

# **Dual Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms**

A Project of the

**International Dual Loyalty Working Group**

A Collaborative Initiative of

[Physicians for Human Rights](#)

and the School of Public Health and Primary Health Care

[University of Cape Town, Health Sciences Faculty](#)

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Printed in the United States of America.

ISBN 1-879707-39-X

Library of Congress Control Number: 2003101403

Cover and report design: Glenn Ruga/Visual Communications

### **About Physicians for Human Rights**

Physicians for Human Rights (PHR) promotes health by protecting human rights. PHR believes that respect for human rights is essential for the health and wellbeing of all members of the human family.

Since 1986, PHR members have worked to stop torture, disappearances, and political killings by governments and opposition groups and to investigate and expose violations, including: deaths, injuries, and trauma inflicted on civilians during conflicts; suffering and deprivation, including denial of access to health care, caused

by ethnic and racial discrimination; mental and physical anguish inflicted on women by abuse; exploitation of children in labor practices; loss of life or limbs from landmines and other indiscriminate weapons; harsh methods of incarceration in prisons and detention centers; and poor health stemming from vast inequalities in societies. PHR also works to protect health professionals who are victims of violations of human rights and to prevent medical complicity in torture and other abuses. As one of the original steering committee members of the International Campaign to Ban Landmines, PHR shared the 1997 Nobel Peace Prize. Along with three other organizations, at the request of the Truth and Reconciliation Commission of South Africa, PHR prepared a report, *Human Rights and Health: The Legacy of Apartheid*, a review of human rights and ethical violations committed by members of the South African health professions under apartheid.

PHR has been at the forefront of integrating human rights and bioethics. Along with the American College of Physicians and other organizations, PHR published *Breach of Trust*, which analyzed the role of physicians in capital punishment. PHR has also been at the forefront of developing and sponsoring academic courses that integrate bioethics and international human rights at medical schools and schools of public health.

## **About the University of Cape Town**

The University of Cape Town (UCT) is a leading academic institution in South Africa. Its Health Sciences Faculty has been deeply engaged in addressing human rights in the health sector, including research to promote human rights, sponsoring courses in health and human rights as part of its undergraduate and postgraduate programs, and its own post-apartheid institutional reconciliation process. Through these activities it is actively grappling with key transformation challenges facing training institutions for health professionals in South Africa at present. Along with the Trauma Centre for Survivors of Violence and Torture, the Department of Public Health of UCT, Health Sciences Faculty sponsored the Health and Human Rights Project, which provided technical assistance to South Africa's Truth and Reconciliation Commission in connection with the Commission's hearings on human rights violations in the health sector. It also prepared a comprehensive review of human rights abuses in the health sector during apartheid, entitled *The HHRP Final Submission to the TRC: Professional Accountability in South Africa (1997)*. The HHRP was instrumental in establishing a regular series in the South African Medical Journal focusing specifically on human rights and health.

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## Preface and Acknowledgements

This project grew out of a disturbing trend: Governments and other third parties often demand that health professionals put allegiance to their patients aside, in deference to the demands of these powerful actors — often in a manner that violates patients' human rights. Although documentation of this ethical and human rights problem, referred to here as the problem of dual loyalty and human rights — has been most thorough in South Africa, it is unfortunately a worldwide phenomenon. However, it is little recognized and rarely discussed. Indeed, in the course of this project we were surprised to see how few materials for guiding professional practice and institutional structures exist, even in organizations where this problem is pervasive, such as the military.

The report of South Africa's Truth and Reconciliation Commission (TRC) documenting the complicity of health professionals in the apartheid regime, provides a particularly compelling illustration of the problem. The TRC report, based on hearings about human rights violations in the health sector, showed how health professionals had been complicit or silent in the face of torture as well as active participants in institutionalized racism in health services. The report urged the adoption of effective standards of conduct in situations of potential dual loyalty, as well as institutional arrangements and educational programs to ameliorate the problem.

We believe the dual loyalty problem needs the urgent attention of individual health professionals, national and international organizations of health professionals, international standard-setting bodies, governments, and civil society. For that reason, Physicians for Human Rights (USA) and the University of Cape Town Health Sciences Faculty (South Africa) brought together a working group of individuals from the health community experienced in human rights, as well as scholars and practitioners in bioethics, human rights and law, from South Africa and internationally, to address the problem. We are grateful to the Greenwall Foundation for its generous support of this project.

The goals of the project are: (1) to identify the problem of dual loyalty and human rights in its many dimensions; (2) develop an approach to the problem that stems from internationally-accepted human rights standards; (3) produce a set of proposed guidelines for health professionals that would apply to all professional practice and a set of specialized guidelines in settings that raise particularly troublesome human rights and ethical issues; and (4) propose institutional arrangements that can help prevent conflicts between a patient's human rights and state or other powerful interests in the first place.

The Working Group convened for a meeting in November, 2000 in Durban, South Africa to review the dimensions of the problem, to take up the role of bioethics in addressing dual loyalty and human rights and, to begin work on appropriate responses. The participants in the Durban meeting are listed below. One product of the conference in Durban was the creation of a set of sub-groups to address particular issues, including the relevance of existing international codes of conduct, the interplay between human rights and bioethics, the relationship between dual loyalty and social, economic and cultural rights, and practice in five settings where dual loyalty and human rights problems arise frequently.

In the two years since the Durban meeting, the Working Group has, through its sub-groups, corresponding members and consulted experts, exchanged drafts, tested out approaches, and ultimately produced a document containing both an analysis of the problem and a set of proposals to address it. It is our hope that the proposals will stimulate wide discussion and be considered by national and international standard-setting bodies as well as organizations responsible for the structure of health practice, including governments, associations of health professionals and licensing and regulatory bodies.

The report and recommendations are available electronically at [www.phrusa.org](http://www.phrusa.org), and [http://caribou.cc.trincoll.edu/orgs\\_scialnce/SFR/Default.htm](http://caribou.cc.trincoll.edu/orgs_scialnce/SFR/Default.htm).

The project was under the general direction of Leonard S. Rubenstein, J.D., Executive Director of Physicians for Human Rights (USA) in close collaboration with Leslie London, M.D., Associate Professor, Head of the Health and Human Rights Division, School of Public Health and Primary Health Care at the University of Cape Town Health Sciences Faculty, and Laurel Baldwin-Ragaven, M.D., now Henry R. Luce Professor of Health and Human Rights at Trinity College (Connecticut, USA) and formerly research fellow of the Health and Human Rights Project in South Africa.

The Participants\* in the Durban, South Africa meeting included:

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Others who did not attend the conference participated in various aspects of the Working Group's activities. These individuals included:

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Lungisile Ntsebeza, of the Program for Land and Agrarian Studies at the University of the Western Cape, acted as facilitator for the meeting. Indres Nadoo, former political prisoner in South Africa and former Senator in the South African Parliament, was keynote speaker on the evening preceding the conference. Mahomed Dada, formerly

Professor of Forensic Medicine at the Nelson Mandela School of Medicine at the University of Natal, acted as liaison between the working group and the Mandela School of Medicine. Barry Kistnasamy, Dean of the Mandela Medical School, also supported the Working Group meeting. Izani Event Planners were instrumental in negotiating the logistics for the Durban meeting in 2000.

The bioethics consultant for the Durban meeting was Catherine Myser, Ph.D., who prepared a background paper on dual loyalty and bioethics for the meeting. The project received support from Professor M. Gregg Bloche and the Georgetown – Johns Hopkins program in Law and Public Health.

Members of the Dual Loyalty Working Group joined an on-line moderated list to facilitate discussion on issues related to dual loyalty and the project. The list was moderated by Sandhya Gupta and Nafia Tasmin Din of Physicians for Human Rights.

Drafts sections of the report were circulated for comments by members of the Working Group. We note that not all members of the Durban meeting participated in subsequent discussions and reviews of drafts, and some members had differing viewpoints. Therefore, all aspects of the final product do not represent the views of all participants in the meeting. An Editorial Review Committee reviewed all drafts. The Committee met face to face twice after the Durban meeting and conferred extensively in shaping the final product and in writing the introduction. The committee consisted of:

Laurel Baldwin-Ragaven  
M. Gregg Bloche  
John H. Bryant  
Erik Holst  
Leslie London  
Wendy Orr  
Leonard Rubenstein

Although not able to attend these meetings, Ann Sommerville contributed enormously to the editing of the final document.

Members of the Working Group participated in drafting and review of guidelines for particular settings and to address difficult substantive questions. Adriaan van Es, along with Chandre Gould and Zeav Wiener, led the work group on guidelines for military settings. Leonard Rubenstein and M. Gregg Bloche led the group on forensic health practice. Wendy Orr chaired the largest sub-group, on prisons, which included Jeanelle de Gruchy, Sebnem Fincanci, Jabu Ngwane, Bidur Osti, Hernan Reyes, and Judith van Heerden. Christian Pross led the subgroup on guidelines for health professionals evaluating refugees or in immigration settings. Leslie London led the subgroup on guidelines on workplace settings and drafted the section on institutional mechanisms based on information drawn from all the settings guidelines. A subgroup researching social and economic rights was chaired by Kausar Khan and included Enrique Accorsi, John H. Bryant, Jeanelle de Gruchy, and Amar Jesani. Future work of the Dual Loyalty Working Group on “toolkits” for health professionals is led by Laurel Baldwin-Ragaven and Ann Sommerville. James Welsh compiled and distributed existing international ethical codes and instruments. Chapter two, describing the circumstances of dual loyalty, was written by Leonard Rubenstein, with extensive research assistance from Sandhya Gupta and Nafia Tasmin Din. Boris

Yudin, Kauser Khan, Debra DeBruin, Gregg Bloche, Solomon Benatar, Laurel Baldwin-Ragaven, Leslie London, and Ann Sommerville contributed to the discussion of the relationship between bioethics and human rights.

Thomas Geoghegan provided research on human rights law. Lt. Col. Eugene Bonventre, United States Air Force, provided consultation (in his personal capacity) on problems in military medicine as did Michael Grodin, Boston University School of Public Health. Sandhya Gupta reviewed the products for clarity and consistency. In addition to her editorial and research role, Ms. Gupta, along with Ms. Din, provided invaluable support in logistics and communication. Additional research support was provided by Genevieve Grabman and Cordelia Frewen.

Barbara Ayotte, Director of Communications of Physicians for Human Rights, prepared the report for publication.

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\* Affiliations are those at the time of the Durban meeting and are for identification purposes only

# I. Introduction

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## The Problem of Dual Loyalty and Human Rights

The problem of dual loyalty – simultaneous obligations, express or implied, to a patient and to a third party, often the state – continues to challenge health professionals. Health professional ethics have long stressed the need for loyalty to people in their care. In the modern world, however, health professionals are increasingly asked to weigh their devotion to patients against service to the objectives of government or other third parties. Dual loyalty poses particular challenges for health professionals throughout the world when the subordination of the patient's interests to state or other purposes risks violating the patient's human rights. Efforts to bolster ethical codes to address these challenges have only marginally succeeded, as will be discussed in [Chapter II](#).

The goals of this project are to identify the dimensions of dual loyalty and to propose guidelines and mechanisms for the prevention of complicity by health professionals in human rights violations. This introductory chapter defines what dual loyalty is, explains how professional ethics and human rights relate in solving dual loyalty problems, and explores the obligations of health professionals to respect human rights. These introductory comments provide the background for a description of the motivation for and scope of this project.

## The Concept of Dual Loyalty

Since ancient times, many societies have held healthcare professionals to an ethic of undivided loyalty to the welfare of the patient. Current international codes of ethics<sup>1</sup> generally mandate complete loyalty to patients. The World Medical Association (WMA) Declaration of Geneva, the modern equivalent of the Hippocratic Oath, asks physicians to pledge that "the health of my patient shall be my first consideration" and to provide medical services in "full technical and moral independence."<sup>2</sup> The

WMA International Code of Medical Ethics states that “a physician shall owe his patients complete loyalty and all the resources of his science.”<sup>3</sup>

In practice, however, health professionals often have obligations to other parties besides their patients – such as family members, employers, insurance companies and governments – that may conflict with undivided devotion to the patient. This phenomenon is dual loyalty, which may be defined as clinical role conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer or the state.<sup>4</sup> The dual loyalty problem is usually understood in the context of a relationship with an individual patient. In many parts of the world, however, clinicians have responsibilities to communities of patients, for prevention, health education and clinical care. Dual loyalty conflicts can and do arise in these settings as well.

In cases where dual loyalty exists, elevating state over individual interests may nevertheless serve social purposes often accepted as justifiable.<sup>5</sup> Evaluations for adjudicative purposes are a common example. A medical evaluation of an individual's condition that is relevant to resolution of a lawsuit or a claim for disability benefits requires the health professional to express opinions about individuals that may result in their exclusion from desired benefits or their being deprived of a desired outcome. Such an evaluation is generally accepted as a justifiable departure from complete loyalty to the individual because of the overriding need for objective medical evidence to resolve the claim in a fair and just manner.

Such socially and legally accepted departures from undivided loyalty to the patient are not restricted to evaluations. For example, a health professional may be required to breach confidentiality in a relationship with a patient in order to protect third parties from harm or to notify a health authority of communicable diseases for health surveillance purposes. However, in all circumstances where departure from undivided loyalty takes place, what is critical to the moral acceptability of such departures is the fairness and transparency of the balancing of conflicting interests, and the way in which such balancing is, or is not, consistent with human rights.

## **Dual Loyalty and Human Rights**

Dual loyalty becomes especially problematic when the health professional acts to support the interests of the state or other entity instead of those of the individual in a manner that violates the human rights of the individual. The most insidious human rights violations stemming from dual loyalty arise in health practice under a repressive government, where pervasive human rights abuses, combined with restrictions on freedom of expression, render it difficult both to resist state demands and to report abuses. In addition, closed institutions, such as jails, prisons, psychiatric facilities and the military, impose high demands for allegiance on health professionals even in the face of often-common human rights violations against individuals held there. But violations of human rights at the behest of the state by health professionals also take place in open societies, for example, in cases of institutionalized bias or discrimination against women, members of a particular ethnic or religious group, refugees and immigrants, or patients who are politically or socially stigmatized. Violations of people's rights of access to health care may also arise from policies imposed by governments, or in health systems, including privately managed health systems, in which health professionals are called upon to withhold treatment from certain groups of people in discriminatory ways.

The problem is compounded when the health professional's conduct is constrained by pressure to yield to other powerful interests, especially those of the state. The pressure may be a product of legal requirements, threats of professional or personal harm for non-compliance, the culture of the institution or society where the professional practices, or even the professional's own sense of duty to the state.<sup>6</sup> In repressive political regimes or in closed institutions like prisons and jails, the personal consequences can be quite severe.

## **Human Rights, Bioethics and the Resolution of Dual Loyalty Conflicts**

Many health professionals are generally familiar with bioethical frameworks to assist in resolving difficult clinical dilemmas, typically arising in end-of-life situations or in the context of limited resources. Less familiar to health professionals is analysis of the human rights dimensions to healthcare practice.<sup>7</sup> This project seeks to extend the ambit of health professionals' decision making to include the protection of patients' human rights in cases of dual loyalty. The frameworks of bioethics and human rights each present approaches to resolving competing claims in principled ways. Where dual loyalty conflicts are associated with human rights violations, it is essential for health professionals to recognize the contributions human rights approaches can make. The following sections outline the respective approaches: one based on human rights and another on bioethics, and how their complementarities can be used to resolve dual loyalty conflicts that threaten violations of human rights.

### **Human Rights**

Human rights have best been described as "rights of individuals in society" that take the form of "...legitimate, valid, justified claims – upon his or her society – to various 'goods' and 'benefits'" deemed essential for dignity and well-being."<sup>8</sup> These claims are not abstractions or based on natural law, social contract, or political theory but stem from international governmental consensus around moral principles considered universal. In the modern era, they were first embodied in the Universal Declaration of Human Rights (UDHR), adopted in the aftermath of World War II, and then extended through international treaties. Grounded on the premise that "all human beings are born free and equal in dignity and rights,"<sup>9</sup> the UDHR enumerates specific rights, many of which have been adopted in international and regional treaties that bind states that have ratified the treaties.<sup>10</sup> Once a treaty is ratified by a state, it becomes law in the state and binds its conduct.

Human rights obligations generally impose duties upon the state rather than private individuals and entities. But the state/private distinction does not fully do justice to the scope of human rights obligations. In certain circumstances, the state has a duty to assure that the conduct of private actors is consistent with human rights. Thus, for example, states have obligations not merely to refrain from racial discrimination but to "prohibit and bring to an end" to discrimination, including racial discrimination, by "any person, group or organization"<sup>11</sup> that interferes with "the right to public health, medical care, social security and social services."<sup>12</sup> Similarly, states have obligations to protect the rights of workers in relations with employers.

Operationalizing the UDHR, principally an aspirational document, are two foundational human rights treaties: the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.<sup>13</sup>

The former recognizes principally the rights to life, liberty, security of the person, freedom from torture and cruel, degrading and inhuman treatment, freedom from unjust discrimination, due process of law, and free expression and association. These rights are not subject to balancing against other state interests and none may be "derogated," or suspended, unless the state officially proclaims the existence of a national emergency and only to the extent "strictly necessary" to meet the exigencies of the situation; and, any derogation cannot involve discrimination on the basis of race, color, sex, language, birth, property,<sup>14</sup> religion or social origin.<sup>15</sup> Moreover, certain rights, including the right to be free from torture and cruel, inhuman, or degrading treatment can never be subject to derogation.

The obligations not to engage in discrimination on the basis of race and gender have been elaborated with more specificity in the Convention on the Elimination of all forms of Racial Discrimination and the Convention for the Elimination of all forms of Discrimination against Women. Under these conventions, states are bound not to engage in discrimination themselves and also to take affirmative steps to eliminate discrimination in society. Moreover, the conventions prohibit discriminatory effects of policies and practices as well as intentional discrimination.

Nations have also adopted a treaty specific to the problem of torture, the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment and Punishment, which sets out both standards of conduct for states and monitoring mechanisms by UN bodies. Other treaties also bear on health and indirectly on the conduct of health professionals. The Convention on the Rights of the Child systematically sets out states' obligations to children. Another convention, dating from 1951, sets out the requirements of states in the treatment of refugees.

In addition, the United Nations General Assembly has promulgated standards and guidelines designed to protect human rights of prisoners, people with mental illness and mental retardation, and other vulnerable groups.

The International Covenant on Economic, Social and Cultural Rights (1966) sets forth obligations states have to meet people's basic material needs, to protect the family as an institution, and to establish rights to work, health, social security and housing, among others. For health professionals, the most important provision is Article 12, which provides that "Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity." In 2000, the UN Committee responsible for interpretation of this Covenant issued a General Comment, or explanation of Article 12 that, while not binding, does serve as a useful guide for monitoring.<sup>16</sup>

The Committee interpreted Article 12 consistent with past interpretations of the Covenant on Economic, Social and Cultural Rights as imposing three types of duties on governments. The first core obligation is to respect, requiring states to refrain from interfering directly or indirectly with the enjoyment of the right to the highest attainable standard of health, for example, by denying or limiting equal access to health care for all persons, engaging in state-sponsored discrimination in health services, marketing unsafe drugs, or limiting access to family planning and reproductive health services. The second is the obligation to protect, requiring states to prevent third parties from interfering in the right to the highest attainable standard of health, for example, by permitting providers to discriminate or by failing to control marketing of medicines and harmful products like tobacco. The third is the

obligation to fulfill, requiring states to adopt appropriate legislative, administrative, budgetary and other steps toward the full realization of the right to the highest attainable standard of health.<sup>17</sup> This obligation requires states to have a national strategy for enabling all members of society to achieve the highest attainable standard of health, to assure that marginalized groups have access to clean water, education and essential health services, to immunize its population against communicable diseases, to provide information to prevent the spread of disease, and to take other steps the Committee sets out.<sup>18</sup>

Although fulfillment of the right to the highest attainable standard of health is subject to resource limitations and of course does not require that every health service (e.g. cosmetic surgery) be made available to all, the Committee makes clear that the Covenant obliges “each State party to take the necessary steps to the maximum of its available resources and failure to do so constitutes a violation.” Moreover, the Committee sets out “core” obligations that exist irrespective of resource constraints. These include, among others, non-discriminatory and equitable access to health care services “especially for marginalized groups,” maternal and child health care services, availability of immunizations against infectious diseases, a public health strategy for the society, essential drugs and access to information about the main health problems in the community.<sup>19</sup>

The rights described in the two foundational covenants are mutually reinforcing and are commonly said to be indivisible. A person cannot enjoy political freedoms unless he or she has the education to be able to exercise those freedoms. Similarly, a person who has access to health care is nonetheless denied health and well-being if forced to live in a repressive society. The connections are evident, too, on a macro scale: as Amartya Sen has explained, no substantial famine has occurred in a democratic country.<sup>20</sup> In Chapter II, greater detail about how these human rights apply to specific problems of dual loyalty is provided.

In sum, the most basic and fundamental purpose of human rights is to respect and protect individual persons. For health professionals, a human rights framework provides a steady moral compass, a blueprint of a just and humane social order that at its core articulates the principles of the dignity and equality of every human being. Decisions made to respect, protect, and fulfill human rights therefore seek to ensure that a rights analysis informs how such conflicts can be resolved. Put another way, a human rights analysis enables the health professional to resolve these conflicts by reference to an agreed-upon, universally applicable set of moral principles. In health care settings, consideration of human rights concerns, as elaborated through the various instruments, conventions and treaties discussed above, should be a requisite for resolving dual loyalty conflicts.

## **Bioethics**

Bioethics is a discipline that enables clinicians to engage in analyses that will determine their courses of action in particularly compelling and morally complex clinical situations. Bioethical analysis can help health professionals address the difficult dilemmas that arise in every day clinical work and provide guidance for identifying rational arguments to substantiate their moral choices in ways that aim to be reasoned and constant.

There are at least two aspects to such a bioethics paradigm: one is ethics formulated as professional codes of conduct that seek to provide guidance to clinicians facing

ethical dilemmas<sup>21</sup> and the other is the process of resolving clinical dilemmas through philosophical reasoning. A widely recognized framework for resolving morally difficult situations in health care identifies four ethical principles and addresses their scope of application.<sup>22</sup> It has been argued that these four principles together with concern for their scope or coverage “encompass most if not all of the moral issues in health care” and reflect the range of moral commitments or options available to support the resolution of competing choices.<sup>23</sup> These have been laid out as:

- Respect for the decision-making ability of autonomous persons (autonomy or self-determination);
- The duty to maximize benefit to the person or people in care (beneficence); often taken together with
- The mandate to avoid the causation of harm (non-maleficence); and,
- Fairness in deciding competing claims, often to resources, but also to human rights and laws or social policy (justice).

Within this framework, bioethical reasoning invokes the application of these principles in a thoughtful and systematic way to provide guidance for appropriate decisions when faced with a clinical or patient-management dilemma. By balancing these principles, and taking into account the contextual factors in which the dilemma occurs as well as the evidentiary support data, clinicians will more often than not make decisions about what they ‘ought’ to do.

More recent developments have sought to expand the scope of bioethics to include its application beyond the individual clinical encounter to considerations of the health of an entire population.<sup>24</sup> It is now widely recognized that societal factors, such as socioeconomic inequalities, discrimination and a lack of respect for dignity have profound effects on health status and life expectancy, <sup>25</sup> and that health disparities are increasingly a matter of ethical concern.<sup>26</sup> This provides a compelling reason for the health sector to identify the moral basis for policies and programs that affect the interests and well-being of groups and populations. However, there is no dominant or presently coherent body of ethical theory, much less one that commands international consensus, on society’s obligations in the public health domain<sup>27</sup> — though reliance on the principle of justice to resolve ethical dilemmas in public health in the most fair manner remains attractive.<sup>28</sup> While each of the four principles may have possible application, depending on the specific nature of violations, human rights offers a societal level framework for identifying, understanding, and responding to the social determinants of health.<sup>29</sup>

## **Human Rights and Bioethics**

In many ways, human rights and bioethics complement each other. The four principles speak strongly to key human rights concepts. The interdiction against participation by health professionals in torture, a key human rights prohibition,<sup>30</sup> is grounded in non-maleficence, the duty to do no harm. Respecting women’s autonomy on reproduction promotes health and the right of access to reproductive health care while combating gender discrimination. Acting in accord with the principle of justice, clinicians who promote fairness in their management of patients—for example, by eschewing racial and gender bias —also uphold human dignity.

The four principles are, in general, consistent with human rights tenets. Yet the principles do not focus on compliance with human rights standards. Indeed, bioethics

often treats human rights compliance as just one of many competing obligations to be considered.<sup>31</sup> Moreover, the four principles do not provide a method for arriving at concrete decisions – particularly decisions about how to prioritize competing principles. Historical traditions in North America tend, in practice, to privilege individual autonomy over other principles,<sup>32</sup> but even there none of the principles has inherent primacy. Various moral theories and philosophical traditions may be invoked to give relative weights to the four principles in particular circumstances.<sup>33</sup>

As a result, there is space for enormous variability in moral decision-making. Moral disagreements per se are not a bad thing and should not make us skeptical about bioethical reasoning. But such disagreements become problematic when human rights are at stake. Therefore, as stated earlier, in health care settings, consideration of human rights concerns, as elaborated through the various international human rights instruments, conventions and treaties should be a pre-requisite for resolving dual loyalty conflicts.

Although not usually the case, it is possible in theory for the process of 'ethical' reasoning to arrive at decisions that are inconsistent with human rights. Two examples illustrate the potential disassociation between bioethical reasoning and the human rights approach.

- Not everyone who needs dialysis and renal transplant can receive such treatments. In clinical practice, decisions about eligibility for renal dialysis involve some form of explicit rationing, usually in the form of agreed-upon criteria for entry into and/or maintenance on the program. Bioethical reasoning is usually critical to informing the development of such criteria, which typically balance beneficence and respect for patient autonomy with considerations of likely capacity to benefit, based on the medical utility of treating any given patient. Typically, patients with other risk factors who have lower likelihood of success on a transplant program are excluded at the outset, so that resources are allocated to those who can "most benefit" from the program. Although some lose out while others gain, ethical reasoning can justify the decision on the basis that all patients are subjected to the same criteria. Unfairness would only be demonstrable if an individual was unfairly treated in the process. Bioethical reasoning, even in its application of the principle of justice, is weaker where criteria for program eligibility discriminate against whole groups of people, usually those for whom social stratification and disadvantage have created social patterning of the risk factors that lead to the individual's disqualification.<sup>34</sup> As a result, group disadvantage may be weakly addressed in a bioethics framework, and the effects of discrimination against whole groups receive less emphasis in the balancing of bioethical principles.

In contrast, human rights standards would view the problem through the prism of discrimination. Analysis would focus on whether clinical protocols were directly or indirectly resulting in unfair treatment, not only of individuals but also of groups subjected to social inequalities.<sup>35</sup> Less emphasis would be placed on the capacity for individual benefit or on questions of autonomy or beneficence. As a result, application of a human rights framework may result in somewhat different decisions about what is fair and just in renal dialysis, particularly because of its capacity to discern group patterning and consider

- the implications of racial or other prohibited forms of discrimination in decisions about the fairness of a policy.<sup>36</sup>
- A second example further illustrates the potential for divergence between human rights and bioethics approaches. In 1997, the provincial health department asked a teaching hospital in Cape Town, South Africa to implement a policy of non-treatment for illegal immigrants, and to report all such immigrants to the Department of Home Affairs.<sup>37</sup> In deliberating whether to implement this policy, the ethics committee of the institution concluded that while containing costs in health care was a legitimate objective for public policy and that the health services were entitled to protect scarce resources for citizens or legitimate immigrants, it was not the health professional's role to be part of such gate-keeping. As a result, the hospital issued an order that placed the onus onto hospital clerical staff to identify and report illegal immigrants seeking health care, sparing the clinicians from such a responsibility. The inherent discriminatory context in which such gate-keeping was to take place, and the potential violations of human rights that may result from mandatory reporting, did not enter sufficiently into the ethical reasoning process. Indeed, in many ways, the policy mimicked earlier policies implemented by the apartheid government in its attempts to arrest anti-apartheid activists seeking medical care at state hospitals for injuries sustained in civil disobedience protests.<sup>38</sup>

In contrast, a human rights approach starts and concludes with the issues of discrimination and access to health care, irrespective of who conducts the gate-keeping. Any policy that results in significant violations of human rights that can not be adequately justified by public health criteria<sup>39</sup> would be deemed unacceptable.

In sum, both the human rights and bioethics approaches generally attempt to promote morally desirable outcomes. Just as bioethics reasoning seeks to balance contrasting principles, human rights approaches sometimes have to balance competing rights.<sup>40</sup> Yet, even though in recent years many professional bodies have adopted human rights principles in their ethical codes,<sup>41</sup> there has been insufficient attention paid to bringing these two paradigms or discourses together conceptually. It is possible to operate within an ethics framework in ways that focus only on the dyadic relationship of the clinician and patient without considering the context in which that relationship is constructed. Likewise, there is little uniformity on how to weigh conflicting principles of bioethics or how far to extend their scope. In the case of dual loyalty, respect for human rights (insofar as this connotes respect for human dignity and the inviolability of personhood) is a pre-condition to engaging in ethical decision-making. Where human rights are at stake in a dual loyalty conflict, it is necessary to look to human rights norms to guide the resolution of these conflicts.

## **The Obligation of Health Professionals to Respect Human Rights**

As discussed earlier, human rights obligations generally fall to governments, not to individuals. But the power and legal standing of human rights norms have enormous implications for the behavior of health professionals. Most generally, the International Covenant on Civil and Political Rights declares that all people have "a responsibility to strive for the promotion and observance of the rights recognized" in the Covenant.<sup>42</sup>

Beyond this general obligation, applicable to the health professional as citizen,<sup>43</sup> are specific obligations imposed by the nature of professionalism, reinforced by the authority given through licensing. Professionalism entails a social pact in which society and its institutions accord the health professional status, power and prestige in exchange for a guarantee that he or she will meet certain standards of practice. It is these expectations that bestow upon health professionals a particular obligation to respect their patients' human rights.

How might a health professional become complicit in a human rights violation? First, when employed by or acting on behalf of the state, health professionals may become agents through which the state commits a violation, for example, by participating in torture of an individual at the behest of state interrogators.

Second, even in private doctor-patient encounters, health professionals can become complicit in violations by adhering to – and thus furthering – state health policies and practices that unjustly discriminate on the basis of race, sex, class, or other prohibited grounds, or that deny equitable access to health care. Where the state has failed to take necessary steps to establish a health system that affords equitable access to health services, the health professional participating in that system has an obligation to press for alternative policies designed to end the violations.

Third, even where no explicit state policy is involved, in circumstances where the health professional engages in cultural or social practices that violate human rights, for example, “virginity examinations” or genital mutilation of women, he or she becomes the vehicle by which the violation is accomplished. Most human rights treaties require states to take affirmative steps to end social or cultural practices that discriminate or otherwise violate the human rights of individuals in private relationships, thereby making it clear that tolerance of the underlying conduct is impermissible.

For example, the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) provides that states parties “shall take all appropriate measures...to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.”<sup>44</sup> The Convention on the Elimination of all forms of Racial Discrimination contains similar language. The commitment to eliminating discrimination in the sphere of civil life thus creates a norm that should govern the conduct of a private health professional as much as it does the state and its citizenry.

The language of ethical codes guiding medical and nursing practice increasingly reinforces values that derive from international human rights law.<sup>45</sup> Indeed, many professional associations have explicitly adopted human rights language in their own ethical principles.<sup>46</sup> Numerous ethical codes and declarations hold that protecting the human rights of patients is considered within the scope of professional duty. Both the World Medical Association and the International Council of Nurses have affirmed the centrality of human rights in health practice.<sup>47</sup> The WMA Declaration of Tokyo focuses on avoiding complicity of health professionals in torture, linking a human rights obligation to fundamental ethical norms: “a doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her

fellow men, and no motive, whether personal, collective or political, shall prevail against this higher purpose." [48](#) The International Council of Nurses' Ethical Concepts Applied to Nursing Code emphasizes that "inherent in nursing is respect for life, dignity, and the rights of man." [49](#) The Code goes on to elaborate that the care provided by nurses must not be restrained by "considerations of nationality, race, creed, color, age, sex, politics or social status." [50](#)

## **Dual Loyalty and Human Rights: The Need for this Project**

As noted above, subordinating loyalty to the patient to the interests of the state is only permissible to serve a higher social purpose. Violations of human rights cannot constitute permissible social purposes. Professional conduct that abets human rights abuse is thus illegitimate. In recent years there has been increasing attention by health professionals and professional associations to promoting, and even leading, efforts to promote human rights. They have done this through promulgation of standards and, even more importantly, through actions to protect the human rights of patients. However, four sets of problems remain:

### **The Extent of Dual Loyalty Problems**

In a wide variety of contexts, settings and clinical roles, health professionals are subjected to demands by governments (and in certain circumstances by other powerful third parties) to subordinate their patients' human rights to third party interests, usually those of the state. The structure of employment relationships, including sources of compensation, supervision and legal authority; expectations to defer to embedded social practices even if they violate human rights; and the state's ability to apply pressure to secure compliance with its demands, all render it difficult for health professionals to maintain fidelity to patients' human rights. As a result, dual loyalty conflicts resulting in human rights violations are common. The variety of circumstances and settings in which violations of human rights take place on account of dual loyalty are described in the next chapter.

