

Shadow Report

**regarding the
Right to the Highest Attainable Standard of Physical and Mental Health
and the medical profession**

UNITED KINGDOM

**for the
International Committee on
Economic, Social and Cultural Rights**

**Palais Wilson, Geneva
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*The right to the highest attainable standard of health
is an absolute right to the best achievable health outcome*

**By
Doctors for Human Rights**

This report has been prepared by Doctors for Human Rights.

Doctors for Human Rights is the working name of Physicians for Human Rights-UK, whose activities described on the Charity Commission website are, *a health and human rights organisation that promotes and defends human rights generally and campaigns for the integration of human rights into healthcare in particular.*

Since participating in the development of General Comment 14 (1998-2000), Doctors for Human Rights has fought a, so far unsuccessful, battle to require that British medical students and doctors receive education on human rights in general, and the right to the highest attainable standard of health in particular.

Doctors for Human Rights (DHR) was established in 1989 under its former name Physicians for Human Rights-UK (PHR-UK).

DHR is an independent organisation of doctors that channels the humanity, influence and special skills of medical practitioners into promoting human rights.

Examples of Doctors for Human Rights' projects include both civil and political as well as economic, social and cultural rights, over its twenty six year existence, including:-

- * investigated torture in Egypt (1993)
- * documented massacres in Rwanda itself as the genocide was taking place (1994);
- * investigated healthcare delivery in Palestine (1997);
- * facilitated the two year gestation of UN General Comment 14 (1998-2000)

In December 1998 the UN Committee on Economic, Social and Cultural Rights (CESCR) considered PHR-UK's suggestion that the Committee return to the question of the right to health as one possible topic for a day of discussion. [UN Doc. E/C.12/1998/SR.51/ Add.1].

CESCR's decision to go ahead with a General Discussion on Article 12, from which a General Comment would spring, was made six months later in May 1999. The Committee's Rapporteur appointed to co-ordinate the programme spent a year consulting with a large number of NGOs and other institutions from around the world. PHR-UK co-hosted an international conference of international health and human rights organisations in November 1999 in St Albans, that was attended by Professors Eibe Riedel (Rapporteur) and Paul Hunt and chaired by Audrey Chapman of the American Association for the Advancement of Science. At the CESCR's open session on May 8th 2000, the Rapporteur publicly singled out that St Albans conference as being particularly helpful to him and his colleagues.

On 29th April 2000 Dr Peter Hall was the only medically qualified participant on a specially invited informal working group, chaired by the Rapporteur and comprising interested CESCR members and representatives of WHO and other NGOs, that approved General Comment 14's final composition.

- * taught health and human rights on the International Health BSc course at UCL medical school (2001-2003)
- * published information on health and human rights in international medical journals over 26 years

Index

Page 2	Doctor for Human Rights
Page 3	Index
Page 4	Foreword, Introduction, Summary
Page 5	Abstract, Relevant articles within General Comment 14

PART 1

Page 5	<u>THE HUMAN RIGHTS CONTEXT WITHIN WHICH HEALTHCARE IS PRACTISED</u>
Page 5	General Comment 14, Relevant articles within General Comment 14
Page 6	Relevant recommendations from the CESCR 2009 Concluding Observations
Page 7	Statement by the Special Rapporteur regarding doctors receiving education in human rights
Page 7	The report by the Special Rapporteur submitted to the General Assembly
Page 9	The report by the Special Rapporteur submitted to the Human Rights Council 2007
Page 11	The report by the Special Rapporteur submitted to the Human Rights Council 2008
Page 12	Statement by the Special Rapporteur submitted to the Commission on Human Rights 2005
Page 13	<u>THE MEDICAL ETHICS CONTEXT WITHIN WHICH HEALTHCARE IS PRACTISED</u>
Page 13	Doctors role in society - medical professionalism in a changing world

PART 2

Page 14	<u>THE HEALTHCARE CONTEXT WITHIN WHICH HUMAN RIGHTS SHOULD BE PRACTISED</u>
Page 14	The reality, Two excerpts on Human Rights Based Approaches
Page 15	UK Doctors and discrimination
Page 17	US doctors and discrimination
Page 18	Psychology and discrimination Doctors' attitude to human rights values
Page 19	The context of contemporary medical practice
Page 20	The importance of human rights to healthcare provision Page 19 Doctors' attitude to human
Page 22	Doctors attitudes to human rights values in healthcare
Page 24	Epilogue, Recommendation

Forward

As the pace of medical advances accelerate, the capacity of medical practice to influence the quality and quantity of everyone's lives grows. Meanwhile medical ethics, the construing of morals and principles into rules of engagement with patients, has evolved only in matters of detail since the time of Hippocrates over two millennia ago.

In 2000 the United Nations developed General Comment 14, which in sixty five paragraphs authoritatively and comprehensively defines patients' right to the highest attainable standard of health.

The value of an ethos for medical practitioners based upon General Comment 14 lies in its foundation in law, its universality, its conceptual practicality, its aspirational appeal, its comprehensiveness, and above all, ownership of its constituent parts by the people.

Introduction

This report focuses on article 12 of the International Covenant on Economic, Social and Cultural Rights and one section of British society - the right to the highest attainable standard of physical and mental health as practised by UK doctors.

Summary

Health is such a precious quality, and healthcare has become so effective at preserving health, that healthcare workers should adopt a human rights based relationship with patients.

This report demonstrates that some doctors discriminate against people with a mental disorder and people with an intellectual disability.

Psychological research explains the cognitive efficiency of discrimination.

Despite most doctors being highly motivated and well intentioned there appears to be a profound unrecognised profession-wide antipathy towards the application of human rights values to medical practice.

The most important aspect of the right to the highest attainable standard of health to medical practice lies in its transformative effect on the nature of the relationship between doctor and patient

Doctor must receive formal human rights education.

Part 1

THE HUMAN RIGHTS CONTEXT WITHIN WHICH HEALTHCARE IS PRACTISED

A. General Comment 14

It is difficult to overemphasise the importance of UN General Comment No 14 regarding Article 12 of the International Covenant on Economic, Social and Cultural Rights - the right to the highest attainable standard of physical and mental health - which has been ratified by over four in every five countries worldwide. Published in 2000, it transformed Article 12 from a statement of principle and four general instructions on health preservation dating from the middle of the last century, into a 65-paragraph instrument that comprehensively defines and clarifies standards and expectations. At its most simple, it requires states to respect, protect and fulfil their health obligations, which include a series of core minimum requirements such as the provision of the WHO essential medicines. States should 'progressively realise' health rights and are monitored using four major criteria (availability, accessibility, acceptability and quality of services) and, increasingly, indicators and benchmarks¹.

