process by which power relations produce particular kinds of subjects [1]. The carceral state produces not merely obedient physicians but physicians who experience carceral logic as internal conviction. The physician's consciousness becomes restructured along lines that serve institutional and legal requirements rather than patient welfare or healing vocation.

5.2 The Fragmentation of Professional Identity

This carceral colonization of consciousness produces identity fragmentation—the splintering of professional self-conception into incompatible roles [63]. The physician must simultaneously be:

- **Healer:** Committed to patient welfare, relief of suffering, restoration of health
- **Risk Manager:** Focused on legal defensibility, documentation adequacy, audit preparedness
- **Bureaucratic Functionary:** Compliant with protocols, algorithms, administrative requirements
- **Potential Defendant:** Aware that every clinical decision might become prosecution evidence

These roles are not merely distinct but actively contradictory. What serves healing may create legal risk. What satisfies bureaucratic requirements may compromise patient care. What protects against prosecution may violate professional ethics. The physician attempting to fulfill all these roles simultaneously experiences role strain—psychological distress arising from incompatible role demands [52].

5.3 The Erosion of Clinical Courage

Perhaps the most insidious effect of carceral consciousness is the erosion of what might be called "clinical courage"—the willingness to advocate for patients, challenge unjust policies, and resist systemic pressures that compromise care [64]. Historically, medical ethics has emphasized courage as a professional virtue: the physician must be willing to take risks, challenge authority, and prioritize patient welfare over personal safety when necessary [64]. But carceral surveillance systematically undermines this virtue. The threat of prosecution, license revocation, or imprisonment creates powerful incentives for caution, conformity, and self-protection. The physician who might once have challenged an unjust policy or advocated for controversial treatment now calculates the personal cost of such actions. This calculation occurs continuously, in countless small decisions that cumulatively

reshape clinical practice. The result is what psychologists call "learned helplessness"—the psychological state where repeated exposure to inescapable threat leads to passive acceptance rather than resistance [65]. The physician comes to experience the constraints of carceral medicine not as injustices to be challenged but as unchangeable features of the clinical landscape to which one must adapt.

6. Ethical Analysis: Duties Under Carceral Pressure

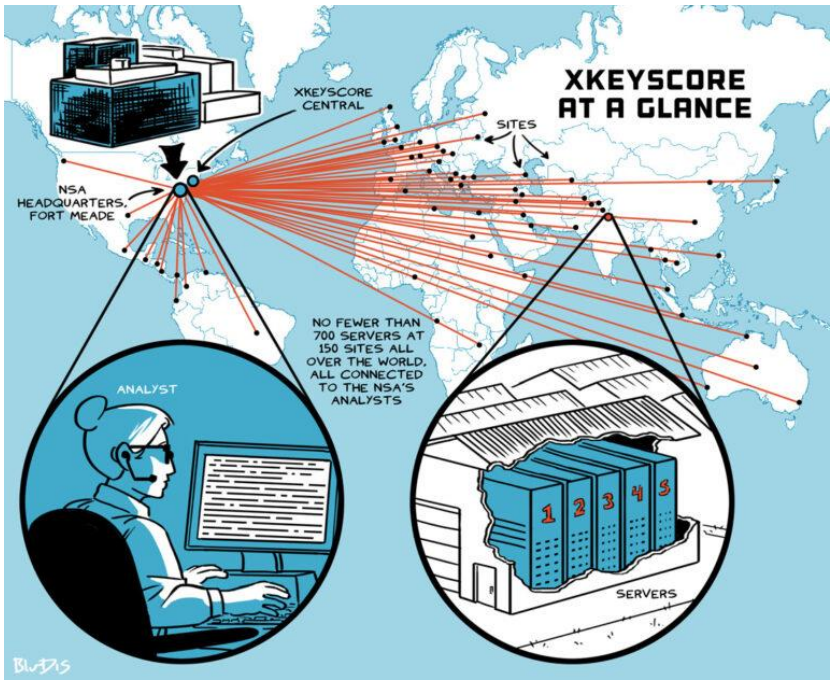
From multiple ethical frameworks, the verdict on carceral chill converges: it fundamentally corrodes medicine's fiduciary core. From a -deontological perspective-, duties of nonmaleficence and respect for persons require resisting practices that foreseeably harm patients through delay or denial of care [66]. When physicians allow fear of prosecution to override clinical judgment, they violate the categorical imperative to treat patients as ends in themselves rather than means to self-protection.

