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Medicine and Human Rights

Upcoming Issues of *Virtual Mentor*

October: Ethics in the Practice of Surgery
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December: Standards of Care: An Ethical Examination

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From the Editor

Medicine and Human Rights

The journal editor introduces a theme issue on medicine and human rights by calling on physicians to speak out against worldwide human rights abuses.

For all who struggle to protect basic rights of humanity, recent accounts of detainee abuse at the Abu Ghraib prison in Iraq [1-4] and the humanitarian crisis in Darfur, Sudan [5-7] remind us that that we have a long way to go before the aspirations of "human rights" declarations [8,9], conventions [10,11], and treaties [12,13] are fully realized. As physicians, we have a special responsibility to be defenders of human rights, one that is grounded in our heritage of caring for the sick and suffering. We are bound by a principle of medical neutrality which requires us to treat the wounded and injured whether they are friend or enemy. Because of our social status, when we speak, people listen, and thus we must speak up for people who have no voice and hold accountable those who commit human rights abuses.

Abuse of human rights is a worldwide problem, and it demands the attention of physicians everywhere. As a founding member of the World Medical Association (WMA), the AMA is committed to realizing the mission of the WMA—to uphold the highest possible standards of ethical behavior and care by all physicians, at all times. Last October, the WMA voted to designate every September 18, the date of its first General Assembly Meeting in 1947, as Medical Ethics Day. On this day, the WMA has called upon all national medical associations to promote the centrality of ethics in medicine. Hence, we have dedicated the September issue of *Virtual Mentor* to the topic of health care and human rights.

The interrelationship of health care and human rights is far too large a topic for one issue of any journal. Indeed, physician-humanitarian Paul Farmer devotes his latest book, *Pathologies of Power*, to defending the thesis that the denial of human rights harms the health of millions, perhaps billions, of people around the world. This issue of *Virtual Mentor* offers what we hope is meaningful sample of the unmanageably huge and important topic. *VM*'s approach to human rights is to start, as we do with all theme topics, by asking how the practicing physician confronts human rights issues in daily clinical situations. Four physicians have commented on 3 clinical situations that involve patients' rights: a young woman requests the "morning after" pill from a physician who is ethically opposed to the use of abortifacients; a physician offers care to a street vendor near his office and then finds himself overwhelmed with patients who cannot pay, once the word of his charity care gets out; and a woman visitor to the US asks for a physician's help in seeking asylum here to escape her husband's abuse.

VM's second tactic is to step back a bit from the clinical encounter and ask the larger questions: how does the interaction of health care and human rights find its way into health policy; into the legal and justice systems? How does it affect the contract medicine has with society? How do medical educators present the topic to students? What aspects of this theme are making news and what is the public reaction? For these broader—social, educational, policy and law—perspectives, *VM* examines allegations of physician participation in war time human rights abuses, physician responsibility to prisoners with mental health problems, physician-scientist engagement in research that might be put to harmful as well as beneficial ends, extending reproductive choices for women, integrating human rights teaching into the medical school curriculum, the stories of physicians who have put themselves at risk by defending the human rights of others, and—the seemingly unanswerable, decades-old question in the US—is health care a right?

The learning objectives for this issue on medicine and human rights are:

1. Understand the physician's role as an advocate for human rights, especially for vulnerable populations.
2. Identify ways in which physicians can participate in providing health care for those who cannot afford to pay for it.
3. Understand health professionals' roles in helping refugees gain asylum.
4. Recognize how health professionals may be involved in the documentation and adjudication of cases of human rights abuses.
5. Recognize that physicians have been used as agents of the state in abusing human rights.
6. Understand the rights-based approach to promoting reproductive rights for women.
7. Learn the guidelines for conduct of physician-investigators engaged in "dual-use" research.

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Clinical Cases

Obtaining Asylum from Partner Abuse: the Physician's Role

Physicians can take an active role in helping victims of domestic partner abuse receive the medical care and emotional support needed.

Commentary by Karin Kalkstein, MD, Nalaini Sriskandarajah, MD, MRCPsych, and Sai Sriskandarajah, JD

Mrs Niro came into the clinic with her cousin, Cheryl, to see Dr Angela Cartwright. Mrs Niro had left her home country 1 month before to live with Cheryl, Cheryl's husband, and their 3 children in the United States.