B. Relevant articles within General Comment 14:

Para 18. By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or **mental disability**, health status (including HIV/ AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls General Comment No. 3, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low- cost targeted programmes.

Para 26. The Committee reaffirms paragraph 34 of its General Comment No. 5, which addresses the issue of **persons with disabilities in the context of the right to physical and mental health**. Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

Para 34. In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, **unless on an exceptional basis for the treatment of mental illness** or the prevention and control of communicable diseases. Such exceptional cases should be subject

¹ UN. General Comment 14. The right to the highest attainable standard of health. Geneva: United Nations, 2000.. http://www.nesri.org/sites/default/files/Right_to_health_Comment_14.pdf accessed 9/5/16

to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

Para 42. While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, **including health professionals**, families, local communities, intergovernmental and non-governmental organisations, civil society organisations, as well as the private business sector - have responsibilities regarding the realisation of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.

Para 44. The Committee also confirms that obligations of comparable priority include the following: [...]

(5) to provide appropriate training for health personnel, **including education on health and human rights.**

[...]

C. Relevant recommendations from the CESCR 2009 Concluding Observations:

*15. The Committee is concerned about the low level of awareness of economic, social and cultural rights not only among the public at large but also particularly among judges, public officials, police and law enforcement officials, **medical practitioners**, and other health care-related professionals, despite the State party's assurances to the contrary.*

The Committee recommends that the State party take effective measures to increase awareness of economic, social and cultural rights among the public at large as well as among judges, public officials, police and law enforcement officials, **medical practitioners**, and other health care-related professionals, including by lending adequate support to civil society and national human rights institutions in their efforts in relation to awareness raising.

*34. The Committee notes with concern that **members of the medical profession at all levels** are not sufficiently aware of the State party's Covenant obligations. It is also concerned that health-care professionals do not receive sufficient training in relation to the care of persons suffering from dementia and Alzheimer's and that there is a lack of awareness and understanding of the diseases among the public.*

The Committee recommends that the State party undertake:

... training programmes **for doctors and health-care professionals** about the State party's Covenant obligations, as well as with regard to the prevention and treatment of dementia and Alzheimer's diseases;

D. Statements published by Professor Paul Hunt during his six year tenure serving as United Nations Special Rapporteur on the right to the highest attainable standard of health between 2002-2008, regarding the imperative that doctors receive education in human rights

1. During his inaugural presentation to the International Federation of Health and Human Rights Organisations' conference in 2006, he explained "the right to a fair trial would not have become so widely accepted and implemented without the active support of lawyers. Equally, the right to health will not animate health policies and systems without greater support from health professionals. This, it seems to me, is one of our greatest challenges: how to educate more health professionals about the practical utility of human rights"²

2. The report submitted to the General Assembly on 12 September 2005 (A /60/348), on the right to the highest attainable standard of physical and mental health³:

Summary

[...]

Health professionals have an indispensable role to play in the promotion and protection of human rights, including the right to health. [...]

8. The practice of health professionals has a significant bearing on the promotion and protection of human rights, in particular the right to health. As providers of health-care services, health professionals play an indispensable role in the realisation of the right to health. They have also often played an important role in helping document and redress violations of human rights, such as violence and torture.

9. While the vast majority of health professionals have made valuable contributions towards human rights, some have, wittingly or unwittingly, been complicit in human rights violations. Political, legal, economic, social or cultural pressures that may conflict with human rights mean that they sometimes have to make decisions in their daily practice which have profound human rights implications. Personal views of health professionals may also influence their practice: at times, their views may be inconsistent with the rights of patients. For example, in some countries, health professionals are subjected to institutional or societal pressures, or make decisions based on their own views and conscience, to deny treatment to marginalized groups, such as immigrants; disclose confidential medical records; or deny sexual and reproductive health information to women or adolescents. Health professionals have also, at times, been subject to pressures to participate in human rights violations including torture, forced sterilizations, and female genital cutting mutilation. Decisions made by health professionals can mean the difference between the protection or violation of human rights.

10. In his preliminary report to the Commission on Human Rights, the Special Rapporteur indicated his intention to examine the roles and responsibilities of health professionals towards the right to health, as well as to the difficulties that they face in this regard (E/CN.4/2003/58, paras.

² Hunt P. Inaugural address. IFHHRO Annual Conference ('Exclusion and the Right to Health: The Role of Health Professionals'), 11–13 October 2006, Lima, Peru. <http://repository.essex.ac.uk/9798/1/inaugural-address-international-federation-conference.pdf> (accessed 14/3/16)

³ http://ap.ohchr.org/documents/alldocs.aspx?doc_id=11460, accessed 14/3/16

95-98). This chapter makes some introductory remarks about just one issue concerning health professionals, namely the importance of their education in human rights.

11. Inadequate compliance by health professionals with human rights standards is often the result of complex and interrelated circumstances, including political pressures and societal influences. However, it is often partly attributable to inadequate or non-existent training in human rights. Human rights education is an essential starting point for equipping health professionals with the knowledge and tools to empower them to promote and protect human rights. As well as enabling them to defend the rights of their patients, human rights education also has an important role to play in assisting health professionals defend their own human rights.

12. The value of educating health professionals in human rights has been widely endorsed by States and the health and human rights communities worldwide. In the Vienna Declaration and Programme of Action, adopted in June 1993 by the World Conference on Human Rights, States recognised the importance of special education in human rights and humanitarian law for health professionals. The World Medical Association (WMA) strongly recommends that medical schools include medical ethics and human rights as an obligatory course in their curricula. The International Council of Nurses, in its position on nurses and human rights adopted in 1998, advocates inclusion of human rights issues and the nurses' role in all levels of nursing education programmes. The Committee on the Elimination of Discrimination against Women recommends that Governments "[e]nsure that the training curricula of health workers includes comprehensive, mandatory, gender sensitive courses on women's health and human rights, in particular gender-based violence".

13. Recent years have witnessed the development of many excellent human rights training manuals and courses for health professionals. These range from general ones to those addressing health-related human rights in specific circumstances where human rights are most at risk, such as in prisons and reproductive health-care services, or the health-related human rights of vulnerable groups, such as refugees. Recent research by the British Medical Association and WMA also shows that there is demand among medical students worldwide to learn more about human rights and ethics during their education. The Special Rapporteur is greatly encouraged by these developments. However, he is also very concerned at the inadequate attention given to the right to health and other human rights in curricula of medical and nursing schools and textbooks around the world. Many health professionals simply do not receive education in human rights.

