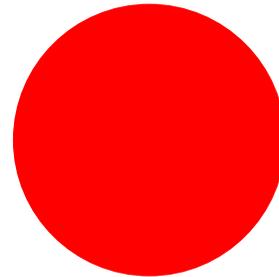


Medico friend circle bulletin

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May-June 2002



Editorial

Following the publication of our report 'Carnage in Gujarat, a Public Health Crisis' we received several comments from individuals who were working in Gujarat during the riots and later. They contested our finding that, by and large, the health professionals in Gujarat had not acted in a discriminatory manner. They cited several instances of patients of the minority community being turned away, or being abused verbally and intimidated and also stray cases of deliberate negligence. We Welcome such comments and also have no cause to disbelieve that such cases of gross violations may indeed have taken place, which we missed.

However, what is even more clear from our report as well as the observation of other groups, there were several acts of omission. Medical documentation was incomplete and inaccurate. Post mortems had not been conducted and women who sexually assaulted and arrived at hospitals for treatment were not examined and the medico-legal evidence related to the assault was not collected. More importantly, the medical profession stood largely as a silent witness to the gross human rights violations taking place and took no position even when members of their own fraternity were attacked or were involved in spreading hate and violence. No doubt, doctors would argue that why should super-human efforts be expected from them when every other system around them had collapsed. But the fact remains that passivity, is not an acceptable response from any profession, especially one which has such a vital influence on people's lives.

Apart from the police, perhaps, the victims' most

frequent contact was with the health profession.

Our general observation was that while victims categorically indicted the police for being involved in the carnage, they had no comments to make about the health profession, neither negative nor positive. Given the usual low level of empathy and respect that people expect of the medical profession, and especially of the public health system, perhaps, this response was predictable. However, the very fact that health system continued to function as it always does, itself is an indictment. Unusual circumstances demand extraordinary responses, which, in this case, were obviously not forthcoming. Doctors continued to stick in that IV and suture that wound without feeling or getting involved in the larger issue of justice.

Undoubtedly, the medical profession was not confronted with such pressures for the first time. Neither was the response of the health profession in Gujarat without precedent. We start the series of background papers for the annual theme meet on 'Conflict, Communalism and the Role of the Health Profession' with two international documents that are meant to set the norm for the health professional's behaviour in times of crisis. They stress the right to autonomy of the profession and, at the same time, exhort the profession not to desert its duty to uphold humanitarianism and justice.

Neha Madhiwalla

Seventy Six Recommendations of the British Medical Association's Steering Group on the Medical Profession & Human Rights

As is made clear throughout the report, many guidelines and protocols have been drawn up by national and international medical organizations as well as by medical groups who campaign on human rights issues.

The British Medical Association, (BMA) recommends that such material be made widely available by their drafters in order to assist individual doctors and medical associations. Ideally, availability through media such as the Internet could assist national medical associations fulfil their role of providing appropriate guidance.

Torture

1. The BMA re-affirms its support for the Declaration of Tokyo and its condemnation of the practice of torture or other cruel, inhuman or degrading treatment. Doctors should neither participate in, nor advise or train others how to carry out torture. Professional associations must play a key role in supporting individual doctors who speak out against such abuses. Similarly where a national medical association itself is attacked for exposing human rights abuses, associations in other countries, including the World Medical Association, have a duty to provide support.
2. Evidence continues to confirm that torture and maltreatment are most likely to occur in places of detention. Medical disciplinary bodies should take a lead in good standard setting for members of the medical profession who work in places of detention. They should ensure the dissemination of codes, guidelines and relevant international statements. In many countries, doctors working with the prison and police services are unaware of internationally agreed standards because these have never been translated into their own language and disseminated. Medical associations and disciplinary bodies have a responsibility to ensure relevant ethical guidance is provided where this does not exist and should also urge employers to do so.
3. All places of detention should establish clear protocols for issues such as 'whistle-blowing'. These protocols need to make unambiguously.

clear the steps doctors should take upon discovering evidence of maltreatment, poor standards of care, corruption or other abuse. It should also be clear to whom the doctor should report. National governments should have ultimate responsibility for ensuring that such mechanisms exist and that there is adequate legal protection for whistle blowers and for alleged victims of abuse.

4. In instances where those in direct authority are complicit, or suspected of being complicit, in abuse, doctors and national medical associations should consider alternative reporting strategies. 'Alternative' medical reports can be produced by doctors who are not subject to direct state pressure and can reflect accurately the physical and psychological sequelae of torture. Reports can be directed to those who are not complicit in covering up abuse. Even alternative medical reports are not without risk both for the drafter and the torture survivor. In particular, medical associations should consider how doctors can be helped to access 'safe' reporting mechanisms within the context of their work and, where appropriate, should help doctors convey evidence of torture for investigation by the UN Special Rapporteur on Torture.

5. The 'Istanbul Protocol', drawn up by an alliance of health professionals, lawyers and human rights organisations provides detailed guidance about the investigation of torture, including such issues as the conduct of an examination, indications for referral and interpretation of findings. The BMA urges all medical bodies to endorse this guidance and draw its existence to the attention of doctors.

6. Disciplinary bodies should have effective mechanisms for addressing promptly any evidence of abuse by their members. Professional associations may be required to pass information which appears credible to agencies that have appropriate investigative procedures.

7. In order to facilitate accurate reporting of the

(Source - the last Chapter in: *The British Medical Association (BMA), "Medical Profession and Human Rights: Handbook for a Changing Agenda", London: Zed Books/IMA, 2001, pages 561*)

cause of death of individuals in places of detention, medical associations should ensure that clear guidance is published about the factors to be recorded on death certificates.

8. All organisations with an interest in human rights issues should be involved in campaigns for the prosecution of perpetrators of serious human rights violations, including health professionals who are complicit with and advise torturers. In effect, this means opposing impunity measures wherever they exist.

9. Medical and educational bodies should take steps to raise professional awareness of human rights. Medical schools should consider offering education in medical ethics and human rights and draw students' attention to the availability of reputable materials on web sites.

10. Medical associations can exercise political influence in resisting some of the indicators of impending periods of crisis, such as the suspension of basic rights - including freedom of expression. Wherever possible, medical associations should also oppose the routine imposition of 'gagging clauses' in doctors' contracts of employment with government bodies.

Prison doctors

11. Many adverse factors seriously affect prison medical staff, ranging from lack of resources to the common practice in many countries of using prisons as 'dumping grounds' for marginalised and mentally ill people. National medical associations have a role in ensuring that their members working in this field obtain good working conditions, adequate resources and appropriate training and support.