### **The Lack of Education and Training**

In some parts of the world, awareness of the relevance of human rights to clinical and community practice is increasing. Nevertheless, health professionals do not usually receive training and guidance to identify situations where dual loyalty violates a person's human rights and even less so on how to formulate and implement appropriate responses. Existing guidelines and ethical codes for health professionals do not provide a firm foundation for assessment of the state's demands. Health professionals lack clear guidance concerning the evaluation of state and other third party demands for subordination of patients' interests. In many cases, the state claims that subordinating patients' interests serves the common good, for example, by enhancing prison security or compelling drug-abusing mothers to receive treatment. But existing guidelines and ethical codes do not advise health professionals how to evaluate these claims – and how to determine when protecting the human rights of patients requires that health professionals turn state interests aside. [51](#)

Guidance is especially murky in cases where state complicity consists only of health professionals doing nothing, passively accepting situations that contribute to violations of human rights. In these cases, the protection of human rights requires

an affirmative stance by the health professional in favor of the patient or larger community. Ethical guidance provided to health professionals is largely silent on questions of advocacy, providing space for the state to encourage health professionals to conceptualize their function narrowly so as not to interfere with its priorities.

Similar gaps in guidance and training, together with pressures to conform, exist in circumstances where health professionals confront often-embedded cultural prejudices that, when applied to health care, interfere with human rights. Examples include denial of reproductive health services to women and institutionalized discrimination in health services. Yielding to these policies and attitudes makes health professionals complicit in human rights violations, but they have few places to turn to develop appropriate responses. To break established patterns of care requires attention not only to general, overarching statements about health professionals' human rights obligations, but guidance about responses in particular circumstances, so that health professionals can assume the responsibilities a human rights-respecting posture asks of them.

### **Systemic Flaws and Limitations**

Institutional structures often inhibit health professionals from meeting their human rights obligations. These structures include: the nature of employment relationships with the state; administrative mechanisms that lack procedures for contesting state demands; disincentives to promote human rights; and licensing and professional organizations that play no part in providing support to health professionals when they are challenged in meeting their human rights obligations. Especially in highly politicized or repressive environments, institutional structures to support responses consistent with the human rights of patients are non-existent or ineffective, forcing the individual health professional to have to make wrenching choices that may require him or her to risk personal safety.

To address the problem of dual loyalty and human rights, the relationship of the health professional to the state (particularly where the health professional is an employee of the state) must be re-structured. This relationship should protect the independence of the health professional from state pressures, minimizing the compulsion to succumb to the state's demands and expectations. Administrative mechanisms to protect whistle blowers must be established. In addition, licensing boards and professional associations need mechanisms to support health professionals who seek to comply with their ethical and human rights obligations in the face of state demands to the contrary. Collective action by colleagues in the professions may be required to enable individual health professionals to fulfill their obligations. For this reason, medical, nursing and other organizations should protect and advocate for colleagues who are at risk of becoming engaged in human rights abuses.

### **The Larger Social Context in which Dual Loyalty Occurs**

Lack of guidance and support for health professionals is especially poignant in an environment where the health system itself violates human rights because it fails to meet basic health needs, because distribution of existing resources is inequitable, or because of racial, gender or ethnic discrimination. Practicing in such an environment can lead the health professional to become complicit in human rights violations despite the professional's personal commitment to human rights.

For example, in some societies systematic racial or ethnic discrimination pervades health policy. A primary care physician who denies or limits care in the service of discriminatory policies elevates conformance to state policies over loyalty to patient needs. In the same vein, social policies that reduce women's ability to protect their reproductive health may lead health professionals to deny women the means to protect their health. The more the health professional "adjusts" his or her conduct to the constraints and inequities built into the system, the more the professional participates in the violation.[52](#)

The systemic nature of role conflict may constrain the power of the individual practitioner to fulfill the human rights of individual patients and communities of patients for whom the practitioner has responsibilities. These communities may include diverse patient populations as well as groups of people often marginalized and neglected, many of whom do not seek care but are in serious need of care. The health professional will often have obligations to all members of the community beyond those seen as patients in clinical settings that raise challenging ethical questions, requiring them to affirm human rights.

Professional organizations and codes of conduct have begun to acknowledge the systemic dimensions of dual loyalty problems. The Turkish Medical Association, for example, has been active both in seeking to end torture and to protect physicians who are pressured not to report it. The British Medical Association is addressing the roles of physicians who practice in prisons and other difficult settings. Nevertheless, a great deal more needs to be done. Indeed, in most countries there is typically no connection made between institutionalized or structural discrimination, inequity, and the ethical requirements of practice. Moreover, the codes and associations of health professionals by and large address only the behavior of individual clinicians, giving little attention to the obligations of the profession as a whole.

## **Scope of the Project and Products**

### **Roles of Health Professionals**

The work of health professionals is broad. At its core is the clinical consultation with patients. Many health professionals also engage in non-clinical roles, for example, public health work, and in policy-making roles as administrators or directors.

Six roles of health professionals can potentially bring about dual loyalty conflicts. They are:

1. clinicians providing one-on-one, direct patient care;
2. clinicians engaged in evaluation for the state and state-approved purposes (e.g. refugee status determination; fitness to stand trial; workplace examinations such as for pre-employment);
3. health professionals responsible for the comprehensive health care of a defined practice population (or group of persons) with extended responsibility for the health outcomes of a community (e.g. the community-oriented primary care approach, which is not only curative care, but includes health promotion, prevention, rehabilitation and palliation);
4. public health workers who provide strictly non-clinical services such as health education, outreach and promotion interventions (e.g. health inspectors, industrial hygienists, epidemiologists, monitoring and surveillance officers);

5. health policy makers in either public or private settings (e.g. health systems planners and administrators);
6. research involving human subjects.

Given the breadth of health professionals' work, dual loyalty conflicts that implicate human rights will be correspondingly broad. The focus of this project, however, is limited to 1) dual loyalty and human rights in the context of clinical evaluation and treatment, 2) to the evaluation function, and 3) to responsibilities for groups and communities that are in serious need of care.

The ambit of this project does not extend to 4) public health roles that may violate human rights or to 5) health professionals engaged in health policy and administration. Those in this category, however, often make decisions on behalf of public bodies and thus are subject to human rights law.

Public health roles are excluded from this project's scope because these roles present different issues, owing to the absence of a clinical relationship between patient and health care provider. Moreover, as discussed above, ethics and human rights analysis in public health is not as well developed as for clinical medicine.<sup>53</sup> Exclusion of public health roles does not diminish the importance of the need to respect human rights in public health practice and policy development. Rather, it acknowledges the complexity of these issues and the need for further work.<sup>54</sup> We view this work as a critical step toward aligning public health practice with promotion of human rights.

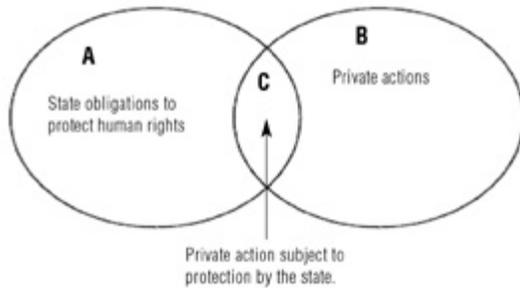
The role of health professionals in research using human subjects (category 6) clearly raises dual loyalty concerns. These conflicts have gained an enormous amount of attention in recent years in connection with tests of drug efficacy in developing countries, chemical and biological weapons research, and other matters. Because of the efforts focused specially on these concerns, in the Declaration of Helsinki<sup>55</sup> and elsewhere, human subject research is not addressed in this project except in institutions like prisons and the military, where a closed environment raises particularly acute human rights issues.

## **Public and Private Domains of Professional Duties to Protect Human Rights**

In defining the scope of the project, it is important to consider the roles of both health professionals and the third parties that compete with the patient for the loyalty of the health professional. Because human rights law generally applies to actions by the state, the guidelines and institutional mechanisms proposed mainly address conflicts between state's demands on health professionals and their duties to patients. As noted above, however, states have the obligation not only to refrain from committing human rights violations, but also to take affirmative steps to protect people from human rights violations by private entities. Discrimination in civil society is an important example. The Convention on the Elimination of all forms of Racial Discrimination requires states to take affirmative steps to eliminate racial discrimination in health<sup>56</sup> in both public and private spheres. Similarly, the right to the highest attainable standard of health requires states to protect individuals by controlling distribution of unsafe products and to assure that health plans operated by private entities provide non-discriminatory access and do not constitute a threat to the availability, accessibility, acceptability and quality of health facilities.<sup>57</sup>

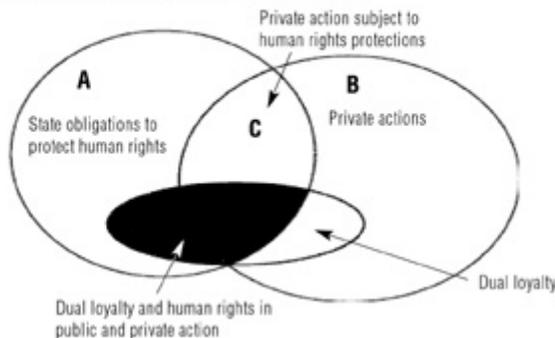
The guidelines and institutional mechanisms this project proposes reflect the reach of international human rights obligations. Accordingly, they apply to cases in which (a) the health professional subordinates loyalty to the patient to the interests of the state in a manner that violates human rights or (b) the health professional subordinates loyalty to the patient to the interests of a private non-state third party in circumstances where the state has an obligation to assure that private actors do not violate human rights.

*Figure 1:  
State Obligation to Uphold Human Rights in the Private Sphere*



The adjacent diagrams illustrate these areas of intersection and, thus, the scope of this project. In Figure 1, Circle A, state obligations to protect human rights, represents the realm of human rights protection, mostly where the state itself is the actor. Circle B, private actions, refers to activities and relationships in the private sphere, most of which are beyond the reach of human rights protection. The two areas overlap where the state has an obligation to assure the protection of human rights in some private relationships, for example to eliminate discrimination on the basis of race or sex in the workplace, in health care institutions, and elsewhere. This area is labeled C, private action subject to human rights protection.

*Figure 2:  
Scope of Dual Loyalty Covered by this Project*



As represented in Figure 2, dual loyalty conflicts may or may not have implications for human rights. The realm of dual loyalty concerns is represented by the entire oval in Figure 2, and shows that dual loyalty may arise in either the public (e.g., physician employed by the state) or private (physician working privately) spheres. The shaded area illustrates where human rights obligations apply to dual loyalty: in the public sector and in that portion of private activity where the state is obligated to assure the protection of human rights. It is only partially shaded to exclude those areas of private action in which the state has no responsibility to assure the

protection of human rights. The shaded area represents the scope of professional conduct covered by this project.

## **Products**

Chapter II contains documented examples in a wide variety of contexts and circumstances to illustrate the ways in which dual loyalty conflicts place health professionals at risk of violating the human rights of patients. Chapter III provides general guidelines for professional practice that are designed to prevent these violations, and are applicable to all health professionals in all settings. A second set of guidelines, in chapter IV, consists of more detailed and tailored guidelines designed to apply in settings where dual loyalty problems are especially prevalent. These include prisons, the military, evaluations for state purposes, refugee and immigrant health, and the workplace. Finally, chapter V proposes institutional mechanisms designed to support health professionals' efforts to comply with the guidelines.

The Working Group also encourages the development of a "toolkit" that can be used by clinicians and practitioners to address dual loyalty human rights conflicts.

## II. Dual Loyalty and Human Rights: The Dimensions of the Problem

- Overview
- (A) Using medical skills or expertise on behalf of the state to inflict pain or physical or psychological harm on an individual that is not a legitimate part of medical treatment
  - Participating in torture and punishment
  - Participation of health professionals in administration of the death penalty
  - Participation in forced abortion, sterilization and contraception and other violations of reproductive health rights relating to bodily integrity
  - Degrading Physical Examinations that Violate Human Rights
  - Female Genital Mutilation
  - Use of chemical and physical restraints and intrusive examinations to enhance security interests of a prison, detention center, or other institution
- (B) Subordinating independent medical judgment, in therapeutic or evaluative settings, to support medical conclusions favorable to the state
- (C) Limiting or denying medical treatment or information related to treatment to an individual to effectuate policy of the state in a manner that violates the patient's human rights
  - Denial of or restrictions on care based on gender, ethnic or racial discrimination, sexual orientation or immigration status
  - Denial of care for political reasons and during armed conflicts
  - Denial of appropriate care to prisoners, detainees, and institutionalized people
  - Withholding information about health or health services
  - The special problem of hunger strikers
  - Denial of care because of inequities in health care in society
- (D) Disclosing confidential patient information to state authorities or powerful non-state actor
- (E) Performing evaluations for legal or administrative purposes in a manner that implicate human rights
- (F) Remaining silent in the face of human rights abuses committed against individuals and groups in the care of health professionals
- Conclusion

### Overview

Dual loyalty conflicts in health practice give rise to human rights violations in all societies. They do so particularly in societies that lack freedom of expression and association, where state officials demand that health professionals contribute to the suppression of dissent. But human rights violations stemming from dual loyalty take place even in the most open and free societies. They occur most frequently in closed settings like prisons and detention facilities, where there is often deliberate ambiguity about the health professional's role in the institution, and in settings where individuals who are otherwise subjected to social or legalized discrimination seek health care.

The circumstances of dual loyalty conflicts are grouped into three categories: to further public health objectives, to serve non-medical ends such as state security or religious or cultural values, and to evaluate individuals for social purposes ranging from receipt of public benefits to determination of criminal responsibility.<sup>58</sup> These categories clarify the justifications and indeed the origins of demands for lending clinical expertise to state or other third-party purposes.

From a health practice point of view, however, the problem of dual loyalty and human rights may best be illustrated by the types of conduct by health professionals that may violate the human rights of patients. This chapter thus provides examples grouped by clinical practices that violate human rights at the behest of or to support the state or other third party,<sup>59</sup> rather than by the type of justification. The examples are not meant to be exhaustive but illustrative, as an aid to understanding the problem and pointing to solutions.

The types of dual loyalty practices that violate human rights are as follows:

**(A)** Using medical skills or expertise on behalf of the state or other third party to inflict pain or physical or psychological harm on an individual that is not a legitimate part of medical treatment.

**(B)** Subordinating independent judgment, whether in evaluative or treatment settings, to support conclusions favoring the state or other third party.

**(C)** Limiting or denying medical treatment or information related to treatment of an individual in order to effectuate policy or practice of the state or other third party.

**(D)** Disclosing confidential patient information to state authorities or other third parties in circumstances that violate human rights.

**(E)** Performing evaluations for state or private purposes in a manner that facilitates violations of human rights.

**(F)** Remaining silent in the face of human rights abuses committed against individuals in the care of health professionals.

In each situation, the chapter discusses which human rights are infringed and identifies guidelines that international medical and nursing organizations have issued to address them. It addresses ambiguities and gaps in the codes of conduct and, where relevant, the reasons why even explicit guidelines for conduct have not been effective in preventing the health professional from becoming embroiled, often reluctantly or unwittingly, in human rights violations against patients. In some cases, health professionals are following legal requirements, in others, adhering to cultural practices.

**A. Using medical skills or expertise on behalf of the state to inflict pain or physical or psychological harm on an individual that is not a legitimate part of medical treatment.**

The deliberate infliction of harm on a patient at the behest of the state through the use of medical skills,<sup>60</sup> for political or other reasons, represents the starkest case of health professionals participating in human rights violations. These practices violate the rights to life, security of the person, and freedom from torture and cruel and inhuman treatment.<sup>61</sup> Not surprisingly, the infliction of harm is proscribed by ethical codes as inconsistent with the most fundamental obligations of health professionals. Nevertheless, ambiguities and gaps remain in the ethical guidance available to health professionals faced with state abuses.

### **Participating in torture and punishment**

The record of health professionals participating in torture, advising torturers on methods, evaluating individuals to determine whether they can survive additional torture, and otherwise using medical skills in the process of torture is well-documented.<sup>62</sup> In the most extreme cases, health professionals have acted as torturers themselves or provided medical advice in the techniques of torture. Health professionals in South Africa advised torturers on ways to break down the resistance of victims and to mask the existence of torture.<sup>63</sup> Under the Pinochet regime in Chile, medical personnel administered overdoses of drugs that led to the eventual deaths of detainees. Other forms of torture applied by the Chilean secret police that required medical knowledge suggested the participation of physicians.<sup>64</sup>

Perhaps more frequently, health professionals are called upon to evaluate victims for torture. Numerous reports have emerged from Venezuela of medical evaluations that assisted in torture. In one case, in 1989, a 32-year-old man was detained and tortured at the Dirección de Inteligencia Militar in Caracas. Over the course of 24 hours, he suffered attempted strangulation and beatings. He reported that a doctor was present during his torture and recalled that he was allowed periods of rest and was even given medication when his blood pressure was found to be too high.<sup>65</sup> In Chile, in 1986, the Colegio Médico de Chile found that health professionals supported the work of the security forces, including by certifying the “good health” of detainees before and after torture.<sup>66</sup> In Israel, where torture during interrogation in the form of “moderate physical pressure” has been well documented,<sup>67</sup> physicians have been asked to examine individuals before interrogation involving torture and provide treatment during it.<sup>68</sup>

Even more common is the participation of health professionals in the aftermath of torture, particularly in covering it up. The most well-documented case is that of Turkey, where physicians working in detention facilities were pressured not only to omit positive indications of torture from their medical reports, but also to change reports written by other health professionals containing evidence of torture.<sup>69</sup> In Uruguay, a military physician was found guilty of “grave ethical fault” for signing a misleading autopsy report in a case where a political prisoner died after having been tortured.<sup>70</sup> One physician in a republic of the former Soviet Union facing circumstances of reprisals for reporting torture felt so compelled to omit signs of abuse on official records that he kept a second, unofficial record, to be presented when the climate of repression subsided.<sup>71</sup>

The most common form of complicity of all, however, is passive acceptance, especially where the health professional's own clinical findings are known by the clinician to be used by authorities to inflict torture. In Uruguay, for example, physicians working at the Libertad Prison were aware that the authorities sought to make the prisoners suffer psychologically and used the clinical information provided

by physicians in routine examinations to further this purpose. But the physicians did not object and continued to furnish the reports. As a result, the physicians became “cogs in an apparatus of torture designed to uncover and crush all that was seen as subversive.”<sup>72</sup> Equally disturbing is silence by professional organizations in the face of torture in detention facilities that is brought to their attention.<sup>73</sup>

Health professionals have also participated in inflicting punishment in settings other than detention or interrogation, especially legally authorized corporal punishment.<sup>74</sup> In Malaysia, a law on caning as a punishment requires medical oversight.<sup>75</sup> Physicians in Iraq<sup>76</sup> and Afghanistan<sup>77</sup> have provided their surgical skills for amputations employed as punishment. Chinese psychiatrists have subjected patients hospitalized for “political mania,” essentially opposition to state policies, to beatings as part of a regime of punishing dissidents and have been complicit in the state’s persecution of Falun Gong practitioners, administering debilitating doses of non-indicated medication, some of which have been fatal.<sup>78</sup>

Many of these practices are explicitly prohibited by the World Medical Association’s Declaration of Tokyo, which states that “the doctor shall not provide any...knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment, or to diminish the ability of the victim to resist such treatment.”<sup>79</sup> The UN Principles of Medical Ethics specifically hold that it is a contravention of medical ethics for a doctor to “participate in the certification of the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health.”<sup>80</sup> The International Council of Nurses also prohibits a nurse’s “participation in any deliberate infliction of physical or mental suffering.”<sup>81</sup>

The World Psychiatric Association’s Declaration of Hawaii establishes guidelines to prevent the misuse of psychiatric concepts, knowledge, and technology.<sup>82</sup> It states, “the psychiatrist must on no account utilize the tools of his profession once the absence of psychiatric illness has been established. If a patient or some other third party demands actions contrary to scientific knowledge or ethical principles, the psychiatrist must refuse to cooperate.”<sup>83</sup> The UN’s 1991 Principles for the Protection of Persons with Mental Illness further prohibit diagnosis of mental illness on the basis of a person’s political values or religious beliefs.<sup>84</sup> Guidelines issued by the International Council of Prison Medical Services take the same position.<sup>85</sup>

Yet these rules do not fully address the problem of complicity in torture and abuse by health professionals. Their application is especially ambiguous where the professional’s role in torture is not overt participation but passive acquiescence or silence, such as where otherwise routine clinical work is used by authorities to inflict harm on prisoners, where a health professional believes that presence during torture can lessen the violence inflicted,<sup>86</sup> or where professionals are aware of torture but simply say nothing.<sup>87</sup> Moreover, existing rules do not address the coercive circumstances that may make it so difficult to resist state demands. Sometimes health professionals are required by employers to take part in violations. In other circumstances they are subject to sanction if they speak up.

In 1997, the WMA adopted a Declaration seeking organizational support for physicians who refuse to participate in torture or who provide rehabilitation services to its victims.<sup>88</sup> It called for national medical associations to support physicians under pressure to participate in torture. Unfortunately, most national medical associations remain weak in providing this support and enforcing existing standards.

Few international supports exist to strengthen their resolve. Additionally, mechanisms to prevent health professionals from being subjected to pressures to cooperate in the first place, for example through employment relationships, need to be developed.

## **Participation of health professionals in administration of the death penalty**

Even though the International Covenant on Civil and Political Rights does not declare the death penalty a human rights violation per se, other human rights treaties do outlaw its use,<sup>89</sup> and in 1998, the United Nations Human Rights Commission called for a moratorium on executions with a view toward its universal abolition.

Most international medical and nursing codes prohibit involvement of these professionals in capital punishment.<sup>90</sup> The World Medical Association's Resolution on Physician Participation in Capital Punishment (2000) prohibits physician participation in any phase of the execution process.<sup>91</sup> The World Psychiatric Association's Declaration on the Participation of Psychiatrists in the Death Penalty (1989) and the Declaration of Madrid (1996), as well as the International Council of Nurses' (ICN) Resolution on the Death Penalty and Participation by Nurses in Execution (1998), prohibit members of the profession from taking part in actions related to execution. The ICN resolution holds that participation, "either directly or indirectly, in the immediate preparation for and carrying out of state authorized executions," is a violation of ethical standards.<sup>92</sup> Other medical and human rights organizations have taken this absolutist position as well.<sup>93</sup>

Despite these resolutions, participation is relatively common, in part because the laws of many countries still uphold the participation of medical personnel in state executions.<sup>94</sup> The problem is especially severe in the United States, where doctors and nurses may be involved in administering the lethal dose of drugs, inserting the intravenous line that carries the lethal dose, or certifying or pronouncing death.<sup>95</sup> Disciplinary and regulatory bodies have refused to take action against health professionals. Moreover, in a case in Illinois, after a court heard arguments that physicians who participate in capital punishment should be the subject of disciplinary sanctions, the state legislature declared that such participation did not involve the practice of medicine and therefore did not fall within the jurisdiction of the licensing agency.<sup>96</sup> In Turkey and Japan, among other countries, physicians are required to be present during execution by hanging. They are then required to certify that death has occurred.<sup>97</sup> Thailand, having proposed the introduction of death by lethal injection, is likely to require health professionals to assess the most effective lethal cocktail. The government of Swaziland has also indicated an interest in using this method, with injections to be administered by doctors.<sup>98</sup>

Moreover, despite the international codes, there remains debate about what conduct amounts to "participation." Administering lethal injections and pronouncing death are clearly proscribed, while providing expert forensic testimony in a criminal trial that could ultimately lead to execution is generally considered acceptable because it is not linked directly to an execution. But some professional organizations take the position that assessments of competency to be executed are also permissible, even though such assessments engage the psychiatrist quite directly in the machinery of execution by requiring him or her to pronounce a person fit for execution.<sup>99</sup>

Thus, there remains some ambiguity in directives given to health professionals.<sup>100</sup> Moreover, professional and regulatory bodies have not sufficiently protected health professionals working in prisons from being ordered to participate, and have not launched efforts to change laws mandating participation. Further, even to the extent clear rules exist, medical discipline is not well suited to curb even universally prohibited forms of participation practice through the disciplinary process.

### **Participation in forced abortion, sterilization and contraception and other violations of reproductive health rights relating to bodily integrity**

Forced abortion and involuntary sterilization severely infringe on the rights of women to privacy, dignity, reproductive freedom and bodily integrity. The UN committee responsible for interpreting the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) has stated that “compulsory sterilization and abortion adversely affect women’s physical and mental health and infringe on the right of women to decide on the number and spacing of their children.”<sup>101</sup> The 1994 International Conference on Population and Development (the Cairo Conference) proclaims that these rights are based on the recognition of the basic right of all couples and individuals to attain the highest standard of sexual and reproductive health by deciding freely and responsibly the number, spacing and timing of their children and to have the information and means to do so.<sup>102</sup> A human rights approach recognizes the importance of respect for diverse cultures, but draws a line where these practices violate such fundamental guarantees.

Yet medical participation in forced abortion and sterilization is relatively common. In China, “violence against women, including coercive family planning practices that sometimes include forced abortion and forced sterilization” is common and continues to worsen.<sup>103</sup> It is clear that physicians are involved in performing the abortions, even if they feel pressured by state authorities to do so.<sup>104</sup> Forced sterilization of women is reported to be common in many parts of Asia and Latin America.<sup>105</sup> In the Indian state of Kerala, health professionals cooperated in government population control programs that often coerced poor women into consenting to be sterilized. Women reported being herded into clinics like animals to undergo sterilization operations at the hands of state physicians.<sup>106</sup> Health professionals in South Africa prescribed injectable contraceptives for black women after childbirth as a result of national policies that made the control of black people’s reproduction a primary objective that did not reflect the choices made by the women.<sup>107</sup>

In many countries, physicians and nurses participate in involuntary sterilization of people with (or believed to have) mental retardation. The practice was common in the United States until the 1970’s, and remains in effect elsewhere. In Australia, a 1997 report commissioned by the government found that during a five-year period, over 1,000 women and girls with mental retardation were sterilized by surgeons in the country’s public health system. Australia’s High Court deemed such sterilizations illegal.<sup>108</sup>

The health community’s ethical guidance counsels respect for voluntary contraception and reproductive choice. The World Medical Association recognizes that “the ability to regulate and control fertility should be regarded as a principal component of women’s physical and mental health and social well-being.”<sup>109</sup> This and national declarations, however, appear to have had little impact on health professionals who practice in societies where the practices occur. In the absence of

clear imperatives accompanied by training and support, they understandably tend to follow cultural practices, some of which are built into law.

### **Degrading Physical Examinations that Violate Human Rights**

Health professionals may also be called upon to conduct degrading or discriminatory examinations, contravening human rights standards that require respect for dignity and prohibit discrimination.<sup>110</sup> In apartheid South Africa, for example, health professionals acquiesced in a policy of conducting degrading examinations in the mining industry, where employees were brought into a hall en masse and publicly checked for signs of sexually transmitted diseases.<sup>111</sup>

In some societies, physicians are called upon to conduct virginity examinations on women and girls, either for state purposes (e.g. school admission) or to reinforce cultural values or sexual mores. A survey conducted in Turkey over a six month period found that while 68% of the physicians interviewed believed “virginity” examinations should only be conducted if there is a reasonable suspicion of sexual assault, nearly one out of every three virginity examinations they conducted was motivated by social reasons. Of the participating physicians, 58% agreed that at least half of the women who have virginity examinations do so against their will. Another 25% of the participating physicians believed such was the case in at least 9 out of 10 examinations.<sup>112</sup>

The Turkish Medical Association (TMA) has continued to stress that even in the face of strong cultural beliefs about the importance of virginity in women and girls, the physician’s most fundamental responsibility remains the health of the patient. While the TMA, along with the Izmir Chamber, has continued to condemn the practice of virginity examinations as “an assault to the body and mental integrity of the person,”<sup>113</sup> very little has changed due to the lack of regulatory mechanisms to curb the practice. As in other areas where cultural practices may collide with human rights, health professionals continue to subordinate their own patients’ human rights to cultural practices.

### **Female Genital Mutilation**

Female genital mutilation (FGM), also known as female circumcision and female genital cutting, is another traditional practice that has been recognized to violate the human rights of women and girls throughout the world. It has been condemned in the 1993 Vienna Declaration of the World Conference on Human Rights as well as by the UN Commission on Human Rights.<sup>114</sup> The World Health Organization has taken the position that to advance health and protect the lives of women and children, including their reproductive and psychological health, FGM must not be institutionalized, nor should any form of FGM be performed by any health professionals in any setting, including hospitals or other health facilities.<sup>115</sup> The World Medical Association (WMA) has condemned female genital mutilation and the participation of physicians in the practice. The WMA has also urged medical associations to stimulate both public and professional awareness of the damaging effects of the practice and cooperate in developing strategies to prevent it.<sup>116</sup> Similarly, the International Council of Nurses has objected to the medicalization of the practice and has pledged to eliminate the practice of female genital mutilation by health professionals in any setting.<sup>117</sup>

Despite these admonitions, health professionals continue to perform the surgery, and in some countries the government permits health facilities to be used for it. They

say, with reason, that the procedure will be far safer if performed by a health professional in a health facility. In Kenya, health professionals continued to practice female genital mutilation in hospitals.<sup>118</sup> In Egypt, the Health Minister's efforts to ban female genital mutilation in hospitals were opposed by many physicians on the ground that the practice was safer if performed in a hospital.<sup>119</sup> Seen in this light, female genital cutting does not represent a conflict, since the health professional's participation protects the individual's health. But that is precisely why clearer guidance is needed: women are better protected if the procedure is not performed at all.

### **Use of chemical and physical restraints and intrusive examinations to enhance security interests of a prison, detention center, or other institution**

Physicians and nurses are often asked or required to use medical skills to serve the security interests of an institution by ordering physical or chemical restraints,<sup>120</sup> or isolation, that have a disciplinary or security rather than therapeutic purpose. These procedures can place individuals at significant health risk. In some facilities, health professionals must perform body cavity searches for contraband. This is as true in psychiatric and mental retardation facilities as it is in prisons. In the United Kingdom, for example, intimate body searches are permitted in certain circumstances, and doctors are asked to participate if detainees are believed to be concealing drugs or weapons.<sup>121</sup>

The use of medical skills solely to serve the security or disciplinary interests of the state is a clear breach of the ethical duty of health professionals to be loyal to their patients, even if the practices, when carried out by security personnel, are not in themselves violations of human rights. In these cases it is the perversion of the fundamental medical role that constitutes the ethical violation. For even if the state has a rationale for the activity, it is still an interference with the obligation of a health professional to intervene only to benefit an individual. The lack of therapeutic purpose is an affront to the person's dignity as well as bodily integrity.