14. While the subject of human rights is regrettably normally absent from medical and nursing education, many medical and nursing schools and textbooks do integrate teaching on bioethics. Bioethics and human rights derive from similar core values. Bioethical frameworks provide valuable, and often human rights-compatible moral guidance to health professionals relating to their professional conduct. The importance of training in bioethics cannot be overemphasised. However, human rights education is also of importance if health professionals are to be fully equipped to defend human rights as an important component of their professional practice. Human rights are grounded firmly in international legal instruments and are subject to a number of monitoring mechanisms. They have a particular preoccupation with accountability and non-discrimination, as well as the protection of the most vulnerable members of society. Human rights therefore provide health professionals with extremely useful tools for promoting and protecting the rights and well-being of patients, as well as their own human rights.

15. To some extent, what health professionals need to know will depend on the country in which they work, as well as their professional specialisation. At a minimum, all health professionals should receive education on the human rights of patients, including their right to health; the health-related human rights of vulnerable groups, such as women, children and people with disabilities; and their own human rights relating to their professional practice. Human rights education should also always include practical instruction in how to implement a human rights approach in clinical practice, including how to maintain respect for the inherent dignity of all patients, resist institutional or societal pressure to commit violations, identify violations, empower patients or colleagues to defend their human rights, and promote accountability in relation to known or suspected abuses, as well as minimising risks of reprisals. More specialised human rights education should be provided to health professionals working in those situations most likely to generate human rights violations, or bring them into contact with evidence of abuses, including in forensic medicine, prisons, mental health services, family planning services, situations of armed conflict, or working with vulnerable communities.

16. Under international human rights law, States have the primary obligation to ensure the right to the enjoyment of the highest attainable standard of health. The Special Rapporteur therefore emphasises the central importance of States building an environment that supports the adoption of rights-based approaches by the health professional community. It is particularly important that States do not place health professionals in a position where they may be called on to use their skills to further violations of human rights of the people they serve, and that States provide accountability mechanisms to redress or prevent human rights violations in the context of clinical practice. However, other actors also have an important role to play. Medical and nursing schools and other bodies training health professionals should integrate human rights education and training at all professional levels. Building on existing examples of good practice, national health professional associations should raise awareness about human rights and stimulate demand for human rights education among their members, and they should also assist health professionals involved in defending human rights through providing specialist advice and institutional support. Although the focus of this particular chapter is the human rights education of health professionals, the Special Rapporteur notes in passing that law schools and other human rights training institutions should include the right to health and other health-related human rights in their curricula. In his country missions, the Special Rapporteur seeks — and will continue to seek — information on whether health professionals receive human rights education, and how far States and national health professional

3. The report submitted to the Human Rights Council in January 2007 (A/HRC/4/28) on the right to the highest attainable standard of physical and mental health:A/HRC/4/28⁴

[...]

The pivotal role of health professionals

38. Here the term “health professionals” is used to encompass all those working in the fields of medical care and public health, including health community workers, policymakers, economists and administrators.

⁴ <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G07/102/97/PDF/G0710297.pdf?OpenElement>. Accessed 1/5/16

39. The Special Rapporteur has submitted over 20 reports on the right to the highest attainable standard of health, and these reports repeatedly confirm the common ground shared between those professionals working in health and those working in human rights. Both groups wish to establish effective, integrated, responsive health systems accessible to all. Both stress the importance not only of access to health care, but also access to water, sanitation, health information and education. Both understand that good health is not the sole responsibility of the Ministry of Health, but a wide range of public and private actors. Both prioritize the struggle against discrimination and disadvantage and both stress cultural respect. At root, those working in health and human rights are both animated by a similar concern: the well-being of individuals and populations.

40. Moreover, these reports not only confirm that health and human rights occupy much common ground; they also show how health and human rights complement and reinforce each other.

41. Obviously, the realization of the right to the highest attainable standard of health depends upon health professionals enhancing public health and delivering medical care. The right to health cannot be realized without health professionals. Equally, the classic, traditional objectives of the various health professions can benefit from the new, dynamic discipline of human rights. Human rights can help to reinforce existing, good health programmes, and they can sometimes help to identify new, equitable health policies. They can help to ensure that health policies and programmes are equitable, effective, evidence-based, robust, participatory, inclusive and meaningful to those living in poverty. The supportive role of human rights extends to the provision of medical care, as well as public health. Also, provided it is done in an appropriate manner, framing a pressing health concern as a human rights issue can enhance its legitimacy and importance. In other words, health professionals can use human rights to help them achieve their professional objectives.

42. Health professionals run the key international health organisations, as well as ministries of health across the globe. Naturally, they dominate the health sector, both public and private. Clearly, there is no possibility of putting the right to health - and other health-related rights - into practice without large numbers of well-positioned health professionals understanding and supporting this endeavour. In short, there is no chance of operationalising the right to health without the active engagement of many health professionals.

43. Here, however, is a very major problem. To be blunt, most health professionals whom the Special Rapporteur meets have not even heard of the right to health. If they have heard of it, they usually have no idea what it means, either conceptually or operationally. If they have heard of it, they are likely to be worried that it is something that will get them into trouble. The problem is partly one of language: while health and human rights have much in common, the language used is often different. That is one of the reasons why the Special Rapporteur is presently completing a short paper on the complementary relationship between equity (a term familiar to many health professionals) and human rights.

44. Earlier in this section, the Special Rapporteur argues that some health professionals have recently begun to take human rights, including the right to health, more seriously. This is undoubtedly true and very encouraging. However, if further progress is to be made towards the operationalisation of the right to health, many more health professionals must begin to appreciate the human rights dimensions of their work. The message must be conveyed much more clearly and

widely that the right to health, and other health-related rights, are allies and assets for health professionals to use. Health professionals can use health-related rights to help them devise more equitable policies and programmes; to place important health issues higher up national and international agendas; to secure better coordination across health-related sectors; to raise more funds from the Treasury; to leverage more funds from developed countries to developing countries; in some countries, to improve the terms and conditions of those working in the health sector; and so on. It is crucial that many more health professionals come to appreciate that the right to the highest attainable standard of health is not just a rhetorical device, but also a tool that can save lives and reduce suffering, especially among the most disadvantaged.

47. It would be unfair to reproach those health professionals who are unfamiliar with the right to health and other human rights. It is not their fault if they have not been exposed to the potential of human rights to reinforce their work. In most countries, health professionals can qualify and practice without being taught anything about human rights. It is for this reason that in one of the Special Rapporteur's earliest reports he devoted a section to the importance of deepening human rights education for health professionals.

4. A report submitted to the Human Rights Council in January 2008 (A/HRC/7/11) regarding the PROMOTION AND PROTECTION OF ALL HUMAN RIGHTS, CIVIL, POLITICAL, ECONOMIC, SOCIAL AND CULTURAL RIGHTS.⁵

[...]

There is a growing recognition that a strong health system is an essential element of a healthy and equitable society. In any society, an effective health system is a core social institution, no less than a fair justice system or democratic political system. However, according to a recent publication of the World Health Organisation, health systems in many countries are failing and collapsing.