12. Many prison doctors feel that they lack adequate practical guidance. Medical associations should raise awareness amongst members working in this field of relevant existing guidance such as that produced by the European Committee Against Torture and Penal Reform International. Guidance on specific health care issues, such as HIV/AIDS and prisons, have been produced by both the World Health Organisation and the Council of Europe. National medical associations should publish guidance for their members on aspects of prison health care that give rise to ethical dilemmas or complaints.

13. Prisoners with medical conditions, including HIV or AIDS, should be medically treated in the

same way as patients in the community with regards to both testing and treatment. There should be the same respect for patient confidentiality and the need for consent. In particular, prison staff should be provided with ongoing training in the preventive measures to be taken and the attitudes to be adopted regarding HIV positivity and should be given appropriate instructions concerning non-discrimination and confidentiality.

14. Prison doctors require specific training, including in some countries trans-cultural education, in order that they can address the often very specific needs of prisoner patients. Medical associations should work with national governments to ensure that such training is provided and properly resourced.

15. There is a major role for professional associations in providing an overview of prison medical services and minimising the likelihood of abuses involving health professionals. A possible mechanism is through the establishment of a prison doctors' committee within the medical association to focus on the particular needs of prison doctors as well as providing general guidance.

16. Regular contact with doctors working in the community can prevent the professional isolation of prison doctors as well as helping create equivalent standards of health care in the prison environment as in the rest of society and encouraging personal professional development. Professional associations should help their members working in prisons to establish good working contacts with doctors within the local community.

17. Regular inspection of places of detention by independent external agencies is essential in all countries. Health care in prisons and other places of detention should be subject to clinical audit in the same way as other areas of medicine.

Forensic doctors

18. Human rights organisations, such as Amnesty International, have frequently stated that the period in which torture is most common, and when detainees are most at risk, is immediately after arrest. Where doctors have access to detainees during this period, their role in protecting them is critical. The pressures on such doctors, however, are unfortunately great and they are frequently unprepared and unsupported. It is crucial that doctor have clear guidelines about

their responsibilities and that workable strategy are in place to provide help. Professional associations can and must play a part in developing such guidelines.

19. Forensic medicine is one of the most important tools for human rights and monitoring organisations. Doctors who undertake forensic work should receive specialised training, including an awareness of international human rights' standards. Professional associations can and should provide assistance in the development of such training programmes.

20. Forensic services should be established with the goal of providing impartial evidence about crimes including human rights violations. Such services should be adequately funded and independent of police or other law-enforcement agencies.

21. Individuals detained by the police have the right to be medically examined by an experienced health professional. The BMA supports the view of the European Committee for the Prevention of Torture that forensic examinations should always be conducted out of the hearing of law enforcement officials. Further, they should be conducted out of the sight of such officials, unless the doctor concerned requests otherwise in a particular case.

22. Results of medical examinations as well as relevant statements by the detainee and the doctor's conclusions should be formally recorded by the doctor and made available to the detainee.

23. Post-mortem examinations should be carried by independent doctors, preferably experts in forensic pathology, on the bodies of all those who die in custody. The post-mortem report should state the cause, manner and time of death and account for all injuries on the body, including any evidence of torture. The family of the deceased should have the right to have a representative present at the autopsy and should have access to the post-mortem report on completion.

Capital and corporal punishment

24. The BMA welcomes the trend to limit the application of capital punishment. The BMA believes that active involvement of doctors in carrying out the death sentence is unethical. The BMA recommends that all medical associations should adopt resolutions condemning active medical involvement in application of this

punishment.

25. In the BMA's opinion, certification of death "is part of normal medical duties and that this extends to death by judicial execution. The BMA strongly recommends that, where judicial executions are carried out, certification of death should take place away from the site of execution and several hours after it so that there is no doubt about life being extinct.

26. The BMA does not consider that giving forensic medical evidence to help determine guilt or innocence at a capital trial is different in substance from giving evidence for such purposes at other trials and therefore believes that giving evidence of fact is non-problematic. The BMA remains concerned that medical speculation about future dangerousness might well be highly unreliable and lacking scientific basis and considers that doctors should not be involved in assessing whether a prisoner should be executed or not.

27. Some forms of corporal punishment inflict grave suffering or disability. Punishments such as amputation are not only cruel but seriously and permanently hinder individuals' ability to provide for themselves and for dependent relatives and so contribute to an under-class of destitute and marginalised people. The medical profession should not only oppose such punishments but exercise an educative influence over such policies which affect the health of society.

28. The BMA is opposed to doctors certifying people fit for corporal punishments or execution. It-calls upon other associations to campaign to remove such requirements from legislation. In the meantime, the reality in many countries, however, is that the task cannot be avoided. If doctors play such a role, it is important that they, and their professional bodies, ensure that poor health of prisoners qualifies for commutation of such sentences rather than simply postponement.

29. The BMA opposes not only doctors assisting in executions and corporal punishments but *any* health professional using medical technology and skills to further the aims of inflicting physical damage on individuals and calls on medical associations worldwide to address this issue.

Abuse in research

30. It is clear that a combination of factors is necessary to reduce the possibility of abusive research, including the obligation of researchers

not to rely solely on their own perception of the ethics or acceptability of projects they wish to pursue. All research must be subject to independent ethical review. Representatives of the public and research subjects should have a voice in deciding the acceptability or otherwise of research projects.

31. Medical associations should ensure the publication of clear ethical guidance on research which includes discussion of safeguards for vulnerable or mentally incapacitated research participants. Medical associations should require researchers to seek appropriate ethical review, even where it is not a legal requirement; this includes research carried out in closed institutions, such as the armed forces.

32. National medical associations should seek to ensure that complaints procedures exist which are accessible to the public and which include investigation of fraud and misconduct in research. Before research is undertaken, compensation arrangements must be in place to recompense any person inadvertently harmed by medical research. Medical journals should scrutinize the ethical aspects of studies submitted for publication, including the requirement for the consent of participants.

Medicine in armed conflict

33. A network of medical associations and human rights groups, including the BMA and the WMA have formally adopted a proposal for a UN Special Rapporteur on the Independence and Integrity of Health Professionals. The rapporteur would be charged with monitoring that health professionals are allowed to move freely and that patients have access to medical treatment, without discrimination on grounds of nationality or ethnic origin, in war zones or in situations of political tension. The BMA calls on medical associations who have not already done so to add their formal support to this proposal.

34. The BMA believes that reporting and denunciation of human rights violations in times of armed conflict is vital but requires careful thought and planning. Reports must be accurate and unbiased. They need to be directed to an organisation or authority able to investigate and take effective action against perpetrators. Inaccurate reporting may lead to discrediting the source. Reporting that has not been thought through and discussed with victims may place both the reporter and victims at serious risk of reprisals.