• Consequentialist Analysis- likewise condemns chill when it increases morbidity, overdose deaths, maternal complications, or suicide [5,7,45]. The aggregate harm produced by systematic undertreatment of pain, delayed reproductive care, and deterred healthcare seeking far exceeds any benefit from marginally reduced prescribing or enhanced legal compliance.

• Virtue Ethics- emphasizes the clinician's character—practical wisdom (phronesis) and courage (andreia)—in navigating competing demands [64]. The physician who allows carceral fear to dictate clinical decisions fails to embody the professional virtues essential to healing practice. Courage requires acting rightly despite risk, and practical wisdom requires judging each situation on its merits rather than defaulting to bureaucratic self-protection.

• Levinasian Ethics- reframes the clinical encounter as responsibility before the vulnerable face of the Other, unamenable to bureaucratic substitution [67]. As I have argued elsewhere, Emmanuel Levinas's radical ethics of alterity positions the patient not as an autonomous agent whose preferences must be respected, nor as a beneficiary whose welfare must be calculated, but as an Other whose very presence calls the clinician into moral being [13,67]. This responsibility cannot be contractually limited or bureaucratically managed. The face of the suffering patient commands before it can be comprehended, demands response before it can be analyzed.

From this Levinasian perspective, the carceral colonization of medical consciousness represents not merely policy failure or institutional dysfunction but a fundamental assault on the ethical foundations of healing relationship. When the physician experiences the patient primarily as potential legal risk rather than as vulnerable Other making infinite ethical demand, the healing relationship has been evacuated of its sacred dimension.



7. Heretical Resistance and the Recovery of Clinical Consciousness

7.1 The Necessity of Resistance

I have argued elsewhere that the technocratic colonization of medicine requires what I term "heretical ethics"—a willingness to transgress conventional boundaries in service of authentic healing relationship [13]. The carceral colonization of physician consciousness makes this heretical stance even more urgent and more difficult. It is more urgent because the stakes are higher: not merely bureaucratic inconvenience but potential criminal liability. It is more difficult because carceral power operates through internalized fear rather than merely external constraint. From a Foucauldian perspective, resistance to disciplinary power cannot take the form of simple refusal or external opposition. Power that

operates through the production of subjects cannot be resisted by subjects it has produced [1]. Instead, resistance must take the form of what Foucault called "practices of freedom"—the cultivation of alternative subjectivities that refuse the terms of disciplinary normalization [68]. For physicians, this means cultivating forms of clinical consciousness that resist carceral colonization. This is not merely a matter of individual courage or moral heroism—though these remain necessary—but of developing practices, communities, and institutional forms that can sustain alternatives to defensive medicine.

7.2 Safeguards: Restoring Ethical Primacy to Care

Policy and practice reforms can mitigate carceral chill. Drawing on legal scholarship, public health analysis, and ethical frameworks, I propose the following safeguards [7,9,14,29,53]:

• **Bright-Line Protections:** Enact shield laws for evidence-based care in reproductive health, gender-affirming treatment, harm reduction, and pain management, with clear safe harbors protecting physicians who follow consensus guidelines [7,9,47]. These protections must include both criminal immunity and civil liability shields, preventing retrospective prosecution of previously lawful practice.

• **Limit Data Exploitation:** Restrict law-enforcement access to clinical data through warrant requirements and judicial oversight. Tighten PDMP use to public health surveillance rather than criminal investigation [5,6,29]. Prohibit subpoenas of medical records without patient consent except in clearly defined circumstances. Create firewalls between clinical databases and law enforcement systems.