International codes generally prohibit the use of these interventions for security purposes, but nevertheless leave some gaps. The UN Principles of Medical Ethics state that health professionals must not "participate in any procedure for restraining a prisoner or detainee" unless the procedure is medically determined to be necessary for the health of the prisoner, fellow prisoners, or guardians, and presents no hazard to the prisoner's mental and physical health.<sup>122</sup> Similarly, the UN Minimum Rules for the Treatment of Prisoners prohibit the use of physical restraints on prisoners but do allow medical officers to authorize the use of restraints on medical grounds.<sup>123</sup> "Medical grounds," however, is undefined, and neither set of standards explicitly addresses whether a health professional is permitted to authorize restraints on non-medical grounds. The UN Principles for the Protection of Persons with Mental Illness prohibit the use of medication "for the convenience of others" and limit the use of physical restraints to circumstances where necessary "to prevent imminent or immediate harm to the patient or to other persons."<sup>124</sup>

The WMA position is more equivocal. It permits medical personnel to participate in body cavity searches, holding that bodily harm could be done if a non-medically trained professional does the search.<sup>125</sup> It further provides that the physician who performs the search should not be the one providing medical care to the patient, and that the physician should explain his role to the prisoner, including the fact that the

usual conditions of medical confidentiality do not apply. This compromised position is insufficient to protect human rights. As the British Medical Association (BMA) and others have observed, allowing doctors to participate in a procedure that requires no medical skills makes the doctor a wielder of force and thus contradicts the doctor's obligation to meet the medical needs of the patient. It also provokes an element of distrust between doctor and patient. Therefore, according to BMA policy, health professionals should only perform body searches when they can obtain consent on the part of the patient. The International Council of Nurses' guidelines take the absolutist position that nurses employed in prison health services should "not assume functions of prison security personnel, such as body searches conducted for the purpose of prison security."[126](#)

The co-option of health professionals for security purposes is not simply a product of ambiguous rules. Sometimes lines of authority permit administrators to order health professionals to engage in these practices. Moreover, even when health professionals report to a separate agency, such as a health department or ministry, they are often steeped in the culture of the institution. When they engage in the work full time, they tend to be isolated from colleagues and perspectives that could help them resist. And even when they do resist the pressure to serve institutional needs over patient human rights, they often receive little support from peers in the health community or from their medical associations

## **B. Subordinating independent medical judgment, in therapeutic or evaluative settings, to support medical conclusions favorable to the state**[127](#)

The principles of honesty and integrity are central to professionalism and professional ethics. Some medical ethics codes highlight the need for honest reporting, especially where human rights violations are taking place. The Tokyo Declaration states that physicians should not "countenance" or witness torture and other cruel procedures, and further says that the clinician should have full independence when deciding on the care of the patient.[128](#) International codes mandate that health professionals certify only what they know to be true.[129](#) Moreover, the WMA's International Code of Medical Ethics stipulates that a physician shall "certify only that which he has personally verified."[130](#)

Yet there have been occasions when health professionals have fashioned medical conclusions in either therapeutic or evaluative settings to favor state policy or results sought by the state. Sometimes these practices are undertaken to mask violations of human rights committed by the state. Health professionals may omit crucial information on medical records, disguise findings, falsify records, or passively accept representations of state agents when the medical evidence indicates otherwise.

A number of such cases have arisen regarding the reports of abuses or deaths in detention. South Africa's Truth and Reconciliation Commission's hearings on the health sector brought submissions on falsification of medical or autopsy reports.[131](#) In one case, psychiatrists, colluding with security forces, gave false testimony in order to cover up abuse of political detainees and protect security forces. In another, a doctor allegedly advised the police to abuse an unconscious prisoner by forcing porridge down a detainee's nose so that in case of death, the cause would appear to be aspiration of food during seizure rather than head injury due to torture.[132](#) The

work and files of Dr. Jonathan Gluckman, a private pathologist, report the extensive complicity of health professionals in falsifying death certificates and medical records to shift responsibility away from state forces. Gluckman recorded reports that failed to mention bullet wounds, neglect and clear indications of trauma resulting from torture and prolonged abuse.[133](#)

The most infamous South African case concerned the death in detention of leading political activist Steve Biko. After his arrest, two physicians failed to record or request information about signs of brain damage as a result of police beatings. They failed to make note of or question the fact that when they examined him, Biko was lying naked and manacled to a grille. They falsely recorded Biko's condition as normal despite obvious signs to the contrary. Recording the truth would have meant incriminating the police and also would have required the doctors to provide appropriate treatment to Steve Biko.[134](#)

In another example of falsification, psychiatrists in China and the Soviet Union made findings of mental illness and imposed "appropriate" interventions to suppress political dissent or religious freedom. Soviet and Chinese psychiatrists participated in the political use of psychiatric diagnosis to label political dissidents as having mental illness.[135](#) Although there remains controversy regarding the extent to which Soviet psychiatrists believed they were employing authentic diagnosis, there exists clear evidence that even assuming they believed in the correctness of the diagnosis, the treatments they prescribed were especially harsh.[136](#) The UN's 1991 Principles for the Protection of Persons with Mental Illness prohibit the diagnosis of mental illness on the basis of political values or religious beliefs.[137](#)

National security interests also led to pressures to falsify reports or withhold critical information in medical reporting. In Russia, health professionals treating patients involved in research or testing of nuclear weapons were prohibited, until 1992, from recording radiation sickness in patients' medical histories.[138](#) In other cases, physicians gave clearance to workers to continued radiation exposure even when they had been previously exposed to high levels of radiation.[139](#) In the United States, in Oak Ridge, Tennessee, because of her employment by the Department of Justice, a physician felt obligated not to deal directly with the health problems of workers or residents ill from exposure to nuclear waste.[140](#) Moreover, medical personnel working for Department of Energy contractors would "divert away" proper treatment and attention sought by workers for symptoms and conditions caused by workplace exposures.[141](#)

Military interests can also lead health professionals to withhold information about health. In Russia, physicians under the supervision of military officials conducted medical examinations of conscripts but failed to register even severe illnesses in order to secure the required number of draftees. The practice caused a number of deaths among soldiers.[142](#)

Although pressure to reach medical conclusions favorable to the state is typically associated with repressive regimes or a national security apparatus, it also occurs in open societies. For example, in 1998, Germany had an interest in repatriating Bosnian refugees. As trauma specialists working through the Ministry of Health were considered too sympathetic to asylum seekers, doctors with the Police Medical Service (PMS) were called in to determine whether the refugees were "fit" for repatriation. Lacking expertise in trauma and knowledge of human rights, the police

doctors overwhelmingly voted for repatriation, ignoring signs of trauma, failing to use professional interpreters, and, in some cases, allowing refugees to be handcuffed and taken to PMS headquarters if they refused to be examined. In one expert's judgment, "the PMS opinions were not medically oriented, but had been written for the political purpose of overruling the expert opinions of trauma specialists and of justifying repatriation."<sup>143</sup> Further, some patients "suffered severe relapses of Post-traumatic Stress Disorder (PTSD) symptoms, including suicide attempts, after being examined by the [Police Medical Service.]"<sup>144</sup>

Emergency room physicians in the United States have reported adhering to requests of police to release a person to their custody rather than admitting the patient to the hospital in accordance with their professional judgment. They have also reported that hospital administrators would be unlikely to support their refusal to follow the wishes of the police.

Finally, fitness evaluations for private employers can be subject to pressure to reach conclusions favorable to the employer or to impose requirements for fitness that are not justified by workplace requirements.<sup>145</sup>

These violations, in a variety of contexts, may be a product of identification with state purposes, which in turn leads to abandonment of the commitment to patients and to human rights. In these situations, health professionals may not even be aware of the full dimensions of their departure from ethical norms. In other cases, health professionals may be under great pressure to comply with demands from their employer, often the state. And in some cases they face an even more complex dilemma: by documenting abuse, they might further endanger the patient. On the other hand, not to document is a clear betrayal of the patient and of the ethics of the medical profession.<sup>146</sup>

### **C. Limiting or denying medical treatment or information related to treatment to an individual to effectuate policy of the state in a manner that violates the patient's human rights**

Individuals have a right to the highest attainable standard of health and to be free from discrimination in health services. Where state policy or practice or their own political views calls for limiting or denying medical treatment or information on grounds unrelated to appropriate diagnosis and treatment, health professionals again confront a situation in which they must decide whether to uphold state policy or uphold the rights of their patients.

#### **Denial of or restrictions on care based on gender, ethnic or racial discrimination, sexual orientation or immigration status**

Health professionals face pressure to limit or deny care in the service of state policies or social norms that encourage discrimination, in violation of the human right to be free from unjust discrimination. Sometimes health professionals obey explicit directives from the state and in other cases passively adhere to cultural or social attitudes devaluing members of certain racial or ethnic groups, or women.

Gender discrimination in health care is pervasive throughout the world. In many countries, women are denied access to critical health services or receive health services of lower quality than men, or are not permitted to obtain medical care without the consent of their husbands.<sup>147</sup> Even in obtaining treatment for a devastating disease like AIDS, women are less likely to gain access than men.<sup>148</sup> Disfavored ethnic, racial and caste groups are also denied equal access to health services due to policies enforced or adhered to at the health professional level. For example, after the Serbian government systematically excluded Albanian Kosovar professionals from practicing in the state health care system in Kosovo in 1989, Serbian physicians restricted health services to Kosovar Albanian patients in crucial ways. In defiance of their obligation to develop positive relationships with their patients, many refused to speak the Albanian language to Albanian patients even when they knew the language.

In South Africa, apartheid-era health professionals adhered to policies of racially based admission to hospitals and provision of care. For instance, a “white” ambulance could not serve black South Africans,<sup>149</sup> and many (but not all) health professionals adhered to government policies on segregated waiting rooms and hospitals and acquiesced in grotesque discrimination in educating health professionals. At a systemic level, apartheid policy required the uneven allocation of resources so that fewer and inferior services were available to blacks. Health professionals participated in distributing differential care in segregated facilities, where, for blacks, beds were too few in number and treatment untimely. In psychiatric hospitals, black South Africans were refused sheets, made to sleep on the floor, and given inferior food. Black women were required to leave the hospital immediately after giving birth. In these cases, the state had the resources to provide better care, but, because of racist policies, did not. Physicians who served black patients, then, adhered to state policy and participated in advancing the interests of the apartheid state in violation of their patients’ human rights.<sup>150</sup>

Members of groups that face other forms of discrimination, e.g., the Dalits in South Asia,<sup>151</sup> the Roma in Europe, migrant workers, and refugees, all face restrictions on access to and quality of health services. In many instances, health professionals have little ability to control or influence discriminatory practices – although they can often speak out against them, especially through collective action. They may also play a role in perpetuating or passively accepting limitations in the care they offer. Moreover, professionals may themselves reflect, consciously or unconsciously, prevailing discriminatory attitudes and reflect them in their clinical practices. In the United States, for example, generations of racism against African Americans has left a legacy of discrimination in health care, and an extensive body of literature has demonstrated continued disparities in diagnosis and treatment based on race in clinical practice.<sup>152</sup>

Immigrants, refugees – including asylum seekers — and migrant workers are often denied access to health care by being excluded by law from health care programs or by prejudice against them stemming from a culture of xenophobia. These exclusions violate the right to the highest attainable standard of health. General Comment 14 of the U.N. Committee on Economic, Social and Cultural Rights, on the right to the highest attainable standard of health, consistent with international treaties on the elimination of discrimination, provides that states should not engage in “denying or limiting equal access for all persons, including prisoners or detainees, minorities,

asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy." [153](#)

Violations are common. Under Proposition 187 in California, for example, undocumented immigrants could not receive health care services, other than emergency care, from publicly funded facilities. The law, which was overturned as inconsistent with federal law, would have required that state employees terminate women's pre-natal care. [154](#) In the Netherlands, a law proposed in 1997 would have severely restricted medical care to undocumented immigrants. The legislation was later revised to give "slightly less limited care." The law was never implemented in part because of opposition from health professionals who would have been required to deny care. [155](#) In both cases, many health professionals did resist compliance.

The examples above, whether involving women, immigrants, ethnic or racial groups, or other victims of discrimination, often involve institutionalized discrimination. As discussed in the Introduction, health professionals are not encouraged to view practices that reflect such institutionalized discrimination as raising ethical concerns for their own practices. As health care providers, they are often discouraged or even repulsed by practices that prevent members of disfavored groups from having equal access to health care, such as the allocation of fewer state resources and less than adequate health care coverage for members of these groups (including lower payment rates for providers). They also commonly experience the consequences of such discrimination in their own clinical and community practices, such as higher patient loads, less ability to provide sophisticated and clinically appropriate interventions. But health professionals understandably often view these dimensions of institutionalized discrimination as beyond their control and thus devoid of ethical consequences for them; rather, they see their role only as providing the best care they can within the frameworks they are provided, recognizing the underlying inequitable or discriminatory nature of the health care structure. But where those very structures are infused with racism, gender discrimination or other forms of bias, "normal" practice, or even efforts to do one's best under the circumstances, can have the effect of reinforcing discrimination and can lead the provider to participate directly in it. Ethical codes and institutional mechanisms need to address this problem so that health professionals can escape the problem of providing discriminatory care on account of state practices that violate human rights.

Codes of professional conduct generally prohibit discrimination based on gender, race or other improper factors. [156](#) But in many countries a countervailing view, that health professionals should be able to choose whom they serve, has often undermined the prohibition on discrimination, and in virtually every nation disciplinary action by licensing bodies or professional associations for violations is exceedingly rare. Moreover, even explicit prohibitions on discrimination almost never address whether the health professional has a responsibility to address, as part of one's professional duty, the structural or institutional dimensions of discrimination that prevent the professional from providing appropriate care to all even when he or she has political space in which to challenge them.

There are exceptions. The International Federation for Gynecology and Obstetrics, whose Committee for the Ethical Aspects of Human Reproduction places its ethical guidance in the context of the "unique vulnerability of women because of their reproductive function and role," "discrimination and abuse" and "exposure to violence, poverty, malnutrition and opportunities for education or employment." [157](#)

The Federation therefore finds “an ethical duty to be advocates for women’s health care.” This includes the obligation, individually and as a profession, “to monitor and publicize indices of reproductive health and provide data to sensitize the public to health issues and rights of women.”<sup>158</sup> This information function should include identifying “the social and cultural causes in each country” of the obstacles to women’s health.<sup>159</sup>

### **Denial of care for political reasons and during armed conflicts**

International humanitarian law – the law of armed conflict – recognizes and demands respect for the principle of medical neutrality, which holds that in time of conflict, medical care for wounded soldiers and civilians in the conflict region should not be impeded. The Geneva Conventions have very specific provisions that require warring parties to enable providers of health care to provide services to persons outside of combat without interference, regardless of the political views or military affiliation of the sick or wounded person.<sup>160</sup> Human rights law also applies in that the state has the obligation to guarantee liberty and security of the person and the right to be free from discrimination.

These laws and principles apply to governments and warring parties but clearly have enormous implications for health professionals as well. Simply stated, the political views or military status of an individual should not affect the availability or quality of health care services by a health professional. The World Medical Association’s Declaration of Geneva holds that a physician should not allow political affiliation or creed to affect her the duty to patients.<sup>161</sup> The WMA’s Regulations in Time of Armed Conflict reinforce the requirements of the Geneva Conventions by demanding the provision of medical care irrespective of political beliefs, nationality or other non-medical factors. Moreover, the WMA declares unequivocally, “Medical ethics in times of armed conflict is identical to medical ethics in times of peace.”<sup>162</sup> And the Declaration of Tokyo by the WMA states, “A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor’s fundamental role is to alleviate the distress of his or her fellow men, and no motive, whether personal, collective, or political, shall prevail against this higher purpose.”<sup>163</sup>

These commitments to medical neutrality often cannot withstand war or political conflict within societies when political leaders and military commanders interfere with medical care, often as part of a general pattern of attacks on civilians or intimidation of opponents.<sup>164</sup> The dual loyalty conflict arises when these impediments to professional independence are either endorsed by or not opposed by health professionals or their organizations, who knowingly participate in the denial of health care to individuals associated with an enemy or political opponent. In many circumstances, they face enormous risks in seeking to provide care without discrimination, but at other times their conduct simply allies their medical practice with their political views.

Military medical personnel working in occupied territories can also face demands to withhold care. South African military doctors stationed in Namibia, whether willingly or unwillingly, limited care to local civilian populations in the occupied territory.<sup>165</sup>

Another variation on the problem occurs within military organizations, where conflicts between the objectives of the organizations and the health care needs of soldiers and other personnel, especially during wartime, create dual loyalty concerns. For

example, usual principles of triage demand that in medical emergencies health professionals attend to the most seriously injured first. But in battle commanders may compel the physician to attend first to soldiers with less severe wounds as a means to return them to battle quickly and maximize force strength; meanwhile, the most seriously injured suffer or may die. Similarly, treatment of sick or traumatized soldiers may diverge from standard civilian protocols to serve military purposes, for example, preparing the soldier as soon as possible for new battle engagements rather than seeking the best long term outcome for the patient.

Although the World Medical Association has sought to reinforce the application of principles of medical ethics in all these situations, military organizations have maintained that a conflict of loyalties is inevitable. A joint statement from the U.S. Army and Air Force Surgeon General states that it is the position of those practicing medicine within the armed forces that "all physicians face issues of divided loyalties in their daily practices...the issue is real for all physicians."[166](#)

This answer is insufficient. Rather, there must be a renewed commitment to maintaining medical ethics in military settings and institutional supports within the military to enable health professionals to adhere to professional ethics. They must take proactive steps to prevent interference with medical independence and respect human rights imperatives even in the face of military and political objectives.

### **Denial of appropriate care to prisoners, detainees, and institutionalized people**

Individuals have a right to appropriate clinical care as part of the right to the highest attainable standard of health. In prison and detention settings, UN Guidelines require no differentiation in medical care from that available to the civilian population,[167](#) and direct that health care services must be provided at no cost. UN Principles of Medical Ethics state, "Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have the duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained."[168](#) Detailed requirements for examinations, access to health personnel and even second opinions, and complaint procedures are designed to assure adequate health services for prisoners. For psychiatric patients, the UN General Assembly demands that facilities for people with mental illness receive "the same level of resources as any other health facility," including sufficient staff, equipment, professional care and treatment.[169](#)

As noted in the discussions of torture and security practices, the disparity between clearly established human rights and ethical obligations on the one hand, and day to day health conditions and practices on the other, is nowhere clearer than in detention facilities, prisons and psychiatric institutions. Even in the absence of intentional abuse, human rights violations are pervasive. Throughout the world, poor health conditions, inadequate nutrition and lack of access to health services lead to rates of morbidity and mortality that are far higher in prisons, detention facilities, and psychiatric and mental retardation facilities than in civilian populations. Health professionals working in these institutions generally do not have the resources or the authority to provide adequate medical care, much less to provide care equivalent to standards in the larger society. The health consequences for inmates are enormous. Tuberculosis, AIDS and mental illness in prisons are common, yet in many countries treatment is rarely adequate or appropriate. Even in non-repressive, non-conflict-

ridden industrialized countries, health professionals often cannot provide appropriate medical care, principally because they are not provided the resources to provide it or because prison authorities impede their ability to provide the care. In some places, too, the commercialization of prison care has made health professionals more accountable to the firm running the institution than to the inmate-patient.

Like health professionals who work in settings where discrimination is common, prisons and detention center health professionals often try to accommodate their medical skills to the limitations imposed on them. They often need to adjust standards of practice to institutional constraints. Health professionals outside the institutions rarely evince interest in what goes on inside them, so clinicians working inside prisons and detention facilities receive neither scrutiny nor support from colleagues in civilian practice or from institutions whose mission it is to uphold practice standards. Moreover, many health professionals working in this environment are subject to employment arrangements that formally subordinate them to officials responsible for institutional operation, thus compromising their ability to exercise independent judgment. In other cases, they become part of an institutional culture that subordinates patient interests to the financial, political, or administrative agendas of the institution.

When ethical guidelines are brought to their attention, health professionals working in these environments often find them meaningless in the world in which they practice. Formal mechanisms for seeking improvements in care or protection of the human rights of their patients are few, and speaking out to improve health care or to change abusive conditions may jeopardize their employment. Improved guidelines for conduct, greater professional training and support, and major changes in structural relationships between health professionals and authorities in these institutions is required.

### **Withholding information about health or health services**

To fulfill individuals' human rights, physicians and other health professionals must share information and their judgments about health condition and health choices. The right to the highest attainable standard of health includes the obligation of the state to provide "health-related information, including sexual education and information."<sup>170</sup> The need has become acute in the era of HIV/AIDS, and the duty is especially crucial in the area of reproductive health, where gender discrimination, stigma and violence against women demand an active and adequate response by health professionals. The right of women to reproductive health information and access to family planning services is recognized in international law. Article 10 of the Convention to Eliminate All Forms of Discrimination Against Women states that "States Parties shall... ensure... (h) Access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning."<sup>171</sup>

State policy in some countries, however, requires health professionals to withhold information on reproductive health services, especially contraception. In several nations in west and central Africa, such as Cameroon, Chad and Cote D'Ivoire, "incitement to abortion" through the sale, distribution, or display of information is a criminal offense.<sup>172</sup> The United States places limitations on its foreign assistance by prohibiting clinics that receive its aid from providing information about abortion. In other countries, the state imposes no legal restrictions on the information

distribution, but inappropriately defers to cultural practices that deny women the needed information.

There often exists little support from professional organizations and institutions to preserve human rights in the face of these social or cultural (or legal) demands. Except for general statements that health professionals should advance the health and well-being of patients, international codes do not provide sufficient guidance to them concerning their obligations to provide information to patients, and are silent about steps to take in the face of state restrictions on information distribution. The WMA's International Code of Ethics holds that physicians should provide "competent medical service in full technical and moral independence," but does not specifically address the obligation of doctors to provide reproductive health information to their patients.

Only the International Federation of Gynecology and Obstetrics (FIGO) has explicitly addressed providing adequate, accurate and relevant information as an ethical obligation.<sup>173</sup> Even FIGO, however, does not address the difficult problems health professionals face where state policies restrict information distribution. Moreover, there exists virtually no enforcement of existing guidelines, and few supports for health professionals that seek to carry out their duty to women to inform them about their reproductive health needs.

### **The special problem of hunger strikers**

Forced feeding of hunger strikers does not fit naturally into the category of denial of health care. The practice does not involve withholding medical treatment, but rather, forcing nutrition on an individual who has freely chosen to refuse for political reasons. One could claim that by engaging in force-feeding the health professional is carrying out a duty to assure the physical well-being of a person, but that perspective ignores both the bioethical principle of autonomy and the human rights at stake, including the right to make decisions about one's body, one's health and one's choices of political strategies.

Thus, while health professionals charged with providing care must remain attentive to the patient's needs, a more central ethical duty is to respect the patient's decisions. It is important to understand, too, that prisoners and detainees often resort to hunger strikes in protest of poor and/or abusive prison conditions or for other political objectives. The health professional should thus resist state demands to supervise force-feeding that effectively end the protest.

A position paper authored by the University of Witwatersand Faculty of Medicine in South Africa, in response to hunger strikes by activists fighting Apartheid, emphasized that "no medical personnel may apply pressure of any sort on the hunger striker to suspend the strike although the hunger striker must be professionally informed of the medical consequences of the hunger strike."<sup>174</sup> Soon thereafter, the World Medical Association's Declaration of Malta on Hunger Strikers held that ultimately, the physician should make an independent decision whether to intervene in a hunger strike, uninfluenced by "third parties whose primary interest is not the patient's welfare."<sup>175</sup> The Declaration respects the rights of hunger strikers, saying that if a physician decides he cannot accept the patient's decision, the patient is entitled to be attended to by another physician.

As in other areas of dual loyalty, health professionals may be called upon by authorities to engage in force-feeding, and have little support in resisting based on the primacy of the individual's choices.

### **Denial of care because of inequities in health care in society**

Gross inequities and inequality in health services are a violation of the right to the highest attainable standard of health. The Committee on Economic, Social and Cultural Rights has interpreted the Covenant on Economic, Social and Cultural Rights as requiring "equality of access to health care and health services."<sup>176</sup> It goes on to assert that "States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities. . . . Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favor expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population."<sup>177</sup>

The General Comment goes on to hold that violations of the right to the highest attainable standard of health include "misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized" and "the failure to take measures to reduce the inequitable distribution of health facilities, goods and services."<sup>178</sup>

The right, of course, is far from realization. As the Committee recognized, "for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote."<sup>179</sup> Some major states refuse to recognize its existence.<sup>180</sup> Policy choices that bring about gross inequities, such as the misallocation of a state's health resources to serve individuals of means at the expense of universal primary care, or the exclusion of tens of millions of people from health insurance coverage, as occurs in the United States, are easy to identify.

Health professionals are always on the front lines when states fail to adhere to the right to the highest attainable standard of health. In some circumstances, moreover, a state's failure can bring about dual loyalty conflicts for health professionals, just as a health professional who practices in a discriminatory environment adjusts the interventions she makes to conform to discriminatory state policies and practices. For example, in South Africa, a provincial health minister ordered a physician at a health clinic not to provide anti-retroviral medication made available at no cost to rape victims, despite the fact that the medication is available to the insured population.<sup>181</sup> The physician's view was that adhering to the government's policy of denying medication to uninsured people unjustifiably subordinated his obligation to affirm his patient's right to the highest attainable standard of health.

In a related case, a state-employed pediatrician in South Africa advocated against the state in support of a campaign for treatment access for the prevention of Mother-to-Child-Transmission (MTCT) of HIV.<sup>182</sup> Despite growing national and international evidence for the effectiveness of antiretrovirals (ARVs) in preventing MTCT, and the spiraling HIV epidemic among South Africa's black female population, the South African government throughout 2000 and 2001 persistently refused to provide ARVs as part of a comprehensive MTCT prevention program. This treatment was, many believed, not only affordable, but also the government's obligation to provide, given

the requirements of South Africa's Constitution progressively to realize the right of access to health care.<sup>183</sup> Faced with the ever-increasing number of HIV-infected infants among his patients, and the intransigence of the government, the pediatrician testified in a Constitutional Court hearing that finally led to a court decision compelling the South African government to develop a comprehensive MTCT program.<sup>184</sup>

The clinicians in the two cases faced inequitable policies that denied the right of access to health care to vulnerable and marginalized populations, and both chose to act in favor of the rights of their patients, the former by resisting state restrictions, the latter by actively joining arms with an advocacy nongovernmental organization to challenge state policy. Although one of the physicians suffered for his action, it took place in the context of a political environment amenable to human rights interventions. It is more common, however, and in many circumstances the only apparently rational option, for physicians to adjust their medical interventions to the constraints they face and offer the best services they can under the circumstances. Especially in environments of scarce resources or explicit limitations on kinds of care available to the poor, they have few options but to engage in forms of triage. For example, physicians working in hospitals in the United States must provide emergency care to patients, but may then be required to discharge them once the emergency is addressed if they are uninsured or cannot pay, even though the condition remains unresolved.

Associations of health professionals have not explicitly recognized the dual loyalty problem in this context. Nor have they taken firm steps toward affirming the obligation of health professionals to work individually and collectively for changes in state policy that would ameliorate the inequality in health services.<sup>185</sup> A full analysis and resolution of these dual loyalty conflicts is beyond the scope of this project, but addressing it should be next on the agenda of those seeking to advance health and human rights.

## **D. Disclosing confidential patient information to state authorities or powerful non-state actor**

The duty of confidentiality is one of the most common articulated ethical obligations to patients, but it is also the one most subject to breach on behalf of the state. This is paradoxical, since the duty to keep patient information confidential is usually asserted in absolute terms. The Declaration of Geneva and the International Code of Medical Ethics, for example, state the duty unequivocally and list no exceptions. Codes even take the position that confidentiality is sacrosanct even in prisons.<sup>186</sup> Yet the duty of confidentiality for health professionals is replete with exceptions designed to serve a range of accepted social purposes. These include the prevention or control of epidemics, the protection of third parties, especially children, from harm, the evaluation of claims to social benefits, and the collection of statistical data about population health.

Some breaches of confidentiality are thus not considered abuses of human rights.<sup>187</sup> But there has been little guidance for health professionals to discern circumstances where breaking confidentiality is acceptable and where it constitutes an abuse of human rights. Mechanisms to ensure protection of confidentiality in these circumstances are almost entirely absent. One consequence is that by revealing

information about their patients to the state, health professionals can put the liberty or security of their patients at serious risk.

The human right to confidentiality of medical records derives from the right to privacy recognized in the International Covenant on Civil and Political Rights.<sup>188</sup> Although medical records or the right to confidentiality of medical records are not specifically discussed in the Covenant, a General Comment by the UN Human Rights Committee to the Covenant creates a framework for evaluating breaches of confidentiality from a human rights perspective. General Comment 16 states that “Effective measures have to be taken by States to ensure that information concerning a person’s private life does not reach the hands of persons who are not authorized by law to receive, process and use it, and is never used for purposes incompatible with the Covenant.”<sup>189</sup>

The General Comment thus has two dimensions: first, protecting private information from going to persons unauthorized by law to have it; second, ensuring that private information is not used for purposes incompatible with the purposes of the Covenant.<sup>190</sup> The second requirement is especially important, for it underscores that while legal authority to disclose the information is an important safeguard (e.g., to protect third parties), legal authority of itself is insufficient to demonstrate that the individual’s human rights have been protected.<sup>191</sup> The provision that information “never be used for purposes incompatible with the Covenant” implies that, at a minimum, information not be disclosed in a manner that would place the person’s liberty or security at risk unless essential for the protection of others’ liberty and security. Further, the “compatibility” requirement suggests that disclosure must not be discriminatory and must not result in discrimination.

Similarly, disclosures that could subject the person to torture or cruel, unusual or degrading treatment, or would likely result in discrimination against the person, are also prohibited.

Yet breaches of confidentiality in these circumstances are common. Those with the most serious consequences for human rights occur where health professionals allow prison or police officials access to information gained in a clinical relationship that can be used by authorities to interrogate, assault, torture or prosecute the patient or to prevent the patient from obtaining redress for harms inflicted during incarceration. In Turkey, officials responsible for the torture of prisoners were given access to those prisoners’ files immediately after a doctor’s examination, raising the threat of additional torture.<sup>192</sup> In apartheid South Africa, prison health professionals were known to hand over prisoners’ confidential clinical files to prison officials, often to the very perpetrators of torture, who could use that information to detain, punish or prosecute the prisoner.<sup>193</sup> In other cases in South Africa, health professionals were pressured to hand over the files of recently admitted hospital patients who had been injured in political demonstrations to the police. Such breaches by hospital personnel were so common that individuals, though wounded, learned to stay away from hospitals after such periods.<sup>194</sup>

These situations, moreover, place health professionals at peril, especially when they resist demands by the state for information, for example, under mandatory reporting laws concerning patient abuse. In Turkey, physicians have been prosecuted for failing to give the state access to medical records and other information about

torture victims, allegedly for the purpose of identifying perpetrators and holding them accountable.[195](#)

Breaches of confidentiality on behalf of the state also takes place in the absence of threat and compulsion. In the United States, physicians and nurses at a South Carolina hospital developed a joint effort with law enforcement officials to seek incriminating evidence of cocaine use against women seeking pre-natal or obstetric care without informing them of the consequences or securing their consent. The medical staff provided positive drug test results to the police. Although the ostensible purpose of the program was to compel the women into treatment, in many cases, the disclosures resulted in the women's prosecution and incarceration. One woman was jailed while eight months pregnant and was forced to wear shackles during labor. The United States Supreme Court held the practice a violation of the constitutional protection against warrantless searches and seizures, but did not address the ethical question.[196](#) It seems clear, though, that the medical staff, by freely breaching confidentiality, had become an arm of the police in infringing the liberty and security of the women.

In Chile, too, medical personnel have breached confidentiality to further the ends of the prosecution of abortion, which is illegal in almost all circumstances. In certain hospitals, the medical staff share reports of women who seek medical treatment in public hospitals after being badly injured during unsafe abortions.[197](#) Although abortion law is less restrictive in Namibia, a similar reporting trend among health workers exists.[198](#) In Russia, during the early 1990's, doctors were required to test all asylum-seekers and refugees for HIV and report those found to be HIV-positive to the immigration service for immediate internment.[199](#)

Even where the breach of confidentiality does not result in prosecution, it can have serious adverse legal and human rights consequences for the patient. In Germany, medical evaluations for asylum were given to the intelligence agency, which subsequently interrogated refugees about their home countries.[200](#) In South Africa, domestic workers – usually, black women – tested for HIV at the behest of their employers have been summarily dismissed when attending doctors shared test results with employers without the workers' consent.[201](#)

Confidentiality is especially endangered in the military and in prisons and detention facilities, where it is not uncommon for records to be shared with non-medical personnel for reasons unrelated to the health of the individual. In some instances, prison health professionals have allowed security personnel to be present during clinical examinations of patients, severely restraining the extent to which patients can freely discuss health problems, including those caused by torture and other cruel treatment.[202](#) Sometimes medical evaluations are held in public areas.[203](#)

The professional response to these breaches has been made more difficult by lack of clarity about the legitimacy of the breach. As noted above, codes have taken an absolutist stance, the effect of which has been to fail to distinguish situations where confidential information may be disclosed to serve crucial and legitimate state purposes and where the disclosure violates the fundamental human rights of the individual. The codes are also deficient in providing procedural guidance. Even where disclosure may be warranted, consent to reveal the information should be sought through counseling, and if the patient refuses, the decision to reveal the medical

information should be done after careful consideration and after informing the patient.