12. The last six decades of international and domestic policy and practice have confirmed that health is not only a human rights issue but also a fundamental building block of sustainable development, poverty reduction and economic prosperity. Recently, there has also been growing recognition that a strong health system is an essential element of a healthy and equitable society. In any society, an effective health system is a core institution, no less than a fair justice system or democratic political system.

[...]

68. What are these functional elements of a health system? The health literature on this issue is very extensive. For its part, WHO identifies “six essential building blocks” which together make up a health system:

[...]

(b) Health workforce. “A well-performing health workforce is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances, i.e. there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive”;

[...]

⁵ http://www.who.int/medicines/areas/human_rights/A_HRC_7_11.pdf. Accessed 14/3/16

82. Health workers' training must include human rights, including respect for cultural diversity, as well as the importance of treating patients and others with courtesy. This issue is explored in the Special Rapporteur's report on health workers and human rights education⁶.

5. Statement submitted to the Commission on Human Rights on 11th Feb 2005 (E/CN.4/2005/51) by Professor Paul Hunt during his tenure serving as Special Rapporteur on the right to the highest attainable standard of health between 2002-2008, regarding discrimination against persons with mental disabilities ⁷

[...]

51. International human rights law proscribes discrimination in access to health care and the underlying determinants of health, and to the means for their procurement, on grounds including physical and mental disability, and health status.

52. Various forms of stigma and discrimination continue to undermine the realisation of the right to health for persons with mental disabilities. For example, they often face discrimination in access to general health-care services, or stigmatising attitudes within these services, which may dissuade them from seeking care in the first place. Stigma and discrimination within the community, schools and workplaces can also act as a barrier to persons seeking social support, diagnosis and treatment.

53. While the majority of families provide deeply caring and supportive environments for family members with mental disabilities, in some cases stigma may lead to inappropriate institutionalisation of persons with mental disabilities against their will, including sometimes in institutions which have inadequate facilities for treatment and care, and where their dignity and other human rights are at risk.

54. Decisions to isolate or segregate persons with mental disabilities, including through unnecessary institutionalisation, are inherently discriminatory and contrary to the right of community integration enshrined in international standards. Segregation and isolation in itself can also entrench stigma surrounding mental disability.

55. A lack of accurate information about mental disability, as well as inadequate support services, often fuels these decisions. The dissemination of information about mental disability, and the human rights of persons with disabilities, is an important strategy for combating stigma and discrimination. States have an obligation "to provide education and access to information concerning the main health problems in the community". The provision of human rights and disability awareness training for health workers, as well as staff in related sectors, is also essential for ensuring equal access to care, and the respect of the human rights and dignity of persons with mental disabilities within care.

56. Under international human rights law, States not only have an obligation to prohibit discrimination, they also have a positive obligation to ensure equality of opportunity for the enjoyment of the right to health by persons with mental disabilities. For example, as well as

⁷ <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G05/108/93/PDF/G0510893.pdf?OpenElement>. Accessed 14/3/16

being entitled to the same health-care services as other members of society, the right to health gives rise to an entitlement of persons with mental disabilities to have access to, and to benefit from, those medical and social services which promote their independence and autonomy, prevent further disabilities and support their social integration.

57. This may demand special measures for particular groups. For example, States should ensure that adolescents with mental disabilities or psychosocial problems have access to necessary services that are sensitive to their needs. The Committee on the Rights of the Child has stressed the particular importance of paying particular attention to, among others, the special needs relating to the sexuality of adolescents with disabilities.

58. Inappropriate resource allocation can lead to inadvertent discrimination. Crucially, the small budgetary allocations that most countries accord to mental health is a significant barrier to persons with mental disabilities enjoying their right to health on the basis of equality of opportunity.

THE MEDICAL ETHICS CONTEXT WITHIN WHICH HEALTHCARE IS PRACTISED

E . Two excerpts from *Doctors in Society, Medical professionalism in a changing world - Report of a Working Party, December 2005*

Medicine bridges the gap between science and society. Indeed, the application of scientific knowledge to human health is a crucial aspect of clinical practice. Doctors are one important agent through which that scientific understanding is expressed. But medicine is more than the sum of our knowledge about disease. Medicine concerns the experiences, feelings, and interpretations of human beings in often extraordinary moments of fear, anxiety, and doubt. In this extremely vulnerable position, it is medical professionalism that underpins the trust the public has in doctors⁸.

[...]

In their day-to-day practice, doctors are committed to integrity, compassion, altruism, continuous improvement, excellence [and] working in partnership with members of the wider healthcare team. These values, which underpin the science and practice of medicine, form the basis for a moral contract between the medical profession and society⁹.

⁸ Working Party of the Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. Clin Med 2005; 5 (6 suppl 1): XI

⁹ Working Party of the Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. Clin Med 2005; 5 (6 suppl 1): 15

Part 2

THE HEALTHCARE CONTEXT WITHIN WHICH HUMAN RIGHTS SHOULD BE PRACTISED

F. The reality

Fifty years on from the adoption of the International Covenant on Economic, Social and Cultural Rights¹⁰, and twenty three years after the UN World Conference on Human Rights in Vienna¹¹ recognised the importance for healthcare professionals of special education in human rights and humanitarian law, doctors remain largely unaware of the significance of economic, social and cultural rights in general, and the right to the highest attainable standard of health in particular.

G. Excerpts from 'Making the Case: What Is the Evidence of Impact of Applying Human Rights-Based Approaches to Health' published in *Health and Human Rights Journal* Vol 7 Issue 2 p 1

In 2003, the United Nations (UN) outlined the pillars of an Human Rights Based Approaches (HRBA) to development, which include universality and inalienability, indivisibility, interdependence and interrelatedness, non-discrimination and equality, participation and inclusion, and accountability and the rule of law. Since then, leaders from national governments and UN agencies have repeatedly emphasised the need to operationalise human rights and incorporate them into the implementation of policies, programs, projects, and other health-related interventions with a view to enhancing effectiveness. Nevertheless, implementation efforts regarding HRBAs to health and development have faced, and continue to face, multiple challenges, including some degree of miscommunication and polarisation between different fields, where the imperatives of health and human rights are not always seen as complementary and rights imperatives are misconstrued to ignore all concerns regarding cost-effectiveness.

Measuring evidence of impact is far from simple in an HRBA. It challenges three fields—human rights, public health, and medicine (as well as related communities and disciplines)—to bridge epistemological differences about the nature of what constitutes evidence and impact, as well as how to establish those truths.¹²

H. Excerpts from 'A Review of the Impact of the Human Rights in Healthcare Programme in England and Wales' by Lindsey Dyer published in *Health and Human Rights Journal* Vol 17 Issue p 111.