According to Cheryl and Mrs Niro, Mrs Niro's husband has been abusing her since the day they married 6 years ago.

"He gets angry if he has a bad day at work or if he loses money on a bet or if the food is a little cold," Mrs Niro explains. "When he starts to get angry I can't do anything to calm him down. He hurt my right arm and broke my nose. My back is always sore from where he hit me with a chair."

After the latest episode, Mrs Niro spent a week in the hospital. The doctors were willing to release Mrs Niro after 2 days, but she convinced one of the doctors to keep her for the rest of the week for "observation" so she could avoid going home while her husband cooled off. This also gave Cheryl more time to get a vacation visa for Mrs Niro to come to the United States. Mrs Niro doesn't want to return home because she knows if she does her husband will kill her. Cheryl wants Mrs Niro to apply for asylum.

Dr Cartwright examines Mrs Niro and takes a medical history. Dr Cartwright sees signs of eye damage and makes a note for an ophthalmologic consultation. Mrs Niro cannot hear very well out of her left ear, and x-rays show signs of fractures to her nose and collar bone that are not fully healed. One of her shoulders has a number of scars. Mrs Niro says these are from when her husband hit her with a bottle.

Dr Cartwright asks Mrs Niro if she calls the police or if she has ever pressed charges against her husband.

"Why would I call the police? Everybody knows they won't do anything to help me. Maybe they will agree with me that I have bad luck to have such a husband, but they won't help me. Besides, that will just make him more angry."

Commentary 1

by Karin Kalkstein, MD

Physicians have traditionally been resistant to diagnosing conditions for which they have no treatments. Historically, domestic violence has fallen into this category. Over the last generation though, most US states have developed legal assistance, police protection, hotlines, and shelters for victims of family violence. Knowing about these resources, doctors now feel somewhat more comfortable asking their patients about abuse and referring victims for available help. Perpetrators of spousal abuse are generally resistant to interventions to change their behavior, so health professionals usually encourage victims to leave the abusers. When a woman tries to leave, the level of abuse often escalates, so outside assistance is often needed.

Immigrant women, however, do not have the same legal support available to them as US citizens do. Rather than supporting such a woman's independence, the immigration laws impair her ability to leave her husband. Many immigrant women must stay with their husbands or be deported. They may be legally forbidden to work, keeping them economically dependent on the abuser. Likewise even legal immigrants may be ineligible for public assistance that provides a safety net for American women. In order to be able to stay in this country, and to access social services if needed, an immigrant must have an independent immigration status. An application for asylum may be the only route to gain this status.

The legal situation of asylum for victims of gender-related persecution has been in evolution, with significant changes over the last decade. In 1995 the Immigration and Naturalization Service issued guidelines recognizing this category of asylum seeker or asylee. The following year a Togoan woman who fled to avoid female genital mutilation was granted asylum based on this category. In 2001 the Department of Justice applied this reasoning to grant asylum to a Guatemalan woman fleeing a violent husband. Gender-related persecution is recognized only in a guideline but not in any regulation, so rules are still being interpreted on a case-by-case basis.

Asylum: the Road to Health

Mrs Niro is fortunate that she is in the United States legally, if temporarily. Asylum applicants who arrive in the United States without a valid visa face additional roadblocks. Many will face immediate deportation under rules of expedited removal, without having their claims heard before an immigration judge. Those not immediately deported may be detained until they can demonstrate a credible fear of persecution. This can mean months of incarceration in immigration detention or in jails, even for those who have family willing to assume responsibility for them. This detention is particularly hard for women with young children, who may be separated from them and even placed in foster care for long periods of time. Women are sometimes retraumatized by the experience of detention, and are susceptible to abuse by guards and others.