Thus, there remains a serious gap in addressing circumstances where a breach of confidentiality can lead to a serious human rights violation by the state and in the guidance and support to health professionals seeking to resist state demands. Addressing the problem will require a more realistic approach to confidentiality generally, away from the deceptively absolutist stance, as well as a commitment to identifying situations where breaches of confidentiality place human rights at risk. Without such a commitment, the state and health professionals each can simply add to the long list of exceptions.[204](#)

At the same time, mechanisms must be developed to support health professionals at risk of state demands for patient records in situations where liberty and security are at stake.

## **E. Performing evaluations for legal or administrative purposes in a manner that implicate human rights**

Evaluations for state purposes are performed by health professionals in a range of situations. These evaluations range from assessment for competency to stand trial to assessments for social security benefits. Although they may not be in the patient's interests, they often serve recognized and compelling social ends, especially in establishing the truth, and do not violate the human rights of the individual evaluated. The existence of legitimate purposes, however, does not end the human rights and dual loyalty concern.[205](#) Both the methods used and the underlying purpose of the evaluation can violate the human right to due process of law.

Even in legitimate forensic evaluations, violations of due process of law can take place in the manner in which the evaluation is conducted. For example, health professionals may fail to disclose the purpose of the examination, leading the individual to believe the professional is acting in the individual's interest when he or she is not. Health professionals may decline to share the results of the evaluation with the person being examined. Because of an employment relationship with the state, they may consciously or unconsciously show bias toward a result that would most favor the legal position of the state. Or they may disclose confidential information about a person irrelevant to the purpose for which the evaluation is being evaluated.

Evaluations can also infringe the right to dignity and to the highest attainable standard of health. Rape investigations, for example, are notorious for degrading the victim. In other instances, health professionals fail to refer the individual being evaluated for treatment of a medical condition identified in the course of the evaluation that needs attention.

These problems are exacerbated, of course, in environments where human rights are generally at stake, such as oppressive regimes and closed institutions. In recent years, international human rights standards for forensic examinations have focused on guidelines for effective forensic examinations of alleged violations of human rights.[206](#) It is appropriate now to take the next step and develop standards for the protection of individuals whose rights are at risk of violation through forensic health

practice itself. Some national professional groups, particularly in psychiatry, have adopted ethical guidelines, but these remain limited in scope. Given the role of the state in virtually all forensic examination, guidance is clearly needed.

Evaluations using medical knowledge are sometimes required for purposes of compensation or assessment of fitness for work. Failure to recognize the dual loyalty between patient and the authority to whom the health professional is contractually bound to provide a service (state or private insurer, corporate employer, etc.) may give rise to situations where patient rights are violated. Pre-employment examinations, widely used at the workplace to ascertain fitness for employment in a particular industry, are one example where the health professional may apply a discriminatory policy to exclude applicants. For example, the use of an HIV test by South African Airways routinely to exclude applicants from work in cabin crews was found to be a violation of rights and not justified by public health criteria.<sup>207</sup> Health professionals who regard employers as entitled to the full results of medical examinations conducted for the purpose of recommending fitness for work may unjustifiably breach patient confidentiality.<sup>208</sup>

## **F. Remaining silent in the face of human rights abuses committed against individuals and groups in the care of health professionals**

Health professionals are often on the front lines of human rights violations. In prisons, psychiatric hospitals, and other settings, they may witness severe abuses that have enormous health consequences. In Kosovo, for example, while under the supervision of health professionals, patients were beaten and interrogated, chained to radiators on a 24-hour basis, burned with cigarettes, and kept under constant supervision by armed Serb police guards.<sup>209</sup>

In South Africa, physicians and nurses working in detention facilities under apartheid witnessed torture and other abuses against political detainees, the consequences of incarcerating children, and other human rights violations. Yet, with some notable exceptions, they remained silent. When the facts were brought to the attention of professional organizations, they by and large declined to take a position opposing them. One young physician, Dr. Wendy Orr, who identified and reported pervasive abuse of detainees, not only lost her position, but received only grudging support from the organized medical community.<sup>210</sup> The chief district surgeon of Johannesburg, when asked why positive steps had not been taken to avoid ill treatment of detainees during later apartheid years, said, "This is a question that must not be put to me, it must be put to my Department, because I merely follow instructions."<sup>211</sup> In the United States, medical organizations long supported racial segregation in medical facilities.<sup>212</sup> Sometimes physicians have recast their own ethical norms or interpretation of norms to avoid criticizing state policies that grossly and systematically violate the human rights of patients.<sup>213</sup>

These are extreme examples. More commonly, health professionals believe they are powerless to affect the abuses. Others believe speaking out about abuses by others are not their professional concern. Health professionals sometimes are prevented from speaking out due to the requirements of their employment. As noted above, prison or military health professionals may have supervisors who are non-medical administrators whose duties include security, preparedness or other functions

unrelated to health care. Even if these health professionals are not overtly pressured to place institutional needs first, their employment relationships make complying with duties to the human rights of patients more difficult. Speaking out against abuse is even more difficult. In certain countries, contractual obligations prevent prison doctors from discussing outside what goes on in the prison.[214](#)

Similar constraints may bar health professionals from speaking out to protect the health and well-being of employees exposed to hazardous workplace agents.[215](#) In one well-publicized case, an occupational health practitioner based at a prestigious U.S. university identified an epidemic of lung disease related to a newly encountered workplace fiber exposure. He was prevented from publishing his findings, however, under threat of litigation by the company he had researched. Despite the support of the workforce and his colleagues, the practitioner's university failed to stand behind him, though his actions were designed to prevent further illness and protect the rights of workers.[216](#)

With some exceptions, international codes generally do not guide health professionals in situations where they might witness harm being done to a patient or group of patients but not be involved directly in the abuse. The World Medical Association's International Code of Medical Ethics states that the physician shall "always maintain the highest standards of professional conduct," but does not mention whether intervention for patient advocacy, or active promotion of patients' human rights vis-à-vis the state, is included in "professional conduct."[217](#) Further, while the Declaration states that the physician shall "not permit motives of profit to influence the free and independent exercise of professional judgment on behalf of patients," it does not say what physicians should do when the motive is not profit, but pressure from a third party like the state or identification with state forces.[218](#)

Guidelines of the International Council of Nurses do address the question of health professional as witness to abuse. They provide that "nurses who have knowledge of ill-treatment of detainees and prisoners must take appropriate action to safeguard their rights."[219](#) They provide a good model for other health professions to follow.

Guidelines regarding collective professional action are developing. In 1995, the World Medical Association enacted a resolution urging national medical associations to provide ethical advice to doctors working in prisons, to create machinery for investigating unethical practices by physicians in human rights, and to "protest alleged human rights violations through communications that urge the humane treatment of prisoners, and that seek the immediate release of those who are imprisoned without cause."[220](#) Two years later, the WMA issued a Declaration Concerning Support for Medical Doctors calling on the organized medical profession "to support physicians experiencing difficulties as a result of their resistance to ... pressure [to act contrary to ethical principles] or as a result of their attempts to speak out or to act against inhuman procedures."[221](#)

This is an important step forward. The duties of an individual practitioner to speak out, however, remain vague. The WMA's 1997 Declaration states that physicians have a "responsibility to honour their commitment as physicians to serve humanity and to resist any pressure to act contrary to the ethical principles governing their dedication to this task."[222](#) The WMA has not, however, clarified the duty of each individual physician to speak out on behalf of victims of human rights violations. Such clarification, as well as developing means for fulfilling it, remains essential.

## **Conclusion**

The situations where health professionals, wittingly or unwittingly, subordinate the human rights of their patients to the interests of the state are varied and wide-ranging. Nevertheless they share some common themes: lack of awareness among health professionals of the problem of dual loyalty and human rights, a lack guidance on how to evaluate dual loyalty problems in human rights terms, lack of institutional supports for those who seek to protect the human rights of their patients, employment and others structural arrangements that prevent professionals from resisting demands of the state or other third parties, and pressures to serve state interests. Each of these problems demands attention to address the serious and pervasive human rights violations that result. The proposed guidelines and institutional mechanisms that follow are designed to address all these problems.

# III. Proposed General Guidelines for Health Professional Practice

- [Preamble](#)
- [Scope](#)
- [Guidelines](#)

## Preamble

These General Guidelines are designed to address how the health professional can (1) identify situations where subordination of patient interests to those of the state or other third party implicates human rights; (2) clarify the responsibilities of the health professional in these situations; and (3) in conjunction with the institutional mechanisms that follow, enable the health professional to respond appropriately, especially where the health professional faces personal or professional risks by adhering to obligations to the patient. Following these General Guidelines are specialized Guidelines designed to address particular concerns in high-risk clinical settings.

## Scope

These Guidelines apply to health professionals, such as physicians and nurses, as well as to health care personnel and health care auxiliaries who work under the supervision of health professionals. As explained in the Introduction, they apply in circumstances where the health professional is at risk of (a) subordinating loyalty to the patient to the interests of the state and (b) subordinating loyalty to the patient to the interests of a private non-state third party in circumstances where the state has an obligation to assure that private actors do not violate human rights.

The guidelines apply to responsibilities of the health professional to individual patients. As noted in the introduction, there are circumstances where a health professional has responsibilities for communities of people — and these too may be subject to dual loyalty conflicts that implicate the human rights of all members of the community. References to “patient” or “clinical practice” in these Guidelines is meant to encompass responsibilities to communities as well, where applicable.

## Guidelines

**1. The health professional should become conversant with human rights and the implications of human rights for clinical practice through study and training in human rights.**

**Commentary:** The health professional’s most fundamental responsibility in relation to the patient is to use medical skills to care for and promote the health, well-being, and human rights of the patient. Lack of awareness of human rights and their implications for clinical practice is one of the most significant factors leading to human rights violations against patients.

Health professionals are not trained in human rights and generally have only the most vague understanding of the impact human rights obligations to patients should have on their relationships with state agents and state policies. Declarations of medical organizations, resource materials and curricula are available to health professionals but reach only a tiny proportion of licensed clinicians. Thus, training in basic human rights and their relationship to medical practice is a crucially important first step in addressing the dual loyalty and human rights problem. The scope of the understanding should include civil and political rights as well as economic, social, and cultural rights, and the indivisibility of such rights. This is essential so that health professionals can understand that their ethical obligations extend to the fulfillment of the rights to non-discrimination and to the highest attainable standard of health. Training should encompass an understanding of rights to information needed to protect health.

Human rights training is especially important in enabling health professionals to understand the impact on state policies and practices in clinical relationships with members of traditionally marginalized groups, such as refugees, racial and ethnic minorities and women.

**2. The health professional should develop skills to identify situations where dual loyalty conflicts threaten human rights and where independent professional judgment may be compromised.**

**Commentary:** Training in human rights is necessary but not sufficient to guarantee that health professionals will uphold their patients' human rights. As the case examples in Chapter II indicate, even when they have a general understanding of human rights, health professionals need to recognize situations where their own behavior toward the state and patient, including the clinical judgments they make, puts the human rights of their patients at risk. Health professionals must develop the skills to identify particular circumstances where dual loyalty concerns implicating human rights arise so that "alarm bells" go off in their minds. This is as important when they are passive bystanders to human rights abuses as when they are active perpetrators. Though they merely observe, the human rights abuses may nevertheless implicate them. An important aspect of the educational process is to examine realistic case studies, including those relevant to local health care concerns and cultural practices, in order to become familiar with real-life problems of dual loyalty.

These skills should include the ability to understand not only where the state is itself violating human rights, but where it has failed to comply with its obligation to protect individuals from violations that may stem from common social practices like discrimination or abuses against women. For example, health professionals should understand how they may be implicated where the state has failed to protect women from female genital mutilation.

**3. The health professional must place the protection of the patient's human rights and well-being first whenever there exists a conflict between the patient's human rights and the state's interests; this responsibility includes affirmatively resisting demands or requests by the state or third party interests to subordinate patient human rights to state or third party interests.**

**Commentary:** As noted above, the health professional has a fundamental obligation to uphold loyalty to the patient when doing otherwise would violate the patient's human rights, whether the violation is committed by the state or is a result of the state's failure to protect individuals from practices that violate human rights. Deference to cultural norms or social practices, such as denial of information about reproductive health to women, is not acceptable if those practices violate human rights. This Guideline should be applied in every dual loyalty and human rights conflict. The health professional should, however, become familiar with circumstances where adhering to state interests does not compromise human rights. Such circumstances include those justified by public health considerations, as set out in [Guideline 7](#).

**4. In all clinical assessments, whether for therapeutic or evaluative purposes, the health professional should exercise judgment independent of the interests of the state or other third party.**

**Commentary:** It is imperative that physicians and other health professionals apply their medical competencies to the needs of patients in an independent manner, preventing their judgments and actions from being controlled, dominated or influenced in any way by the interests of the state or other third party. Equally important, health professionals need to recognize circumstances where the state or other third party, overtly or subtly, seeks to compromise the independence of their judgments through rewards, incentives, demands, threats, or appeals to the political beliefs of the clinician. This includes whether an evaluation should be done at all, e.g., evaluations of women for "virginity" should be declined because the evaluation violates the woman's human rights.

**5. The health professional should recognize how their professional skills can be misused by state agents to violate the human rights of individuals—especially in settings where human rights violations are pervasive—and take appropriate steps to avoid this misuse.**

**Commentary:** The health professional who cooperates with a regime in which human rights violations are pervasive may breach loyalty to the patient even if not an intentional perpetrator of abuses. Health professionals cannot insulate themselves from responsibility by turning aside from human rights violations that are often furthered by the state's reliance on their competencies, such as in involuntary sterilization or female genital mutilation.

Circumstances of indirect complicity in human rights violations include, but are not limited to, situations where the health professional's evaluations or treatment interventions are used by the state to assist in inflicting harm on individuals. For example, where torture is common, the torturers may rely on what seem to be otherwise independent clinical findings. Under this Guideline, a clinician has an obligation to assure that his or her professional skills are not misused, and if they are, to take actions set out in Guidelines [11](#) and [12](#).

**6. The health professional should recognize that passive participation, or acquiescence, in violations of a patient's human rights is a breach of loyalty to the patient.**

**Commentary:** Circumstances and environments where human rights violations are institutionalized present the most difficult challenges to health professionals. Where, for example, women are denied access to birth control or immigrants are denied access to medical care, acquiescence by the health professional is the means by which the state achieves its objective of violating human rights. This Guideline means that passivity in the face of state requirements that violate patients' human rights is not excused.

**7. The health professional should only depart from loyalty to the patient within a framework of exceptions established by a standard-setting authority competent to define the human rights obligations of a health professional; any such departure should be disclosed to the patient.**[223](#)

**Commentary:** There exist many circumstances where strong state interests permit a health professional to subordinate patient interests to those of the state. These generally fall into the categories of promoting public health, serving important non-medical interests of the state or society (such as protecting third parties), and evaluating individuals for legitimate state purposes such as social benefits or criminal responsibility. For example, all three rationales have been invoked to breach patient confidentiality in particular circumstances.

These exceptions to the duty of absolute loyalty should be established only through legitimate processes and should be incorporated into ethical guidance provided to health professionals by national and international standard-setting bodies competent to define the ethical obligations of a health professional. "Competent" authorities are bodies that are both knowledgeable about medical ethics and free of undue state influence; a national medical organization operating under constraints of pressure from a repressive state is not considered competent. Similarly, "legitimate" implies appropriate mixtures of transparency, consultation and broad-based input in the formulation of such guidance by bodies that are sufficiently diverse in their constituencies, skills, and perspectives to capture adequately the implications of such policies for human rights.

In the absence of explicit Guidelines setting out the exceptions, the health professional should not engage in a process in which he or she weighs the interests of society or the state against the human rights of the individual. Rather, the clinician should only depart from loyalty to the patient when bona fide medical authorities authorize the departure.

This Guideline also means that the existence of a law requiring the health professional in a given circumstance to favor state interests over patient human rights does not absolve the health professional of the responsibility to uphold human rights. State demands reflected in law are only subject to deference if they are enacted in a procedurally appropriate way and if they are substantively consistent with human rights requirements and ethical standards. Health professionals have an obligation to be critical and vigilant of any legislative requirements that result in infringement of the rights of patients, and should seek guidance from appropriate authorities to resolve such conflicts.

It should also be noted that, in exceptional circumstances, a health professional may face a conflict where the rights of third parties are threatened by a state policy that mandates fidelity to the patient (such as proscribing notification the patient's partner

be of the patient's sexually-transmitted diseases). Ethical considerations under these specific circumstances may justify departure from the principle of patient fidelity, and here the professional's conflict with the state is of a different nature. Again, any decision to depart from fidelity to the patient should be within a recognized framework of exceptions. Where such guidance is unavailable, or does not stem from legitimate processes by bodies competent to develop such Guidelines, the health professional should seek to stimulate appropriate professional action to develop such Guidelines before undertaking any departure.

Any departure from loyalty to them should be disclosed and the role the health professional is playing on behalf of the state as well as the reasons for it should be fully explained.

**8. The health professional should maintain confidentiality of medical information except where the patient consents to disclosure or where an exception recognized by competent authorities in medical ethics permits disclosure.**

**Commentary:** An essential principle of medical ethics is that medical information about a patient shall be kept in strict confidentiality. This is particularly important with respect to disclosure to law enforcement agencies. There are, however, important exceptions to this principle—for example, where the health of a larger population or the well-being of an innocent third party could be affected. The health professional should not seek to determine the validity of such exceptions alone but instead should rely only on competent authorities in medical ethics, as provided in [Guideline 7](#).

**9. The health professional should take all possible steps to resist state demands to participation in a violation of the human rights of patients.**

**Commentary:** Although difficult to carry out when the environment is repressive and punitive, this Guideline is essential. When the health professional will suffer financial, psychological, or physical consequences for carrying out the duty of loyalty, medical authorities and peer organizations should provide the necessary aid and support (see chapter V on Institutional Mechanisms).

**10. The health professional should act with an understanding of health professionals' collective obligation to uphold and promote the human rights and well-being of the patient.**

**Commentary:** In many clinical environments, there will be teams of health professionals, all of whom have a duty of loyalty to the patient. The success or failure of clinical consultation and consequent medical action often depends on the competencies and commitment of the range of health professionals. A key obligation, therefore, is solidarity among the health personnel to protect human rights. Delegation of decision-making to avoid dual loyalty conflicts that implicate human rights is inappropriate.

This ethical solidarity also applies with respect to other health professionals at risk of reprisal for complying with their ethical and human rights responsibilities. Each health professional should cooperate with peers and colleagues to protect those subject to retaliation for protecting the human rights of patients.

**11. The health professional should take advantage of opportunities for support from local, national and international professional bodies to meet their ethical and human rights duties to the patient.**

**Commentary:** When individuals or local groups of physicians and other health professionals are confronted with demands by the state to violate the human rights of patients on its behalf, they may be unable to counter that influence effectively on their own. They may be subject to reprisals in employment and, in extreme cases, to legal harassment or even physical threats. As described in Chapter V, Institutional Mechanisms, it is the responsibility of associations of health professionals, locally, nationally and, when necessary, internationally, to protect health professionals at risk of such reprisals.

The responsibility of the health professional to invoke the action of professional bodies is described further in [Guideline 14](#). Recommendations for implementation of action by the professional bodies are contained in the chapter on institutional mechanisms.

**12. The health professional should report violations of human rights that interfere with their ability to comply with their duty of loyalty to patients to appropriate authorities, both civil and medical.**

**Commentary:** A duty to report violations of human rights is necessary because a health professional cannot fulfill his duty of loyalty to patients if they are being subject to human rights violations that interfere with the medical service the professional provides or if the professional's services are being misused or manipulated by the state. Reporting the violations is often the only means by which the professional can end them so as to be able to fulfill ethical and human rights duties.

Wherever possible, the health professional should consult with the patient before reporting information to assure that the patient is not further abused as a result of reporting. If the patient does not agree to be identified, the health professional should consider reporting abuses in a manner that does not identify individuals. Also, the health professional should have confidence that the report is submitted to persons or entities that are in a position to stop the abuse or influence authorities to stop it. Depending on the circumstances, these may include state authorities, medical organizations, and colleagues. Before reporting such sensitive information to colleagues or medical associations, health professionals need to ensure the security of the information they entrust to others and have some clear picture about what they expect the recipient to do with it.

[Chapter V](#) outlines steps to deal with these situations.

**13. The health professional should act individually and collectively to bring an end to policies and practices that prevent the health professional from providing core health services to some or all patients in need. These practices include, among others, a state's failure to take steps needed to achieve the highest attainable standard of health for all; inequity in allocation of health resources or benefits; discrimination (or tolerance of discrimination) in health based on sex, race, ethnicity, class, sexual orientation, refugee and immigrant status, religion, language, caste or class**

**or disability; denial of health information (such as information about reproductive health). This Guideline also applies in private settings where the state's obligations extend to ending discrimination and assuring the highest attainable standard of health.**

**Commentary:** Health professionals have an obligation to bring to an end practices that effectively lower the extent and quality of health services they provide to certain individuals. When the professional denies or limits appropriate care to an individual because of constraints caused by unfair or inequitable allocation of public resources, institutionalized discrimination, or state failure to address the needs of vulnerable groups, the professional becomes a vehicle or instrument by which a violation of the protection against discrimination or the right to the highest attainable standard of health takes place. Rather than adjust one's behavior to the constraints imposed by discrimination or the state's failure to develop a fair and equitable allocation of health resources, the health professional should act to change it.

Health professionals can carry out this obligation in their own practices by being attentive to the standard of care they provide to their patients and acting to assure that their own practices do not reflect institutionalized discrimination or policies that otherwise violate the human rights of some or all of their patients. Thus, for example, they should never accede to state or cultural policies of racial or ethnic segregation in health, denial of appropriate clinical treatment of women (including reproductive health services), or refusal to offer care to undocumented workers.

There are obvious limits to protecting patients' human rights, however, where the violations are structural and pervasive. In these instances the only means by which health professionals can protect, respect and fulfill the human rights of their patients is through collective action or through organizations of health care professionals, working to bring about a fairer and less discriminatory system.

**14. The health professional should support colleagues individually and collectively—through professional bodies—when the state acts to impede or threaten their ability to fulfill their duty of loyalty to patients.**

**Commentary:** As noted above, there are many circumstances where individual health professionals are subject to pressures or threats, or even sheer indifference, by the state, when they act in ways that fulfill their duties to patients but contradict state policy. Collective action is necessary to provide redress, and each individual health professional has the responsibility to support colleagues at risk.

## IV. Proposed Guidelines for Practice in Difficult Settings

- (A) [Prison, Detention and Other Custodial Settings](#)
- (B) [Health Care for Refugees and Immigrants](#)
- (C) [Health Professionals in the Workplace](#)
- (D) [Health Professionals Engaged in Forensic Evaluations](#)
- (E) [Military Health Professionals](#)

### A) Guidelines for Prison, Detention and Other Custodial Settings

#### Preamble

The problem of dual loyalty and human rights is particularly challenging for health professionals who are responsible for providing health care services to prisoners. On the one hand, such professionals are subject to professional ethics and mores governing their conduct; on the other, they work within institutions primarily concerned with state and/or public security. It is inevitable that these dual obligations will at times seem to be, or actually will be, opposed to each other.

Health professionals working in prisons often willingly and knowingly comply with policies that violate one or more aspects of medical ethics, and may even participate in drawing up separate codes of 'medical ethics' specifically for use in such institutions. Others may be unsure of how to cope with situations where their ethical responsibility to the patient seems to be in conflict with state or prison policies and practices. They tend to be passive participants in unethical practices, rather than willing perpetrators of ethical violations.

In some situations, subordination of patient interests to the requirements of the state undeniably serves legitimate purposes. For example, a prison health professional who becomes aware of sexual or other abuse among prisoners themselves may in certain cases have to intervene and breach confidentiality in order to protect others from harm. Under some circumstances, particularly when public health is at risk, a health professional may have to consider betraying confidentiality for the wider public interest, for example, in combating contagious diseases. More frequently, however, elevating the interests of the state over those of the patient leads to violations of that patient's human rights. As noted above, in Chile, as well as in other South American countries, physicians participated in torture under orders from the military; in South Africa, as well as in many other countries, prison health professionals routinely failed to record or report torture and abuse of political detainees.

Numerous international codes and declarations address (directly and indirectly) the responsibilities and obligations of prison health professionals. The fact that such health professionals still find themselves facing apparently irresolvable ethical dilemmas, or even acting unethically, indicates the complexity of these situations, for which existing codes may be inadequate or incomplete. This set of guidelines intends to reinforce the principles already stated in existing codes and declarations, while

specifically addressing the dual loyalty concerns experienced by health professionals working in prisons and other closed institutions.

The Dual Loyalty Working Group has thus attempted to address the almost inevitable ethical conflict that will confront prison health professionals, by developing guidelines that build on and add to existing codes, and by suggesting ways in which institutional support mechanisms can be strengthened.

## **Scope and context**

The following guidelines apply to health professionals who are responsible for providing health care services to persons in custody, whatever their legal situation — whether they are awaiting trial or already sentenced, detainees being held without charge or in any other form of custody. The rules apply wherever the health professional is called upon to provide medical treatment or any other form of medical expertise, whether that be in a prison itself, a police station, a holding cell, a health care facility or any other place where people are held in custody.

## **Guidelines**

In addition to being required to adhere to the principles outlined in relevant World Medical Association, World Health Organization, United Nations, and other guidelines, health professionals who are responsible for providing health care services to those in custody should follow the following guidelines.

### **1. The health professional should act in the best interests of his or her patient at all times.**

**Commentary:** While this precept may seem to conflict with others, it is the basis for medical ethics outlined in such documents as the World Medical Association's Declaration of Geneva and International Code of Medical Ethics, as well as other declarations such as the Malta Declaration on Hunger Strikes. It must continue to be the primary goal of health professionals caring for prisoners, even in situations of dual loyalty. Acting in the best interests of patients does not necessarily preclude taking steps to prevent harms to, or violations of the rights of other parties, where the health professional has information that could prevent such harms. However, the Guideline does imply that actions that are not in the interest of the patient should be considered only within a framework of exceptions described in [General Guideline 7](#).

### **2. The health professional is responsible for ensuring physical and mental health care (preventive and promotive) and treatment, including specialized care when necessary; ensuring follow-up care; and facilitating continuity of care— both inside and outside of the actual custodial setting— of convicted prisoners, prisoners awaiting trial, and detainees who are held without charge/trial.**

**Commentary:** Health professionals face an ethical conflict when they are called upon to limit or deny care to prisoners, as well as when they are called upon to engage in or passively accept practices that harm the physical and mental health of the patient. This guideline makes clear the responsibility of the health professional to provide care, regardless of outside pressures, and to advocate for the health interests of the patient. This guideline goes beyond Principle 1 laid out in the UN Principles of Medical Ethics Relevant to the Role of Health Personnel in the Protection

of Prisoners, which states that health personnel have a duty to “provide [prisoners] with protection of their physical and mental health and treatment of disease of the same quality and standard...afforded to those who are not imprisoned or detained.” It is recognized that not all health professionals will be able to ensure follow-up and continuity of care outside the custodial setting, but to the extent they can, they should.

**3. The health professional must be ensured, and must insist on, unhindered access to all those in custody.**

**Commentary:** Health professionals may unknowingly deny care to prisoners when custodial officials deny them access to prisoners, often to manipulate which prisoners get care. This practice may be undertaken for a variety of reasons, including corruption, harassment or enforced discrimination. This guideline makes clear the health professional’s responsibility to ensure his or her duties are not neglected or impeded because of the actions of prison officials.

**4. The health professional should examine a detained or imprisoned person as soon as possible after incarceration, and thereafter should provide medical care and treatment to such persons whenever necessary, and consistent with the principle of informed consent for such treatment.**

**Commentary:** This guideline, building on [Guideline 3](#), ensures that health professionals are able to provide care to all prisoners within the custodial setting, especially ones who may have experienced abuse. This guideline reinforces Principle 24 of the UN Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment. Furthermore, even though incarcerated, prisoners do not lose their right as patients to be consulted on any treatments they receive consistent with the principle of informed consent.

**5. The health professional must regularly inspect and report on sanitary, living and general health conditions to the custodial authority and an independent medical authority; and should, when necessary, advocate for better custodial conditions with custodial authorities and/or an independent medical authority.**

**Commentary:** Health professionals in prison settings face an ethical conflict when their duty is to protect the health of the prisoners, yet the material and/or psychological living conditions of those prisoners, whether through lack of resources or deliberate neglect on the part of prison authorities, make that impossible. In such cases, health professionals can uphold the best interests of their patients by reporting on sanitary and living conditions. This guideline is more specific than those of other medical codes, which do not address the responsibility of health professionals to monitor living conditions in prisons.

**6. The health professional should report to the custodial authorities and, where appropriate, to an independent medical authority any situation in which he or she becomes aware of allegations or evidence that those in custody are being subjected to torture or cruel, inhuman or degrading treatment. The health professional must, however, weigh this action against any reprisal or further punishment to the prisoner that may result. When**

**appropriate, the health professional should gain the consent of the prisoner before making such a report.**

**Commentary:** This guideline builds on current principles barring complicity in torture outlined in the UN Principles of Medical Ethics and the WMA's Declaration of Tokyo, but goes further by calling on health professionals to report the abuses they may witness. When there is potential for reprisal, however, health professionals must take care to report only to those who will not misuse the information. Bearing in mind [Guideline 1](#), they should take into account the need to protect the safety of the patient. This guideline requires that there be strong institutional mechanisms to support the health professional who blows the whistle, including an independent medical authority and a supportive national medical association.

**7. The health professional should certify only that which he or she has personally verified; should not falsify evidence and should ensure that complete and accurate medical records are kept for all patients.**

**Commentary:** Health professionals are often called upon by the state, or another powerful third party, to omit, falsify, or disguise crucial information in medical records. The WMA International Code of Medical Ethics holds that health professionals should certify only what they have personally verified, but it and others do not address the specific problem of omitting or falsifying information for the benefit of a party that does not have the best interest of the patient in mind. This guideline goes further than existing codes in addressing this omission brought on by dual obligations. The guideline requires strong institutional mechanisms to support the health professional who maintains complete and accurate records as well as to support his or her patients.

**8. The health professional should abstain from participating, actively or passively, in any form of torture.**

**Commentary:** This guideline is basic to medical ethics and is supported by international human rights covenants, as well as by the WMA Declaration of Tokyo and by the UN International Code of Medical Ethics. A health professional passively participates by permitting his or her clinical findings or treatment to be used by authorities to aid the process of torture.

**9. The health professional should not provide any means or knowledge to facilitate the practice of torture or cruel, inhuman, or degrading treatment or punishment; should not authorize, approve, or participate in punishment of any form, in any way, including being present when such procedures are being used or threatened.**

**Commentary:** Health professionals, while they may not participate directly in torture or punishment, may be called upon to participate indirectly, by providing instruments to facilitate torture, by using medical knowledge to monitor torture, or by authorizing punishment. This indirect participation includes examinations to declare an individual "fit" for caning, shackles, solitary confinement or any other type of abuse, and dietary restrictions. It also includes being present while the punishment is being administered, for example, observing caning, or examining a patient in solitary confinement to declare him or her "fit" for continuation of the punishment. This guideline does not prevent a health professional from providing

necessary medical care to an individual in solitary confinement; nor does it prevent a health professional from intervening to seek removal of a prisoner from solitary confinement on medical grounds.

**10. The health professional should not participate in capital punishment in any way, or during any step of the process. This includes an examination immediately prior to execution and one conducted after the execution has been carried out.**

**Commentary:** Health professional participation in capital punishment continues to occur, despite the World Medical Association's resolution prohibiting physician participation and the many codes that prohibit physician involvement in other cruel, inhuman, and degrading treatment. Health professionals are called upon to participate in a range of activities – from preparing intravenous lines for lethal injection to certifying the death of executed prisoners. This guideline goes beyond existing codes to hold that health professionals should not participate in any part of the process, including the certification of death. We are aware, however, that in some countries, prisoners facing execution may prefer to have death certified by a health professional to ensure, for example, that organs for donation are not removed prior to death or that the individual is not buried alive. In these situations, the health professional should obtain explicit informed consent from the prisoner who is to be executed, stipulating that he or she wishes that health professional to certify death. Strong institutional mechanisms are needed to support health professionals in these positions, as many countries' laws require that health professionals do participate.