The Human Rights in Healthcare Programme was established in England in 2005 as part of a government-led initiative to embed human rights into public services and develop a culture of respect for human rights. The purpose of the Programme—a collaboration between the Department of Health, the British Institute of Human Rights, and, by 2012, eight participating National Health Service (NHS) trusts—was “[t]o assist NHS Trusts to use a human rights based approach (HRBA) to place human rights at the heart of healthcare.”

¹⁰ United Nations General Assembly. International Covenant on Economic, Social and Cultural Rights. Adopted 16 December 1966. <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>. Accessed 11/5/16

¹¹ United Nations World Conference on Human Rights. Vienna Declaration and Programme of Action. Adopted 25 June 1993. <http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx>. Accessed 11/5/16

⁹ Hunt P, Yamin A, Bustreo F. Making the Case: What Is the Evidence of Impact of Applying Human Rights-Based Approaches to Health. https://cdn2.sph.harvard.edu/wp-content/uploads/sites/13/2015/12/Editorial_17.2_Jan21.pdf. Accessed 11/5/16

Five broad principles, known as the PANEL principles, were recognized as core elements of an HRBA:

- People’s right to participate in decisions that affect their lives;
- Accountability of duty-bearers to rights-holders;
- Non-discrimination and prioritisation of vulnerable groups;
- Empowerment of rights-holders; and
- Legality: the express application of the 1998 Human Rights Act.

The aim was to use human rights as both an end and a means—in other words, as a source of legal standards and obligations as well as one of principles and practical methods that determine how those standards and obligations are to be achieved. At the time of its launch, the programme enjoyed high-level support; for example, in the words of the minister of state for health services, “Quite simply we cannot hope to improve peoples’ health and well-being if we are not ensuring their human rights are respected.”¹³

[...]

A 2009 inquiry to assess the progress being made toward a culture of respect for human rights in Great Britain found that much remained to be done to give effect to international agreements. While there has been no UK-wide survey since the 2003 Audit Commission report, Donald and colleagues found no evidence to show that the lack of attention to human rights in health care has changed¹⁴.

I. UK doctors and discrimination

The seminal report *Recognising the importance of physical health in mental health and intellectual disability-achieving parity of outcomes* was published by the British Medical Association in 2014¹⁵

The report was prepared under the auspices of the Board of Science of the British Medical Association which acts as an interface between the medical profession, the Government and the public. It describes premature and unnecessary deaths amongst people with mental health disorders and people with an intellectual disability, and points out that about a quarter of the population will experience some kind of mental health problem in the course of a year.

- i) Excerpt from the 'Foreword' of the report written by Chair of the Board of Science, Professor Sheila the Baroness Hollins—a former Professor of the Psychiatry of People with a Learning Disability.

'It is distressing that in the 21st Century someone with a mental health condition will typically die between 15 and 20 years earlier than someone without, and that people with intellectual disabilities continue to suffer unnecessarily with untreated, or poorly managed, conditions. These vulnerable groups deserve the same rights as everyone else, to live healthier and longer lives. The medical profession has a vital role in helping to achieve this. Not only do we need to

¹³ Dyer I, A Review of the Impact of the Human Rights in Healthcare Programme in England and Wales. HHRJ 1717 pp111-122. 2105. https://cdn2.sph.harvard.edu/wp-content/uploads/sites/13/2015/12/12.Dyer_.pdf. Accessed 11/5/16

¹⁴ 1. A. Donald, J. Watson, and N. McClean, Human rights in Britain since the Human Rights Act 1998: A critical review (London: Human Rights and Social Justice Research Institute, London Metropolitan University, and Equality and Human Rights Commission, 2009), p. 184. https://www.equalityhumanrights.com/sites/default/files/human_rights_in_britain_since_the_human_rights_act_1998_-_a_critical_review.pdf

¹⁵ *Recognising the importance of physical health in mental health and intellectual disability*. BMA Board of Science. p vi. BMA publications unit. London 2014) <http://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/recognisingtheimportanceofphysicalhealthinmentalhealthandintellectualdisability.pdf>

set the standard in raising aspirations for these groups and in challenging discrimination, but we also need to make sure our healthcare services deliver the best possible care.'¹⁶

ii) Excerpt from the 'Introduction'

'Third world mortality in a first world country'. This is how one expert in the field of psychiatry describes the disparity in mortality rates experienced by people with mental health problems in high-income countries like the UK. One in three of the 100,000 people who die prematurely each year in England have a mental illness: on average, men with mental health problems die 20 years earlier, and women die 15 years earlier, than the general population. While this shortened life expectancy reflects higher rates of suicide, as well as accidental and violent fatalities, the majority of deaths in this group arise from preventable causes and could have been avoided by timely medical intervention"¹⁷

iii) Criticism of the attitudes of healthcare professionals, as described within the report:

Discriminatory attitudes towards mental health and learning disability patients persist across the health sector. [...] Feelings of fear, mistrust and impatience among healthcare professionals, stemming from societal prejudices and limited experiential training, may further hamper the provision of good quality care. [...] Healthcare professionals may be unaware that they are discriminating and acting in ways that have detrimental consequences. [...] judgements may be based upon the practitioner's prejudices about that person's quality of life, their capabilities, or value as a citizen, rather than clinical evidence.¹⁸

Comment

The BMA Board of Science report *Recognising the importance of physical health in mental health and intellectual disability - achieving parity of outcomes*, though magisterial in scholarship and analysis, compounds the egregious violation of the patients' health rights to which it alludes by disregarding them. Most avoidable deaths were due to inadequate diagnosis, treatment, or prevention.

Despite acknowledging that these marginalised groups of people enjoy the same rights as everyone else, and that stigmatisation, discrimination and prejudice were significant drivers underlying their untimely deaths, the authors fail to join up the dots. The disregard of the fact of the violation of the victims' right to the highest attainable standard of health, coupled with the anonymising effect of mortality figures, effectively euphemises the tragedy of each avoidable death into a statistic.

It is to the credit of the BMA that the report launches the campaign entitled 'Promoting parity of esteem between mental health, intellectual disability, and physical health' but the employment of such archaic terminology as a substitute for a campaign explicitly promoting patients' health rights, only serves to highlight the reluctance of doctors to engage with human rights - ultimately to the detriment of patients.