As a physician, Dr Cartwright may be the most authoritative figure that Mrs Niro has approached for help. Since police and courts in her own country were unwilling to intervene, Mrs Niro probably will not approach the US police or court system. Doctors have aided her in the past, as when they hospitalized her to keep her safe. For Dr Cartwright to properly treat her patient, she must address her legal situation, and have knowledge of social agencies and basic understanding of asylum laws. Asylum in the United States is available to people who "have been persecuted or have a well-founded fear of persecution on account of their race, religion, nationality or membership in a particular social group or political opinion" [1]. This is commonly referred to as "political asylum," a misnomer which unfortunately keeps women like Mrs Niro from considering this option. She clearly does not view her situation as a political one. Domestic violence has for long been thought of as a private issue confined to a particular family. In recent years however, feminists and legal scholars have described domestic violence as one of many ways of imposing male domination over women. Other examples include female genital mutilation, rape or threat of rape, honor killing, and forced marriage.

Mrs Niro's symptoms are clear-cut and obviously stem directly from her abuse; women in her situation may present with anxiety and depression, or with somatic complaints stemming from their distress, where the diagnosis of domestic abuse is harder to detect. Her physical scars, while of course unfortunate for Mrs Niro, may make it easier to prove her persecution in an immigration court.

Mrs Niro is fortunate to have physically survived her abuse, successfully left her husband, and reached physical safety. She has also found a sympathetic relative who is willing to help and is knowledgeable about asylum. Dr Cartwright can now help her take the next steps. She can write a medical affidavit to document her injuries and correlate them with the violence that Mrs Niro described. She can encourage her to find an attorney and proceed with her asylum application. The application must be filed within 1 year of arriving in the United States. Some immigrant advocacy organizations will provide low-cost legal referrals. Finally, the physician can provide ongoing medical care and screen for complications, including psychological sequelae of abuse. Dr Cartwright will also be able to provide the psychosocial support that Mrs Niro and Cheryl are going to need in the coming months.

Reference

1. Immigration and Nationality Act, 8 USC §1186b (2002).

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Commentary 2

By Nalaini Sriskandarajah MD, MRCPsych, and Sai Sriskandarajah, JD

From the case history, one assumes that Mrs Niro came to the clinic for treatment of her injuries. She is, however, reporting a serious problem with intimate partner abuse (IPA), and there is an indication that she might apply for asylum. In formulating a comprehensive treatment plan for her, Dr Cartwright has to consider other factors in addition to the patient's clinical needs. Dr Cartwright's own level of awareness about IPA issues will influence her decisions regarding this patient.

Physical examination revealed recent as well as old injuries and some permanent damage. Dr Cartwright plans to refer Mrs Niro for the necessary medical consultations. The health consequences of IPA are psychological as well as physical [1]. Dr Cartwright should ask about psychological symptoms or obtain a psychiatric consult. Mrs Niro will need support and nurturing if she is to regain her confidence and self-esteem. Many medical centers offer support services for trauma survivors and crime victims, but not everyone is eligible for those services. As we will see, a grant of asylum can help with that.

Cultural Awareness

Dr Cartwright asks Mrs Niro whether she ever reported her husband or pressed charges. By doing so, she is showing empathy and sensitivity. However, she is applying US norms to Mrs Niro. Legal recourse may not have been a realistic option in Mrs Niro's country of origin.

Many developing countries do not have laws protecting victims of IPA. Even in countries where there is protection, religious and cultural beliefs sometimes run counter to provision of safety for women. Despite laws that protect them, women are vulnerable in countries with rigid gender roles, inequalities, and cultural norms that support a man's right to inflict violence. Mrs Niro's statement that the police would probably do nothing except remark that she is unfortunate indicates how IPA is viewed in Mrs Niro's country and explains her failure to involve the law as a self-protective response [2]. If Dr Cartwright is unaware of that country's situation and cultural biases, she may tend to doubt the veracity of Mrs Niro's report. This could lead to less than adequate health care for Mrs Niro and incomplete protection of her human rights.

Even in the United States, physicians who are not well versed in the law continue to overlook such abuse. Since the mid-1980s, many states have enacted laws to protect victims of IPA. Some states have mandatory reporting. There is also much debate over whether involving law enforcement truly provides protection [3].

It is likely that Mrs Niro, exposed to chronic abuse by her husband, has difficulty trusting people [1,3].To provide treatment in a sensitive manner, Dr Cartwright needs to gain her trust. She could explore the political, cultural, and religious beliefs of Mrs Niro's country with her to gain understanding and build trust. Physicians for Human Rights, Human Rights Watch, and other watchdog NGOs as well as US government Web sites also provide accurate and pertinent information to help this part of the asylum process [4-7].