**11. The health professional should respect medical confidentiality; should insist on being able to perform medical duties in the privacy of the consultation, with no custodial staff within earshot; should divulge information strictly on a need-to-know basis, when it is imperative to protect the health of others.**

**Commentary:** Confidentiality is a cornerstone of medical ethics and is upheld in the WMA's Declaration of Geneva, among other codes. Yet health professionals are often called upon to divulge patients' confidential medical information to authorities, or may perform examinations with authorities present, constraining the extent to which a patient can speak openly with the healthcare provider. When the health of other prisoners is at stake, however, the health professional has an obligation to balance their needs with the confidentiality due the patient, for instance, in circumstances of contagious disease or prisoner-to-prisoner abuse. When confidentiality in such circumstances is breached, care should be taken not to disclose any information beyond that which is needed for the asserted purpose. Such balancing of cases should be openly discussed with peer supervisors from medical authorities/bodies outside of the custodial setting in order to guard against abuses.

**12. The health professional should have the unquestionable right to make independent clinical and ethical judgements without untoward outside interference.**

**Commentary:** Health professionals in prison settings are often called upon to subordinate their sound medical judgment in order to support conclusions or outcomes favorable to the state. This includes situations of falsifying or omitting information, but it also includes recommending treatment or action that is not in the

best interest of the patient, for example, allowing an ill patient to be transferred when the transfer will lead to further harm, or not hospitalizing an ill patient because authorities believe he is a security threat. Existing codes call for complete clinical independence. This guideline reinforces those codes and further requires that health professionals actively insist on and be granted this right. There may, however, be situations where legitimate restrictions are put on the health professional's independent judgment. For instance, a physician may be asked to prescribe medication from an essential drug list, with medicines not on the list requiring particular motivation. In such instances, the physician may legitimately accept the restriction, if it is indeed for the greater benefit of the larger community— as long as that restriction does not bring harm or untoward consequences to the patient.

**13. The health professional should not perform any medical duties on shackled or blindfolded patients, inside or outside the custodial setting. The only exception should be in circumstances where, in the health professional's judgment, some form of restraint is necessary for the safety of the individual, the health professional and/or others, and treatment cannot be delayed until a time when the individual no longer poses a danger. In such circumstances, the health professional may allow the minimum restraint necessary to ensure safety.**

**Commentary:** Health professionals in prisons are often expected to ignore or passively accept the physical restraints imposed on their patients. Many codes outline the duty of health professionals not to participate in any form of restraint except when medically determined to be necessary for the health of the patient and others (UN Principles of Medical Ethics, UN Minimum Rules for the Treatment of Prisoners, UN Principles for the Protection of Persons with Mental Illness). This Guideline goes beyond the others by permitting only a narrow exception, that health professionals should not treat a patient in restraints unless an urgent situation requires immediate action that cannot be performed safely without restraints — and even then with the minimum possible restraints.

**14. The health professional should not perform medical duties or engage in medical interventions for security purposes.**

**Commentary:** Health professionals should never engage in medical interventions that are not in the individual's therapeutic interests, even when requested to do so by authorities for security purposes. Principle 3 of the UN Principles of Medical Ethics states that the purpose of the professional relationship must be "solely to evaluate, protect or improve ... physical and mental health [of prisoners and detainees]." For individuals in psychiatric hospitals, the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care state that medication "shall only be used for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others."[224](#)

**15. The health professional should not participate in police acts like body searches or the imposition of physical restraints unless there is a specific medical indication for doing so or, in the case of body searches, unless the individual in custody specifically requests that the health professional participate. In such cases, the health professional will ascertain that informed consent has been freely given, and will ensure that the prisoner**

**understands that the health professional's role becomes one of medical examiner rather than that of clinical health professional.**

**Commentary:** This guideline follows from [Guideline 14](#). The World Medical Association's Statement on Body Searches holds that health professionals should participate in body cavity searches as they have the medical knowledge and skills to ensure that the prisoner is not harmed. The BMA and others, however, assert that such participation makes the doctor a wielder of force, which contravenes basic medical ethics. The British Medical Association holds that only if the doctor can ascertain true informed consent should he or she perform the search. This guideline goes beyond the WMA Statement and the BMA policy to say that the prisoner must request the participation of the health professional. Any breach of confidentiality will concern only the search and no other confidential medical information that the prisoner may confide to the health professional.

**16. The health professional should, if prepared to treat a hunger striker, respect the rights and freedom of choice of a detained hunger striker regarding medical intervention and intravenous feeding without the intervention of a third party whose primary interest may not be the patient's welfare.**

**Commentary:** Health professionals treating detained hunger strikers are challenged to uphold the sanctity of life while respecting the rights and choices of their patients. The WMA Declaration of Malta addresses this issue far more thoroughly than it is within the scope of this document to do. For the purpose of guidance in cases involving dual loyalty, where authorities may pressure health professionals to force feed hunger strikers, the health professional must not submit to the wishes of a third party whose primary interest may not be the patient's welfare.

**17. The health professional should not engage or participate in any form of human experimentation amongst prisoners, unless the research will provide significant health and other benefits for prisoners and facilitate promotion of their human rights.**

**Commentary:** The Working Group is aware that this is a controversial issue and that some existing guidelines do allow for research on prisoners, provided that voluntary informed consent is given. It is the view of the Working Group that true "voluntary informed consent" is almost impossible to obtain in the prison setting, because of the various overt and covert factors which govern the relationship between prisoner, prison staff and health professional. There may however, be some particular circumstances when research with prisoners may provide significant health and other benefits and facilitate promotion of their human rights. The Group acknowledges, moreover, that research issues are not strictly part of its mandate; it would thus welcome further discussion with and guidance from those directly involved in the ethics of research.

## **B) Guidelines on Health Care for Refugees and Immigrants**

### **Preamble**

States often explicitly discriminate against refugees and immigrants. As countries

seek to restrict the entry of refugees, they also limit state welfare services, including health care. Even in countries with strong traditions of state services, refugees are often denied equal access to health care. State policies restricting entry to the country and restricting access to care can bring about severe dual conflicts for health professionals.

Ethical codes of the UN and the WMA focus on the health of vulnerable groups such as torture victims, prisoners, the mentally ill, the mentally retarded, the handicapped and women. However they contain no provisions on refugees. Some human rights treaties address rights of refugees to health services. Article 24 of the UN Convention on the Rights of the Child states that every child has a right “to the highest degree of health and to access to health care” and calls on all states to assure that no child is prevented from access to health care institutions. Article 22 clarifies that refugee children have the same rights.

The European Convention on Social Rights recognizes, in Article 11, everybody’s right on protection of health, and calls on states to remove the causes of health hazards, to create health counseling and education facilities and to prevent epidemic diseases. The attachment to the Convention (item 2) holds that refugees must be treated as favorably as possible and in no case less favorable than defined in the preceding articles of the Convention.

For the health professional, guidelines are needed in two circumstances: in the evaluation of claims for asylum and in state restrictions on access to health care.

## **Scope and context**

The following guidelines apply to health professionals who are responsible for providing health care services to refugees or immigrants and for evaluating claims for asylum. In the latter case, reference should also be made to the [Guidelines for Forensic Evaluations](#).

## **Guidelines**

### **1. The health professional should recognize that refugees and immigrants have a human right to equal access to health care.**

**Commentary:** The health professional should be guided by two fundamental human rights principles, that everyone has the right to the highest attainable standard of health and that health services should be made available on a non-discriminatory basis. When state policies limit access to health care, either through legal requirements or limitations on reimbursement for services, the individual health professional should not acquiesce.

It is unreasonable, however, to place the full responsibility for equal health care of refugees on individual health professionals facing legal or financial impediments to equal care however. Most often collective action will be required. For example, the British Medical Association’s guidelines for refugee health care demand that doctors offering an extended range of services to this group of patients get additional payments. Medical organizations can also organize voluntary medical services for this group.

## **2. Health professionals should not report immigrants who lack legal status to government authorities.**

**Commentary:** The state has the responsibility for immigration matters and law enforcement. It is not part of the health professional's function to participate in law enforcement activities, and the health professional should resist where a breach of confidentiality amounts to a violation of human rights that could result in incarceration, prosecution, deportation or all three.<sup>225</sup> In immigration and refugee matters, where there exists no likelihood of harm to a third party in the absence of disclosure, the principle of confidentiality and of making health services available to people in need should take precedence over the state's interest in using health professionals to assist in enforcement of immigration laws. Health professionals must therefore decline to report undocumented immigrant to state authorities. It may be particularly difficult for health professionals working in state institutions or on a government payroll to resist pressures to report. Strong institutional mechanisms must be in place to support them.

## **3. Health professionals should not disclose information gained in the course of treatment of refugees to state authorities.**

**Commentary:** Doctors may face pressure from immigration authorities to disclose information about patients for planning, administrative, law enforcement and other purposes. Disclosing confidential information in these circumstances, however, can have potentially severe human rights consequences for the patient. By contrast, assuring refugees and immigrants that confidentiality will be respected will also aid the therapeutic mission, since it can gain trust from refugees and immigrants who may be very anxious and reluctant to give information on their health background and may be fearful of examination. Fears that information disclosed to a health professional may reach authorities should be addressed directly.

Where the health professional is engaging in examination for state authorities for purposes other than treatment, the health professional must clearly disclose the purpose of the examination and the limits on confidentiality to the person being examined.<sup>226</sup> Proper counseling should be given to the patients regarding the uses of the information obtained by state immigration authorities.

## **4. Health professionals should not participate in medical examinations on behalf of the state for the purpose of determining a refugee's eligibility for entry into the country except in cases where public health and preventive measures are needed to counter the risk of epidemic. Screening or testing is only permitted with prior informed consent. In case of repatriation the results of medical assessments and necessary treatment programs should be provided to the refugee.**

**Commentary:** In some countries immigration authorities rely on medical techniques such as X-ray or dental screening to seek to determine the age of the refugee or immigrant. They may also engage in examinations purporting to engage in "fitness to travel" when forced repatriation is likely. These examinations are often superficial and misused and rarely include an assessment of the overall health of a refugee e.g. a psychotrauma caused by war atrocities or other kinds of violence. This high potential for serious abuse should lead health professionals to avoid participation.

**5. Health professionals should insist that medical services for refugees and immigrants, and examinations for determination of status include interpreters.**

**Commentary:** Health care services usually do not provide interpreters. They rely upon relatives or friends (often children) for translation. This practice violates medical confidentiality and the principle of neutrality. The enormous stakes for the individual in cases of examinations also supports the need for interpreters.

**6. Health professionals acting as evaluators in asylum procedures and court procedures should be aware of potential dual loyalty conflicts if providing treatment to refugees as well.**

**Commentary:** Although this separation of function would provide the greatest protection of the human rights of refugees, in practice it is rare, either because there are few health professionals with specialized knowledge in transcultural medicine, refugee health and refugee trauma, or because the state does not take adequate steps to avoid role conflicts. Health professionals should urge that the separation of function be instituted.

## **C) Guidelines for Health Professionals in the Workplace**

### **Preamble**

Health professionals frequently provide a range of services at the workplace to employed persons. Such services may include direct clinical care such as periodic health examinations, curative and rehabilitative care, preventive education, and health promotion interventions directed at high-risk individuals. In addition, health professionals at the workplace are frequently called on to provide services where the primary motivation is neither therapeutic nor clinical, but evaluative. These may further a legitimate administrative or institutional purpose. For example, medical personnel are frequently called upon to provide medical reports in support of compensation claims, to evaluate a candidate's fitness for a particular job, or to provide expert opinion on the sickness record of a particular employee in the context of a perceived absenteeism problem. At other times, health professionals have the responsibility of conducting measurements of potential hazards to workers' health as part of industrial hygiene programs.<sup>227</sup>

In such circumstances, the health professional is subject to expectations from a third party, usually an employer. At the same time, the health professional has ethical obligations towards his or her patient. As a result, he or she is faced with the problem of dual or divided loyalty.

Dual loyalty conflicts at the workplace may be exacerbated by potential conflict generated by adversarial employer-employee relations.<sup>228</sup> Usually such conflicts arise out of a contractual relationship between the health care provider and the company, which is also the employer of the worker-patient. Conflicts also arise vis-à-vis non-business employers, however, for instance, workers' trade union, or the government safety department, which may seek confidential information for purposes of addressing a perceived health hazard at a workplace.

The presence of a dual loyalty conflict at the workplace does not inevitably result in violation of workers' rights. It can, however, if inadequately managed. Health professionals may, for instance, subordinate independent therapeutic judgment in order to promote an objective of the employer, thus placing workers at further risk of injury. The Dual Loyalty Working Group has attempted to address such ethical conflicts by drawing on recognized human rights standards in developing guidelines which build on and add to existing ethical codes.

## Scope and Context

These Guidelines apply to health professionals responsible for providing occupational health services to employed persons. Occupational health service provision is taken to cover the full range of preventive, promotive, curative and rehabilitative services for persons at the workplace, and includes both direct health care and occupational hygiene services. These Guidelines are a particular application of the [Guidelines for Forensic Health Professionals](#) and apply to clinical care as well as to health professionals' non-clinical obligations, such as monitoring workers to meet statutory requirements.

## Guidelines

Health professionals responsible for providing occupational health services should adhere to the following guidelines, in addition to the principles outlined in relevant national and international professional ethical codes.

### **1. Health professionals should exercise independent judgment<sup>229</sup> in their clinical management and non-clinical assessment of the worker/patient.**

**Commentary:** This is a particular application of [General Guideline 4](#). Generally, independent judgment requires the health professionals to act in the best interests of patients at all times and ensure that occupational health service provision remains focused on the promotion of the health of the workforce, regardless of the role (therapeutic or non-therapeutic) he or she is asked to play. Cost may be regarded as a legitimate consideration if the occupational health service is seeking to identify the most cost-effective way to attain a health objective. However, it is not ethically acceptable to subordinate independent judgment to cost considerations nor to trade off a health objective as too costly to achieve based upon a company's concerns solely to minimize costs or maximize profits.

Third party requests for clinical judgments that benefit their interests are, in the occupational setting, common but misguided. Requests to limit sickness absenteeism, or favor a particular conclusion in a medical assessment should not influence the clinical judgment of the health professional. Occupational health professionals should not be party to the misuse of a clinical examination as a means to dismiss workers.

Where requests from third parties pose irreconcilable ethical and human rights conflicts, the occupational health professional should consider withdrawing his or her services, as long as this does not disadvantage the patient unreasonably. Occupational health professionals should avoid any judgments, advice, or activities that may endanger trust in their integrity and impartiality. Treating all workers in a non-discriminatory manner, basing judgments on scientific knowledge and technical competence, and respecting diversity and equity at the workplace will help to

establish a relationship of trust and confidence in the health professional among all stakeholders.

**2. Even when acting in a non-therapeutic role in relation to the patient, such as that of independent evaluator, a health professional cannot ignore the ethical obligations to the individual patient, to which he or she would be subject in a typical clinical encounter.**[230](#)

**Commentary:** Even when acting in a non-therapeutic role, such as assessing employees for purposes of fitness for work, disability, or compensation, the health professional must conduct the assessment in a manner that complies with ethical and human rights norms.

Importantly, the health professional should inform the patient before the assessment that he or she is acting in a non-therapeutic role and should make sure the patient understands the implications of this role. This gives the worker-patient the opportunity to take responsibility for choosing another health care provider or refusing the examination.

If the employee consents to the examination, the health professional should conduct the examination with respect for the patient's dignity and autonomy, using his or her independent judgment and knowledge of the workplace to reach a considered assessment of the worker's fitness. The findings of the examination and tests and the contents of the report should be discussed with the worker prior to submitting the report, which, again, should only contain details relevant to the purpose of the examination.

Of note is that in assessing employees with recurrent absence due to illness, the role of the health professional is to provide advice to both the employer and the employee. Other than providing advisory information, however, the health professional should not be involved in absenteeism control, which is the job of management.[231](#)

**3. Health professionals should maintain confidentiality of medical information, and not disclose clinical information not directly germane to the purpose of evaluation.**[232](#)

**Commentary:** No medical information about a worker should be revealed to a third party, including employers, without the express consent of the worker concerned unless the following apply. 1) Revealing such information is clearly in the interests of the worker concerned; 2) The information required is germane to the specific determination of the worker's fitness for the job, and is consonant with the precise requirements of the job; 3) Release is required by overwhelming public health considerations and is mandated by law.

Confidential medical information obtained in the course of periodic or pre-placement examination should not be revealed to an employer except to the extent it is relevant to the worker's fitness to do the job and any limitation of function. Thus, for example, medical tests should only be permitted as part of a fitness examination if they are relevant to the requirements of the job. On the other hand, the health professional should reveal anonymous group data from biological monitoring, as part

of his or her responsibility to bring any workplace risks to the attention of management.[233](#)

**4. Health professionals must release information regarding workplace hazards to affected workers or the appropriate authorities, where definable harm – either existing or threatened – to the worker-patient, other workers, or third parties outweighs the right of the company and of the patient to privacy.**

**Commentary:** As in normal practice, health professionals are obligated to share the results of medical testing and examinations with the worker-patient, and to counsel the patient on the implications of such findings. Health professionals may come under pressure to omit certain information from reports that have statutory or financial implications for the employer, so as to protect the company from legal or financial liability. Under no circumstances, however, should such considerations induce the health professional to alter his or her judgment in determining the best course of action with regard to hazard or risk communication for the worker-patient or worker-patients.[234](#)

[General Guideline 12](#) requires that health professionals report violations of human rights that interfere with their ability to comply with their duty of loyalty to patients to appropriate authorities. Where wider knowledge about the existence of hazards or of occupational disease or disability in a workplace may help to reduce health risks to workers, the health professional has a responsibility to act upon such information to the best of his or her capacity.[235](#) The health professional's action should be aimed at ensuring that communication of the data prompts removal or control of such hazards. The first step is to inform workplace management, stressing the need for timely remedial action. If attempts to address the hazard through routine management channels fail, the health professional should 'blow the whistle' on the existence of such hazards to an appropriate body (professional, employer, governmental, trade union, or other) that can take action to remedy the hazard. These considerations also apply where a health professional is aware of hazards posed to families of workers or to neighboring communities as a result of workplace processes.

Companies often invoke commercial secrecy to prevent disclosure of information about hazardous workplace conditions. This appeal is unjustified, however. The specific hazard posing a health risk rarely reveals proprietary agents or processes. Even where it might do so, considerations relating to the prevention of disease and disability should take precedence over commercial secrecy. As mentioned above, in such a circumstance, the occupational health professional should urge the company to release the information. If this fails, he or she should "blow the whistle" and consider resorting to court action to secure legal protection. Occupational health professionals should, as a preventive measure, make sure that health considerations override secrecy clauses in their employment contracts.

Occasionally, an occupational health professional may identify information relating to the fitness of a worker that places fellow workers or third parties at risk of harm or injury. In such circumstances, the health professional is justified in breaking confidentiality, but only after he or she has counseled the patient carefully and sought the patient's informed consent, and such counseling does not itself compel voluntary disclosure.

**5. Health professionals should ensure that any audit or regulatory monitoring undertaken to ascertain risks to workers, their families, or the neighboring community, is undertaken with the highest standard of scientific integrity.**

**Commentary:** The inspection or monitoring of workplaces for potential hazards (such as dust or chemicals), whether by outside agencies or by in-house professionals, is critically important to detect the presence of conditions that may threaten the health of workers, their families, or the neighboring community. It is well recognized that advance knowledge of such inspections often prompts management to clean up the workplace in advance of the inspections.

Health professionals should avoid participating in actions designed to create a false impression of safe conditions at the workplace, and should draw any such action to the attention of inspecting authorities. If possible, the health professional should prevent selective monitoring from taking place, rather seeking to ensure that representative monitoring provides a true picture of the extent of any workplace hazards. Similarly, where possible, the health professional should maintain medical and environmental monitoring records intact, accessible for statutorily mandated inspection.

**6. Health professionals should support other occupational health professionals facing conflicts arising from dual loyalty conflicts.**

**Commentary:** Occupational health professionals have collegial obligations to fellow professionals facing pressure to compromise ethical standards. Not only is this obligation part of one's professional identity, but it is also necessary to strengthen the ability of the profession collectively to establish ethical and human rights norms and standards that protect others. Experience has shown that such support from peers is among the most powerful counters to pressures on occupational health professionals to abandon ethical principles. See [General Guideline 15](#) and [Institutional Mechanisms](#).

**7. Health professionals should identify and declare any conflicts of interests before helping disseminate research findings or formulate policy for the control of occupational health hazards.**

**Commentary:** Occupational health professionals should seek to disseminate existing health and safety knowledge, support research to identify and control new hazards, and publish such findings.<sup>236</sup> Additionally, they should participate in policy formulation for the promotion of workers' health and the control of occupational hazards, through serving on expert committees, regulatory reviews, and other policy structures. In doing so, however, they should be explicit about the existence of any conflict of interests, for instance, financial, that may burden independence.<sup>237</sup> Declaration of existing or potential conflicts of interests establishes transparency in research dissemination and policy formulation.

**D) Guidelines for Health Professionals Engaged in Forensic Evaluations**

## Preamble

The job of a forensic health professional is to document, obtain, preserve or interpret evidence. Forensic health professionals are often called upon to engage in evaluations for courts or administrative bodies. In criminal cases, forensic health professionals<sup>238</sup> may be asked to evaluate whether a person is criminally responsible for his or her conduct, whether a person is competent to stand trial, and even whether an element of an offense has been established, e.g., intoxication. Forensic health professionals may also examine victims of crimes, e.g., rape or assault victims, for the purpose of gathering evidence. In civil cases, they may engage in evaluations in divorce, child custody, disability benefits, workers' compensation and other cases.<sup>239</sup> In applications for political asylum, health professionals may be asked to establish medical evidence of torture. Health professionals engaged in treatment may also be called upon to provide evidence about a person to a court or other adjudicative body. For instance, a physician may be asked to provide information about a person's medical condition in connection with an application for social benefits.<sup>240</sup>

All these functions are designed to assist the state in gathering and presenting evidence to decision-making bodies, rather than to assist or treat the person subject to evaluation. As a health professional, however, the evaluator retains a duty to respect the human rights of the person being evaluated and to adhere to ethical standards of the profession, including the duty to inform the person about the nature and objectives of the examination.

There exists an inevitable tension between a health professional's role as forensic evaluator contributing to the development of evidence in a legal proceeding and his or her role as a health professional with a duty of loyalty to the individual<sup>241</sup>. This tension is magnified when loyalty to the state or a third party contradicts medical ethics and implicates the human rights of the person being evaluated, e.g., medical evaluations for corporal punishment. The health professional cannot resolve this tension by claiming that the evaluative role frees him or her from ethical duties to the individual being evaluated.<sup>242</sup> Rather, the tension must be resolved by performing the evaluative role consistent with the human rights of the individual.

Human rights standards have been established regarding the health professional's role in torture and participation in the death penalty.<sup>243</sup> More general standards for forensic evaluations, however, are needed.

## Scope and Context

The following guidelines apply to health professionals engaged in forensic evaluations on behalf of the state or other third party. They apply wherever the forensic professional is called upon to evaluate – whether in a criminal setting or a civil setting. Additional, more particularized guidelines have been drafted for evaluations of refugees and asylum seekers as well as evaluations in the workplace. These guidelines do not apply to forensic evaluators retained by the person, for example, for his or her criminal defense.

## Guidelines

**1. The judgment of the forensic medical evaluator must be completely independent of influence by the state or other third parties.**

**Commentary:** The single most serious threat to the human rights of individuals being evaluated comes from forensic medical evaluators who fashion medical judgment to serve state or powerful third-party interests. Although the function of the medical evaluator may result in findings that are not in the interests of the individual (e.g., to support a criminal conviction or to support the denial of benefits), the medical evaluator must never distort documentation or tailor findings to achieve outcomes desired by state or private actors on whose behalf the professional is making the evaluation, no matter how worthy the evaluator believes these outcomes to be. These distortions can occur by making findings or interpretations that are not supported by the facts, or by refraining from making or failing to disclose fully findings that are warranted by the facts.

Although this guideline appears self-evident, there are many examples of medical evaluators permitting their allegiance to a state or state policies to distort their findings, either by making determinations favorable to the state or, more commonly, by failing to make or disclose findings. In doing so, medical evaluators become complicit in the violation of the human rights of the person being evaluated. For example, German doctors examining Bosnian refugees, seeking to support a government interest in excluding the refugees from the country, failed to include evidence of Post-Traumatic Stress Disorder in their reports despite ample evidence of its existence.<sup>244</sup> In Turkey, health professionals failed to record evidence of torture or abuse in detention.<sup>245</sup> In South Africa, medical cover-ups were very clearly documented in the "Gluckman files."<sup>246</sup>

**2. The medical evaluator should disclose to the person being evaluated the purpose of the evaluation, the fact (where applicable) that the examination is not confidential with respect to the entity seeking the evaluation, and the findings. In the event the evaluatee is mentally incompetent to understand the purposes and findings, disclosure should be made to the person authorized to act on the evaluatee's behalf. Individuals being evaluated should also be informed of any oversight mechanisms that exist.**

**Commentary:** Any individual examined by a health professional has legitimate reason to expect that the information will be used for the benefit of that individual, not for some other purpose, and will be held in confidence. It is therefore incumbent upon the health professional engaged in a forensic evaluation to explain when these assumptions, valid in other circumstances, do not apply.

Disclosure of the purpose of the examination and the findings is required by the human right to due process of law. It is also the responsibility of the institution to give a hard copy of the forensic evaluation to the individual being evaluated, his personal doctor outside the institution and/or another individual (family member) chosen by the subject.

**3. In any report, the medical evaluator should explain the reasons for his or her conclusions and indicate where the evidence is insufficient to support certainty concerning these conclusions. The medical evaluator should indicate or make note of alternative interpretations of his or her findings.**

**Commentary:** In many cases, the findings of the evaluator lend themselves to alternative explanations. In other cases, the findings are themselves equivocal. Medical evaluators working for prosecutors or other state agents are often under

pressure to provide an interpretation of findings that is most favorable to the state. The forensic health professional should resist these pressures and instead provide his or her best judgment about the proper interpretation of findings, including the limitations of the findings. This can often be accomplished by providing alternative explanations of the findings in the report that the health professional believes are supportable.

**4. Forensic evaluators cannot ignore the obligation to treat a person in distress and must take steps either to offer treatment or to refer the person to another clinician for therapy when the person's condition requires.**

**Commentary:** This guideline is consistent with the principle that a health professional does not forego the therapeutic role and concomitant obligations simply because the professional's skills are used in a particular instance for evaluation. The health professional should offer emergency treatment when qualified to do so and in all cases make an appropriate referral for medical care when the person's condition warrants.

**5. A forensic evaluator should not include clinical information about the person being evaluated that is not germane to the purpose of the evaluation.**

**Commentary:** The forensic evaluator may ascertain that the information he or she obtains from the history, physical and additional examination of the evaluatee includes matters that are irrelevant for the party on whose behalf he or she performs the forensic evaluation. This clinical information is within the boundaries of professional confidentiality.

**6. The forensic medical evaluator must not engage, directly or indirectly, in practices that aid or support torture or cruel or inhuman treatment or punishment.[247](#)**

**Commentary:** Health professionals should absolutely not participate in evaluations whose purpose or effect is to facilitate torture or cruel or inhuman treatment. Such participation extends not only to engaging in acts that themselves amount to torture or cruel or inhuman treatment, but also to evaluations that can help the torturer determine the individual's "suitability" for torture, ability to withstand torture, or medical condition as a session of torture continues. A health professional can, of course, provide medical attention to a victim of torture where treatment does not amount to a de facto involvement in an interrogation to allow continued torture.

**7. The forensic health professional should not participate in evaluations incident to legally sanctioned executions and corporal punishment.**

**Commentary:** International norms against medical participation in legally-sanctioned executions are well-established.[248](#) Evaluations used for executions include competency for execution and certification of death. With respect to corporal punishment, the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment excludes pain or suffering arising from lawful sanctions from the definition of torture, but the Declaration of Tokyo prohibits physician participation even if the person is guilty of an offense. Accordingly, health professionals should not participate in assessments of medical condition before

corporal punishment or in monitoring medical condition during the course of and after punishment.

Existing guidelines prohibit indirect as well as direct participation, since furthering the infliction of pain without therapeutic purpose and the taking of life<sup>249</sup> violate a health professional's duty. For example, a forensic medical professional may be asked to assess a person's "suitability" or competence or tolerance for torture, isolation, or aversive treatment, without actually participating in the event. But the assessment is a crucial dimension of the process and thus is prohibited.

**8. The forensic health professional who, while acting in an evaluative role, witnesses (the sequelae of) torture and cruel, inhuman and degrading treatment or punishment, should proactively report these cases.**

**Commentary:** Forensic reports are commonly produced upon request of certain parties, for example, the prosecution. Forensic medicine is in this respect a reactive or responsive discipline. However, the health professional may witness torture or other abuses, which should be reported even when there is no request for forensic reporting. Examples are child abuse, domestic violence, torture, and police abuse.

## **E) Guidelines for Military Health Professionals**

### **Preamble**

Health professionals working in institutions that serve state interests, where human rights are easily at risk, are most likely to be confronted with dual loyalty conflicts. Among these, military health professionals face unique conflicts. They must navigate their way between very different and sometimes antagonistic or even irreconcilable goals: on the one hand, to preserve life, attend to the sick, and reduce suffering (the obligation of the health professional), and on the other, to support killing and inflicting harm on the enemy (the obligation of the military officer or soldier).

As long as the interests of the patient and the military organization are in line with each other, dual loyalty conflicts can be avoided. As one military physician put it: "What's good for the patient is good for the military, and you want a fit, happy troop." But even in peacetime the two objectives may conflict. The military health professional is a member of civil society's health professions subject to ethical and human rights standards and goals. As such, the military health professional attends to the soldier who is sick, wounded, or in need of other medical attention and who, like any other patient, seeks the expertise, counseling, and support of his doctor or nurse in privacy and confidentiality. Indeed, this medical function is protected by international humanitarian law, which forbids warring parties from interfering or obstructing efforts by medical personnel to care for the sick and wounded, regardless of affiliation.

From the military's point of view, however, even treatment goals can be subordinated or reinterpreted to reinforce military objectives. For example, usual principles of triage demand that in medical emergencies health professionals attend to the most seriously injured first. But in battle the commander may compel the physician to attend first to soldiers with less severe wounds as a means to return them to battle quickly and maximize force strength; meanwhile the most seriously injured suffer or may die. Similarly, treatment of sick or traumatized soldiers in both

physical and mental health may differ from standard civilian protocols in order to serve military purposes, for example, preparing the soldier as soon as possible for new battle engagements rather than seeking the best long term outcome for the patient. Soldiers are often not entitled to exercise informed consent regarding medication and vaccines. Indeed, even interventions to promote the health and well being of soldiers are designed to further the fitness of troops for battle or other military tasks.

In more extreme circumstances, the ethical medical role can be even more severely compromised. A military health professional may be requested to declare troops fit for engagement even when they are not. The health professional may be called upon to participate or advise in interrogation of suspects of terrorism, insurgency, or espionage to an extent that may amount to torture or cruel and inhuman treatment, to prepare (and be present at) executions, or to administer pharmaceutical substances or vaccines to soldiers (own or enemy) without medical justification. He or she may be called on to participate in biological, chemical or pharmaceutical research and experimentation where civilian protocols, regulations and supervision are reduced or absent. When such research takes place in secrecy – often for legitimate reasons of national security – the military health professional may be required or asked to yield to security interests and forego medical ethical principles and professional codes of conduct.

These dual loyalty conflicts place the health professional in an untenable position. In some of the above examples the practitioner is put in a situation where the underlying conduct violates human rights. In other cases the health professional may be called upon to support a violation of the laws of war, such as supporting acts of violence against a civilian population. Further, during engagements and missions, military health professionals are likely to witness human rights violations on the battle field or in peace-enforcing actions. Yet their duty to report these violations may be inconsistent with the perceived needs of the combat unit.