¹⁶ Recognising the importance of physical health in mental health and intellectual disability. BMA Board of Science. p vi. BMA publications unit. London 2014)

¹⁷Recognising the importance of physical health in mental health and intellectual disability. BMA Board of Science. p1. BMA publications unit. London 2014

¹⁸ Recognising the importance of physical health in mental health and intellectual disability. BMA Board of Science. p72-3. BMA publications unit. London 2014

vi) A 2010 ICM survey on discrimination

A 2010 ICM survey carried out on behalf of Mencap demonstrated that more than a third of doctors and nurses think the NHS discriminates against patients with a learning disability, and approaching half of doctors (including 61% of GPs) considered they receive lower standards of healthcare¹⁹

vii) A 2012 follow up ICM survey on discrimination

In a 2012 follow up ICM poll carried out on behalf the General Medical Council, more than a third of doctors reported that they had witnessed a patient with a learning disability facing direct discrimination.²⁰

viii) The 2012 Confidential Inquiry

The 2012 Confidential Inquiry into premature deaths of people with a learning disability established that the risk of someone with a learning disability dying as a result of inadequate medical care, to be more than four times that of the remainder of the population²¹

ix) Physical health disparities and mental illness

It seems clear, therefore, that medical staff, guided by negative stereotypes, tend to systematically treat the physical illnesses of people with mental illness less thoroughly and less effectively. For example, people with co-morbid mental illness and diabetes who presented to an emergency department, were less likely to be admitted to hospital for diabetic complications than those with no mental illness. It is clear that such consistent patterns of less access to effective physical healthcare can be considered as a form of structural discrimination.²²

J. US doctors and discrimination [included because it helps demonstrate how widespread is the evidence of discrimination in healthcare, and because of the useful complex analysis of its conclusions]

i) The executive summary of the 2002 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* published by the US National Institute of Medicine, is reproduced below.

Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled. The sources of these disparities are complex, are rooted in historic and contemporary inequities, and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilisation managers, healthcare professionals, and patients.

¹⁹ Perceptions of the care and treatment of people with a learning disability in the NHS according to health professionals in England, Wales and Northern Ireland. Mencap. ICM Poll. June. 2010.

²⁰ ICM poll of doctors, unpublished research, January 2012.

²¹ Heslop P, Blair P, Fleming P et al. Confidential Inquiry into premature deaths of people with learning disabilities. p92. Norah Fry Research Centre. 2012. <http://www.bris.ac.uk/cipold/fullfinalreport.pdf>

²² Thornicroft G. Physical health disparities and mental illness: the scandal of premature mortality. BJ Psych 199, 441–442. 2011
<http://www.nationalelfservice.net/cms/wp-content/uploads/2011/11/BJPsych-Dec-2011-Graham-Thornicroft-editorial.pdf> (accessed 15/3/16)

Consistent with the charge, the study committee focused part of its analysis on the clinical encounter itself, and found evidence that stereotyping, biases, and uncertainty on the part of healthcare providers can all contribute to unequal treatment. The conditions in which many clinical encounters take place—characterised by high time pressure, cognitive complexity, and pressures for cost-containment—may enhance the likelihood that these processes will result in care poorly matched to minority patients’ needs. Minorities may experience a range of other barriers to accessing care, even when insured at the same level as whites, including barriers of language, geography, and cultural familiarity²³.

ii) Physicians for Human Rights (US)

A follow up study of the National Institute of Medicine report, published by Physicians for Human Rights a year later confirmed that stereotyping and bias subvert healthcare across the full spectrum of diseases and treatments ²⁴

K. Psychology and discrimination

[this section comprises direct quotes from three papers by three different authors].

The first author is Narinder Kapur, visiting professor of neuropsychology, University College London, London WC1E 7HJ.

Unconscious Bias ²⁵

Human bias can be defined as a disposition to think, feel, or act in a particular way. It may stem from longstanding personality attributes, from particular sets of knowledge or past experience, or from a current predicament. Unconscious bias occurs when such tendencies are outside our awareness and conscious control.

The Nobel Prize winning psychologist, Daniel Kahneman, has postulated the operation of fast and slow cognitive processing systems, where the fast, unconscious system is particularly prone to errors such as unconscious bias. In recent years our understanding of cognitive bias has advanced, both as a general phenomenon²⁶ and as a phenomenon within specific domains such as racism.²⁷

The second author is Barbara Reskin, the S. Frank Miyamoto Professor of Sociology at the University of Washington

Stereotypes ²⁸.

Man’s brain favours stereotyping because of its cognitive efficiency but stereotypes assimilated by a society as shared knowledge can become ingrained as unconscious prejudice even after intentional discrimination has been eliminated

²³ Smedley BD, Stith AY, Nelson AR. Unequal treatment: confronting racial and ethnic disparities in health care. Exec Summary p11. Washington: National Academy Press, 2002 http://www.nap.edu/catalog.php?record_id=10260 - accessed 15/3/16

²⁴ Physicians for Human Rights. The right to equal treatment. p1. Boston 2003. <http://www2.paeaonline.org/index.php?ht=a/GetDocumentAction//135605-> accessed 15/3/16

²⁵ Kapur N, Unconscious bias harms patients and staff. *BMJ* 2015;351:h6347 doi: 10.1136/bmj.h6347

²⁶ Banaji M, Greenwald A. *Blind spot: hidden biases of good people*. Delacorte Press, 2013.

²⁷ Van Ryn M, Burgess DJ, Dovidio J, et al. The impact of racism on clinician cognition, behaviour, and clinical decision making. *Du Bois Rev* 2011;8:199-218.

²⁸ Reskin B. Unconscious raising. Regional review. Federal Reserve Bank of Boston. p 32-7. Vol 2005 <http://www.bos.frb.org/economic/nerr/rr2005/q1/section3a.pdf> - accessed 15/3/16

The third author is Nathalia Gjersoe - a lecturer in developmental psychology at the Open University ²⁹

Racist Stereotypes

Racist stereotypes, at their root, come from quite a fundamental learning mechanism. Humans are able to learn and adapt so quickly because they are excellent at making generalisations about the world based on very limited experience.

While the majority ³⁰ of people in Western countries are egalitarian believers in a fair meritocracy, on tests of unconscious racial bias about 70% ³¹ show a preference for their own race. The classic test is the Implicit Association Test ³², which measures how quickly you are able to categorise photos of members of your own race with positive characteristics and members of a minority race with negative characteristics.

Being aware of implicit racial prejudice is important. We need to know it's there to guard against it influencing our behaviour and we need to shape society to minimise its effects.

L. The context of contemporary medical practice

The threatened nature of the doctor-patient relationship in today's medical practice

Traditionally the basis for patients' care has been the shared relationship between doctor and patient.

Healthcare evolves continuously, sometimes with unintended consequences. Even as medical interventions become evermore pervasive and invasive, sustained doctor-patient relationships become increasingly rare because of logistic pressures. This undermining of continuity jeopardises the quality of medical care, and patients' confidence in the profession. Increasingly, the vision of the 2005 Royal College of Physicians' working party on professionalism—that a doctor's purpose is realised through a partnership based on mutual respect, individual responsibility, and appropriate accountability—becomes more tenuous³³.