Physician's Role in the Asylum Application Process

If Mrs Niro applies for asylum, the physician will be expected to provide a report of her medical findings and to indicate whether they are compatible with IPA. However, the burden of proof of IPA is not Dr Cartwright's.

Mrs Niro indicated that she doesn't want to go back to her country. If she returns, she could face further, possibly more severe, violence or even death. Regardless of Dr Cartwright's views about spousal abuse as a cause for asylum, failure to give adequate consideration to Mrs Niro's safety is suboptimal medical care. Justice requires Dr Cartwright to ensure that Mrs Niro is not discriminated against because of the physician's bias.

Conversely, Dr Cartwright might conclude that Mrs Niro should be kept away from her husband. In the United States, if the victim is fearful, such separation is possible by referring her to a women's shelter or a safe house. In this instance, the alleged abuse took place in another country where such protection is probably unavailable. Asylum remains the only reasonable option.

If Dr Cartwright wishes to help, she now needs to educate herself about the asylum application process and its pitfalls. It would be tragic if the attempt to help resulted in more harm. *Primum non nocere*—first do no harm—is one of the fundamental tenets of medical practice.

Asylum Seekers Face Legal Hurdles

Regrettably, Dr Cartwright will find that the US immigration laws are murky on the issue of gender asylum. Although women are identified as a group whose human rights are violated in many countries, women who apply for asylum due to IPA are often denied asylum. If returned, these women are at a greater risk of harm.

Under US immigration law, Mrs Niro is in the country under "visitor" status; as such, she is only permitted to remain in the country for a limited period of time. However, Mrs Niro may legally apply for asylum while she is in the United States as a visitor. The Immigration and Nationality Act (INA) requires an applicant for asylum outside her country of citizenship or habitual residence to be unwilling to return to that country because of persecution, or justifiable fear of persecution, on the basis of her "race, religion, nationality, membership in a particular social group, or political opinion" [8]. Whether victims of domestic violence are members of "a particular social group"—and therefore qualify for asylum—is a subject of significant controversy. A case in point is the story of Rodi Alvarado [9].

Rodi Alvarado was a Guatemalan woman who came to the United States in 1995. Alvarado applied for asylum on the ground that she was the victim of rape and brutal, unrelenting violence at the hands of her husband. Alvarado was granted asylum by a US immigration judge in 1996, but the Board of Immigration Appeals overturned the judge's decision. Janet Reno, who was then US Attorney General, overturned the board's decision, reinstated approval of Alvarado's application, and issued proposed regulations making domestic violence an express basis for asylum. The US Departments of Justice and Homeland Security are currently determining whether the regulations proposed by Reno should be put into effect. In February 2004, the Department of Homeland Security filed a brief asking the Attorney General to issue regulations that would allow gender asylum for women who are victims of IPA.

Under current United States law it is unclear whether Mrs Niro would be granted asylum on the ground that she is a victim of IPA. Currently, immigration is under the jurisdiction of the Department of Homeland Security (DHS). Further clarification of the laws will depend on how the Alvarado case is resolved [10-11].

Awareness of asylum laws will help Dr Cartwright make decisions about her role in the process. Providing comprehensive health care has led to collaborations with legal and other professionals as well. Mrs Niro has, under the 1948 UN Declaration of Human Rights [12], the right to live without fear of harm. If Dr Cartwright wants to help uphold this right, she must provide the necessary medical information to the legal professionals involved in the case when Mrs Niro requests her to do so. Dr Cartwright must also make herself available to testify regarding her medical findings, if called upon to do so.

Finally, the economic, political, and human rights status of foreign visitors like Mrs Niro is quite controversial. The government does not provide any direct financial support to asylum seekers. As a physician, Dr Cartwright should follow the rules established for such patients at the clinic, at the same time making sure that Mrs Niro is not left

without health care. There are some faith-based organizations that assist refugees [13]. Commonly, asylum seekers are dependent on their relatives or fellow countrymen (sometimes strangers) until asylum is granted and they can legally work.

Dr Cartwright should approach this case with the 4 basic principles of medical ethics in mind; ie, respect for patient autonomy, beneficence, nonmaleficence, and justice. Dr Cartwright needs to be caring, empathic, trustworthy, and fair in order to apply these principles to Mrs Niro's care in a sensitive manner.

