Shadow Submission regarding

the medical profession and the
Right to the Highest Attainable Standard of Health

in the

UNITED KINGDOM

for the
International Committee on Economic,
Social andCultural Rights

Pre-sessional Meeting, 14th October 2015
Palais Wilson, Geneva

By
Doctors for Human Rights

This report has been prepared by Doctors for Human Rights

Since helping to facilitate the development of General Comment 14 (1998-2000), Doctors for Human Rights has fought a largely lone, and ultimately 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).
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> DHR is an independent organisation of doctors that channels the humanity, influence and special skills of medical practitioners into promoting human rights.
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> Examples of its projects, which include both civil and political, and economic, social and cultural rights, over twenty six years include:-

i) investigated torture in Egypt (1993)

ii) documented massacres in the Rwanda itself as the genocide was taking place (1994);

iii) investigated healthcare delivery in Palestine (1997);

iv) helped facilitate the two year gestation of UN General Comment 14 (1998-2000)

> In December 1998 the 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].
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> 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 Committees' 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, 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.
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> 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 comprised of interested CESCR members and representatives of WHO and other NGOs, that approved General Comment 14's final composition.

v) taught health and human rights on the International Health BSc course at UCL medical school (2001-2003)

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

Summary

Healthcare provision is one of the most important services in civil society. The role of doctors in healthcare provision is critical to the success of much of curative, preventative and palliative healthcare.

This report describes examples of discrimination against people with a mental disorder and people with intellectual disability, as an illustration that British doctors violate the right to the highest attainable standard of physical and mental health.

Psychological research demonstrates the cognitive efficiency of discrimination.

Despite most doctors being highly motivated and well intentioned, there is an unrecognised profession-wide antipathy to the application of human rights values to doctors' role in healthcare provision.

Doctor must receive education on education on the International Covenant on Economic, Social and Cultural Rights.

A. Relevant articles within General Comment 14:

> **Para18**. 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.
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> **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.
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> **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 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.**

B. 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;

C. Statements published 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 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".

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 (last accessed 15/8/15)

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 health:

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

[http://ap.ohchr.org/documents/alldocs.aspx?doc_id=11460, accessed 15/8/15]

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

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.

[http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G07/102/97/PDF/G0710297.pdf?OpenElement accessed 20/8/15]

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

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";

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 education.

[http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/105/03/PDF/G0810503.pdf?OpenElement. Accessed 20/8/15}

D. Realizing Rights

The time limited mission of *Realizing Rights*, founded in 2002 by the former United Nations High Commissioner for Human Rights Mary Robinson - in putting human rights at the heart of global governance - identified equal access to basic healthcare as one of five key global challenges. The international medical profession, as primary implementer of curative, preventative and palliative healthcare globally, has an immense responsibility to ensure everyone enjoys the right to the highest attainable standard of health.

E. Statement published 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

The report submitted to the Human Rights Commission on the 11th February 2005 (E/CN.4/2005/51) on the right to the highest attainable standard of health

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 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.42 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.

Background

Doctors' role and responsibilities in healthcare

Health is critical to everyone's quality and quantity of life. The primacy of doctors' role in healthcare provision is pivotal - to the extent it justifies privileged access to, and influence over, private and intimate aspects of everyone's lives. This uniquely powerful role in society brings with it commensurately onerous responsibilities and obligations.

Threats to the doctor-patient relationship.

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

Healthcare evolves continuously, sometimes with unintended consequences. Even while medical interventions become increasingly pervasive and invasive, sustained doctor- patient relationships have 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 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 tenuous.

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 sub-specialisation of doctors (different doctors responsible for different parts of the body/methods of investigation/treatment), enhanced pressures on doctors' time and the burgeoning influence of multidisciplinary teams decision-making processes that further distances patient-care from any semblance of sentiment regarding individual patients, or awareness of the impact medical management decisions might have on the patient.

The importance of human rights to healthcare provision

Perceptions dictate attitude, and attitude dictates behaviour. There is no higher moral, nor more comprehensive, a standard regarding the relationships people share, than one based upon human rights law.