Time pressures engendered by diminished hospital capacity and increased demand for medical services have inevitably had a negative effect on the quality of care provided. The ever increasing transience and fragmentation of individual doctor responsibility towards, and relationship with, individual patients in contemporary medicine is compounded by the march of medical sub-specialisation (the multiplicity of doctors responsible for different parts of the body, gender or age groups, or methods of investigation or treatment), enhanced pressures on doctors' time and the burgeoning influence of multidisciplinary teams decision-making processes that further distance patient-care from any semblance of sentiment particular to individual patients, or sense of awareness of the impact medical management decisions might have on individual patients. The disintegration of the quality of professional relationships between a doctor and patient risks degrading experiential benefits, skills, motivation and

²⁹ Gjersoe N. How can we fix unconscious racism? Guardian 8/7/15 www.theguardian.com/science/head-quarters/2015/jul/08/how-can-we-fix-unconscious-racism. Accessed 16/3/16

³⁰ Is Britain really becoming more racist? Easton M. BBC 28 May 2014 <http://www.bbc.co.uk/news/uk-27608252> accessed 22/8/15

³¹ Implicit Association Test: Are You Secretly Racist? (Hint: You Are) Scientific Blogging 6/8/12 http://www.science20.com/news_articles/implicit_association_test_are_you_secretly_racist_hint_you_are-92783 accessed 22/8/15

³² Implicit-association test. Wikipedia. https://en.wikipedia.org/wiki/Implicit-association_test accessed 22/8/15

³³ Working Party of the Royal College of Physicians. Doctors in society: medical professionalism in a changing world. Clin Med 2005; 5 (6 suppl 1): 14

emotional rewards of such relationships for doctors and patients, and the abandonment of patients to the whims of tactically, as opposed the strategically applied, medical care.

The importance of human rights to healthcare provision

Perceptions dictate attitude, and attitude dictates behaviour. The Royal College of Physicians' working party on professionalism's determined that medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors.³⁴

There is no more moral, nor more comprehensive, a standard concerning the quality of relationships people share, than one based upon human rights values. Traditionally the quality of the relationship that doctors and patients share, one almost invariably characterised by a significant power disparity in favour of the doctor, has been governed by medical ethics - though latterly the march of legislation such as the Mental Capacity Act supersedes doctors' former hegemony in this regard.

Currently, in the United Kingdom, the standard of medical practice has long been governed by three independent regulatory frameworks:-

- i) standards of medical care overseen by the individual Royal College particular to each specialty;
- ii) medical ethics construed from historical and contemporary moral principles and law into rules of engagement with patients, which apply to every doctor;
- iii) and those of the regulatory authority's (the General Medical Council which licenses doctors to practise) eighty meticulously selected obligatory rules specified in *Good Medical Practice*, reinforced by annual appraisal and backed up by a five yearly formal revalidation process.

Uniquely, the medical profession lays claim to two and a half millennia of ethically based medical practice. The astonishing longevity of the Hippocratic Oath is testament to the enduring appeal of the principles espoused within it. Yet, despite the complexities of contemporary life and modern healthcare provision having marginalised the Oath's role to one of symbolism, and the plethora of earnest attempts by the profession to develop new codes with which to synthesise paradigmatic practice, no alternative has met the requisite combination of scope, gravitas and authority.

Although ethical rules are considered to ensure a reliable framework with which to guide medical practice, they tend to be, perhaps as a result being exclusively within the purview of doctors, subject to inflexibility or susceptibility to cultural and geographical disparities. When, as recently as 13 years ago, UK medical students were reported to have—either alone or in groups—been performing rectal and vaginal examinations on unconscious patients without consent, the author euphemistically proposed ethical drift to be the confounding factor³⁵. A leading UK ethicist has described how the principle of respect for autonomy held little weight in rural India. Doctors there act as the decision makers in a population that is largely illiterate and medically unsophisticated.³⁶ During the apartheid era the Medical Association of South Africa became complicit with healthcare discrimination on an industrial scale via speciously warped interpretations of medical ethics.

³⁴ Working Party of the Royal College of Physicians. Doctors in society: medical professionalism in a changing world. Clin Med 2005; 5 (6 suppl 1): xi

³⁵ Coldicott Y, Pope C, Roberts C. The ethics of intimate examinations teaching tomorrow's doctors. BMJ 2003;326:97-101

³⁶ Sokol D. We must do more for doctors trained abroad. BMJ 2010;341:c4837

Even the ostensibly sacrosanct tenet that doctors should make the care of the patient their first concern can fail to stand up to analysis. The same leading ethicist has argued persuasively that despite the absolute disposition of the statement, it is ethically justifiable to hedge it with conditionalities into ‘in your professional capacity as a doctor, make the care of your patient your first concern, acting within morally and legally acceptable limits and bearing in mind your other patients, including at times future patients and their particular needs as well as any protective obligations to the broader community, your own obligations to develop your skills and knowledge as a clinician, and obligations you may have towards others for whom you are responsible.’³⁷

The current edition of *Good Medical Practice* comprises an exhaustively comprehensive series of instructions regarding medical practice that eschews reference to human rights, though it does insist that patients be treated equally. Notably, in the first paragraph of a list of general principles placed on the first page, it specifies that doctors "must show respect for human life". The qualification 'human' is intriguing not least because doctors deal exclusively with human lives. It suggests the authors felt compelled to recognise the unique importance of human life, despite subsequently studiously avoiding any allusion to the human rights discourse whose very *raison d'être* is the unique value of human beings. Importantly, while doctors' ethical obligation to respect patients' autonomy has long been the cornerstone of ethical medical practice, it is not, of itself, enough.

During the GMC's consultation with the medical profession over the content of the current edition of *Good Medical Practice*, Doctors for Human Rights urged the GMC to require medical students to receive human rights education, citing the scandalously poor healthcare record for people with intellectual disabilities. The GMC's underwhelming response was to distil the authority of binding international human rights law on discrimination in healthcare provision ratified by over four in every five countries world wide, into the requirement to “recognise the rights and the equal value of all people and how opportunities for some people may be restricted by others’ perceptions”.

Modern healthcare is developing into such a potent and pervasive dynamic in the quality and quantity of everyone's lives, that the cogency of application of human rights values within medical practice is becoming increasingly incontestable. The culture changing attributes that a human rights perspective brings to medical practice are primarily confined to enhancing the quality of doctor patient relationship, and are three fold:

Firstly, General Comment 14 comprehensively defines patients' right to the highest attainable standard of health in sixty five paragraphs.

Secondly, everyone's individual human rights entitlements coalesce to form an overarching ideology that gives expression to the human rights innate to each patient. The summation of each patient's entitlements has an ennobling effect that can only augment a doctors' perception of the worth and value of each patient, over and above that of a human rights free perception. This ennobling effect forms the bedrock upon which every doctor patient relationship should be founded.