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Other Web Site

- US Citizenship and Immigration Services. http://uscis.gov/graphics/index.htm

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views and policies of the AMA.

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Clinical Cases

Reproductive Rights

Physicians have an ethical duty to provide safe and effective care to patients even when the care conflicts with their own personal values.

Commentary by Watson A. Bowes Jr., MD, Karen E. Adams, MD, and Martin T. Donohoe, MD

Dr. Richard Ward is the only family practitioner in a small rural town where he has been practicing for 30 years. One morning 16-year-old Theresa Scholtz comes to Dr. Richard Ward's office alone. She does not have an appointment and tells the receptionist she will wait until Dr. Ward has time to see her. Dr. Ward has quite a few scheduled appointments that morning, so Theresa has to wait more than an hour before she can be seen.

The nurse finally takes Theresa back to an examination room, weighs her, takes her temperature and blood pressure and then asks the reason for her visit. Theresa looks nervous and ill at ease; she doesn't immediately answer.

Theresa doesn't look at the nurse but says quietly, "I am afraid I might be pregnant."

"So you are here to get a pregnancy test?" the nurse asks.

Theresa shakes her head, "No, I want Dr. Ward to give me the morning-after pill so I don't have to get a pregnancy test or have an abortion."

The nurse gets ready to leave, saying, "Dr. Ward will be in shortly."

When Dr. Ward comes into the exam room Theresa explains to him that she was out at a party, had a few too many drinks, and ended up having unprotected sex with her boyfriend. She says she is worried about the possibility of being pregnant and wants the Plan B® pill.

"I don't want to have a baby right now. I'm too young. I have to finish school," she says. "And I don't want to have to make a decision about an abortion. I want to just take this pill and move on."

Dr. Ward listens to Theresa's concerns and then says, "I understand why you are here. I have always had a policy of not performing abortions, and I won't start now by prescribing the morning-after pill. You can make an appointment with me in a couple of weeks for a pregnancy test to find out if you are pregnant. If you really want the morning-after pill I can give you the card of a physician I know in Gardendale who will see you."

"Gardendale?" Theresa says. "But Gardendale is 115 miles away. How will I get there without telling my parents why I am going? And how will I get there soon enough for the pill to work?"

Commentary 1

by Watson A. Bowes Jr, MD

The most obvious, although not the only, ethical issue in this situation is the conflict between the principle of patient autonomy and the health care provider's right of conscience. Personal autonomy is one of the cardinal principles of modern medical ethics. It implies personal rule of the self that is free both from controlling interference by others and

from personal limitations that prevent meaningful choice. Respect for patient autonomy, like all ethical principles, cannot be regarded as absolute and may at times be in conflict with other principles or other moral considerations. In this case such a conflict arises because the physician, Dr. Ward, is asked to provide care which he regards as potentially equivalent to performing an abortion—by prescribing Plan B®. It is generally accepted that a patient's right of autonomy does not trump the physician's parallel right to conscientiously abstain from a practice on religious or moral grounds provided that (1) the physician provides the patient information that would allow her to seek care with another health care provider who does not have such reservations and (2) the physician's refusal to treat does not endanger the patient's life or result in serious harm.

A meaningful resolution of ethical issues depends to a great extent on accurate clinical facts. Apparently, Dr. Ward knows that the effectiveness and probable mechanism of action of post-coital levonorgestrel 0.75 mg x 2, 12 hours apart (Plan B®) used for post-coital birth control depends upon the time the medication is taken in relationship to the time of ovulation. If taken before ovulation occurs, the effect is temporary delay of ovulation and interference with sperm penetration of the cervical mucous. If taken after fertilization has occurred, the effect might be prevention of implantation of a fertilized ovum, which is the basis for Dr. Ward's refusal to provide this medication. Evidence suggests that the effect on ovulation and on sperm penetration of ova are the predominant mechanisms of action. We are not told when, in relationship to the office visit, Theresa had unprotected sex with her boyfriend, nor is information given about Theresa's menstrual cycle, facts that might provide Dr. Ward a basis for modifying his advice to Theresa. For any particular patient, however, it is difficult to ensure that the medication is being given before fertilization has occurred.