A complex dual loyalty problem may arise in jurisdictions where military service is voluntary and members of the armed forces are generally held to have voluntarily waived some of their rights by choosing to join the armed services. As patients, they take some responsibility in advance for deciding the extent to which they are willing to “give up” their rights, including, for example, the right to doctor-patient confidentiality. However, this agreement does not mean all of a military patient’s rights are necessarily waived and health care providers should therefore not exceed what is “necessary” in any disclosure. Indeed, it is debatable whether the waiving of rights by conscripts could be reasonably accepted as voluntary.

Health professionals engaged in peacekeeping face other dual loyalty conflicts. In such operations, military health professionals confront the medical needs of civilian populations in the area of their assignment; yet they may be subject to rules and regulations preventing them from providing professional assistance to these civilians.

Military health professionals – being members of the troops and placed in the hierarchical chain of command<sup>250</sup> – thus face an extraordinary set of medical-ethical and human rights conflicts. The following Guidelines are meant to address these conflicts. The Guidelines follow the World Medical Association’s Regulations in Time of Armed Conflict in insisting that the health professional in the military is bound by the same standards of practice as civilian health professionals.

## Scope and Context

The following Guidelines apply to military doctors and other military health professionals, both in times of combat and in peacekeeping and peace-enforcing operations. These guidelines apply both to the individual health professional and to the military institutions and civil authorities and organizations related to the services of the military health professional.

## Guidelines

### **1. The military health professional's first and overruling identity and priority is that of a health professional.**

**Commentary:** Although this guideline appears self-evident, many military organizations teach physicians that they are officers or soldiers first and physicians second. As such, they are supposed to make their medical skills available exclusively for military purposes. In some countries, such as France, the military physician is trained in a separate military medical school, rather than trained as a military doctor after graduating from civilian medical school. Even where such training takes place, the primacy of the medical function should always be reinforced, even if there exist circumstances where the needs of the military prevail over the needs of the soldiers.

### **2. Civilian medical ethics apply to military health professionals as they do to civilian practitioners.**

**Commentary:** The starting point for the conduct of military health professionals should be the ethical and human rights standards of civilian professionals, with exceptions only for absolutely essential military purposes. These exceptions should be reviewed on a regular basis. Where deviations from normative ("regular") medical ethics are proposed, such deviations should be subject to careful review and oversight by a suitable structure such as a medical ethical commission with membership that includes an adequate number of civilian health professionals skilled in ethical issues.

Upholding medical ethics includes the obligation to obtain informed consent for treatment. The health professional should consider his or her relationship to the individual under treatment or evaluation as comparable to a civilian health professional-patient relationship rather than as part of a military hierarchy. In considering modes of treatment, a health professional should engage in the same kinds of dialogue with a patient about medical procedures as he or she would in civilian practice. Adherence to civilian informed consent practice does not imply that there will never be circumstances where consent is not required, but rather that the same standards should apply as in civilian health practice. For example, compulsory vaccinations should only be administered without consent in the military to the extent that such vaccinations can be administered in the absence of consent in civilian practice. Even though joining the armed forces may imply 'voluntary' waiving of some patient rights, this does not relieve the health professional of responsibility to apply general rules of obtaining informed consent.

### **3. The military health professional should adhere to the principle of confidentiality in a manner consistent with practice in civil society.**

**Commentary:** Many military organizations consider the health professional as part of the chain of command who must thus disclose information concerning patients to his or her commanding officer, whether that officer is a health professional or not. This blanket abrogation of the confidentiality principle is not always necessary to achieve military objectives, however. Information about a person's medical condition may be needed to make a determination for fitness to serve, but this function is no different from fitness to work determinations in the civilian employment context (except that soldiers are not permitted to withhold consent and leave the position). Military health professionals can provide their opinions and disclose their medical judgments about fitness for duty, extent of disability (and projected length of disability), or required restrictions in a soldier's scope of responsibilities without providing detailed medical information and without sharing the information with personnel not directly involved in the assignment decision. The information disclosed should be made known to the soldier.

Divulging confidential information simply on the basis of command interests should, as in civilian society, be regarded as unethical behavior. Exceptions to this general rule should be reviewed by a mechanism similar to that applicable in civilian life as described in [General Guidelines 7 and 8](#).

#### **4. The military health professional is a member of the national and international health professionals' community.**

**Commentary:** In many, if not most, countries the military medical community identifies itself with the military rather than with the larger medical community. This identification may be due in part to training and organization, but it is also psychological. Military health professionals sometimes feel that they are not an accepted part of the civilian medical society. In other circumstances they do not separate their role from that of the military generally. The supremacy and priority of the military health professional's identity as a professional can be promoted by this Guideline as well as by the membership of military health professionals in national and international associations.

#### **5. The military health professional should treat the sick and wounded according to the rules of medical needs and triage.**

**Commentary:** The Geneva Conventions require medical attention according to usual medical practice for persons outside of combat, whether civilians or wounded enemy soldiers. Thus, a guideline requiring adherence to the usual rules of triage should not be controversial. Because this principle is so often breached, it warrants repetition.

Existing international human rights and humanitarian law and international professional codes of conduct support the responsibility to follow the rules of triage. The military health professional should ensure on the basis of a pre-engagement agreement that he or she will be able to treat civilians of his or her "own side" and civilians and military (POW and otherwise) of the "enemy side" or those caught in between, with the understanding that medical need and triage be the exclusive criteria for selection. A similar guideline should apply in peacekeeping operations where emergency medical care is needed.[251](#)

Finally, the usual rules of triage should apply with respect to soldiers within a health professional's own unit. As indicated above, the military's goal in returning the

maximum number of wounded soldiers to battle as quickly as possible often results in different rules of triage than those applied in civilian life. In the military context, the least wounded may receive treatment first, while treatment for the most seriously wounded is delayed. The delay in treatment increases the risk of death to the more severely wounded. This practice should be considered unacceptable.

**6. Health professionals should not participate in research or development of chemical or biological weapons (CBW) that could be used for purposes of killing, disabling, torturing or in any way harming human life.**

**Commentary:** Military health professionals may be called upon to apply their specific expertise for offensive chemical and biological weapons research. Such projects to develop weapons of mass destruction against civilian populations are often shielded by formal or informal secrecy and immunity. Military health professionals have participated in horrific chemical and biological weapons experimentation<sup>252</sup> on human beings, hidden behind a wall of secrecy and immunity. This guideline prohibits such participation because it is fundamentally inconsistent with human rights.

Any research involving methods to protect human beings from the effects of CBW weapons, or with materials that could directly or indirectly contribute to CBW weapons, must be subject to systems of ethical review and scrutiny. Such systems of ethical review and scrutiny, even when conducted in secrecy due to national security concerns, should have built into them mechanisms for civilian participation in the oversight of research.

**7. The military health professional should refrain from direct, indirect and administrative forms of cooperation in torture and cruel, inhuman and degrading treatment and punishment at all times, including in wartime and during interrogation of prisoners.**

**Commentary.** The Guideline prohibiting civilian health professionals from participating in cruel and unusual treatment and punishment applies to military health professionals as well. Military health professionals have been called upon to assist in interrogation of prisoners and, in some cases, domestic dissidents. Despite their military status, however, these professionals are bound by existing prohibitions on medical participation in torture and cruel and inhuman treatment. Special attention should be given to practices such as certifying fitness of individuals to undergo intensive forms of interrogation, to be punished for non-cooperation, or to be subjected to medical and/or pharmaceutical 'treatment' after such interrogations or punishments.

**8. The military health professional should refrain from direct, indirect, preparatory and administrative participation in capital punishment, both within the military court martial system and elsewhere.**

**Commentary:** Many countries that have abandoned capital punishment for criminal offenses permit its use in military courts. In such cases the military health professional is likely to be involved when he or she is requested to declare the sentenced prisoner fit for execution. International codes prohibiting the participation of medical personnel in capital punishment and contain no exceptions for the military

setting. It is never justified for health professionals to participate, directly or indirectly, in capital punishment.

**9. Military health professionals should report violations of human rights that interfere with their ability to comply with their duty of loyalty to patients to appropriate authorities and report human rights violations perpetrated by their own troops as well as by others.**

**Commentary:** Military health professionals should maintain their independence and report human rights violations as civilian health professionals do (see [General Guideline 12](#)). The military health professional should especially take steps to report violations of the Geneva Conventions.

**10. The health professional should not engage or participate in any form of human experimentation among members of military services unless the research will provide significant health and other benefits for military personnel and facilitate promotion of their human rights.**

**Commentary:** It is the view of the Working Group that true “voluntary informed consent” is extremely difficult to obtain in the military setting, because of the various overt and covert factors which govern the relationship between military personnel, their chain of command and the health professional. There may however, be some particular circumstances when research with military personnel may provide significant health and other benefits and facilitate promotion of their human rights. The Working Group acknowledges, moreover, that research issues are not strictly part of its mandate; we would thus welcome further discussion with and guidance from those directly involved in the ethics of research.

# V. Institutional Mechanisms to Promote Human Rights in Health Practice

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  - Employment relationships
  - Administrative and legal arrangements to preserve professional independence
  - Peer review, professional credibility, support
  - Monitoring
  - Education and Training
  - Accountability
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- [Institutional Mechanisms by Stakeholders/Agents](#)
  - Roles for Professional Organizations: National
  - Roles for Professional Organizations: International
  - Roles for Statutory (licensing) Bodies
  - Roles for Civil Society
  - Roles for Government
  - Role of the United Nations and Related International and Regional Intergovernmental Bodies
  - Role of Training and Research Institutions

## Introduction

Developing and strengthening institutions to address the problem of dual loyalty at a systemic level is critical to promoting high standards of professional practice among health professionals and protecting patients' human rights. Institutional mechanisms may serve either to protect the practitioner from being placed in the conflict in the first place or to help the practitioner address it effectively once it arises. In many cases of dual loyalty conflicts, particularly in repressive societies, the absence of institutional mechanisms to support an ethical response leaves the individual health professional isolated and facing extremely difficult decisions, sometimes regarding loyalty to the patient and personal safety. In addition, the absence of institutional mechanisms to hold health professionals accountable for the human rights consequences of their actions or inaction encourages violations of human rights when conflicts arise.

Experience worldwide has confirmed that these two factors — health professional vulnerability and lack of oversight and support from professional organizations and administrative institutions — create a lethal combination that, under the circumstances of dual loyalty, may easily give rise to human rights violations on a wide scale. Thus, how key institutions both within and outside the health sector operate is central to the effective implementation of the Guidelines.

The term "Institutional Mechanisms" is used to capture the full spectrum of agencies, organizations, social and administrative structures and functions that work to achieve an agreed social objective. In relation to dual loyalty and health professionals, such institutional mechanisms include activities and policies of professional organizations

and disciplinary bodies, educational institutions, and stakeholder groups, regulation, consumer action, administrative and legal structures and procedures, and employment arrangements.

Some of these institutional mechanisms, such as education and training, are straightforward. Others require changing the manner in which health professionals relate to the state, such as in the structuring of employment relationships, and, as important, augmenting the role of health professional organizations in promoting human rights and preventing dual loyalty conflicts. This is critical because in many cases individual practitioners are not in a strong position to resolve conflicts on their own – and in some cases put themselves in serious jeopardy if they try. Under these circumstances, only collective action will enable individual health professionals to fulfill their human rights obligations towards their patients. Organizations of health professionals must therefore play an active role in speaking out against practices that compel individual practitioners to ally with the state against the human rights of their patients. They should also advocate for systemic changes that end or ameliorate discriminatory practices and structural violations of the right to the highest attainable standard of health. Such actions will help prevent health professionals from becoming instruments of human rights violations.

## **Objectives of the Institutional Mechanisms**

Institutional mechanisms to address the problem of dual loyalty have seven key functions:

- To structure the relationship of the health professional to the state in a manner that will protect the independence of the health professional from state demands or pressures, ameliorating both the sense of obligation to the state and the pressure to succumb to them.
- To support health professionals who seek to comply with their ethical and human rights obligations in the face of state demands to the contrary.
- To hold professionals accountable for violations of human rights where adherence to state interests prevail unjustly over their fidelity to the patient.
- To provide an avenue to challenge state practices or policies that impede or prevent a health professional from acting to protect the human rights of patients.
- To increase awareness among health professionals of the problem of dual loyalty and human rights through training and ongoing peer discussion.
- To bolster the role of health professional organizations in preventing human rights abuses that stem from dual loyalty.
- To minimize the secrecy that can mask dual loyalty conflicts.

Broadly speaking, the institutional mechanisms may be described both in terms of the agency or stakeholder responsible and in terms of the purpose of the mechanism. These are set out in the table below. Different agencies may play complementary roles in attaining the same objective and many of the mechanisms described below can therefore be construed as existing in a two-dimensional (or even multi-dimensional) matrix, in which an agency is represented on one axis while the activity is represented on the other axis (see Annex).

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## **Table 1. Institutional Mechanisms – Functions and Responsibilities**

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### **Functions**

- Monitoring violations
  - Speaking out against violations and advocacy
  - Lobbying
  - Problem solving, advisory service
  - Legal proscription of undesirable practices
  - Legal encouragement of best practices
  - Victim redress
  - Education and Training
  - Protection from reprisal
  - Holding professionals and their organizations accountable
- 

### **Agency and Stakeholders**

- Professional Association
    - National (local)
    - International
  - The State and its sub-divisions:
    - Health services
    - Military
    - Police and security services
    - Prison services
    - Judiciary:
      - Parliaments and legislative bodies
      - Multinational and Transnational governmental agencies
      - Patients and patients organized as consumer groups
      - Professional licensing and disciplinary bodies
      - Universities and Training institutions
      - Private corporations
  - Human Rights NGOs
    - National
    - International
- 

The following discussion details a range of institutional mechanisms applicable to settings and situations in which dual loyalty conflicts are likely to lead to human rights violations. This section describes generic mechanisms relevant to a range of settings, not only those “high-risk” settings singled out for detailed examination. These institutional mechanisms are presented in a way that maximizes the generalizability of the underlying strategy of the mechanism, first by approaching mechanisms by what they intend to achieve (by strategy) and second, by where the institutional responsibility lies (by stakeholder/agent).

## **Institutional Mechanisms by Strategy**

## **1. Employment relationships structured to avoid role conflicts and reduce interference with professional independence**

In a wide range of settings, the independence of the employed health professional from overt or implicit pressures by his or her employer must be assured. This is as true of the primary care practitioner in a prison as it is of the forensic specialist dealing with highly vulnerable populations such as those who are incarcerated or who belong to a group that is subjected to pervasive discrimination. Whether health professionals are employed by the state or by private companies, it is important that institutional lines of accountability facilitate compliance with ethical obligations and protect human rights. Agencies that employ or use services of health professionals should ensure:

**1.1.** That in settings with a high potential for human rights abuses, state agencies structure employment relationships such that health professionals do not report directly to superiors in agencies under whose authority the violation may take place. For example, forensic health professionals should report to management structures other than the police or prosecuting authorities and prison doctors should not report to prison administrators. Even where independent lines of accountability may not be completely feasible (e.g., in the military), health professionals should report to other health professionals rather than to administrators responsible for operations.

**1.2.** That health professionals do not receive their salaries from the department or agency for which their services are provided, but rather from an independent source, even if that source is another government department, for example, a health agency rather than a prison agency. Similarly, forensic health professionals conducting evaluations for the criminal justice system should not receive their salaries from the police or prosecutor's offices.

**1.3.** That employment agreements and job descriptions in settings posing high risks of human rights violations such as prison, police, the workplace serving vulnerable populations or the military have explicit clauses stressing the responsibility of the health professional to uphold patients' human rights and adhere to ethical and human rights standards. The clauses can be effective in dissuading state authorities from seeking the allegiance of health professionals to the state, and can institutionalize access to an independent ombudsman.<sup>253</sup> In the military setting, pre-engagement agreements should be an essential part of contracts and regular contract review. Pre-engagement agreements should cover issues such as monitoring and reporting human rights violations as well as triage and confidentiality.

**1.4.** That adherence to human rights standards is made part of job descriptions for health professionals. These standards should include non-discriminatory standards of care, including protector of women's health. Performance standards incorporating human rights should be established for health professionals and non-professionals and should reward behavior that creates positive role models for newer employees.

**1.5.** That employment agreements for health professionals explicitly recognize the ethical and human rights obligations of health professionals to report human rights violations, and subordinate any secrecy provisions (e.g., related to commercial or military secrecy) to the professional's ethical and human rights obligations where these may conflict with secrecy. In other words, contracts should neither gag nor

hold the threat of retaliation over health professionals where human rights are at stake. Rather, such contracts should actively encourage reporting of abuses. As noted in 1.3 above, pre-engagement agreements may serve this function in the military context.

**1.6.** That conditions of employment, such as restrictions on time spent with prisoner patients, do not compromise the capacity of the professional to exercise his or her independent judgment. Care should also be taken that a professional is not indirectly influenced by conditions of employment to “turn a blind eye” to human rights violations. At the least, conditions of service should be equal to that of colleagues in other settings.

**1.7.** That some method of rotation or alternative employment arrangement exists to address the threat of over-identification with an employer. Rotation may promote a greater sense of objectivity on the part of the professional and bring a non-institutional perspective to practice in closed environments, and thus limit identification with the state. Forensic specialists, for example, may benefit from dividing their professional time performing evaluations between working on behalf of the state and working on behalf of individuals. Similarly, wherever possible, health professionals should rotate periodically out of settings like detention facilities where they are likely to face pressures to subordinate patient human rights to state interests. In the workplace setting, where rotation is more difficult, alternative forms of employment, for example, professionals employed by different levels of government or by collective organizations of workers, may “balance” occupational health professionals employed solely by industry.

**1.8.** That agency leadership at the highest levels ensures that administrators of state institutions understand and defer to the ethical and human rights responsibilities of health professionals. Leaders should ensure that health professionals are recruited and selected for positions in high-risk settings without conditions that would compromise their independent clinical judgment in favor of state policies.

**1.9.** That education and awareness-raising is provided to policymakers, employers, health services users, the public, and health professionals regarding the relationship between empowerment relationships and human rights.

## **2. Administrative and legal arrangements to preserve professional independence**

Administrative and legal mechanisms to preserve professional independence include:

**2.1.** Administrative and legal systems that assure the availability of professionals whose judgment is not compromised by loyalty to the state. For example, states should put into place policies and procedures to permit individuals (or their families) who may have been a victim of a human rights violations at the hands of police, prisons or detention facilities to have access to an independent health professional to conduct examinations. Registers of specialists with necessary skills should be made publicly available.

**2.2.** Provisions for independence of professional associations and licensing bodies, guaranteed in these organizations' enabling legislation (where applicable), constitutions, composition, and reviewed through audit of their practices.

**2.3.** The issuance of ongoing guidance to health professionals from professional organizations on the problem of dual loyalty and human rights, including the identification of circumstances where subordination of patient interests to a social or state objective is acceptable to further legitimate public health, non-medical interests, or evaluative needs. This guidance can be issued both categorically and in specific cases. The guidance should be sufficiently detailed to enable a health professional to judge whether a particular behavior is acceptable.

**2.4.** An independent source of advice and support for health professionals, through peers and respected colleagues, in settings where a high risk of human rights violations exists.

**2.5.** The establishment of an independent "ombudsman" body to which violations and potential violations of human rights stemming from dual loyalty can be reported. The body may also act in an advisory role to practitioners, offering skills and resources through which problems and questions can be discussed (see also monitoring below under [Mechanism 4](#)).

**2.6.** Policies and charters (e.g. Patients' Bills of Rights, Public Service Charters, occupational health and safety policies) to create a framework where dual loyalty conflicts are recognized, prevented or resolved before they lead to human rights violations. Such frameworks should not only address rights of users and communities, but also address how best to solve human rights problems generated by dual loyalty conflicts. Policies can also make use of recognized private sector standards to ensure consonance with best human rights practice.

**2.7.** Establishment of accountability for violations of patients' human rights through mechanisms of professional discipline. In most countries, the existing licensing and disciplinary entities do not consider violations of the human rights of patients as a basis for discipline and do not have effective means to hold health professionals accountable for human rights violations. See [Mechanism 6](#).

**2.8.** Administrative procedures available to health professionals in the event they seek to protect themselves from pressures to act in ways that subordinate the human rights of the patient. The procedures must also guarantee freedom from reprisal if a health professional chooses to take advantage of them.

**2.9.** Whistle blowing provisions to protect health professionals from reprisals if they resist pressure to subordinate patient human rights to state interests or if they report violations. Whistle blowing protections are especially important where administrative procedures to protect professional independence do not exist or fail to function adequately. Whistle blowing legislation has been introduced in various countries with varying degrees of success<sup>254</sup> and should apply in all sectors including high-risk sectors such as the military and security environment.

### **3. Establishment of an ethos of peer review, professional credibility, support and inclusiveness in the profession that addresses the problem of dual loyalty**

Because many of the most egregious dual-loyalty-related violations of human rights are accompanied — indeed, facilitated — by isolation and lack of oversight, cultivating awareness, professional review, and cohesion among health professionals at risk should be at the center of restructuring professional relationships. A culture of support and peer review in the health professions, based on transparency and professional acceptance, can play a critical role in constraining the potential for abuse, and in supporting professionals at risk. Measures to foster such a culture include:

**3.1.** The development and adoption of practice standards that have wide acceptability in the profession, and that address the human rights of patients. Such standards should be uniformly applicable, without exception, to all settings where health professionals deal with patients, including settings at high risk for human rights violations (e.g., military, police, health clinics serving vulnerable populations). They should also address areas where professional obligations may conflict with state policy or cultural norms and reinforce understandings of human rights, such as, the right to reproductive health services for women, rights of immigrants and refugees. See also [2.3](#) regarding promulgation of guidance interpreting standards.

**3.2.** Establishment of appropriate professional structures for peer review such as case conferences, grand rounds, and journal club discussion among health professionals working in high-risk settings, and professional sub-groups for relevant disciplines, e.g. prison medicine, military medicine, and workplace and forensic services within existing professional associations. National professional associations should actively recruit members from high-risk settings, such as the military, to end the isolation that facilitates complicity in human rights violations.

**3.3.** Professional audits and/or quality assurance mechanisms that focus on compliance with obligations to uphold the human rights of patients.

**3.4.** The creation of newsletters and other media (e.g., web-based) aimed at professionals in particularly isolated settings (e.g., prisons, military).

**3.5.** Financial and other incentives for students and trainees to undergo training in high-risk settings such as prisons, military, workplace, and forensic health care.

**3.6.** Continuing education, clinical case conferences, and other mechanisms of ongoing training that support the practitioner's professional development in human rights, especially in high-risk settings.

**3.7.** Regular discussion of human rights issues at professional meetings.

**3.8.** Ongoing mentoring and peer support, especially from senior colleagues.

**3.9.** Support from professional organizations for health professionals threatened with or experiencing reprisals for respecting or defending human rights. Support in the form of public denunciation of the harassment and offers of professional, moral and,

where necessary, material support are critical. Having chapters, committees or other structures within professional associations dedicated to support for health professionals defending human rights encourages those in high-risk situations to defend ethical principles and human rights.

**3.10.** Membership of national associations in international professional bodies. By making membership contingent on the establishment of support, accountability and mentoring structures (as demonstrated in organizational constitutions), international bodies can encourage national professional organizations to set up those structures.

**3.11.** Removal of impediments, legal or otherwise, preventing health professionals in the military, police, or prison services from belonging to the same professional associations as civilian health professionals; indeed, such arrangements should be encouraged. Even in the military, where pressures to close ranks may be strong, structures should be put in place to make sure that health professionals in the security environment are fully engaged with colleagues in the civilian sphere, and that non-military health professionals participate in relevant professional structures, such as ethical bodies established to provide oversight of research and practice.

## **4. Monitoring**

Independent oversight and reporting structures must be established to monitor and respond to practices in the health sector that threaten human rights. These structures should support audit activities undertaken by health professionals and should enable professionals to make independent reports of potential or actual violations of the human rights of patients or other victims. These structures would also have the capacity to refer appropriate cases to professional disciplinary structures. These structures may or may not be linked to an independent ombudsman to whom violations can be reported without fear of reprisal and with whom problems and questions can be discussed.

Monitoring the complicity of health professionals in human rights abuses, moreover, should also be linked to monitoring the underlying human rights violations. Monitoring can take place at the local or national level (by national professional associations, statutory bodies, or human rights organizations) and may often be done as well by international bodies, including United Nations agencies, professional bodies, and human rights organizations. Such monitoring should aim to:

- Identify countries, locales or settings where violations of human rights within the health sector or in connection with health services are common.
- Provide an accessible means by which individuals subject or potentially subject to a human rights violation as a result of the actions of a health professional can receive advice and guidance how to proceed and can file complaints about conduct of health professionals that violates their human rights with appropriate agencies with protection from of reprisal.
- Monitor trends in relation to new legislation or policies, including health policies, so as to identify points of intervention to address the compromise of human rights by dual loyalty conflicts.
- Identify weaknesses in the organization or facilities which are supposed to help individual health practitioners to report violations and to recommend improvements.

*Mechanisms for monitors include:*

- 4.1.** A monitoring body empowered to gain access to all facilities, including closed institutions (psychiatric facilities, prisons, and military), including staff and records, to allow comprehensive and unbiased evaluations of adherence to human rights standards. Internal monitoring structures to promote quality assurance may be effective, but should not be used as a substitute for, or as an obstacle to, access to external monitoring. Justified concerns for security may impose certain restrictions on how publicly the information obtained can be divulged but should never be used to prevent scrutiny of ethical and human rights practices. Health personnel working in such settings should have no unreasonable obstacles placed in the way of submitting information to such monitoring bodies.
- 4.2.** Legislation to support the monitoring function. In establishing or recognizing a monitoring body, appropriate administrative, investigative and financial powers and duties should be established in law. While the exact placement of such a body as a statutory, quasi-governmental or non-governmental body remains a matter for local determinations the independence of the monitoring body must be established by law.
- 4.3.** A clearly articulated purpose for the monitoring and protocols establishing methods and procedures.
- 4.4.** Effective access to the monitoring process for patients or the public through an effective complaint procedure and access to assistance in filing complaints. Patients and the public should be informed about the availability of such a mechanism. They should be protected from reprisal for filing complaints.
- 4.5.** In monitoring by professional bodies, inclusion of non-professionals, including patients or consumers in setting priorities, criteria for evaluation, systems to monitor and monitoring activities.
- 4.6.** National professional association membership of international bodies contingent on demonstrated commitment to implementing monitoring for human rights violations arising from dual loyalty.
- 4.7.** Take into account international conventions and human rights agencies, such as UN Rapporteurs (including Special Rapporteur on the Right to the Highest Attainable Standard of Health) as well as information contained in shadow reporting<sup>255</sup> by NGO's, professional organizations and civil society bodies.
- 4.8.** Promoting and safeguarding prioritized provisions for the active participation of the organized profession (such as National Medical Associations ) and their members, and of specialized health and human rights organizations, in the preparation and production of alternative ("shadow") reports for the supervising committees of relevant UN treaties and conventions such as the Convention on Civil and Political Rights, Convention on Economic, Social and Cultural Rights, Convention on Rights of the Child, Convention on the Elimination of Racial Discrimination, Convention on the Elimination of Discrimination Against Women, as well as the networking and advocacy work that is related to the production of alternative reports.

## **5. Education and Training**

Lack of specific skills in ethical and human rights concerns contributes to the vulnerability of health professionals to pressures that will result in the violation of their patients' human rights. Education and training in human rights, including in identifying dual loyalty conflicts, should be integrated into professional training at all levels.

Educational content should address at least the following concerns:

- Understanding the human rights of patients, including the right to be free from discrimination and the right to the highest attainable standard of health, and implications for health practice.
- Education on ethical and human rights standards that inform the Guidelines, including distinguishing situations where serving state interests is legitimate from those where it is not.
- Education on ethical and human rights reasoning.
- Identification of the elements of a dual loyalty conflict and how to address it.

*Mechanisms for education and training include:*

**5.1.** Specific focus in undergraduate and graduate health professional training in understanding ethics and human rights in the education of health professionals so that graduates have the competencies to deal with potentially rights-compromising situations. The objectives should include an understanding of human rights and ethics, the skills to identify a dual loyalty conflict, and the problem-solving skills to identify an appropriate resolution of the conflict, either independently or by consulting peers or other resources.

**5.2.** Incorporation of respect for human rights as part of mandatory ethics training for health professionals. This should include exposure to areas of human rights concern such as prison health care, immigrant and refugee health, practice in the workplace, women's health, mental health, and the military and forensic examinations. It should also address obligations to communities of patients. In addition to the identification of the human rights concerns in these areas, the training should aim to engender positive experiences among students about the challenges in these areas as a means to counter the low prestige these practice areas may be held in the eyes of peers

**5.3.** Requirements for continuing professional development or education to include ethical and human rights knowledge and competencies across all practice sectors, and be used to upgrade specific clinical skills needed for particular settings.

**5.4.** Investment in postgraduate training in key competencies at national or local levels to ensure that there are sufficient skilled professionals available in settings where the risks of human rights violations are greatest and where communities are in greatest need. In many countries, forensic skills should be a priority. Where professionals are working in at-risk settings, particular attention should be paid to ethics, human rights, humanitarian law, and dual loyalty conflicts (including these guidelines).

**5.5.** National and international conferences and workshops that focus on settings at high risk of human rights violations, such as prisons, refugee health care, immigrant and refugee health, the workplace, the military and forensic evaluations.

**5.6.** Educational activities directed at professional staff other than health professionals whose conduct can have important impacts on patient human rights (e.g. custodial staff in total institutions; non-health personnel in the military; state administrators, private employers, trade unions). Employers of health professionals should be educated on the ethical and human rights responsibilities of health professionals.

**5.7.** Accreditation of training of health professionals by national ministries, professional councils that includes requirements for knowledge in ethics and human rights, particularly as they affect the problem of dual loyalty, as a core competency. In setting standards for health professional training curricula, these core competencies should be reflected in curricula content and outcomes criteria.

**5.8.** Training in efficient and professional monitoring and reporting procedures, such as the preparation and production of alternative (“shadow”) reports for the supervising committees of relevant UN treaties and conventions, as well as the networking and advocacy work that is related to the production of alternative reports.

**5.9.** National professional organizations develop programs to address these recommendations.

**5.10.** International professional bodies encourage training and education by supporting activities consistent with these mechanisms undertaken by national members and by putting pressure on those national members who fail to engage in them.

## **6. Accountability**

Although many of these institutional mechanisms seek to provide incentives and support for health professionals in protecting the human rights of their patients in the face of conflicting demands by the state or employer, it is necessary to complement such mechanisms with effective means of holding health professionals accountable for violations of human rights. To do so will require a commitment to end the long record of inadequate disciplinary procedures and standards within the health professions and neglect of human rights violations as a basis for discipline. It will also require a commitment to apply ethical and human rights standards to health professionals in all settings equally. Steps include:

**6.1.** Professional codes that establish violations of the human rights of patients as a subject for discipline. The codes should be supported as appropriate in national practice by legislation.

**6.2.** Disciplinary and licensing bodies institute measures to ensure the independence of professionals in health practice.

**6.3.** Disciplinary and, where appropriate, professional organizations have effective systems in place to discipline members for ethical and human rights transgressions.

**6.4.** Standards for discipline are consistently applied to health professionals in all settings equally, including the military.

**6.5.** Victims of a human rights abuse arising from a dual loyalty conflict have appropriate access to, and support in, complaint mechanisms in a disciplinary process.

## **7. Collective action by the professions**

Ethical conflicts are typically conceptualized as matters for the individual health practitioner to resolve. But in many cases dual loyalty human rights conflicts arise in an environment of state demands or threats on the practitioner to comply. These may be accompanied by legal barriers to professional independence or circumstances where structural arrangements or institutionalized human rights violations preclude the individual practitioner from avoiding the conflict or changing the practice environment. For this reason, mechanisms of collective action are needed. They include:

**7.1.** Support for individual health professionals who are subjected to reprisals, threats, or demands by the state for subordinating patient human rights to state interests, through every means possible, including speaking out publicly.

**7.2.** Advocacy to change laws and regulations that prevent or impede health professionals from meeting their human rights obligations to patients.

**7.3.** Proactive steps to prevent health professionals from being placed in positions where they will be at risk of participating in a violation of a patient's human rights.

**7.4.** Advocacy to end state policies and practices that prevent health professionals from providing health care to some or all patients in need, including communities of patients, consistent with professional standards of care. These practices include, among others, a state's failure to take adequate steps needed toward the attainment of the highest standard of health for all, inequity in allocation of health resources or benefits, and discrimination (or tolerance of discrimination) against women, refugees and immigrants and ethnic, racial or religious groups or on the basis of disease or disability.