35. National medical associations should ensure that their members are properly informed about their ethical and legal responsibilities to treat all patients impartially during situations of civil conflict or international war.

Doctors and weapons

36. A number of medical associations, including the BMA, the Commonwealth Medical Association and the WMA have endorsed the SIRUS project which attempts to draw up medical criteria based on wound ballistics which can be used to measure whether a weapon causes 'superfluous injury or unnecessary suffering' as provided by humanitarian law. Individual doctors and medical associations are encouraged to endorse this important project.

37. While doctors may have a legitimate role in reviewing the defensive capability of weapons, the BMA considers that doctors should not knowingly use their skills and knowledge for weapons' development. It objects to doctors' participation in weapons' development for the same reasons that it opposes doctors' involvement in the design and manufacture of torture weapons and more effective methods of execution: through their participation doctors are lending weapons a legitimacy and acceptability that they do not warrant. Doctors may consider that they are, in fact, reducing human misery through their involvement, but in reality the proliferation of weapons show this to be untrue. Doctors must also be aware that information they gather and knowledge they disseminate for legitimate medical and scientific reasons may be open to abuse and misuse by others.

38. Doctors should not be discouraged from collecting data on wound ballistics as accurately and objectively as possible. Indeed its collection is seen by many doctors as a prerequisite to improving triage and wound management. Ensuring an ethical and scientific review of military medical research is essential and could contribute to minimising the ethical dilemmas. Such ethical review should examine whether the medical benefit from the research outweighs its possible use for weapon design.

The abuse of institutionalised patients

39. Professionals working in closed institutions for the mentally ill, the elderly and children may lack appropriate training to enable them to address

the specific social and health needs of the residents/patients. Staff should be familiar with humane methods of dealing with disturbed or distressed patients and not rely on physical forms of restraint and sedation in order to manage patients' behaviour.

40. Contact with colleagues and support in the community are necessary to ensure that the staff working in closed institutions do not become too isolated. The BMA considers that it is highly desirable for staff to be offered training possibilities outside their establishments as well as secondment opportunities.

41. The BMA considers that in all countries institutions' treatment of residents/patients should be effectively monitored by an independent body. This body should be authorised to talk to patients privately, receive directly any complaints from patients, their relatives and/or staff and make appropriate recommendations.

42. Closed institutions should develop an agreed policy on how to deal with allegations of abuse and neglect. Such policies should include mechanisms for health professionals to discuss any suspicion of abuse with an independent individual, at least initially, on a confidential basis. This independent person should be in position to advise as to the appropriate action that can be taken in the future.

43. Cases invariably arise in institutional settings where some method of restraint is necessary either to protect the individual or others from serious harm. In all circumstances, restraint should be the minimum necessary to attain the objective. Physical restraint should not be used purely to force compliance with staff instruction when there is no immediate risk to people or property. The BMA recommends that all institutions in which restraints are used develop formal policies as to their use. Such guidelines should outline proper procedures for monitoring and reviewing the type and frequency of restraints used. The guidance should also identify and encourage alternatives to the use of restraints.

44. The BMA notes with concern studies that reflect the over prescribing of sedatives and tranquillizers to the elderly and supports the recommendation of the Royal College of Physicians that national guidelines for the administration of medication in nursing and residential homes be reviewed, with the help of health and local authorities, sharing examples of good practice.

45. Doctors caring for the mentally ill in closed institutions should be encouraged to be aware of relevant national and international standards on ethics and human rights. In particular, those produced by WHO, the WMA, the European Committee for the Prevention of Torture and the UN.

Gender issues

46. Doctors have ethical obligations to ensure that medical treatments - especially irreversible or invasive procedure - are carried out for the patient's benefit. If coercion is suspected, doctors should try to ascertain the patient's own wishes and act in conformity with those, where possible. Procedures involving patients who lack capacity require special care and should only be provided when it is in the patient's best interests. Potentially controversial treatments, such as sterilisation, tissue donation or invasive research, should be subject to independent external monitoring where the individual is not competent.

47. It has been suggested that national, regional and international medical organisations should consider developing a specialised Code of Ethics for Reproductive Health Providers, covering issues such as autonomy, individual choice and respect for personal integrity. The BMA considers that in areas of the world where reproductive rights seem to be under threat, this could be a helpful development.

48. Doctors and professional medical organisations can have a profound influence on attitudes and prejudices existing within the communities in which they work. Compliance with practices that help promote inequality and disadvantaging of girl children will be seen as endorsement of the attitudes that underpin them. Medical education must raise awareness of the possibilities for influencing society in a positive direction and reducing unfair gender discrimination. It must stimulate awareness of the damaging effects of cultural practices such as female genital mutilation.

49. As studies continue to document incidence of systematic violence, including mass rape, against civilians in war, the drive for establishing mechanisms for identifying and prosecuting perpetrators needs to be accompanied by sensitivity about the effects on victims of being drawn into the collection of evidence rather than just receiving treatment. For many, therapy involves gaining some sense of control over what has happened and, where possible, obtaining

redress. Survivors also need to be able to safeguard their own privacy. Ways in which this can be achieved need further discussion and, particularly, require an input from experts in torture rehabilitation. An aim of such discussion should be the development of standard protocols at national level for the care and examination of rape victims.

50. Health professionals working in settings such as refugee camps' should ensure that programmes have been established to address victims' past experience of rape and that there are mechanisms in place to prevent the future occurrence of sexual violence.

51. The BMA endorses the 1993 World Medical Association declaration condemning female genital mutilation and recommending actions for individual doctors and medical associations. These involve the provision of information to women men and children about its harms and risks, and impose a duty upon medical associations to stimulate awareness about the need for preventative legislation.

52. Effective mechanisms must be in place to ensure the protection of vulnerable populations against coercive family planning. Doctors and aid workers should be aware that in some jurisdiction, the monitoring bodies that exist to safeguard the rights of vulnerable individuals fail to do so.

53. Medical organisations should develop educational materials and guidelines to raise the awareness of doctors about the prevalence and indicators of domestic violence and child abuse. Guidance from professional bodies should set out steps for the care of victims and ways in which they can be encouraged and supported towards voluntary disclosure of it.

54. Doctors or medical organisations who have information about the abuse of women and children covered by international standards established by the United Nations should raise the matter with the relevant Special Rapporteur.

Doctors and asylum seekers

55. As the right to seek asylum is gradually being challenged in many countries the BMA considers that medical associations should object when individuals' with a well-founded fear of persecution are sent back to situations of high risk.