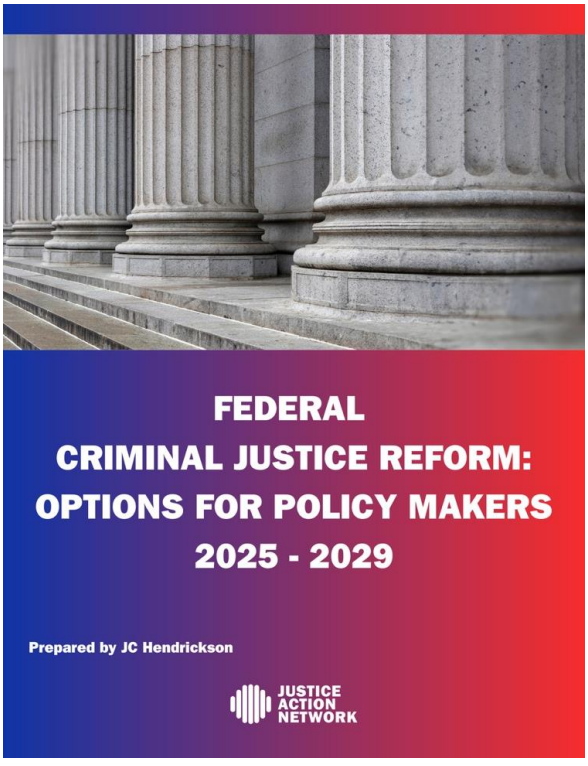
• **Carceral-Care Firewalls:** Codify rules for police presence in hospitals: require warrants for bedside questioning, prohibit vehicle searches in hospital property, restrict immigration enforcement in healthcare settings [33,34,57]. Protect patient privacy through robust HIPAA enforcement that recognizes trust as essential to effective care. Train clinicians on appropriate responses to law enforcement requests.

• **Prison Health Independence:** Place correctional healthcare under public health authorities separate from security departments; adopt international dual-loyalty standards that prioritize patient welfare [14,53–55]. Ensure confidentiality of medical records from custody staff. Prohibit retaliation against physicians who advocate for improved conditions or refuse to participate in coercive practices.

• **Education and Legal Support:** Train clinicians on evolving law, ethical frameworks for navigating dual loyalty, and strategies for principled non-compliance when institutional demands violate professional ethics [9,13,15]. Provide rapid legal counsel and institutional backing for physicians who face investigation for ethically indicated care. Develop peer support networks to sustain clinicians under investigation.

• **Measurement Reform:** Replace punitive performance metrics with equity-sensitive, patient-reported outcomes that capture quality of care rather than mere compliance with protocols [3,16]. Eliminate pay-for-performance systems that incentivize undertreatment. Recognize social determinants of health in quality assessments, avoiding victim-blaming when marginalized patients have worse outcomes.

These measures honor medicine's fiduciary obligation while acknowledging legitimate state interests in safety. They recognize that effective healthcare requires trust, and trust cannot coexist with pervasive surveillance and criminalization.



7.3 Practices of De-Carceralization

Beyond policy reform, the recovery of clinical consciousness requires what might be called "counter-subjectification"—deliberate cultivation of professional identities organized around healing vocation rather than risk management. I propose several overlapping approaches:

• **Contemplative Practice and Moral Attention:** The carceral colonization of consciousness operates partly through cognitive and emotional overwhelm. Contemplative practices—meditation, reflective writing, peer consultation—can create psychological space where alternative responses become possible [69]. These practices do not eliminate external threat but cultivate internal resources for responding to threat without being consumed by it. As I have argued regarding the Kabbalistic concept of tzimtzum (divine self-contraction), healing sometimes requires the withdrawal of expertise to create space for the patient's own resources to emerge [13].

• **Community Formation and Mutual Support:** Resistance to carceral pressure cannot be sustained individually. Physicians need communities of practice that can provide emotional support, practical guidance, and moral encouragement for maintaining patient-centered care despite institutional pressure [70]. These might include peer support groups, professional networks committed to heretical ethics, or institutional alliances across disciplines.

• **Documentation as Resistance:** One ironic form of resistance involves using surveillance tools against carceral pressure. Detailed documentation of how institutional policies harm patients, systematic collection of cases where defensive medicine compromises care, careful recording of administrative pressures to undertreat—these create evidence that can support advocacy for policy change while also providing ethical cover for individual clinicians [71].

• **Strategic Non-Compliance:** In some contexts, resistance requires deliberate violation of policies or protocols that harm patients, undertaken with full awareness of risks and appropriate safeguards [61]. This represents the most demanding form of heretical practice, requiring not merely courage but sophisticated judgment about when non-compliance serves genuine healing versus merely expressing physician frustration.