Evidence also indicates that post-coital steroids, by reducing the risk of conception, actually decrease the incidence of induced abortion of clinically apparent pregnancies. Therefore, a physician who opposes abortion for religious or moral reasons must decide whether the use of a medication that occasionally prevents the implantation of a fertilized ovum but decreases the number of abortions overall is an acceptable moral and ethical tradeoff.

Ideally, Theresa's decision to use Plan B® should be made after she has received as much information about the drug as she is capable of understanding. Most importantly, she should understand that post-coital steroids are not 100 percent effective in preventing pregnancy, regardless of when the medication is taken. Even if Dr. Ward were to prescribe the medication, a follow-up visit might be necessary if there were subsequent symptoms or signs of an ongoing pregnancy.

Another important ethical issue is to what extent Dr. Ward's conscientious objection to providing Plan B® for Theresa should be affected by the distance she must travel (115 miles) to reach the nearest physician who will prescribe the medication. And what of Theresa's claim to have no transportation unless she informs her parents, which she does not want to do?

Importantly, Dr. Ward's refusal to provide the prescription for Plan B® is not a threat to Theresa's life. Furthermore, Dr. Ward has offered to provide follow-up, and he would, presumably, be willing to refer her to a colleague if pregnancy were diagnosed. A physician's ethical responsibilities do not extend to solving all social and domestic difficulties of every patient. In other words, short of a life-threatening emergency, he is not obliged to drive her to Gardendale. It is, nevertheless, Dr. Ward's responsibility to advise Theresa about reasonable options, such as confiding in her parents or enlisting the aid of her boyfriend.

As noted above, Dr. Ward should fully inform patients about circumstances in which he cannot provide care on moral or religious grounds, and this information should be readily available in time for patients to seek alternative care. Inasmuch as Dr. Ward is the only physician in a small town, it is likely that his personal position against induced abortion is well known in the community. However, patients in general and Theresa in particular may have no knowledge that Plan B® might in some instances act as an abortifacient. Then too, a physician should be consistent in his or her conscientious objection. To be ethically and morally consistent, a physician who objects to the use of post-coital steroids on the grounds that their effect in some cases may be to prevent implantation of the fertilized ovum should also object to the use of other forms of steroid contraception (eg, birth control pills) that affect the endometrium in ways that can prevent implantation.

Finally, two other important ethical dimensions illumine this encounter between Dr. Ward and Theresa Scholtz: beneficence, the physician's obligation to promote the well-being of the patient; and confidentiality, the responsibility not to divulge information to a third party. As regards beneficence, Theresa Scholtz has engaged in self-destructive behavior (binge drinking and unprotected sex). Simply providing her with a prescription for Plan B® without giving some attention to this behavior is not in her best interest nor does it contribute to her overall well-being. Dr. Ward's beneficence-based responsibility, at the very least, requires that he counsel Theresa about the dangers of her recent behavior and the possible benefits of confiding in her family.

As regards confidentiality, Theresa at age 16 is a minor. In most situations, physicians do not treat minors in nonemergent circumstances without the consent of a parent or guardian. Many state laws, however, protect adolescent confidentiality regarding diagnosis and treatment of sexually transmitted diseases, contraceptive counseling, and pregnancy. Dr. Ward probably knows almost everyone in town and is aware of their physical and emotional ailments and their socio-domestic circumstances. In a small community, the close relationship of the sole family physician with his patients does not diminish his ethical responsibilities, and it may complicate and intensify them.

In the future it is possible that Dr. Ward and other physicians will not be confronted with the necessity of prescribing Plan B® or similar medications, if the FDA approves these medications for nonprescription (over-the-counter) availability. The risks and benefits of such a decision are currently being debated.

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Commentary 2

by Karen E. Adams, MD, and Martin Donohoe, MD

This case illustrates a classic ethical conundrum: what to do when a physician's moral stance conflicts with a patient's request for care? Physician-assisted suicide and termination of pregnancy are examples of services that a reasonable patient might request but that a physician may refuse to provide on grounds of moral objection to the practice. Objecting physicians argue that these services fall outside of the realm of medical care, considering one or both practices to be murder. Participating in PAS, the physician contributes directly to the death of a human being. Some physicians see termination of a pregnancy in the same light, equating the life of the fetus to that of a living person.