56. Not all forms of torture result in physical scars. In some cases a medical report may confirm the claims made by an asylum applicant. It can take time and many interviews before incidences of torture or abuse are fully revealed, particularly where the abuse has been sexual in nature. Therefore, it is crucial that sufficient time is allowed to obtain crucial medical evidence that can be vital to the case of an asylum seeker alleging torture or ill-treatment in their country of origin. Doctors are encouraged to use existing guidance, such as the 'Istanbul Protocol', to investigate and document allegations of torture.

57. The BMA considers that evidence of torture should be identified at the earliest possible opportunity in order that such evidence can be used to supplement any claim for asylum, to prevent that individual from being detained if this is proposed and to ensure that the individual receives appropriate counselling, medical treatment and other rehabilitative support. The BMA calls on national governments to develop appropriate mechanisms to facilitate this.

58. Doctors should be careful not to discriminate against asylum seekers who seek to register with their practice and should ensure that administrators are aware of procedures for registering asylum seekers. The BMA has issued guidance for doctors on access to health care for asylum seekers in the UK which confirms that there is no requirement to demand the immigration status of an individual who is seeking to register at primary health care level.

59. The BMA supports training for all doctors who regularly treat asylum seekers, some of whom will be victims of torture, in order that they are able to address their particular health care needs. The BMA calls on national governments to develop training programmes with the help of specialist bodies such as the London-based Medical Foundation. National governments should ensure that there are sufficient support services for doctors who treat asylum seekers, including specialist rehabilitative and interpreting services.

60. The BMA considers that detention for asylum seekers should be used only in the "most exceptional circumstances. The BMA is opposed to the immigration detention of asylum seekers in penal institutions.

61. The BMA supports the WMA resolution that physicians can not be compelled to participate in any punitive or judicial action involving refugees or to administer any non-medically justified

diagnostic measure or treatment, such as the use of sedatives, to facilitate easy deportation from the country.

Rehabilitation of torture victims

62. The BMA strongly supports the development of social and health services for individuals who have 'been tortured and for their families who cope with the effects of torture and exile. We urge national medical associations in countries where such specialist rehabilitation centres exist to support this work, through publicity, material aid and any other means that they find appropriate. In addition, governments have a responsibility to devote sufficient resources to permit the mainstream health system to cope with the needs of this group.

63. While recognising the important work undertaken by specialist rehabilitation centres the BMA would welcome more research into the different models for rehabilitation of survivors of torture in order that guidance can be provided on those that have proved the most effective.

64. The London-based Medical Foundation welcomes professional volunteers to treat torture survivors and their families and to prepare medical reports documenting evidence of torture in support of applications for asylum. The BMA urges its members to consider this valuable area of voluntary work.

Truth, justice and reparation

65. International law permits governments to punish torture and other crimes against humanity even in cases where neither victim nor perpetrators have links with the state. Medical associations interested in helping victims of torture obtain a hearing should seek appropriate advice from human rights organizations with expertise in this area.

66. Truth commissions that hear evidence but are unable to punish known perpetrators of human rights violations have been criticised for fostering the notion of impunity. The BMA opposes blanket immunity and considers that all perpetrators should be brought to justice. Nevertheless, the BMA recognises that in circumstances where no other means of justice or redress are forthcoming there are arguments for using such commissions to establish the truth and allow victims to have a hearing.

67. Allowing perpetrators to benefit from impunity can only lead to contempt for the law and to renewed cycles of injustice. Doctors and their professional associations should use their power to ensure that international tribunals, such as that for the former Yugoslavia and Rwanda, are effectively supported and their work monitored. Professional organisations should support mechanisms such as the International Criminal Court to try those guilty of serious breaches of humanitarian law.

68. It is the responsibility of national governments to uphold the law. National medical associations and disciplinary bodies have clear duties to determine the innocence or culpability of doctors against whom allegations of abuse are made. Where the national body is unable or unwilling to act on an alleged incident of abuse, or where the crime is of such a serious nature that the national mechanisms are incapable of action, there should be resort to an international criminal tribunal.

69. Victims of human rights abuses are entitled to redress, including medical and psychological care and rehabilitation for physical or mental damage. Wherever possible, medical organisations should support appropriate mechanisms to promote redress.

70. Perpetrators of abuse should be punished, including doctors who breach basic principles of ethics and human rights. The WMA has passed a resolution calling on national medical bodies to prevent doctors who have committed abuses from evading justice. The BMA supports the proposal for an international registry of doctors against whom there is evidence of participation in gross violations of human rights. Such doctors should not be able to achieve automatic licensing in the jurisdiction of any national medical licensing body without submitting to some review of the evidence against them.

Teaching ethics

71. The value of international consensus statements, such as the Declaration of Tokyo, is lost if they are not known to doctors. Ideally, such guidelines should be brought to the attention of medical students, particularly those who intend to work in settings where human rights violations might be encountered, such as prisons, police stations and other places of detention.

72. In many countries, forensic doctors, prison doctors and those employed in closed institutions are most likely to see evidence of abuse. Such

specialists should have access to training in ethics and human rights standards, including safe reporting procedures and the powers of various monitoring mechanisms, such as the European Committee for the Prevention of Torture (CPT).

73. Training materials should address common practical dilemmas encountered in closed institutions and by doctors with dual responsibilities, including issues such as use of restraint, punishment, covert administration of drugs and use of solitary confinement.

74. Quality teaching materials should be available via media such as the Internet so that they can be accessed by doctors and medical students who have no other means of learning about medical ethics.

75. Human rights organisations should consider making anonymised case examples and other materials available for undergraduate teaching in medical ethics and human rights.

76. Further consideration should be given to the production of non-culture specific, ethics and human rights training materials for health professionals. Such materials should be adaptable for use by medical groups or by doctors working in isolation from colleagues and other sources of advice.

Communalism, Conflict and the Role of the Health Profession

The 29th Annual Theme Meet of the Medico Friend Circle will be held at

Jeevan Darshan Retreat House,
Opposite Methodist Church. Near Lady Pilar Hospital/ Convent School, Fatehganj, Baroda-2

on December 28th-29th, 2002.

Violence in Vadodara: A Report At the Receiving End; Women's Experience of Violence in Vadodara

*PUCL: Vadodara and Vadodara
Shanti Abhiyan*

The Vadodara Shanti Abhiyan was formed about a decade ago in the wake of communal violence in the city. Its members include trade union activists, women's organisations, voluntary organisations and NGOs, as well as individuals like doctors, artists, school and university teachers, and other concerned citizens. Since March, Shanti Abhiyan, along with PUCL- Vadodara, has been working consistently to involve citizens in the city - students, teachers, residents of affected areas in peace initiatives. It has also been involved in relief and rehabilitation work for those affected in the violence, while being constantly in touch with the local administration, on issues of relief and rehabilitation of victims, and appraising them of developments in specific areas which could lead to potential violence.