**7.5.** Advocacy for policies to promote, protect and fulfill human rights that avoid dual loyalty conflicts, such as Patient Rights Charters, workplace occupational health policies and Public Service standards.

## **Institutional Mechanisms by Stakeholders/Agents**

Different stakeholders and agents may share responsibility for many of the above strategies, while others may be highly specific to particular constituencies. Institutional mechanisms are detailed below particular to each category of stakeholder/agent identified in the analysis.

### **1. Roles for Professional Organizations: National**

**1.1.** Establish professional practice standards that address the problem of dual loyalty and human rights for across a wide spectrum of practice settings and situations. These may include adoption of international standards on human rights

and professional practice. These practice standards can also help identify situations for health professionals where furthering state interests is legitimate and does not violate a patient's human rights. By clarifying the relationships between human rights and state interests, standard-setting bodies can promote compliance where loyalty to the patient is essential. Such standards should be promoted so as to ensure widest professional acceptance and adoption by state and other agencies and by health professionals themselves. Associations should provide ongoing attention to standards and practices through a high-level committee.

**1.2.** Where violations of professional standards take place, hold members accountable to these standards through appropriate disciplinary action. This will require that professional organizations have effective systems in place to discipline or, where appropriate, expel members for ethical and human rights transgressions. To do so will require a commitment to end the long record of inadequate disciplinary procedures and standards within the health professions and neglect of human rights violations as a basis for discipline. It will also require a commitment to apply ethical and human rights standards to health professionals in all settings.

**1.3.** Facilitate adoption of self-audits by health services to complement application of standards. Special audits can be commissioned in various settings.

**1.4.** Make available advisers and counselors skilled in human rights and ethics to health professionals practicing in circumstances where problems of dual loyalty and human rights arise.

**1.5.** Provide direct support for health professionals in high-risk situations, for example establishing sectoral groups of professionals (e.g. prison health care, occupational health, military medicine) under the auspices of the professional association to discuss dual loyalty problems that arise and how to address them. Moral, material, and professional support should be provided to colleagues placed at risk by the state for upholding human rights. Support should always include advocating on behalf of a colleague who is placed in career or legal jeopardy on account of upholding the human rights of patients. This support may include establishing the capacity to come to the aid of health professionals under threat for protecting human rights in other countries (e.g. a committee of the association specifically dedicated to collegial support around victimization for human rights).

**1.6.** Establish or facilitate an independent oversight and reporting structure to play a monitoring and/or ombudsman role. Ombudsman services should aim to provide clear advice to health professionals at risk.

**1.7.** Issue newsletters and create web sites to raise awareness in the professions and the public, and conduct ongoing debate on dual loyalty problems in a range of vehicles, such as journals and professional meetings. Hosting of conferences and workshops on ethical and human rights issues inherent in high-risk areas may also be used for this purpose.

**1.8.** Initiate and support ongoing ethical and human rights training that addresses the problem of dual loyalty and human rights and support other groups doing such work.

**1.9.** Ensure that constitutions of national professional organizations establish the organization as independent of the state and of state policy and that the organization can exercise this independence in voicing concerns or criticisms of state policies that infringe medical ethics and human rights.

**1.10.** Submit shadow reports on national reports to United Nations treaty monitoring bodies for human rights treaties such as the Convention Against Torture and the Covenants on Civil and Political Rights and Economic, Social and Cultural Rights on issues concerning dual loyalty and human rights.

**1.11.** Advocate for legal, administrative, and social changes that will enable health professionals to respect, protect and fulfill the human rights of their patients. This includes advocacy to bring an end to practices where state agents demand or threaten the practitioner to subordinate patient human rights to state interests; where there exist legal barriers to professional independence; where structural arrangements or institutionalized human rights violations preclude the individual practitioner from avoiding the conflict or changing the practice environment; and where discrimination or structural inequity preclude health professionals from providing equal care to patients or communities. Associations should advocate to develop, implement and monitor policies that prevent human rights violations resulting from dual loyalty conflicts in the health sector. Associations should establish formal components and have adequate staffing to engage in human rights advocacy.

**1.12.** To implement many of the above mechanisms, national associations may have to develop plans and invest resources to increase members' support for these organizational actions.

## **2. Roles for Professional Organizations: International**

**2.1.** Develop standards and guidelines on the problem of dual loyalty and human rights, to be disseminated internationally and applied at country level. The organization should incorporate such standards within or coordinate them with other existing policy guidelines and ongoing working groups or committees to oversee further development of standards and guidelines to address current concerns.

**2.2.** Support national professional associations or other health professional or human rights groups and bodies that are threatened or experience reprisals as a result of speaking out in favor of human rights.

**2.3.** Support individual professionals at risk of reprisal for their actions in promoting human rights through international publicity and other mechanisms such as support to local professional organizations supporting the victim.

**2.4.** Facilitate and encourage international monitoring, through UN Rapporteurs, including the Special Rapporteur on the Right to the Highest Attainable Standard of Health, and international human rights organizations, of high-risk environments.

**2.5.** Establish or expand sectoral interest groups of professionals (e.g. prison health care) under the auspices of the international body in order to develop standards for wider application and to facilitate support, networking and monitoring.

**2.6.** Monitor national professional associations to ensure that they remain independent of the state in structure, as shown in their constitutions; in actions, as shown by their compliance with international humanitarian law and international professional declarations; and by their activities, as shown in their response to dual loyalty human rights conflicts. International professional organizations need to have their own systems of certification and sanctions in place to put pressure on member associations.

**2.7.** Urge policies and practices that promote the protection of human rights, including the right the highest attainable standard of health and facilitate development of such policies at international, regional, national and local levels as appropriate.

**2.8.** Host conferences and workshops on ethical and human rights issues inherent in high-risk areas.

### **3. Roles for statutory (licensing) bodies**

Licensing bodies have enormous power over the health professions and on the institutions in society that use them. The licensing bodies can establish standards and requirements, discipline offenders, and demand respect by other entities for their professional independence. Mechanisms include:

**3.1.** Where educational standard setting is part of a statutory function, set standards for undergraduate and postgraduate training in the health professions that ensures competency in basic skills in and sensitivity to ethical and human rights aspects of practice. If graduates will be expected to perform forensic evaluations, ensure that training provides the necessary technical and conceptual skills required.

**3.2.** Maintain a register of health professionals with specific expertise (e.g. forensic) who are available for independent evaluations where human rights violations at stake.

**3.3.** Establish mechanisms for providing guidance to practitioners in high-risk settings.

**3.4.** Establish or facilitate an independent oversight and reporting structure to play a monitoring and/or ombudsman role.

**3.5.** Apply ethics and human rights standards to health professionals in all settings equally, including the military. Where indicated, hold members accountable to these standards through appropriate disciplinary action. Systems must be in place to discipline professionals for ethical and human rights transgressions and to allow victims of abuse to have appropriate access to and support in the complaint process.

**3.6.** Extend continuing professional education requirements to all settings and establish special programs for professionals working in high-risk settings.

**3.7.** Consider requiring that knowledge of human rights obligations be a condition of practice in high-risk settings.

**3.8.** Review and make recommendations for the structuring of employment relationships in high-risk settings.

## **4. Roles for civil society**

Civil society organizations can promote professional independence and the protection of patients' human rights. They can:

**4.1.** Establish or facilitate an independent oversight and reporting structure to play a monitoring and/or ombudsman role for individuals who are subjected to human rights violations by health professionals. Use such information to lobby, publicize, prompt independent investigations, and seek redress.

**4.2.** Protest any failures by national professional associations and international professional associations to prevent violations or to fail to take action in the face of violations.

**4.3.** Encourage participation of community, trade union and consumer groups in developing policies and standards to protect human rights by all relevant entities. Raise awareness among health service users and the public about their rights in situations of dual loyalty and what the role of health professionals should be.

**4.4.** Write shadow reports on national reports to United Nations treaty bodies monitoring human rights conventions.

**4.5.** Promote the independence of health professionals from the state. Organize skilled professionals to conduct independent examinations in settings where human rights are at stake. Assert the rights of patients or families to a reasonable degree of choice of health professional. Advocate for systems that enable forensic evaluators to divide their time between service to the state and service to individuals and family members so as to improve their sensitivity to human rights.

**4.6.** Advocate for health and human rights and for appropriate policies to protect human rights in the health sector, such as Patient Rights' Charters or Bills of Rights and workplace health and safety policies. Civil society organizations should also press for performance standards for service providers to specifically include human rights standards and encourage self-regulation mechanisms in the private sector (such as employer codes of practice) to include attention to human rights standards.

**4.7.** Support health professionals who face reprisals for defending human rights.

**4.8.** Facilitate training of non-professional staff in the health sector to ensure respect for ethical and human rights standards. This should include training of employers of health professionals, both state agencies and private companies, as well as employer associations, on the ethical and human rights responsibilities of health professionals.

## **5. Roles for government (other than statutory bodies)**

Government can also show leadership in embracing and promulgating policies that reinforce the importance of human rights protection in health care environments. Government ministries also play a key role in establishing mechanisms to protect

health professionals from the role conflicts that often lead to complicity in human rights violations. Government action is especially important in structuring employment and reporting relationships in high-risk settings. Government policy is also central to ending discrimination and inequity in health. Mechanisms include:

**5.1.** Legislation and administrative regulations and practice that commit the state to respect, protect and fulfill human rights. This includes explicit policies on equal access to health care, recognition of women's right to reproductive health services, the protection of immigrants and refugees, non-discrimination, and the right to the highest attainable standard of health. They should require health professionals to respect, protect and fulfill the human rights of their patients, in whatever setting they practice, including closed institutions. These provisions should outlaw contracts that gag or subjugate ethical and human rights responsibilities to other concerns in all settings, including the military. An entity within government Ministries of Health should be responsible for overseeing these standards.

**5.2.** Legislation and administrative regulations and practice that prohibit state employers from compelling or influencing health professionals to violate human rights. Contracts with all health professionals employed by the state should recognize the primacy of their ethical and human rights obligations. In the military setting, pre-engagement agreements are best included as an essential part of contracts and regular contract review. Pre-engagement agreements cover issues such as monitoring and reporting human rights violations and treatment of non-military casualties and sick.

**5.3.** Legislation and administrative regulations and practice that explicitly permit and, where possible, encourage, all state health professionals (including those in the military and police) to belong to and participating in civilian associations of health professionals. At the very least, legislation should outlaw rules or practices that prevent health professionals employed by the state or private bodies from joining their own professional bodies.

**5.4.** Legislation and administrative regulations and practice to structure employment and conditions of service for health professionals in high-risk settings in a manner most likely to protect human rights. Provisions should allow for lines of professional accountability to professionals and for independent reporting to professional or human rights oversight bodies, without fear of reprisal. Where health professionals provide a service to patients at risk due to their detention, a government department other than the one responsible for holding the patient should pay and oversee the work of health professionals. For example, health professionals in detention facilities should not be employed by the facility and forensic evaluators should not be paid by the police or prosecution authorities. Regulations should also not act as barriers to rotation of staff, nor to establishing alternative form of employment relationships in high-risk settings that facilitate adherence to human rights standards.

**5.5.** Legislation and administrative regulations and practice to protect health professionals who are employed by the state from serving victims of human rights abuses to protect whistleblowers from reprisal. These provisions should apply to all sectors, including the military.

**5.6.** Legislation and administrative regulations and practice to assure that state-employed or contracted health professionals are able to maintain professional

standards that protect human rights and have incentives to receive training when practicing in high-risk settings. Performance appraisals should routinely include reference to health professionals' record in meeting human rights standards in their practice and reward behavior that creates positive role models for newer employees. Responsible agencies should respect the obligation to maintain ethical and human rights standards in the recruitment and selection procedures for posts in settings where human rights may be under threat and should allow state-employed practitioners in high-risk settings to undertake work on behalf of victims of human rights violations and their families. Agencies should also encourage state-employed health professionals to belong to non-statutory professional associations.

**5.7.** Legislation and administrative regulations and practice to establish, empower, and fund a monitoring entity for human rights violations in health that includes access to closed institutions. Such entities should have adequate representation of civilian/ patient sectors.

**5.8.** Legislation and administrative regulations and practice that provide funding for independent medical assessments where human rights violations may have occurred. Such policies should also facilitate forensic examiners being able to conduct evaluations for individuals, so that their professional time is spent in service of both state and individuals (or families).

**5.9.** Legislation and administrative regulations and practice to encourage development, implementation and monitoring of policies to promote, protect and fulfill human rights that avoid dual loyalty conflicts, such as Patient Rights Charters or Bills of Rights, workplace occupational health policies and public service standards.

**5.10.** Legislation to ensure that human rights violations are not permitted in the private sector as a result of dual loyalty conflicts in health care. Such legislation may range from preventive measures such as regulating the structure of employment relationships to holding employers accountable for intentionally exploiting dual loyalty conflicts to the detriment of the rights of their employees.

## **6. Role of the United Nations and Related International and Regional Intergovernmental Bodies**

*Mechanisms include:*

**6.1.** Use of international monitoring bodies such UN Special Rapporteurs (including the Special Rapporteur on the Highest Attainable Standard of Health) and treaty body monitoring mechanisms to address the problem of dual loyalty and human rights.

**6.2.** Use of existing and future International Labour Organization Conventions to establish practice standards in workplace occupational health that protect human rights from potential dual loyalty conflicts.

**6.3** Draw on, and provide input on dual loyalty issues facing health professionals to guidance issued by the International Committee of the Red Cross, whose role is to develop and uphold humanitarian law in armed conflict.

## **7. Role of Training and Research Institutions**

There is a significant role for academic training and research institutions to establish standards, to identify circumstances where dual loyalty problems are acute, to provide initial and ongoing training, and to provide support for health professionals. Mechanisms include:

**7.1.** Establishment of support systems for health professionals in high-risk settings such as military, prisons, forensic evaluations, and workplace services, including involving them in academic activities, peer review, and the development of and provision of relevant postgraduate training opportunities.

**7.2.** Participate in structures established for human rights oversight and monitoring.

**7.3.** Undergraduate training of health professionals should include specific skills required to deal with potentially human rights-compromising situations of dual loyalty. Quantity and quality of training devoted to ethics and human rights should be auditable and examinable. Competencies should include the ability to identify a dual loyalty and human rights conflict and to develop an appropriate resolution of the conflict, either independently or by consulting peers or other resources, as well as specific technical skills to the competency level expected of undergraduates. For example, if medical graduates are expected to be able to perform post-mortem examinations, their training should equip them to do so adequately, and to be mindful of the human rights challenges. Post-graduate training should extend such competencies into relevant specialist fields, ensuring both ethical and human rights sensitivity, and technical skills such that there are sufficiently trained personnel with high level skills in high-risk settings. In addition to skills competencies, curricula should give strong attention to training methods aimed at attitudinal change and values, such as self-reflective techniques, peer discussions, and role modeling. Sufficient time should be allocated to providing students at all levels with exposure to services in high-risk settings.

**7.4.** Host conferences and workshops on ethical and human rights issues inherent in professional practice. Link such awareness-raising education to requirements for continuing professional education.

**7.5.** Collaborate with other agencies to develop training for non-professional staff working in the health sector to protect patients from human rights violations arising from actions by non-professionals. Provide education and training to employers of health professionals, including state agencies and private companies, and organizations of employers on the ethical and human rights responsibilities of health professionals.

**7.6.** Include attention to dual loyalty and human rights conflicts in research management through, for example, conflict of interest provisions in research contracts. Develop capacity to train researchers and others in monitoring and documentation skills in human rights.

**7.7.** Promote research to inform policies and legislation and to implement systems to prevent human rights violations arising from dual loyalty conflicts, including research to redress structural and systemic violations of the right to the highest attainable

standard of health. Conduct research to support the dissemination of best practices in the management of dual loyalty conflicts and human rights in high-risk settings.

[View Annexure - Matrix of Institutional Mechanisms by Agency/Stakeholder and by Function](#) *Note: The references in the Table refer to numbers contained in [Institutional Mechanisms by Strategy](#)*

## VI. Appendices

- [Appendix 1: Works Cited](#)
- [Appendix 2: Relevant Treaties, Professional Codes and Declarations](#)
  - General
  - Prisoners
  - Refugees
  - The Workplace
  - Forensic Evaluations
  - Military

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## **Appendix 2: Relevant Treaties, Professional Codes and Declarations**

### **I. General**

[Universal Declaration of Human Rights](#)

#### **A. International Human Rights Treaties**

[International Covenant on Economic, Social and Cultural Rights](#)

[International Covenant on Civil and Political Rights](#)

[Optional Protocol to the International Covenant on Civil and Political Rights](#)

[International Convention on the Elimination of All Forms of Racial Discrimination](#)

[International Convention on the Elimination of All Forms of Discrimination Against Women](#)

[Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment](#)

[Convention on the Prevention and Punishment of the Crime of Genocide](#)

[Convention on the Rights of the Child](#)

#### **B. United Nations Documents on Human Rights**

[Code of Conduct for Law Enforcement Officials](#)

[Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Execution](#)

[Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care](#)

[Principles on the Effective Documentation of Torture](#) (Istanbul Protocol)

Committee on Civil and Political Rights. General Comment 16. The right to respect of privacy, family, home and correspondence, and protection of honour and reputation

[Committee on Economic, Social and Cultural Rights. Twenty-Second Session. The](#)

[Right to the Highest Attainable Standard of Health: "General Comment 14," 2000](#)

[Committee on the Elimination of Discrimination against Women. Eleventh](#)

[Session. Violence against Women: "General Recommendation 19," 1992](#)

[Vienna Declaration and Programme of Action: World Conference on Human Rights. 1993](#)

#### **C. International Professional Organizations**

*1. World Medical Association*

[International Code of Medical Ethics](#) (Declaration of Geneva)

[Resolution on Human Rights](#)

[Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment](#)

(Declaration of Tokyo)

[Declaration Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading](#)

[Treatment](#) (Declaration of Hamburg)

[Hunger Strikers](#) (Declaration of Malta)

[Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-Wide](#) (Declaration of Tel-Aviv)

[Ethical Principles for Medical Research Involving Human Subjects](#) (Declaration of Helsinki)

[Statement on Family Planning and the Right of a Woman to Contraception](#)

[Statement on Condemnation of Female Genital Mutilation](#)

[Declaration on Professional Autonomy and Self-Regulation](#)

[Statement on Professional Responsibility for Standards of Medical Care](#)

[Statement on Human Organ and Tissue Donation and Transplantation](#)

[Declaration on the Rights of the Patient](#)

[Statement on Patient Advocacy and Confidentiality](#)

[Declaration on Physician Independence and Professional Freedom](#)

*2. International Council of Nurses*

[Nurses and Human Rights](#)

[Ethical Concepts Applied to Nursing](#)

[Elimination of Female Genital Mutilation](#)

*3. World Psychiatric Association*

[Declaration of Hawaii](#)

*4. International Federation of Gynecology and Obstetrics*

[The Role of the Ob/Gyn as Advocate for Women's Health](#)

[The Ethical Aspects of Sexual and Reproductive Rights](#)

[Ethical Framework for Gynecologic and Obstetric Care](#)

## **II. Prisoners**

### **A. United Nations Documents**

[Standard Minimum Rules for the Treatment of Prisoners](#)

[Basic Principles for the Treatment of Prisoners](#)

[Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment](#)

[Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment](#)

### **B. Geneva Conventions**

[Geneva Convention Relative to the Treatment of Prisoners of War](#)

## **C. International Professional Organizations**

### *1. World Medical Association*

[Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment](#)  
[Statement on Body Searches of Prisoners](#)  
[Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases](#)

### *2. International Council of Nurses*

[The Nurse's Role in the Care of Prisoners and Detainees](#)  
[Ethical Concepts Applied to Nursing](#)  
[Torture, Death Penalty and Participation by Nurses in Executions](#)  
[The Nurse's Role in the Care of Prisoners and Detainees](#)

### *3. International Council of Prison Medical Services*

[The Oath of Athens](#)

## **III. Refugees**

### **A. International Human Rights Treaties**

[Convention Relating to the Status of Refugees](#)

### **B. International Professional Organizations**

#### *1. World Medical Association*

[World Medical Association Resolution on Medical Care for Refugees](#) Adopted by the 50th World Medical Assembly, Ottawa, Canada, October 1998

## **IV. The Workplace**

### **A. International Human Rights Treaties and ILO documents**

[International Labour Organization. Convention 161](#): Convention concerning Occupational Health Services. 1985.

[Recommendation 97](#): Recommendation concerning the Protection of the Health of Workers in Places of Employment. 1953.

[Recommendation 112](#): Recommendation concerning Occupational Health Services in Places of Employment.

[Recommendations 143](#): Recommendation concerning Protection and Facilities to be Afforded to Workers' Representatives in the Undertaking. 1971.

[Recommendation 164](#): Recommendation concerning Occupational Safety and Health and the Working Environment. 1981.

### **B. International Professional Organizations**

#### *1. World Medical Association*

[World Medical Association Statement on Safety in the Workplace](#)

2. *International Commission on Occupational Health*  
[International Code of Ethics of Occupational Health Professionals](#), (ICOH)

## **V. Forensic Evaluations** (see also prisoners, refugees and workplace)

### **A. United Nations Documents**

[Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.](#)

[Code of Conduct for Law Enforcement Officials](#)

Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Execution.

[Principles of international co-operation in the detection, arrest, extradition and punishment of persons guilty of war crimes and crimes against humanity](#)

### **B. International Professional Organizations**

1. *World Medical Association*

[Resolution on Physician Participation in Capital Punishment](#)

2. *International Council of Nurses*

[Torture, Death Penalty and Participation by Nurses in Executions](#)

## **VI. Military**

### **A. United Nations Documents**

[Principles of International Co-Operation in the Detection, Arrest, Extradition and Punishment of Persons Guilty of War Crimes and Crimes Against Humanity](#)

### **B. Geneva Conventions**

[Common Article 3 of the Geneva Conventions](#)

[Fourth Geneva Convention](#)

[Protocol Additional to the Geneva Conventions of 12 August 1949](#), and relating to the Protection of Victims of International Armed Conflicts (Protocol I)

[Protocol Additional to the Geneva Conventions of 12 August 1949](#), and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II, 1977)

[Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field](#)

[Geneva Convention for the Amelioration of the Condition of Wounded, Sick, or Shipwrecked Members of the Armed Forces at Sea](#)

[Geneva Convention Relative to the Protection of Civilian Persons in Time of War](#)

### **C. International Professional Organizations**

1. *World Medical Association*

[Regulations in Time of Armed Conflict](#)

[Declaration on Chemical and Biological Warfare](#)

[World Medical Association Resolution on the Medical Workforce](#)

2. *International Council of Nurses*

[Armed Conflict: Nurse's Perspective](#)

[Geneva Convention Relative to the Protection of Civilian Persons in Time of War](#)

# Footnotes

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1. These refer to ethical codes promulgated by international and national bodies of health professionals such as the World Medical Association and intergovernmental organs like the United Nations.

2. WMA, *Declaration of Geneva*. This and other ethical codes adopted by international bodies applicable to health professions can be found in Amnesty International, *Ethical Codes and Declarations Relevant to the Health Professions*. See [Appendix 1](#) for full citations.

3. WMA, *International Code of Medical Ethics*.

4. For an overview of dual loyalty, see Bloche, "Clinical Loyalties and the Social Purposes of Medicine," *Journal of the American Medical Association*. 281 (3): 268-274. For a discussion of dual loyalty concerns in everyday practice, see British Medical Association, *Medical Ethics Today: Its Practice and Philosophy*. It should be noted that not every conflict or ethical dilemma presents a dual loyalty problem. Questions of transactions by health professionals with an entity in which they have a financial interest, for example, represent a direct conflict between the health professional and a patient rather than a problem of allegiance or submission by the health professional to an external agency or authority. In medical triage of ill and injured patients, health professionals may face conflicts between the medical needs of some patients at the expense of others; however, there is inherently no dual loyalty problem as the term is defined here since making these often difficult decisions means balancing the medical needs of patients rather than considering non-medical interests of a third party. Dual loyalty can arise in triage situations if, however, the decision is influenced by social objectives, such as gender or racial preferences. By contrast, where the reimbursement policies of a third party are such as to influence the health professional's judgment in ways that are detrimental to the patient's best interest, a dual loyalty conflict may be said to exist. This project concerns dual loyalty conflicts that have the potential to violate human rights.

5. Bloche, "Clinical Loyalties and the Social Purposes of Medicine," *Journal of the American Medical Association*. 281 (3): 268-274.

6. Some commentators have suggested that health professionals are at times unaware or even unconscious of the connections between clinical practices and the furtherance of social norms that may not be in the patient's interest. See Bloche, "Caretakers and Collaborators," *Cambridge Quarterly of Healthcare Ethics* 10 (3): 275-284.

7. BMA, *The Medical Profession and Human Rights: a Handbook for a Changing Agenda*, 478-502.

8. Henkin, *The Age of Rights*, 4.
9. United Nations, *Universal Declaration of Human Rights*, art. 1.
10. Not all states have ratified all human rights treaties, but so many states have agreed to them and the norms have become universal such that the state's obligations can be considered binding under customary international law. See Steiner and Alston, *International Human Rights Law in Context*.
11. United Nations, *Convention on the Elimination of All Forms of Racial Discrimination*, art. 2, sec. 1(d).
12. *Id.*, art. 5(e).
13. Human rights instruments, treaties and declarations are all available at the web site of the UN High Commissioner for Human Rights, [www.unhchr.ch](http://www.unhchr.ch). These covenants, moreover, are supplemented by regional instruments such as the *Interamerican Convention on Human Rights* and the *European Convention on Human Rights*. Also, see [Appendix 2](#).
14. Property and birth can be understood to encompass caste and class.
15. United Nations, *International Covenant on Civil and Political Rights*, art. 4.
16. United Nations, Committee on Economic, Social and Cultural Rights, *The Right to the Highest Attainable Standard of Health*, "General Comment 14."
17. *Id.*, para. 33. The Committee makes clear that Article 12 does not articulate a right to "be healthy," but rather demands action by states to provide the underlying conditions, health policies and services that enable individuals to obtain the highest attainable standard of health for themselves. See also Chapman and Russell, eds, *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*.
18. Rights related to the highest attainable standard of health are also reflected in other treaties, particularly the *UN Convention on the Rights of the Child* and the *UN Convention on the Elimination of all forms of Discrimination against Women*.
19. United Nations, Committee on Economic, Social and Cultural Rights, *The Right to the Highest Attainable Standard of Health*, "General Comment 14," para. 43.
20. Amartya Sen, *Development as Freedom*, p. 51.
21. See footnotes [1 to 3](#) above, for example.
22. Beauchamp and Childress, *Principles of Biomedical Ethics*.
23. Gillon, "Preface: Medical Ethics and the Four Principles," in *Principles of Health Care Ethics*, ed. Gillon and Lloyd, xxi.

- 24.** Mann, Gostin, et.al., "Health and Human Rights," *Health and Human Rights: An International Journal*. 1 (1): 7-23; Kass, "An Ethics Framework for Public Health," *American Journal of Public Health*. 91 (11): 1776-82; Roberts and Reich, "Ethical Analysis in Public Health," *Lancet*. 359 (9311): 1055-9; Beauchamp and Steinbock, *New Ethics for the Public's Health*; Kessel, "Public Health Ethics: Teaching Survey and Critical Review." *Social Science and Medicine*, in press.
- 25.** Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*; Evans et. al., "Comparative Efficiency of National Health Systems: Cross National Econometric Analysis," *British Medical Journal*. 323 (7308): 307-10; Evans et. al., "Measuring Quality: From the System to the Provider," *International Journal for Quality in Health Care*. 13 (6): 439-446.
- 26.** Fabienne and Evans, "Ethical Dimensions of Health Equity," in *Challenging Inequalities in Health. From Ethics to Action*, ed. Evans, Whitehead, Diderichsen, Bhuyia, and Wirth, 24-33.
- 27.** Roberts and Reich, "Ethical Analysis in Public Health," *Lancet*. 359 (9311): 1055-9; Mann, "Medicine and Public Health, Ethics and Human Rights," in *Health and Human Rights. A Reader*, ed. Mann, Gruskin, Grodin, and Annas, 439-452.
- 28.** Daniels, *Just Health Care*.
- 29.** Mann, "Medicine and Public Health, Ethics and Human Rights," in *Health and Human Rights. A Reader*, ed. Mann, Gruskin, Grodin, and Annas, 439-452.
- 30.** See the UN *Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment and Punishment* and the WMA *Declaration of Tokyo: Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*.
- 31.** For example, see Gillon, "Medical Ethics: Four Principles Plus Attention to Scope," *British Medical Journal*. 309 (6948): 184-8, and WHO "25 Questions and Answers on Health and Human Rights," 22.
- 32.** See for example, Ezekiel Emanuel, Amitai Etzioni, Martha Nussbaum, Margaret Walker.
- 33.** There are multiple schools and philosophical traditions that bioethicists draw upon. To cite a few examples: utilitarianism, contractarianism, communitarianism, virtue based and relationship ethics.
- 34.** Lowe, Kerridge, and Mitchell KR. "These Sorts of People Don't do Very Well: Race and Allocation of Health Care Resources," *Journal of Medical Ethics*. 21 (6): 356-60; Epstein, Ayanian, Keogh, Noonan, Armistead, Cleary, et al. "Racial Disparities in Access to Renal Transplantation – Clinically Appropriate or Due to Underuse or Overuse?" *New England Journal of Medicine*. 343 (21): 1537-1544; Schulman, Berlin, Harless, et. al., "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," *New England Journal of Medicine*. 340 (8): 618-626.

**35.** See, for example, Gruskin and Tarantola, "Health and Human Rights," in Oxford Textbook of Public Health, ed. Detels, McEwen, Beaglehole, Tanaka; Kawachi and Kennedy, *The Health of Nations: Why Inequality is Harmful to Your Health*.

**36.** Ngwena, "The Recognition of Access to Health Care as a Human Right in South Africa: Is it Enough?" *Health and Human Rights: An International Journal*. 5 (1): 26-44; Scott and Alston, "Adjudicating Constitutional Priorities in a Transnational Context: A Comment on the Soobramoney's Legacy and Grootboom's Promise," *South African Journal on Human Rights*. 16: 206-268.

**37.** Groote Schuur Hospital Notice #12/97, cited in the Health and Human Rights Project, *Final Submission to the Truth and Reconciliation Commission*.

**38.** Baldwin-Ragaven, de Gruchy, and London, *An Ambulance of the Wrong Colour*, 69.

**39.** Gruskin and Tarantola, "Health and Human Rights," in *Oxford Textbook of Public Health*, ed. Detels, McEwen, Beaglehole, Tanaka, citing the UNECOSOC 1985, list the conditions under which restrictions of rights could be considered as being 'necessary' and carried out in accordance with the law: the restriction is in the interest of a legitimate objective of general interest; the restriction is strictly necessary in a democratic society to achieve the objective; there are no less intrusive and restrictive means available to reach the same goal; and the restriction is not imposed arbitrarily, i.e., in an unreasonable or otherwise discriminatory manner.

**40.** Note that in some situations, balancing rights may not be permitted. These are situations that threaten non-derogable rights, such as freedom from torture.

**41.** See, for example, the compilation of *International Instruments, Resolutions, Declarations and Statements on Torture* compiled by the International Rehabilitation Council for Torture Victims; WMA, *Resolution on Human Rights*; ICN, *Nurses and Human Rights*; ICN, *Ethical Concepts Applied to Nursing*.

**42.** United Nations, *International Covenant on Civil and Political Rights*, preamble.

**43.** For a discussion on the imperative for ordinary citizens to act against injustice, see Shklar, *The Faces of Injustice*.

**44.** United Nations, *Convention on the Elimination of all forms of Discrimination Against Women*, art. 5(b).

**45.** See, for example, the compilation of *International Instruments, Resolutions, Declarations and Statements on Torture* compiled by the International Rehabilitation Council for Torture Victims.