Thirdly, a recognition of the cruciality to health of protecting all human rights, because violations of any human right has the potential to jeopardise health.

³⁷ Sokol D. Make the care of your patient your first concern BMJ 2011;342:d646

Once doctors become familiar with human rights they should develop a form of human rights mindfulness, whereby they are constantly aware of every patient's intrinsic importance as defined by human rights law

Of note, a medical profession in denial of patients' human rights is inconsistent with a number of the values the Working Party of the Royal College of Physicians concluded formed the basis for a moral contract between the profession and society, not least integrity³⁸.

M. Doctors' attitude to human rights values being incorporated into medical practice

Ten years ago a Royal College of Physician's working party on professionalism quoted a paper that had perceptively commented that the "organisational culture of healthcare – the shared attitudes and norms that govern patterns of behaviour in health settings – remains a neglected determinant of quality in the UK's health system." ³⁹ Attitudes are influenced by perceptions which are formed through experience. The most important attitude the profession holds is that towards patients.

The fact is-most doctors are in denial of the cogency of the discourse supporting the application of human rights values to the relationship shared by doctors and patients. This apparently universal sentiment amounts to a phenomenon, in the sense that it exists, is unexpected, and is counter intuitive. Moreover, the phenomenon appears to amount to, not so much a disinclination to adopt human rights values in clinical medical practice, as an aversion so profound and prevalent as to suggest cognitive dissonance, not to mention an unspoken conspiracy.

Cognitive dissonance is the feeling of uncomfortable tension which comes from holding two conflicting thoughts in the mind at the same time. Dissonance increases with the importance of the subject to us, how strongly the dissonant thoughts conflict, and our inability to rationalise and explain away the conflict. Dissonance is most powerful when it is about our self-image.

These observations, commentary and premises are based upon my experience over 45 years of practising medicine in the NHS (including 25 years specialising in physical healthcare for people with a learning disability) and of reading (English language) international medical journals, and of over 25 years of promoting human rights values in presentations and international medical journals.

Whilst it is a true that doctors occasionally employ human rights terms in mainstream medical journals or daily medical practice, as slogans or rhetoric, an example being "These vulnerable groups deserve the same rights as everyone else" in the report *Recognising the importance of physical health in mental health and intellectual disability*. In my experience doctors never appear to conceptualise patients for what they are - the beneficiaries of multiple inherent human rights entitlements. I am aware of only two doctors who explicitly manifest a conviction regarding human rights values within medical practice, as demonstrated within articles in medical journals. Their existence very much forms the exception that proves the rule, an example being Professor Jennifer Leaning's marking of the 50th anniversary of the Universal Declaration of Human Rights- "... what the Universal Declaration of Human Rights provides is a recognition of the separate, inviolate nature of the individual person who will face that young doctor in the casualty area, the examination room, the office, the conference room. From the opening statement in article 1, that every human being is 'born free and equal in dignity and

³⁸ Working Party of the Royal College of Physicians. Doctors in society: medical professionalism in a changing world. Clin Med 2005; 5 (6 suppl 1): 15

³⁹ Mannion R, Davies HTO. Taking stock of social capital in the production of health care. J Health Serv Res Policy 2005;10:129–30.)

rights,' the document enumerates the critical freedoms that fill the space surrounding every man, woman, and child on earth"⁴⁰

How does a medical profession comprising so many with career aspirations driven by a fierce desire to help mankind, remain so ill disposed towards human rights? At some stage during the transition from idealistic medical student to jobbing doctor a change in the nature of their relationship towards patients takes place involving emotional disengagement. A striking example is the way medical students experience a very real shock when first witnessing an abdominal operation, yet within weeks they learn to comfortably participate in abdominal surgery without a second thought. The process of professionalising medical students appears to involve a form of 'othering' whereby the student gradually adopts a newly empowered persona whose perception of ill people adapts, to a greater or lesser extent, from fellow human beings suffering, into problems to be analysed and treated. This 'objectification' of patients is not only inevitable but essential if the doctor is to be able to make dispassionate decisions based upon factual information, and the relationship unsurprisingly reflects that detachment.

It is difficult to be certain of the nature of the conflict that provokes the dissonance. It seems likely to be something to do with doctors being intimidated by a conviction that the adoption of human rights values within medical practice means introducing some form(s) of moral imperative that threatens the precious emotional detachment that allows doctors to make dispassionate decisions.

The Hippocratic Oath and subsequent versions of medical ethics have long set standards for medical practice. Doctors' honouring of ethical medical practice is a means to an end in a number of ways - it is a method of promoting a brand, it manifests and encourages a commitment to maintaining standards and it includes an element of not necessarily unjustified self aggrandisement.

Health rights on the other hand do not set standards of medical practice, other than they require services be of a good quality and be provided without discrimination, but they do govern the nature of the doctors' perception of patients, and therefore the doctor patient relationship. That might appear to amount to a new moral imperative, but it does not. Adopting a human rights informed perception of others is challenging, not least because it requires a degree of humility, but it does not introduce any new subversive moral imperative(s). Once a doctor has developed the habit and intellectual rigour of perceiving every patient as the recipient of multiple entitlements, there is no trigger for debilitating emotional fluxes that can destroy the detached clinical analysis as can happen when treating loved ones, because there is no reason for emotional engagement. Every patient receives the same (high) standard of treatment - no moral imperative, no problem.

A second compelling reason for doctors becoming human rights aware is the transitory nature of many of the doctor patient relationships in contemporary medical care. This system-induced denial of the confidence boosting benefit for the patient of being cared for by a doctor with whom they are familiar may be unavoidable, but as long as patients are aware their human rights are being prioritised by their doctors, their certitude will be maintained.

⁴⁰ Leaning J. Human rights and medical education. *BMJ* 1997;315:1390-1)

N. Epilogue

In modern times medical practice has become so effective at advancing the quantity and quality of everyone's lives, that those responsible for providing medical services should understand and adhere to the discipline of the human rights.

That accepted, the medical establishment is traditionally conservative and sometimes obdurate. Most doctors are at the coalface day in day out, conscientiously dealing at speed with challenging intellectual and emotional demands within a milieu of momentous competing priorities not to mention an ever present threat of litigation or public shaming over errors of judgment, such that a not unnatural element of siege mentality might well exist amongst many.

Developing and maintaining a human rights philosophy will be challenging in terms of requiring some adjustment to many doctor's values and way of life, but medicine can no longer afford to adhere to a methodology that, as demonstrated by the Hippocratic Oath's staying power, has changed only in matters of detail over millennia.

O. Recommendation

The UK government should be asked when health professionals will receive education on human rights in general and the International Covenant on Economic, Social and Cultural Rights in particular