PUCL- Vadodara and Shanti Abhiyan fact-finding teams investigated incidents of violence in different areas. Teams from outside Gujarat, particularly of women's organisations from Delhi and Mumbai, worked with PUCL- Vadodara and Shanti Abhiyan members to investigate some incidents of violence in different areas of the city and surrounding villages.

Violence in Vadodara: A Report contains chapters on the history of communal violence in Vadodara, the roles of the police and the media, women's experiences of the violence, relief and rehabilitation packages. The report also lists names of those accused as perpetrators including the police and political leaders.

At The Receiving End, Women's Experiences of Violence highlights the police atrocities on women of the minority community of Vadodara through the period of February end till mid May 2002. It also brings out certain recurrent themes that emerged from women's testimonies. Women's demands as well as PUCL-Shanti Abhiyan's recommendations for justice are presented. Selected testimonies included in the report give an idea of the range of experiences that the women went through. It also includes memoranda and protest letters to the Prime Minister and President.

(For Information and Discussion Only -Strictly not to be Quoted) Dual Loyalty

[Given below is the **draft** of the first chapter - Introduction - of the report of an International Working Group jointly set up by the Physicians for Human Rights, USA and the University of Cape Town, South Africa, on the problem of DUAL-LOYALTIES in relation to doctors. I am a member of this working group and share basic concerns expressed in the document, but I must confess that I have not substantially contributed in writing various drafts of the report. This chapter - Introduction - gives overall idea about the international human rights laws related to health and health care; and explains the concept of dual loyalties. I have draft of full report presently undergoing revision. The full report also has general and specific guidelines (in prison, forensic work, military duties, refugees/immigrants, etc) for medical professionals; and also on the institutional mechanism needed to deal with Dual Loyalties situations. If anybody is interested, please let me know.

Amar Jesani

DRAFT November 4, 2002

Introduction: The Problem of Dual Loyalty and Human Rights

The problems of dual loyalty - simultaneous obligations, express or implied, to the patient and to a third party, often the state - continues to challenge health professionals. The ethics of health professionals have long stressed the need for loyalty to people in their care. In the modern world, however, health professionals are increasingly asked to serve goals that require them to balance their devotion to patients with service to the objectives of government or other third parties. Dual loyalty poses special challenges for health professionals throughout the world when the subordination of the patient's interest to those of the state or other agents risks violating the patient's human rights. Despite efforts to bolster ethical codes to protect patients' rights, these efforts have only marginally succeeded, as will be elaborated in more detail in Chapter 2.

The goal of this project is to identify the dimensions of dual loyalty, and provide guidelines and mechanisms to prevent complicity by health professionals in human rights violations. We set out in this introduction to define what dual loyalty

is, how professional ethics and human rights relate in solving dual loyalty problems, and explore the obligations on health professionals to respect human rights. These introductory comments then provide the background to a description of the motivation for and scope of this project.

A. 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 ethics¹ 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."² The WMA International Code of Medical Ethics states, that "a physician shall owe his patients complete loyalty and all the resources of his science."³

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 the 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.⁴

It should be understood that not every conflict or ethical dilemma presents a dual loyalty problem. Medical triage of ill-and injured patients typically raises ethical challenges, since health professionals may face conflicts between medical needs of some patients at the expense of others; however, these are not dual loyalty problems, since there is no clinical role conflict.⁵ Moreover, even when dual loyalty exists, elevating state over individual interests may serve social purposes often accepted as justifiable.⁶ Evaluations for adjudicative purposes are common examples. 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.

B. Dual Loyalty and Human Rights

Dual loyalty becomes especially problematic where the professional acts to support the interests of the state or other entity over 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 providers 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 institutionalised bias or discrimination against women, members of a particular ethnic or religious group, refugees and immigrants, or against patients who are politically or socially stigmatised. 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 where 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 noncompliance, the culture of the institution or society where the professional practices or even the professional's own sense of duty to the state.⁷ In repressive political regimes or in closed institutions like prisons and jails, the personal consequences can be quite severe.

C. Human Rights, Bioethics and the Resolution of Dual Loyalty Conflicts

Many health care professionals are generally familiar with applying bioethics frameworks to assist in resolving difficult clinical dilemmas, such as those which typically arise in end-of-life situations or in the context of limited resources. Less familiar perhaps to health professionals is the process of actively highlighting the human rights dimensions to healthcare practice.⁸ This project seeks to extend the ambit of health professionals' decision making to include the protection of patients' human rights, such as might be required in a case of *dual* loyalty. The frameworks of bioethics and human rights each present approaches to resolving conflicts or competing claims in morally principled ways. Where dual loyalty conflicts are associated with human rights violations, it is essential for health professionals to have sight of what contributions human rights approaches can make to better resolving the problem. In the following sections, we outline what is core to 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.

1. 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.⁹ These claims are not abstractions or based on natural law, social contract, or political theory but stem from international governmental consensus, 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,"¹⁰ the UDHR enumerates specific rights, many of which have been adopted in international and regional treaties that bind states that have ratified the treaties.¹¹ Unlike principles of medical ethics, 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 organisation?"¹² That interferes with "the right to public health, medical care, social security and social services."¹³

Similarly, states have obligations to protect the rights of workers in relations with employers.

Operationalising 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.¹⁴ The former recognises principally the rights to life, liberty, security of the person, freedom from torture and cruel, degrading and inhuman treatment, freedom from 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, religion or social origin.¹⁵ 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 for 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.¹⁶

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 *fulfil*, requiring states to adopt

appropriate legislative, administrative, budgetary and other steps toward the full realisation of the right to the highest attainable standard of health.¹⁷ 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 marginalised groups have access to clean water, education and health services, to immunise its population against communicable diseases to provide information to prevent the spread of disease, and to take other steps the Committee sets out.¹⁸

Although fulfillment of the right to the highest attainable standard of health is subject to resource limitations, 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 marginalised groups," maternal and child health care services, immunisations against infectious diseases, a public health strategy for the society, essential drugs and access to information about the main health problems in the community.¹⁹

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. In Chapter 2, we provide greater detail about how these human rights apply to specific problems of dual loyalty.

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. As such, human rights might be considered as "shorthand" for a process of prior moral reasoning that has gone into the formulation and articulation of these rights as expressions of moral principles considered universal. In health care settings, it is the human rights approach, as elaborated through the various instruments, conventions and treaties discussed

above, which must be the pre-requisite for resolving those dual loyalties conflicts that have the potential to violate human rights?