Currently, in the United Kingdom the quality of medical practice is 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, most important of all - those of the regulatory authority's (General Medical Council which licenses doctors to practise) eighty meticulously selected obligatory rules comprising *Good Medical Practice,* reinforced by annual appraisal and backed up by an individualised five yearly revalidation process.

Uniquely, the medical profession lays claim to a 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. Doctors have long sought to honour codes that synopsise paradigmatic practice, though none has supplanted the authority of the Hippocratic Oath. However, medical ethics, being within the purview of doctors, can become inflexible or susceptible to cultural and geographical disparities between nations, and over time. Only 12 years ago some British medical students were still encouraged to perform vaginal examinations on anaesthetised patients without consent for training purposes - on reflection an authorised form of sexual offence. During the apartheid era the Medical

Association of South Africa justified complicity in healthcare discrimination on an industrial scale, with speciously warped interpretations of medical ethics.

Good Medical Practice comprises a set of exhaustively comprehensive instructions that rigorously shuns any notion of patients having human rights, though it does demand patients be treated equally.

The game changing advantage that a human rights perspective has over *Good Medical Practise* is that, in recognising the profusion of entitlements innate to each person, the inherent worth and value of each person is implicitly acknowledged. Furthermore, while non-discrimination is the sine qua non of human rights, in medical ethics non-discrimination is but one requirement amongst many others.

British doctors' discrimination

A. The report *Recognising the importance of physical health in mental health and intellectual disability* was published by the British Medical Association in 2014

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. About a quarter of the population will experience some kind of mental health problem in the course of a year

i) Excerpt from the 'Forward' of the report written by Chair of the Board of Science, Professor Sheila the Baroness Hollins

"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 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."

ii) Excerpt from 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"

iii) Descriptions of the attitudes of healthcare professionals 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.

Comment

> The 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, compounded the egregious violations of patients' rights it describes by disregarding them. Most avoidable deaths were due to to inadequate diagnosis, treatment, and preventative medicine.
>
> 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 deaths, the authors of fail to join up the dots. Ignoring violations 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.

B. A 2010 ICM survey carried out on behalf of Mencap showed 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 healthcare

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.

C. More than a third of doctors in a 2012 poll carried out on behalf the GMC reported that they had witnessed a patient with a learning disability facing direct discrimination

ICM poll of doctors, unpublished research, January 2012. http://www.gmc-uk.org/publications/12563.asp

D. 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 population

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

US doctors' discrimination [included because is helps to demonstrate how widespread discrimination in healthcare is, and because of the complex analysis of the findings]

The executive summary of the 2002 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (1) was published by the prestigious US National Institute of Medicine*,* the summary of which is copied 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.
>
> 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 familiarity.

1. Smedley BD, Stith AY, Nelson AR. Unequal treatment: confronting racial and ethnic disparities in health care. Exec Summary p 11. Washington: National Academy Press, 2002 http://www.nap.edu/catalog.php?record_id=10260(accessed 22/8/15)

Psychology and discrimination [important to understanding why doctors discriminate]

Stereotypes

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 (1.) Unsurprisingly doctors are not exempt - the US Institute of Medicine's exhaustive investigation into disparities in healthcare concluded that social stereotyping and attitudes are often biased to the extent that even egalitarian well meaning doctors can harbour unconscious negative attitudes that stigmatise minority ethnic and racial groups (2). A follow up study by Physicians for Human Rights confirmed that stereotyping and bias subvert healthcare across the full spectrum of diseases and treatments (3).

The roots of racism

Explicit (conscious) racial biases start at about 5-years of age (1) but, where they are not supported, tend to peter out from about 10-12 years (2) . This is likely because children become more aware of principles of fairness and social justice that shape how they believe people should be treated. But if racial stereotypes are supported by the people around then the are likely to be fostered

Implicit (unconscious) racial biases can develop as young as 3 years of age (3) . Once established in the preschool years they are surprisingly resilient to change. While explicit racial prejudice drops off in most children, implicit racial biases usually remain consistent (4) through to adulthood.