• **Prophetic Witness:** Drawing on theological traditions of prophecy, physicians can engage in public testimony about how carceral medicine harms patients [72]. This witness operates through media engagement, legislative testimony, community organizing, and collective advocacy. The goal is to shift public discourse away from punitive responses toward recognition of medicine as healing vocation requiring clinical autonomy.

8. Conclusion

The penal system's evolution—from spectacle to surveillance—has expanded its reach into medicine, producing a pervasive chilling effect that discourages ethically indicated care precisely where patients are most vulnerable [1-4]. A historically informed critique clarifies that this is not incidental; it is the predictable consequence of governing through crime and risk [2,3]. The physician has become subject to disciplinary power that operates through internalized surveillance and fear, transforming clinical consciousness from patient-centered care to defensive risk management. This carceral colonization represents a profound betrayal of medicine's healing vocation. When physicians experience patient encounters primarily as potential crime scenes, when clinical judgment becomes subordinated to legal defensibility, when relief of suffering takes second place to self-protection—medicine loses its soul. The technical expertise remains, institutional structures persist, but the sacred dimension of healing relationship has been evacuated.

Yet Foucault's analysis also suggests grounds for hope. If disciplinary power operates through the production of subjects, then resistance must take the form of counter-subjectification—the cultivation of alternative professional identities that refuse carceral logic [1,68]. This is not utopian fantasy but urgent necessity. Without practices of resistance that can sustain patient-centered care despite institutional pressure, medicine devolves into bureaucratized symptom management conducted under legal surveillance. The recovery of clinical consciousness requires both individual courage and collective transformation [13]. Individual physicians must cultivate heretical ethics that prioritize healing relationship over institutional convenience. But they cannot do this alone. Professional communities must develop supports for principled non-compliance with unjust policies. Institutional structures must be reformed to protect rather than threaten clinical autonomy through the safeguards outlined above: bright-line legal protections, restrictions on data exploitation, carceral-care firewalls, prison health independence, legal support for ethically indicated care, and measurement reform [5,7,9,14,29,53].

Rebalancing requires legal protections, institutional firewalls, and ethical resolve—so that clinical judgment serves the patient first [2,16]. The mechanisms that produce chill—legal indeterminacy, surveillance infrastructures, professional discipline, and institutional co-production with law enforcement—must be dismantled and replaced with structures that support rather than undermine healing relationships [5,7,9,12,33,34]. This is difficult, dangerous work. Physicians who resist carceral pressure face real risks of investigation, prosecution, and professional ruin. But the alternative—passive acceptance of medicine's transformation into defensive bureaucracy—represents an even greater danger: the death of healing as sacred calling, the reduction of the physician-patient relationship to a legalistic transaction, the final triumph of technocratic rationality over human wisdom.

Foucault taught that power creates resistance, that wherever there is power there are also spaces for freedom [68]. The carceral colonization of medical consciousness, while profound, is not total. In every patient encounter, in every clinical decision, in every moment of therapeutic presence, there remains the possibility of resisting the logic of self-protection and returning to the sacred obligation to relieve suffering. This possibility requires what I have elsewhere called heretical faithfulness—fidelity to healing vocation that is willing to transgress conventional boundaries

when those boundaries harm patients [13].

The physician standing at the bedside of a suffering patient, aware that her next prescription might become evidence in a prosecution, faces a fundamental choice: to be ruled by fear or to be guided by conscience. This is not merely a clinical decision but an existential one—a choice about what kind of physician, and what kind of person, one will be. The recovery of medicine requires physicians who choose conscience, who cultivate the courage to practice patient-centered care despite institutional threat, and who refuse to allow carceral logic to colonize their clinical consciousness.

As Emmanuel Levinas reminds us, the face of the patient calls us beyond our systematic ethics into a more demanding moral space—one where healing becomes a sacred encounter that resists capture by institutional convenience and technological reduction [67]. This is the essence of heretical medical ethics: fidelity to the irreducible mystery of human suffering in the face of systems that would domesticate and control it [13]. In asking these questions, in struggling with them, in supporting each other in the difficult work of heretical resistance, physicians can begin to recover the clinical consciousness that carceral logic has colonized and to remember what it means to be healers rather than risk managers.

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