2. Bioethics

In contrast to human rights standards, bioethics tends to be process oriented, encouraging clinicians, primarily, to engage in reasoned analyses that will determine their courses of action in particularly compelling and difficult clinical situations. The goal of bioethics is to steer health care professionals away from making arbitrary, impulsive or personalised decisions about how people in their care ought to be treated, providing a rational approach to moral decision-making while choosing between possible alternatives, 'the rock' and the 'hard place'.

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 dilemmas²⁰ and the other is the process of resolving clinical dilemmas through philosophical reasoning. A widely recognised framework for resolving morally difficult situations in health care identifies four ethical principles and addresses their scope of application.²¹ 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.²² 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, it is expected that clinicians will far

more often than not, be able to make decisions about what they 'ought' to do. Most health professionals will be familiar with the paradigm based upon the application of these four principles as the bioethical approach.

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.²³ It is now widely recognised that societal factors, such as socioeconomic inequalities, discrimination and a lack of respect for dignity have profound effects on health status and life expectancy,²⁴ and that health disparities are increasingly a matter of ethical concern.²⁵ 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 in the public health domain.²⁶ even though reliance on the principle of justice to resolve ethical dilemmas in public health in the most fair manner remains attractive.²⁷ 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." More work needs to be done to develop bioethics frameworks for public health, which are currently in their infancy.

3. Human Rights and Bioethics

In many ways, human rights and health care ethics complement each other. The four principles speak strongly to key human rights concepts. The interdiction against participation by health care professionals in torture, a key human rights prohibition," is grounded in non-maleficence, the duty to do no harm. Respecting women's autonomy over their reproduction promotes health and the right of access to reproductive health care while combating gender discrimination. Acting in terms of the principle of social justice, clinicians who promote fairness in their management of patients—for example, confronting bias based on race or sex in insurance coverage—also uphold the cornerstone of human dignity.

However, while the four principles may be consistent with human rights tenets in their application, they are not inherently preoccupied with ensuring that human rights standards are met. Indeed, rights may well be constructed in bioethics as only one of many competing duties

and concepts to be considered in a framework of moral philosophical reasoning.³⁰

Moreover, the four principles do not provide a method for arriving at a decision, particularly in how to prioritise or rank competing principles, although historically, ethical traditions, particularly those from North America, have tended to privilege individual autonomy over other principles.³¹ As well, none of the principles carries inherent primacy; and, various moral theories and philosophical traditions may be employed to analyse the relative weighting and importance between these four principles.³²

As a result, there is space for enormous variability in moral decision-making. While moral disagreements *per se* are not a bad thing and should not make us skeptical about the process of bioethical reasoning, in the case of resolving dual loyalty conflicts, there should be little room for negotiation when human rights are at stake. 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.

(1) 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 specifically disadvantaged 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.³³ 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.³⁴ 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.³⁵

(2) 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, presumably for deportation.³⁶ 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.³⁷

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 criteria³⁸ would be deemed unacceptable.

In sum, both the human rights and bioethics approaches generally attempt to promote morally desirable outcomes. Just as bioethical reasoning seeks to balance contrasting principles, human rights approaches sometimes have to balance competing rights.³⁹ Yet, even though in recent years many professional bodies have adopted human rights principles in their ethical codes,⁴⁰ 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-requisite to engaging in ethical decision-making. Where human rights are at stake in a dual loyalty conflict, it therefore becomes necessary to look to human rights approaches to guide the resolution of these conflicts.

D. 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 recognised" in the Covenant.⁴¹

Beyond this general obligation, applicable to the health professional as citizen⁴² are specific obligations imposed by the nature of professionalism, reinforced by the authority given through licensing. Professionalism in essence represents 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 in these expectations

that health professionals carry a particular obligation to respect their patients' human rights, and where failure to do so translates into a fundamental breach of upholding patients' 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 discriminate on the basis of race, sex, 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 equal and equitable access to health care services, the health professional participating in that system has an obligation to contribute to the development of alternatives that have the purpose of ending 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 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."⁴³ 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.⁴⁴ Indeed, many professional associations have explicitly adopted human rights language in their own ethical principles.⁴⁵ 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.⁴⁶ 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?"⁴⁷ The International Council of Nurses' Ethical Concepts Applied to Nursing Code emphasises that "inherent in nursing is respect for life, dignity, and the rights of 'man."⁴⁸ 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."⁴⁹

1. Dual loyalty and human rights: 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. Health professional participation in including complicity with, a violation of human rights does not constitute a permissible social purpose and thus is illegitimate. This general principle, however, has failed to inform professional behavior in the world of practice. With regards to role conflict inherent in dual loyalty, four problems have emerged:

1. *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; the expectations to defer to embedded social practices even if they violate human rights; and the power of the state to use 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.

2. *The Lack of Education and Training*

Health professionals have rarely received 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 often do not provide a reliable foundation for health professionals to assess and respond to state demands. Clarity is particularly lacking in helping health professionals evaluate when a demand to subordinate patients' interests to those of the state is legitimate and when it is not. In many of these cases, the state claims that subordinating patients' interests is a public or common good, for example, 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, particularly when protecting the human rights of patients requires that the health professional should turn state interests aside.⁵⁰

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 conceptualise their function narrowly so as not to interfere with its priorities by, for example, speaking out against abuses.

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, as in denial of reproductive health services to women or institutionalised 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 will require

attention not only to general, overarching statements about health professionals' human rights obligations, but guidance about responses in particular troubling circumstances, so that health professionals can assume the responsibilities a human rights posture asks of them.

3. *Systemic Flaws and Limitations*

Institutional Structures do not support and 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 organisations that play no part in providing Support to health professionals when they are challenged in meeting their human rights obligations. Especially in highly politicised 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 remain loyal to patients.

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 in a manner that will protect the independence of the health professional from state pressures, minimising 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 active state demands to the contrary. Collective action by colleagues in the professions, as for example through their professional organisations, may be required to enable individual health professionals to fulfill their obligations. For this reason, medical, nursing and other organisations should protect and advocate for colleagues who are at risk of becoming engaged in human rights abuses.

4. *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 devalue 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 imposed or inequities built into the system, the more the professional participates in the violation and hence supports the state over the patient.⁵¹

The systemic nature of role conflict may severely constrain the power of the individual practitioner to act to fulfill the human rights of individual patients and communities of patients for whom the practitioner has responsibilities. The latter may include diverse patient populations as well as groups of people or communities, often marginalised and neglected, many of whom do not seek care but are in serious need of care that will often be community-based rather than in clinical settings. Where health professionals have adequate guidance and support, however, they can and should be expected to make decisions affirming human rights.