**46.** See note [40](#).

**47.** WMA, *Resolution on Human Rights*; ICN, *Nurses and Human Rights*.

48. WMA, *Declaration of Tokyo: Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*, sec. 4.
49. ICN, *Ethical Concepts Applied to Nursing*.
50. *Id.*
51. The UN Principles of Medical Ethics explicitly prohibit any such distinctions: "There may be no derogation from the foregoing provisions on any grounds whatsoever, including public emergency." *UN Principles of Medical Ethics*, principle 6.
52. This phenomenon is well documented in South Africa under apartheid. See AAAS and PHR, *Human Rights and Health: The Legacy of Apartheid*, 111-113.
53. Roberts and Reich, "Ethical Analysis in Public Health," *Lancet*. 359 (9311): 1055-1059. There are instruments to evaluate the human rights impact of public health policies – see Gostin and Mann, "Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies," in *Health and Human Rights. A Reader*, ed. Mann, Gruskin, Grodin, and Annas, 54-71; International Federation of Red Cross and Red Crescent Societies and the François-Xavier Bagnoud Centre for Health and Human Rights, "The Public Health - Human Rights Dialogue," in *Health and Human Rights. A Reader*, ed. Mann, Gruskin, Grodin, and Annas, 46-53; Heyman, and Sell, "Mandatory Public Health Programmes: To What Standards Should They Be Held?" *Health and Human Rights: An International Journal* 4 (1): 195-203. However, one weakness of these frameworks is that they leave open the question of practitioner accountability for particular policies, and therefore need further elaboration to deal with the problem of dual loyalty conflicts arising in the context of health systems that generate structural inequalities. In addition, they are presently better suited to situations where health policies potentially restrict citizens' and patients' rights, particularly civil and political rights, and are less well suited to considerations of respecting, promoting and fulfilling social and economic rights – see London, "Human Rights and Public Health: Dichotomies or Synergies in Developing Countries? Examining the Case of HIV in South Africa." *Journal of Law, Medicine and Ethics*.
54. Roberts and Reich, "Ethical Analysis in Public Health," *Lancet*. 359 (9311): 1055-9.
55. World Medical Association, *Ethical Principles for Medical Research Involving Human Subjects* (Declaration of Helsinki). [www.wma.net/e/policy/17-c\\_e.html](http://www.wma.net/e/policy/17-c_e.html)
56. United Nations, *International Convention on the Elimination of All Forms of Racial Discrimination*, Article 5 (e) (iv).
57. United Nations, Committee on Economic, Social and Cultural Rights (CESCR), *The Right to the Highest Attainable Standard of Health*, "General Comment 14," para. 35.
58. Bloche, "Clinical Loyalties and the Social Purposes of Medicine," *Journal of the American Medical Association* 268-74.

**59.** The phrase “or other third party” refers to those parties subject to human rights obligations, as explained in the [Introduction](#).

**60.** In rare cases health professionals engage in criminal assaults on their own patients, as in the case of Serbian physicians in Kosovo who assaulted Albanian patients they believed to be terrorists. PHR, “Medical Group Documents Systematic and Pervasive Abuses by Serbs against Albanian Kosovar Health Professionals and Patients.”

**61.** United Nations, *International Covenant on Civil and Political Rights*; UN, *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment*.

**62.** Stover and Nightingale, eds., *The Breaking of Bodies and Minds*; BMA, *Medicine Betrayed*; BMA, *The Medical Profession and Human Rights*, 56-96.

**63.** *Id.*, 100.

**64.** Stover and Nightingale, eds., *The Breaking of Bodies and Minds*, 32. Amnesty International reported 18 cases in which medical personnel participated in torture in Chile. *Id.*, 43 n. 7.

**65.** BMA, *Medicine Betrayed*, 47-48.

**66.** *Id.*, 44.

**67.** The United Nations Committee Against Torture has condemned the use of “moderate physical pressure” as a form of torture. Human rights groups operating in the region have reported that “torture is routine” in Israel and “is used against ...at least 800 Palestinians every year.” *British Broadcasting Corporation*, “Israel Defends Torture in Interrogation Methods.” The practice of physical pressure has been successfully challenged in Israeli courts.

**68.** PHR-Israel, *Physicians and Torture: The Case of Israel*.

**69.** PHR, *Torture in Turkey and its Unwilling Accomplices*, 129-130.

**70.** Bloche, “Uruguay’s Military Physicians, Cogs in A System of State Terror,” *Journal of the American Medical Association*. 255: 2788-2793.

**71.** Reyes, submitted to the Dual Loyalty Working Group.

**72.** Bloche, “Uruguay’s Military Physicians: Cogs in a System of Terror,” *Journal of the American Medical Association*. 255: 2792.

**73.** Baldwin-Ragaven, de Gruchy, and London, *An Ambulance of the Wrong Colour*; AAAS and PHR, *Human Rights and Health: The Legacy of Apartheid*.

**74.** The United Nations Human Rights Committee has held corporal punishment generally as tantamount to torture. United Nations, Human Rights Committee. *Report of the Human Rights Committee*, “General Comment 7,” para. 2.

- 75.** Amnesty International, *Malaysia: The Cane to Claim More Victims*.
- 76.** Amnesty International, *Iraq. State Cruelty: Branding, Amputation and the Death Penalty*.
- 77.** Neuffer, "Forced to do Amputations, Doctors Horrified Under Taliban." *Boston Globe*
- 78.** Munro, "Judicial Psychiatry in China and Its Political Abuses," *Columbia Journal of Asian Law*. 13 (2): 72-81.
- 79.** WMA, *Declaration of Tokyo: Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*.
- 80.** United Nations, *Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment*.
- 81.** ICN, *Torture, Death Penalty and Participation by Nurses in Executions*.
- 82.** Psychiatric participation in forcing medication on unwilling patients, especially in the context of state-sanctioned coercion, raises serious ethical and human rights issues as well, but they are not dual loyalty issues when the psychiatrist believes that the medication is in the patient's best interest.
- 83.** World Psychiatric Association, *Declaration of Hawaii* (1977, 1983).
- 84.** United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Care*, principle 4.
- 85.** International Council of Prison Medical Services, *The Oath of Athens*.
- 86.** The British Medical Association has stated that such examinations, if done in places that do not comply with accepted standards of treatment of detainees, may serve, rather, to help the torturers by making certain that a patient does not die accidentally during questioning. Such participation renders the physician complicit in the abuse. See BMA, *The Medical Profession and Human Rights*, 72-76.
- 87.** Some health professionals have said that passivity does not amount to participation. This response is unsatisfactory since their clinical skills are being used to advance the interests of the torturer, or their acts of omission – including their silence – make it possible for torture to go on undetected.
- 88.** WMA, *Declaration of Hamburg: Declaration Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman, or Degrading Treatment*.
- 89.** Certain regional human rights treaties, such as the *European Convention on Human Rights*, outlaw the death penalty. Moreover, many human rights organizations, including Amnesty International, oppose the death penalty without

reservation and work for its abolition. Of the international health professional codes, only that of the International Council of Nurses opposes the death penalty per se. ICN, *Torture, Death Penalty and Participation of Nurses in Executions*.

**90.** American College of Physicians, Human Rights Watch, National Coalition to Abolish the Death Penalty, and Physicians for Human Rights, *Breach of Trust: Physician Participation in Executions in the United States*; Carlson, "Witnesses For the Execution." *Washington Post*.

**91.** WMA, Resolution on Physician Participation in Capital Punishment.

**92.** ICN, *Torture, Death Penalty and Participation by Nurses in Executions*.

**93.** American College of Physicians, Human Rights Watch, National Coalition to Abolish the Death Penalty and Physicians for Human Rights, *Breach of Trust: Physician Participation in Executions in the United States*.

**94.** *Id.* See also, LeGraw and Grodin, "Health Professionals and Lethal Injection in the United States," *Human Rights Quarterly*. 24 (2): 382-423. (11 states exclude participation in executions from the practice of medicine).

**95.** American College of Physicians, Human Rights Watch, National Coalition to Abolish the Death Penalty and Physicians for Human Rights, *Breach of Trust: Physician Participation in Executions in the United States*; LeGraw, and Grodin, "Health Professionals and Lethal Injection in the United States," *Human Rights Quarterly*. 24 (2): 382-423. "Certifying" the death of the executed prisoner – that is, signing a form stating that the prisoner is indeed dead – is regarded as acceptable by the American Medical Association. However "pronouncing" the death, which implies monitoring the execution process and determining at what point the prisoner has expired, is not seen as ethical. AMA Committee on Ethical and Judicial Affairs. *Code of Medical Ethics*. "E-2.06: Physician Participation in Capital Punishment."

**96.** BMA, *The Medical Profession and Human Rights*, 177-78. Physicians for Human Rights was one of the parties to the court case who argued that medical participation was unethical.

**97.** Amnesty International, "Turkey: Possible Imminent resumption of executions."

**98.** Thailand proposes to use the new execution method in 2003. Swaziland has not introduced legislation at time of writing. "Lethal Injections Next Year," *Bangkok Post*.

**99.** AMA Council on Ethical and Judicial Affairs, AMA Committee on Ethical and Judicial Affairs. *Code of Medical Ethics*. "E-2.06: Physician Participation in Capital Punishment; . Evaluation of Prisoner Competence to be Executed; Treatment to Restore Competence," 1998-99 ed. Section 2.06 Capital Punishment. While formally it is a judicial decision whether a prisoner is competent or not, the advice of mental health specialists is regarded as compelling and definitive where the finding is one which supports a view that the prisoner is competent for execution.

**100.** In addition, recent papers by Farber and colleagues suggest that there is a wide diversion between the principles of ethics enunciated by the AMA and the views

on medical participation in the death penalty adopted by practicing physicians. See, for example, Farber, et. al., "Physicians' Attitudes About Involvement in Lethal Injection for Capital Punishment," *Archives of Internal Medicine*. 160 (19): 2912-2916.

**101.** United Nations, Committee on the Elimination of Discrimination Against Women, *Violence Against Women*, "General Recommendation 19," para. 22.

**102.** United Nations, International Conference on Population, *Programme of Action*.

**103.** US Department of State, *1999 Country Reports on Human Rights Practices*. See also, BMA, *The Medical Profession and Human Rights*, 350-352, 354-55.

**104.** Pomfret, "Victim of Birth Control Policy Struggles After Rare Court Win," *Washington Post*, A1.

**105.** BMA, *The Medical Profession and Human Rights*, 349. In certain cases the policies are directed against indigenous people or ethnic minorities. *Id.* at 352-353.

**106.** *Reproductive Health Matters*, 6: 85.

**107.** Baldwin-Ragaven, de Gruchy, and London, *An Ambulance of the Wrong Colour*, 31-3.

**108.** "Illegal Sterilizations are Reported in Australia," *New York Times*.

**109.** WMA, *Statement on Family Planning and the Right of a Woman to Contraception*.

**110.** UN, *International Covenant on Civil and Political Rights*; UN, *Convention for the Elimination of All Forms of Discrimination Against Women*; UN, *Convention on the Elimination of All Forms of Racial Discrimination*.

**111.** The Democratic Nursing Organization of South Africa as quoted in *Human Rights and Health: The Legacy of Apartheid*, AAAS and PHR, 41.

**112.** Frank et. al., "Virginity Examinations in Turkey," *Journal of the American Medical Association*. 282 (5): 485-490.

**113.** Chamber of Medicine of Izmir press release as quoted by Frank, et. al., "Virginity Examinations in Turkey."

**114.** United Nations, *Vienna Declaration and Programme of Action: World Conference on Human Rights*. The threat of mutilation has been the basis for granting applications for asylum in the United States, Canada, France and other countries. The European Commission on Human Rights held that female genital mutilation constitutes inhuman treatment.

**115.** WHO, *Female Genital Mutilation Information Pack*

**116.** WMA, *Statement on Condemnation of Female Genital Mutilation*.

**117.** ICN, *Elimination of Female Genital Mutilation*.

**118.** UN Integrated Regional Information Networks, *Focus on Female Genital Mutilation*, January 25, 2002 [allafrica.com/stories/200201250404.html](http://allafrica.com/stories/200201250404.html)

**119.** PHR, *Fact Sheet on Female Genital Mutilation*.

**120.** Human rights concerns may also arise around the forcible medication of psychiatric patients for therapeutic purposes. See United Nations, *Principles for the Protection of People with Mental Illness and Improvement in Mental Health Care*. Without diminishing the seriousness of the human rights issues involved, compulsory medication does not usually involve dual loyalties since the psychiatrist seeks to act in the patient's therapeutic interest rather than to advance the interest of the state.

**121.** BMA, *The Medical Profession and Human Rights*, 138.

**122.** United Nations, *Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment*, principle 6.

**123.** United Nations, *Standard Minimum Rules for the Treatment of Prisoners*.

**124.** UNHCHR, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, principle 11.

**125.** WMA, *Statement on Body Searches of Prisoners*.

**126.** ICN, *The Nurse's Role in the Care of Prisoners and Detainees*.

**127.** This also applies to non-state actors to the extent the state has obligations to assure the protection of human rights in relations with non-state actors, e.g., the protection against discrimination.

**128.** WMA, *Declaration of Tokyo: Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*.

**129.** WMA, *International Code of Medical Ethics*.

**130.** *Id.*

**131.** *Truth and Reconciliation Commission of South Africa Report*, vol. 4, chap. 5.

**132.** Baldwin-Ragaven, de Gruchy, and London, *An Ambulance of the Wrong Colour*, 106.

**133.** *Id.*, 107-8.

**134.** *Id.*, 91-9. See also, AAAS and PHR, *Human Rights and Health: The Legacy of Apartheid*; Rayner, *Turning a Blind Eye: Medical Accountability for Torture in South Africa*.

**135.** Munro, "Judicial Psychiatry in China and Its Political Abuses," *Columbia Journal of Asian Law*. 13 (2): 72-81; Stover and Nightingale, eds., *Breaking of Bodies and Minds*.

**136.** Bloch and Reddaway, "Psychiatrists and Dissenters in the Soviet Union," in *Breaking of Bodies and Minds*, ed. Stover and Nightingale, 153-57.

**137.** Article 4.

**138.** Roudik, submitted to the Dual Loyalty Working Group. For reasons explained in the [Introduction](#), dual loyalty and human rights conflicts arising in connection with clinical research is not within the scope of this project.

**139.** Larin, "Mayak's Walking Wounded," *The Bulletin of Atomic Sciences*. 55 (5): 20-27.

**140.** Elofson-Gardine and Hurst, "EIN Open Letter to DOE Sec'y Richardson for Meeting on 10/02/98 at Rocky Flats."

**141.** *Id.*

**142.** Roudik, submitted to the Dual Loyalty Working Group.

**143.** Pross, "Dual Loyalty – A Case in Point: German Police Doctors Break Medical Confidentiality," *Torture*. 10:100. See also, Pross, "The Police Medical Service of Berlin: Doctors Agents of the State?" *Lancet*. 356 (9239): 1435-6.

**144.** *Id.*

**145.** The requirement for independent judgment on the part of occupational health personnel is explicitly cited in ILO Recommendation 112 (Recommendation concerning Occupational Health Services in Places of Employment) and in ILO Convention 161 (Convention concerning Occupational Health Services). The convention has been ratified by 21 countries.

**146.** This problem is illustrated in PHR, *Torture in Turkey and its Unwilling Accomplices*, 130-132.

**147.** See generally, Cook, "Gender, Health and Human Rights," in *Health and Human Rights. A Reader*, ed. Mann, Gruskin, Grodin, and Annas, 257. For an extensive discussion of the discrimination in health services under the Taliban regime in Afghanistan, see PHR, *The Taliban's War on Women*; PHR, *Women's Health and Human Rights in Afghanistan: A Population Based Assessment*. Human Rights Watch includes health dimensions of gender discrimination in its annual World Report. For 2002, see [staging.hrw.org/wr2k2/women.html](http://staging.hrw.org/wr2k2/women.html).

- 148.** WHO, *Health and Freedom from Discrimination*.
- 149.** Baldwin-Ragaven, de Gruchy, and London, *An Ambulance of the Wrong Colour*, 42.
- 150.** AAAS and PHR, *Human Rights and Health: The Legacy of Apartheid*.
- 151.** Human Rights Watch, *Caste Discrimination: A Global Concern*.
- 152.** Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. See also, Smith, *Health Care Divided: Race and Healing a Nation*; "Racial and Ethnic Inequities in Access to Medical Care," *Medical Care Research and Review* 57:Supplement 1 (2000).
- 153.** United Nations, Committee on Economic, Social and Cultural Rights, General Comment 14: *The Right to the Highest Attainable Standard of Health*.
- 154.** Ziv and Lo, "Denial of Care to Illegal Immigrants: Proposition 187 in California," *New England Journal of Medicine*. 332 (16): 815-816. See also, Mailman, "California's Proposition 187 and Its Lessons," *New York Law Journal*, and DeVille, "Parties to the Social Contract? Justice, Proposition 187 and Health Care for Undocumented Immigrants" *Trends in Healthcare, Law, and Ethics*. 19 (1-2).
- 155.** Adriaan van Es, submitted to the Dual Loyalty Working Group.
- 156.** See, for example, WMA, *Declaration of Geneva*.
- 157.** International Federation of Gynecology and Obstetrics, Committee for the Ethical Aspects of Human Reproduction and Women's Health, *The Role of the Ob/Gyn as Advocates for Women's Health*.
- 158.** *Id.*
- 159.** *Id.*
- 160.** Detailed rules with respect to medical facilities, personnel and vehicles are contained in the *Fourth Geneva Convention of 1949*, Common Article 3 of the *Geneva Conventions and Additional Protocol I* (1977), relating to the Protection of Victims of International Armed Conflicts, and *Additional Protocol II* (1977), relating to the Protection of Victims of Non-International Armed Conflicts. The conventions can be found on the web sites of the International Committee of the Red Cross, [www.icrc.org](http://www.icrc.org), as well as (along with human rights treaties) at the web site of the UN High Commissioner for Human Rights, [www.unhchr.ch](http://www.unhchr.ch).
- 161.** WMA, *Declaration of Geneva*.
- 162.** WMA, *Regulations in Time of Armed Conflict*, para 1.
- 163.** WMA, *Declaration of Tokyo: Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*, sec. 4.

**164.** See PHR "Medical Group Documents Systematic and Pervasive Abuses by Serbs against Albanian Kosovar Health Professionals and Patients." In Chechnya, physicians and nurses have been harassed and arrested for providing care to victims associated with one side or another. PHR, [\*Endless Brutality: Ongoing Human Rights Violations in Chechnya\*](#). In Turkey, health professionals face the threat of prosecution for providing care and treatment to victims of torture if those victims belong to banned political groups. PHR, "The Arrest and Detention of Human Rights and Political Activists in Turkey."

**165.** *Truth and Reconciliation Commission of South Africa Report*, vol 4, chap. 5: 124-125.

**166.** Surgeon General Ronald R. Blanck LTG (US Army), and Surgeon General Charles H. Roadman, Lt. Gen (US Air Force), Statement on "Divided Loyalties of Military Physicians," 13 June 1998.

**167.** United Nations, *Basic Principles for the Treatment of Prisoners*, para. 9; see UN, *Body of Principles for the Protection of all Persons Under Any Form of Detention or Imprisonment*, principle 24. For specific requirements of care, see also, UN *Standard Minimum Rules for the Treatment of Prisoners*, para. 22-26.

**168.** United Nations, *Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment*, principle 1.

**169.** United Nations, *Principles for the Protection of People with Mental Illness and Improvement in Mental Health Care*, principle 14.

**170.** United Nations, Committee on Economic, Social and Cultural Rights, *The Right to the Highest Attainable Standard of Health*, "General Comment 14," para. 11, 34. See also, para. 44(d).

**171.** United Nations, *Convention on the Elimination of all forms of Discrimination Against Women*,. See also, art 14(2), art. 16(e).

**172.** For an overview, see Center for Reproductive Law and Policy, *Reproductive Rights 2000 Moving Forward*.

**173.** International Federation of Obstetrics and Gynecology, Committee for the Ethical Aspects of Human Reproduction, *The Ethical Aspects of Sexual and Reproductive Rights; Ethical Framework for Gynecologic and Obstetric Care*.

**174.** The University of Witwatersand Faculty of Medicine, "Voluntary total fasting: ethical-medical considerations." See also the important guidelines published by the Johannes Weir Foundation for Health and Human Rights. *Assistance in hunger strikes: a manual for physicians and other health personnel dealing with hunger strikes*.

**175.** WMA, *Declaration of Malta on Hunger Strikers*, preamble, sec. 4.

- 176.** UN Committee on Economic, Social and Cultural Rights, *The Right to the Highest Attainable Standard of Health*. "General Comment 14," para. 19.
- 177.** *Id.*
- 178.** *Id.* para. 52.
- 179.** *Id.* para. 5.
- 180.** The United States, for example, has signed but not ratified the *Covenant on Economic, Social and Cultural Rights*.
- 181.** For information on this case, see [www.hsf.org.za/focus25/focus25mollen.html](http://www.hsf.org.za/focus25/focus25mollen.html); [www.phrusa.org/campaigns/aids/action040202.html](http://www.phrusa.org/campaigns/aids/action040202.html).
- 182.** Saloojee. Affidavit in Support of the Treatment Action Committee Against the Minister of Health and Nine Provincial MEC's for Health.
- 183.** London, "Human Rights and Public Health: Dichotomies or Synergies in Developing Countries? Examining the Case of HIV in South Africa." *Journal of Law, Medicine and Ethics*.
- 184.** Baleta, "South African Judge Reaffirms Judgment to Expand Access to AIDS Drug," *Lancet*. 359 (9310): 954.
- 185.** There are some exceptions, such as the ethical stands taken by the International Federation for Obstetrics and Gynecology.
- 186.** See, for example, International Council of Prison Medical Services, *The Oath of Athens*.
- 187.** Even in these conventional circumstances, however, potential for abuse exists. In occupational health settings, health workers are regularly asked by the employer to evaluate a person's fitness to work, or claim for disability. In these circumstances, disclosure of information to the state may be legitimate if the doctor fulfills his or her ethical obligation to obtain the patient's full consent and does not disclose more information than necessary. If the doctor is not aware of and faithful to these ethical obligations to the patient, there is potential for violation. London, "The Challenge of Ethics in Occupational Health: Part 1," *Occupational Health Southern Africa*. 6: 10-13.
- 188.** The Covenant states that "no one shall be subjected to arbitrary or unlawful interference with his privacy, . . ." *International Covenant on Civil and Political Rights*, art. 16.
- 189.** UN Committee on Civil and Political Rights, General Comment 16. The right to respect of privacy, family, home and correspondence, and protection of honour and reputation (art. 17).
- 190.** The European Court of Human Rights, in the case of *MS v. Sweden*, 28 EHRR 313, allowed medical records to be disclosed to an agency making a decision on a

workers' compensation claim on the ground that they were essential to the determination and that procedural safeguards were in place.

**191.** In armed conflicts, Protocol II of 1977 has been interpreted to mean that authority under national laws is a sufficient basis to breach confidentiality. This position has been subject to criticism. Reyes, "Confidentiality Subject to National Law: Should Doctors Always Comply?" *Medisch Contact, Journal of the Royal Danish Medical Association*. 51 (9): 1456-1459.

**192.** PHR, *Torture in Turkey and its Unwilling Accomplices*, 55.

**193.** AAAS and PHR, *Human Rights and Health: The Legacy of Apartheid*, 88.

**194.** Some health professionals did resist; at Baragwanath Hospital and Alexandra Clinic, some physicians simply refused to hand over clinical files. Baldwin-Ragaven, de Gruchy, and London, *An Ambulance of the Wrong Colour*, 55.

**195.** PHR, *Torture in Turkey and its Unwilling Accomplices*.

**196.** *Ferguson v. City of Charleston*. 531 U.S. 67.

**197.** Rahman, Katzive, and Henshaw, "A Global Review of Laws on Induced Abortion, 1985-1997," Center for Reproductive Law and Policy. 24 (2): 56-64.

**198.** *Id.*

**199.** Bercault, submitted to the Dual Loyalty Working Group.

**200.** Pross, submitted to the Dual Loyalty Working Group.

**201.** "Tests for HIV Without Consent: Activists," *Mail and Guardian*; "Taking the Policy Battle to Court," *Sunday Times* (South Africa); "Secret HIV Tests Alleged in South Africa," *Associated Press*.

**202.** AAAS and PHR, *Human Rights and Health: The Legacy of Apartheid*, 88.

**203.** *Id.*, p. 41.

**204.** In apartheid South Africa, many health professionals defended the disclosure of patient records to the security police as a part of the need to protect law and order. See Rubenstein and London, "The UDHR and the Limits of Medical Ethics: The Case of South Africa," *Health and Human Rights: An International Journal* 3 (2): 161-171.

**205.** As indicated in the discussion of torture, moreover, forensic evaluations can serve purposes that themselves violate human rights, e.g., to further or cover up the existence of torture or to evaluate competency for execution.

**206.** UN High Commissioner for Human Rights, *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, Professional Training Series No. 8.

- 207.** "Dramatic Ruling on Jobs for Aids Sufferers," *Mail and Guardian*.
- 208.** See, for example, recommendations in ICOH. (1997). International Commission on Occupational Health, *International Code of Ethics of Occupational Health Professionals*
- 209.** Physicians for Human Rights "Medical Group Documents Systematic and Pervasive Abuses by Serbs against Albanian Kosovar Health Professionals and Patients."
- 210.** Baldwin-Ragaven, de Gruchy, and London, *An Ambulance of the Wrong Colour*, p.201-202.
- 211.** Quoted in *An Ambulance of the Wrong Colour*, Baldwin-Ragaven, de Gruchy, and London, 83.
- 212.** Smith, *Health Care Divided: Race and Healing a Nation*.
- 213.** Rubenstein and London, "The UDHR and the Limits of Medical Ethics: The Case of South Africa," *Health and Human Rights: An International Journal*. 3 (2): 161-171.
- 214.** BMA, *Medical Profession and Human Rights Handbook*, 104.
- 215.** The Convention concerning Occupational Safety and Health Convention and the Working Environment (ILO No. 155)(1983) provides that member States shall adopt policies designed to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, by minimising, so far as is reasonably practicable, the causes of hazards inherent in the working environment. The Convention has been ratified by 38 countries.
- 216.** Frumkin, "Right, Wrong, and Occupational Health: Lessons Learned," *International Journal of Occupational and Environmental Health*. 4 (1): 33-4; Kerns, "The Unexpected Result of an Investigation of an Outbreak of Occupational Lung Disease," *International Journal of Occupational and Environmental Health*. 4 (1): 19-32.
- 217.** WMA, *International Code of Medical Ethics: Declaration of Geneva*.
- 218.** *Id.*
- 219.** ICN, *The Nurse's Role in the Care of Prisoners and Detainees*.
- 220.** WMA, *Resolution on Human Rights*.
- 221.** WMA, *Declaration Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment*.
- 222.** *Id.*

**223.** There may, however, be circumstances where it is necessary to breach loyalty to one patient to protect the human rights of another.

**224.** *UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1991), Principle 10(1).

**225.** See discussion of human rights and confidentiality in [Chapter II](#).

**226.** See guidelines on evaluations for relationship of confidentiality and evaluations for state purposes.

**227.** Farrar, "Industrial hygiene ethics in the 90's: A professional challenge."

**228.** Nemery, "The conflict prone nature of occupational health research and practice."

**229.** The requirement for independent judgment on the part of occupational health personnel is explicitly cited in ILO Recommendation 112 (Occupational Health Services in Places of Employment, 1959) and in ILO Convention 161 (Occupational Health Services, 1985).

**230.** This Guideline is consistent with [Forensic Guideline 4](#).

**231.** See, for example, Convention 161, which absolves health professionals of the obligation to verify employees' reasons for absence from work.

**232.** The obligation to maintain medical confidentiality is contained in ILO Recommendations 112 (Occupational Health Services in Places of Employment, 1959) and 97 (Recommendation Concerning the Protection of the Health of Workers in Places of Employment, 1953).

**233.** Because an occupational health service will include clerical and other non-professional staff who may have access to medical records, the health professional responsible for treatment or evaluation must ensure that non-professional staff are fully apprised of the need to maintain confidentiality, trained in how to do so, and monitored to ensure that no breaches of confidentiality occur, either by intent or by negligence. Certification of illness from health professionals outside the service, if it contains confidential information, must receive equally thorough attention to confidentiality.

**234.** Workers' right-to-know is enshrined in a number of ILO Conventions (161) and Recommendations (143 and 164), as is the occupational health practitioner's responsibility to provide such safety and health information (Convention 161).

**235.** One difficulty in communicating risk to workers has to do with the degree of certainty of the risk. It is often the case with the way scientific knowledge is advanced that the level of certainty regarding a workplace hazard has not reached a level that would be regarded definitive evidence of risk. Under such circumstances, the health professional should use his or her judgment as to the best interests of the patient or collective of patients, bearing in mind that waiting for evidence of well-established human disease, or for experimental data, may risk potentially injurious

exposure. Although no international human rights law explicitly cites such an obligation, a number of professional ethical codes (including the *International Code of Ethics of Occupational Health Professionals*, (ICOH), 1996; *Guidance on Ethics for Occupational Physicians*, Royal College of Physicians, Faculty of Occupational Medicine, UK, 1999; and the American Occupational Medicine Association *Code of Ethical Conduct for Physicians Providing Occupational Medical Services*, 1976) make the responsibility for hazard communication to workers a positive obligation on professionals. Indeed, the American College of Occupational and Environmental Medicine *Code of Ethical Conduct* (1993) describes a positive obligation to disseminate medical knowledge pertaining to workplace hazards as part of good ethical practice.

**236.** This is explicitly cited in ethical codes such as the American College of Occupational and Environmental Medicine *Code of Ethical Conduct* (1993).

**237.** For an extended discussion of the reasons for this, see "An International Code of Conduct (Ethics) for Occupational Health Professionals," in *The International Journal of Environmental and Occupational Health*, September 2001.

**238.** In these guidelines, the terms *forensic health professional* and *medical evaluator* are used interchangeably. The evaluator may be a health professional other than a physician.

**239.** See also [Workplace Guidelines](#).

**240.** For the purposes of these guidelines, a clinician who has treated an individual and is subsequently subpoenaed to testify in court is not a forensic evaluator but one who has been engaged to diagnose and treat the patient. A health professional who has provided diagnosis and treatment to an individual should follow the usual rules to maintain confidentiality of findings and judgments about a patient unless the patient consents to disclosure.

**241.** Note that even though much of forensic practice does not relate to patients in the sense of individuals seeking health care, the professional relationship of the evaluator to the person being assessed is in certain respects analogous to the traditional health care provider – patient relationship because of the use of clinical skills in ways that affect the interest and well-being of the person being evaluated. [Guideline 4](#) addresses this dimension of the relationship.

**242.** See Bloche, "Psychiatry, Capital Punishment, and the Purposes of Medicine." *International Journal of Law and Psychiatry* 16: 301

**243.** See [Introduction](#).

**244.** Pross, "The Police and Medical Service of Berlin: Doctors or Agents of the State?" *Lancet*. 356 (9239)

**245.** Physicians for Human Rights, *Torture in Turkey and its Unwilling Accomplices*.

**246.** Baldwin-Ragaven, de Gruchy, & London, *An Ambulance of the Wrong Colour*. See also *Health and Human Rights Projects*, "Professional Accountability in South Africa."

**247.** See [Guidelines for Prisons, Detention and Other Custodial Settings](#).

**248.** See [Introduction](#).

**249.** The question of participation in physician-assisted suicide is not within the scope of these Guidelines because it is done at the behest of the person not the state.

**250.** In many armed forces, the military health professional, as a non-combatant, is not in the chain of command in the sense of having the power to give orders to combat soldiers. In addition, the health professional may not be subject to the same obligation to fight in order to avoid surrender.

**251.** The question to what extent the military health professional is required to serve the health needs of the civilian population of the area assigned should be explicit.

**252.** South Africa's Chemical and Biological Weapons Programme, Special Investigation into Project Coast. *Truth and Reconciliation Commission Final Report* Volume II chapter 6, 29 October 1998.

**253.** Part of the role of a proposed ombudsman service (see Sections [2.5](#) and [4](#) below) would be to offer advice to concerned health professionals on how to shape, negotiate, and manage employment contracts to further ethical and human rights considerations.

**254.** For example, the *Protected Disclosure Act in South Africa* (Act 26 of 2000), sets out a framework to promote responsible whistleblowing, based on the core notion that it is in the common interest of the employer, the employee, and society to disclose unlawful, corrupt, or abusive behaviors.

**255.** Shadow reporting is the practice in which non-governmental organizations submit parallel reports to those presented by national governments to reporting bodies under the UN system. By commenting on or providing additional information, these shadow reports increase the scrutiny of governmental commitments to human rights standards.