

# Physicians For Human Rights: Reporting on the Symposium at the Third World Congress

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One of the three concurrent symposia held the day after the end of the World Congress was one run by Physicians for Human Rights. Despite their non-inclusive title, their sub-heading is 'An Organisation of Health Professionals, Scientists, and Concerned Citizens' and their meeting was a highly stimulating and inspirational day of testimony, discussion and debate – a highlight at the conference.

The opening address was from the British-based medical director with Amnesty International, Jim Welsh. He spoke of the barriers which can stop health professionals from speaking out, including the culture of fear (the gun), economic pressures such as demotion or losing one's job and the state's ignoring of medical evidence. He also spoke of less well-known causes such as inadequate training in the methodologies of examining for torture, a poor understanding of ethics and a lack of clinical freedom. He emphasised the need to promote ethics, rights and responsibilities, to monitor ethics and make changes where necessary, and, to promote standards for health professionals. Disobeying corrupt and evil governments requires solidarity and support from groups of health professionals. He identified four ways forward:

- make it difficult for governments to subvert medicine through concerted collective action;
- strengthen the role of ethics in medicine and medical education;
- support basic rights;
- offer the strongest support to those at risk in the front line.

Christian Pross outlined the lessons learnt from Germany regarding health professionals' involvement in human rights abuses. Apart from the well-known Nazi abuses, he also cited examples from World War I where shell-shocked soldiers were 'treated' with electric shocks until the soldiers 'preferred' to return to the front, and, more recently, the revelation that many doc-



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tors were informers in the former East Germany – especially psychiatrists, who had a role in the continued imprisonment of political dissidents. He summarised the lesson from history as 'be wary of any attempt to rewrite ethical codes in the name of a higher state morality'.

Several other speakers examined the relationship of physicians to society. In many senses all physicians are collaborators or caretakers of larger societal aims and purposes beyond the individual patient (a benign example is public health issues, e.g. smoking). Identifying and understanding the relationship between health and other societal goals emphasises the legitimacy for all health professionals to be involved in human rights issues (something some states may choose to dispute). This naturally introduced Vincent Iacopino's discussion on Medical Education in Human Rights<sup>1</sup>. He emphasised that epistemology matters and determines action. Involvement in human rights requires a conceptualisation of health, illness and the role of the physician which is quite different from that taught in many medical schools. It requires a need for education and a multi-disciplinary approach with as many levels of interaction as possible. This can

then demonstrate to others the many bridges between health and human rights. Jonathan Mann subsequently outlined the inadequacies of AIDS programmes within this framework, where societal determinants overwhelmed constructing sound medical care.

Jonathon Glover (author of *Causing Death and Saving Lives*) gave a superb presentation on the psychology of barbarism, a subject he had alluded to in an earlier presentation at the World Congress and the subject of his forthcoming book. He felt there was much to learn about ethical principles from a careful analysis of twentieth-century atrocities. Generally philosophers talk about small issues, not about the role of public opinion (for example) in controlling atrocities. He is interested in the idea of what moral law we would discover by examining these larger issues.

First he explored what aspects of human psychology restrain us from committing atrocities and how these can be undermined. Some would argue that it is only rational self-interest reinforced by social pressures, but Glover believes it is more than this alone; respect for human dignity, sympathy and a sense of moral identity (we don't want to be a certain type of person) are also important. These he labelled as 'inner moral resources'. The psychology of barbarism attacks all of these.

When atrocities occur, people are stripped of their dignity. 'The cold joke' – such as referring to a bath of battery acid as 'the swimming pool' – expresses contempt for the victims. Dehumanisation, including specific comparisons of people to repulsive animals, and gross humiliation of victims softens up the victims and hardens the torturers, thus preforming a dual function. Mechanisms to reduce any sympathy for the victims, e.g. citing a need to be ruthless and tough to bring about a better society, the end justifies the means, etc. are also used. Killing at a distance is preferable be-

cause this weakens sympathy further. Moral identity particularly is endangered in wartime, when there is huge pressure to replace it with obedience. Moral identity is eroded by 'a moral slide, a slippery slope from reflective positions of who we want to be'. Moral identity is also eroded by fragmentation of responsibility, e.g. dropping the nuclear bombs. Moral identity is particular; many Nazis had a moral identity but a wrong one.

Glover's conclusions were that, on the whole, squeamishness is a virtue and toughness is a vice. Moral identity should be rooted in the important human responses. Deontology is usually opposed to examining conse-

quences, but here the kind of person you are is important to the consequences (this is from a deontologist!). A presentation by R. Cook on relativism concluded a weighty and fascinating afternoon session.

*Further information about these sessions and the Physicians for Human Rights is available from Dr Katherine Hall at the Bioethics Research Centre.*

<sup>1</sup> Vincent Iacopino is the Western Regional Director of PHR. Apart from treating torture victims, he also teaches several courses in human rights for physicians. Details can be obtained from the author.

### Information for Contributors

The *Otago Bioethics Report* publishes short papers on Bioethics, particularly those with an emphasis upon current New Zealand issues.

Authors should send their written material to John McMillan, Editor *Otago Bioethics Report*, Bioethics Centre, Otago Medical School, PO Box 913, Dunedin.

## News

### National Standard for Ethics Committee

In september 1996 the New Zealand Ministry of Health published the 'Interim New Zealand Guideline for Good Clinical Research Practice'. This document makes reference to most of the major guidelines and draws heavily upon the World Medical Association's Declaration of Helsinki. A good guide for those involved in clinical research would seem to be indispensable. There are, however, a couple of troubling aspects to these guidelines. There is no mention of the obligations that researchers have when conducting research that involves Maori. There is also no mention of what ought to be done when the research participant cannot, because of age or illness, give informed consent. The Introduction to the guidelines notes that the guidelines are not intended to replace or reduce the obligations to or rights of consumers provided by other legislation (such as the Privacy Act and the Code of Health and Disability Services Consumers' Rights). Even so, neither of these Acts deals explicitly with these issues. Furthermore, this document is supposed to be a guide for researchers, with everything else that is involved in getting research underway, how much can we expect them to read?

The Health Research Council is piloting the use of new standard ethics application forms. Presently application forms vary, depending upon where the committee

is located. One of the major hopes is that standardised forms will make the process of applying for ethical review easier to understand and more efficient, particularly for multicentred trials.

The National Advisory Committee on Health and Disability Services Ethics released the National Standard For Ethics Committees in July of last year. This document is the result of the evolution of National Standards over the last few years. The first standard was published in 1988 by the Ministry of Health following the Cartwright Inquiry. This new standard is the fourth and is the result of work by the National Advisory Committee, the regional ethics committees and representatives from regional ethics committees. The wide range of input and process of evolution seems to be reflected in the breadth and clarity of the document. The new guidelines include recommendations on the membership of ethics committees, the scope of ethics committees, the monitoring of ethics committees and assessing applications for ethical review. The guidelines are clear about the two areas which I mentioned as missing in the clinical research guidelines. Perhaps when the interim guidelines for good clinical research practice are revised, the authors could utilise some of the material from the National Advisory Committee's guidelines for ethics committees.