Professional organisations and codes of conduct have not acknowledged the systemic dimensions of dual loyalty problems, nor have they addressed these human rights concerns in concerted ways. Indeed, there is typically no connection made between institutionalised 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, ignoring the obligations of the profession as a whole.

F. Scope of the Project and Products

1. Roles of Health Professionals

The work of health professionals is broad. At its

core is the clinical consultation with the patient or client, which many times extends to the health of a defined practice population and the wider community. Many health professionals also engage in non-clinical roles, for example, through public health work or in a purely policy role as administrators or directors.

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

A) clinicians providing one-on-one, direct patient care;

B) 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 preemployment);

C) 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);

D) 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)

E) health policy makers in either public or private settings (e.g. health systems planners and administrators).

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 include dual loyalty and human rights in the context of clinical evaluation and treatment (category A), as well as when the Scope extends beyond the therapeutic role with individual patients to both the evaluation function (category B) and to responsibilities for groups and communities that are in serious need of care (category C).

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

Public health roles are excluded from this

project's Scope because of the different set of issues presented in those roles and because, as discussed above, ethical and human rights analyses in public health are not as well developed as for clinical medicine.⁵² The analytical tools available to explore the human rights dimensions of dual loyalty in public health are still in their infancy.⁵³ 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 and need for further work.⁵⁴ We believe that the public health community may want to take on this task. Indeed, we would view such an undertaking as a critical step in aligning public health practice with the promotion of human rights.

2. Public and Private Domains of Professional Duties to Protect Human Rights

In defining the scope of the project, *it is* important not only to *consider* the roles of health professionals but the *third* parties *competing 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 we propose principally address conflicts arising where the health professional is under pressure to subordinate the patient's interests to those of the state. 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* the best example. Thus, for example, the Convention on the Elimination of all forms of Racial Discrimination requires states to take affirmative steps to eliminate racial discrimination in health" 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 like tobacco and to assure that health plans operated by private entities provide equal access and do not constitute a threat to the availability, accessibility, acceptability and quality of health facilities.⁵⁶

The guidelines and institutional mechanisms this project proposes are meant to follow the reach of human rights obligations. Accordingly, they apply to cases where (a) the health professional subordinates loyalty to the patient to the interests of the state in a manner that violates human rights *or* where (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.

Notes

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*.

3 WMA, *International Code of Medical Ethics*.

4 For an overview of dual loyalty, see Bloche, "Clinical Loyalties and the Social Purposes of Medicine," 268274. For a discussion of dual loyalty concerns in everyday practice, see BMA, *Medical Ethics Today: Its Practice and Philosophy*.

5 An ethical concern also arises, for example, where a physician faces financial incentives to withhold care or to order tests or referrals to businesses in which the physician has a financial interest. Here the conflict of interest is between the patient's welfare and the financial self-interest of the physician, rather than an allegiance or submission to an external agency or authority. The problem here is not one of dual loyalty, but of potentially unethical practice. However, where the reimbursement policies of a third party are such as to influence the physician's practice in ways that are detrimental to the patient's best interests, a dual loyalty conflict may be said to exist.

6 Bloche, "Clinical Loyalties and the Social Purposes of Medicine," 268-274.

7 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," 275-284.

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

9 Henkin, *The Age of Rights*, 4.

10 UN, *Universal Declaration of Human Rights*, art. 1.

11 Not all states have ratified all human rights treaties, but many have been agreed to by so many states and the norms have become so universal, that the state's obligations can be considered binding under customary international law. See Steiner and Alston, *International Human Rights Law in Context*.

12 UN, *Convention on the Elimination of All Forms of Racial Discrimination*, art. 2, sec. 1(d).

13 *Id.*, art. 5(e).

14 Human rights instruments, treaties and declarations are all available at the web site of the UN High Commissioner for Human Rights, 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.

15 UN, *International Covenant on Civil and Political Rights*, art. 4.

16 UN, 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 UN, Committee on Economic, Social and Cultural Rights, *The Right to the Highest Attainable Standard of Health*, "General Comment 14," para. 43.

20 See footnotes 1 to 3 above, for example.

21 Beauchamp and Childress, *Principles of Biomedical Ethics*.

22 Gillon, "Preface: Medical Ethics and the Four Principles," in *Principles of Health Care Ethics*, ed. Gillon and Lloyd, xxi.

23 Mann, Gostin, et al., "Health and Human Rights," 7-23; Kass, "An Ethics Framework for Public Health," 1776-82; Roberts and Reich, "Ethical Analysis in Public Health," 1055-9; Beauchamp and Steinbock, *New Ethics for the Public's Health*; Kessel, "Public Health Ethics: Teaching Survey and Critical Review."

24 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," 307-10; Evans et al., "Measuring Quality: From the System to the Provider," 439-446.

25 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.

26 Roberts and Reich, "Ethical Analysis in Public Health," 1055-9.

27 Daniels, *Just Health Care*.

28 Mann, "Medicine and Public Health, Ethics and Human Rights," in *Health and Human Rights. A Reader*, ed. Mann, Gruskin, Grodin, and Annas, 439-452.

29 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.

30 For example, see Gillon, "Medical Ethics: Four Principles Plus Attention to Scope," 84-8, and WHO "25 Questions and Answers on Health and Human Rights," 22.

31 See for example, Ezekiel Emanuel, Amitai Etzioni, Martha Nussbaum, Margaret Walker.

32 There are various moral philosophies and traditions that bioethicists draw upon; among these are utilitarianism, contractarianism, communitarianism, virtue based and relationship ethics.

33 Lowe, Kerridge, and Mitchell KR. "These Sorts of People Don't do Very Well: Race and Allocation of Health Care Resources," 356-60; Epstein, Ayanian, Keogh, Noonan, Armistead, Cleary, et al. "Racial Disparities in Access to Renal Transplantation: Clinically Appropriate or Due to Under use or Overuse?" 1537-1544; Schulman, Berlin, Harless, et al., "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterisation," 618626.

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

35 Ngwena, "The Recognition of Access to Health Care as a Human Right in South Africa: Is it Enough?" 26-44; Scott and Alston, "Adjudicating Constitutional Priorities in a Transnational Context: A Comment on the Soobramoney's Legacy and Grootboom's Promise," 206-268.

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

37 Baldwin-Ragaven, de Gruchy, and London, *An*

Ambulance of the Wrong Colour, 69.

38 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.

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

40 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*.

41 UN, *International Covenant on Civil and Political Rights*, preamble.

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

43 UN, *Convention on the Elimination of all forms of Discrimination Against Women*, art. 5(b).

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

45 See note 40 above.

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

47 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.

48 ICN, *Ethical Concepts Applied to Nursing*.

49Id.

50 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.