Insidious racism*

While the majority (5) of people in Western countries are egalitarian believers in a fair meritocracy, on tests of unconscious racial bias about 70% (6) show a preference for their own race. The classic test is the Implicit Association Test (7) , 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.

This conflict between people's dearly held explicit beliefs and their unconscious racial biases has real-world consequences (8) . For example, presented with identical, moderately good resumes attached to a picture of a white or black candidate, interviewers are significantly more likely (9) to shortlist the white candidate for interview. This study was originally conducted in 1989 but the results were exactly the same when it was repeated in 2005.

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. For instance, racial information is now excluded from job applications and kept confidential so as not to influence decisions at the shortlisting stage.

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* copied from "How can we fix unconscious racism?" written by Nathalia Gjersoe in the Guardian 8/7/15 <<www.theguardian.com/science/head-quarters/2015/jul/08/how-can-we-fix-unconscious-racism>> (accessed 22/8/15)

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

Seven years ago a Royal College of Physician's working party on professionalism commented perceptively 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." Attitudes are influenced by perceptions which are formed through experience. The most important attitude the profession holds is that towards patients.

The unacceptable fact is - doctors are in denial of the appropriateness of applying of human rights values to medical practice. This all but universal sentiment amounts to a phenomenon, in the sense it is a reality (though unrecognised), it is unexpected (not to say shocking), and it counter intuitive (not to say difficult to believe). Furthermore, the phenomenon appears not so much to be disinclination to adopt human rights values in medical practice; more an aversion so prevalent and profound it is consistent with cognitive dissonance.

Cognitive dissonance is a state of tension that occurs whenever a person holds two conflicting cognitions (ideas, attitudes, beliefs, opinions) that are psychologically inconsistent. Dissonance produces mental discomfort ranging from minor pangs to deep anguish. Cognitive dissonance appears in virtually all evaluations and decisions and is the central mechanism by which we experience new differences in the world. Cognitive dissonance increases with the importance of the issue to us, how strongly the dissonant thoughts conflict, and our inability to rationalise and explain away the conflict. The tension can be injected suddenly or allowed to build up over time. People can be moved in many small jumps or one large one.

This conclusion is based upon my experience over 25 years of practising medicine in the NHS, and of reading, and advocating human rights values within medical practice in international medical journals. Whilst it is true that doctors occasionally use human rights terms as slogans or rhetoric to emphasise a point, they never conceptualise patients for what they all are - the beneficiaries of multiple inherent human rights entitlements. I am aware of only two doctors who manifest a strong belief in human rights values within medical practice as demonstrated by their published articles. Both are women, and their existence amount to the exception that proves the rule.

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 process of 'distancing' takes place. For example, every medical student experiences a shock when first witnessing an abdominal operation, yet within weeks learns to participate in abdominal surgery without a second thought. The process involves acquiring a benign form of 'othering' whereby the student transforming into a doctor adopts a newly empowered persona whose perception of the ill person changes, to a greater or lesser extent, from 'sufferer' into a problem to be analysed and corrected. This objectification of an ill person is inevitable if the doctor is to be able to make detached objective decisions based predominantly upon factual information, and the relationship will inevitably reflect that detachment.

What the nature of the conflict is that provokes the dissonance is more difficult to explain. Perhaps doctors are intimidated by the complexity of the human rights legal field - it is after all a foreign country to them, and as experts in their own field they may not relish a real or illusionary threat of a loss of control. Perhaps they are under the misapprehension that the stakes of their day to day work will be increased by making health a human rights issue. Maybe they anticipate their power base in the patient – doctor relationship being tipped too far in favour of the patient by health rights. Is it possible that doctors fear that health rights might convert the patient – doctor relationship from being detached and objective into something too intimate – too subjective?

The conclusion is that a belief in human rights values in medical practice for every patient is the only objective, detached method of valuing each and every patient appropriately that does not involve the engagement of emotions, in such a way that might damage a doctors' judgement.

Recommendation

The UK government should be asked when health professionals will receive education on the International Covenant on Economic, Social and Cultural Rights.