51 This phenomenon is well documented in South Africa under apartheid. See AAAS and PHR, *Human*

Rights and Health: The Legacy of Apartheid, 111-113.

52 Roberts and Reich, "Ethical Analysis in Public Health," 1055-1059.

53 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 Francois-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?" 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."

54 Reich and Roberts, "Ethical Analysis in Public Health," 1055-9.

55 UN, *International Convention on the Elimination of All Forms of Racial Discrimination*, Article 5 (e) (iv).

56 UN, Committee on Economic, Social and Cultural Rights (CESCR), *The Right to the Highest Attainable Standard of Health*. "General Comment 14," para. 35.

Postbox

Letter to the British Medical Journal
(BMJ)

*A Letter of Concern: Regarding the Health
Situation in the Relief Camps of Ahmedabad*

Dated: June 18, 2002

Gujarat has been engulfed by unprecedented violence since February 27, 2002 following the Godhra train massacre. Systematic and gruesome attacks have been unleashed against local communities. Hundreds have lost their lives and even larger numbers have been injured. Over a lakh of people continue to live in refugee camps.

We, a team of health professionals from Christian Medical College and Hospital, Vellore, India undertook medical relief in the refugee camps of Ahmedabad, Gujarat between May 28-June 4 in response to the request of a group of Non Governmental Organisations.

Our primary objective was to provide medical services to refugees in the relief camps of Dariakhan Ghummat, Shahalam and the Vatwa Dargah camp No.2 located in various parts of Ahmedabad, Gujarat, India. The first two camps are the largest among the 35-40 camps in the city. On the basis of our initial experiences in providing medical care, our team also undertook an assessment of the public health situation in these three camps. We have been disturbed and concerned by what we have seen and experienced. We have attempted to summarise our observations and concerns.

In the three camps thousands of people are crowded together. Two of the camps are situated in burial grounds and one in a school. People are exposed to heat and rain with minimum shelter. A large number of people have to share a few toilets. Food rations are minimal. People huddle together with a few belongings without privacy or protection. Recreation facilities are nonexistent. In this physical condition, families are struggling to cope with loss of family members, homes and livelihood in an atmosphere of extreme mistrust, physical and emotional insecurity. This is the scenario three months after the camps came into being.

These conditions do not meet the basic living standards and are inimical to health.

In this context the community members and non-governmental organisations through their own efforts and resources have played an outstanding role in ensuring that minimum services and relief are available in the face of extreme odds. However their efforts are overstretched.

Camp inmates have not been provided adequate facilities and guaranteed security in the relief camps. No comprehensive rehabilitation package is in place for the refugees. There is therefore a crisis of confidence in the state.

These camps should not be closed down in view of threat to life and property that still continues in the original localities. The facilities in the camps must be upgraded so that they meet minimum standards required for healthy living.

Observations

Shelter

When the violence erupted, the riot victims fled to mosques, dargahs and burial grounds for refuge. These have been spontaneously been converted into relief camps.

There is extreme overcrowding.

In two of three camps people were housed in makeshift shelters consisting of shamianas (cloth erected on poles as roof and cloth as floor).

Families have been staying in these camps for over three months and despite this length of time a more physically secure structure has not been erected.

The shelters do not protect the people from the intense heat of summer. We observed numerous cases of heat related skin conditions and heat exhaustion.

The monsoons, which are imminent, will flood these camps and make them inhospitable, exposing people to cold and constant damp.

Water and Sanitation

Water supply in the camps has been met by the Municipal Corporation. There are few water points as compared to the international

standard of one water point for 250 people 1. Chlorination of drinking water has been ensured. The drinking water source has been segregated from the toilets.

Toilet facilities in all the camps are inadequate for the population served (1: 70 to 1: 370 people). They are not easily accessible and are poorly maintained. The International Humanitarian charter prescribes one toilet for 20 people within one minute's walk.

There is a potential threat of outbreaks of acute gastroenteritis and other water borne diseases with the coming of the monsoon. Currently sporadic cases of gastroenteritis and viral hepatitis are being reported.

Medical Services

The lack of adequate and coordinated medical facilities has been and continues to be a major problem.

While the bigger camps have managed to organise at least skeletal outpatient and referral systems, the smaller camps have little or no facilities.

Whatever facilities are in place here are due to efforts of the local communities and various non-governmental organisations.

People in the camps are reluctant to access public and private hospitals in view of the perceived discrimination.

Post-traumatic stress disorder and other psychiatric problems related to the extreme physical violence, sexual abuse, loss to life and property are widespread among men, women and children. There has been no provision for specialised counseling and psychological support required to manage these problems. The persisting physical and emotional insecurity has prevented any improvement of these problems.

Patients with chronic diseases such as tuberculosis, hypertension, diabetes, ischaemic heart disease, seizure disorder and psychiatric disorders are unable to continue their regular medical care.

Special needs of women and children have not been addressed adequately.

Food

The food supplies provided by the government do not meet optimal dietary requirements. The camp organizers have to purchase extra supplies to meet the shortfall.

Only two meals per day are provided to the camp inmates. People frequently complain of hunger.

The food provided falls short in taste and dietary quality in relation to proteins, vitamins and mineral requirements.

Pregnant women and children are nutritionally vulnerable, and no extra provision has been made for them. We have seen several cases of anemia and malnutrition.

We recommend:

That the current camp shelters be upgraded to more secure and protective structures. This is urgently required in view of the continuing physical insecurity outside the camps and the imminent arrival of the monsoons.

The provision of coordinated, comprehensive and acceptable medical care at the camps with adequate referral services. Sensitive counselling and psychological support to the survivors of sexual assault, physical violence, and traumatised and bereaved children by trained health professionals is urgently required.

The quality of diet provided at the camps be improved. Balanced diet should be provided for everyone. Pregnant women, lactating mothers and children require special attention.

An increase in the number toilets and in the quality of their maintenance.

A comprehensive and innovative rehabilitation programme, keeping in mind the physical mental and social aspects of health. The NGO's and the local communities do not have adequate resources for this. It is the responsibility of the State to carry out this work.

An independent assessment [refer to the MFC report] of the health situation in the relief

camps of Gujarat between April 15th and 29th, demonstrated an identical health scenario. Over the last month, there is no evidence of any improvement in the poor living conditions and inadequate health care provision. In this context, urgent intervention on the part of national and international agencies is required. We strongly urge you to respond to this humanitarian crisis and provide all possible assistance.

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References

1. Humanitarian charter and Minimum Standards in Disaster Response. www.sphere.project.org/handbook
2. Carnage in Gujarat: A Public Health Crisis, Report of the Investigation by Medico Friend Circle. May, 2002. www.mfcindia.org

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