Such a viewpoint rejects abortions as unethical and even immoral since it involves the taking of life. On the other hand, pro-choice observers argue that abortion is a legal right and patients are harmed physically and psychologically by delays in obtaining abortion services. They feel that the physician ought to provide the abortion or at least refer the patient to another physician who will. But this stance ignores the reality that conscientiously objecting physicians do not view lack of access to abortion services as harmful, but rather as beneficial, because the fetus can potentially remain viable and can grow to term. The opponents of abortion feel that, if the pregnant woman does not want to raise the child, she has the option of giving up the child for adoption, thus respecting both her life and the life of the child. If she is determined to obtain an abortion, she may do that herself without the help of her usual physician, who believes that even assisting her to find a provider makes him or her guilty by association. Although Dr. Ward in this case did refer Theresa to another physician, the barriers to timely care remain substantial due to her youth, the distance she must travel, and the short time during which emergency contraception (EC) is effective.

Weighing Rights and Responsibilities

Evaluation of such a case requires consideration of the obligations of the physician to himself or herself and consideration of the rights of the patient. What are the rights of the patient in this case? All women of reproductive age in the United States have the legal right to safe abortion services. Yet barriers to reproductive services are now substantial, and in recent years the government has raised more barriers: Diversion of federal funding to abstinence-only education, mandatory waiting periods and parental notification laws for teens seeking abortions, and the implementation of Targeted Regulation of Abortion Provider (TRAP) laws are only a few examples of the increasing obstacles to safe access to abortion services in the United States [1,2]. The outcry from the scientific community following the FDA's refusal to approve EC for over-the-counter use was based on the conclusion that this decision had

more to do with politics than science [3].

The scarcity of qualified physicians also impacts women's access to safe abortion. Eighty-seven percent of US counties have no abortion provider, including 30 percent of metropolitan areas [4]. The situation is worst in rural areas, where women may have to travel 100 miles or more to obtain abortion services or, as in this case, even to obtain EC [5]. This burden falls disproportionately on the young and the poor, who often do not have the resources to travel such long distances to obtain care. A hopeful sign is the new ACGME requirement that all OB/GYN training programs provide training in abortion techniques, with residents opting out only in cases of moral objection [6].

Conscientious Refusal to Treat

Although conscientiously objecting physicians do not see harm in the consequences of delayed or unavailable abortion services, the data regarding these consequences are clear, with higher complication rates for terminations at a later gestational age. The burden of traveling long distances to obtain care and the potential of carrying an undesired pregnancy to term simply due to unavailability of services are additional harms that should be considered. Horrific complications, including sepsis and death, were not at all unusual when abortion was illegal in the United States. Even today, some women, faced with an undesired pregnancy and no safe means of termination, may resort to desperate measures, potentially endangering their own lives. The rights of the patient in such a case may stand in direct conflict with the rights of a provider to remain true to his or her moral compass.

Physicians are not only physicians; they are also individuals whose moral thinking, like that of nonphysicians, has been shaped throughout their lifetimes by personal experience, religious beliefs, and the influence of role models [7]. Moral reasoning takes on special significance when a physician's values place him or her in conflict with patients who request a legal and socially sanctioned service such as pregnancy termination.

Dr. Ward's stance, although true to his own values, places his patient in an unduly burdensome situation. Asking Theresa to travel an extreme distance within a very short time to obtain EC constitutes a heavy burden when compared to the minimal burden on Dr. Ward to provide the medication, and that squarely places the obligation on Dr. Ward to provide the care. EC must be utilized within 72 hours after intercourse, when the embryo is still in a rudimentary multicellular stage. Thus, only the most adamant opponents would consider provision of this medication to be in the same category as first or second-trimester pregnancy termination.

Prescription of EC—a few pills—a matter of days after conception, as opposed to performance of a surgical procedure, places a much lesser burden on an objecting physician. Were Theresa asking for a surgical termination, a much more invasive procedure, the balance of burdens would be very different and Dr. Ward could ethically refuse to provide such care. He could reasonably be expected to offer referral to a willing provider for surgical termination, however, given the lack of availability of a second opinion in this rural community.

Theresa is already unusual in that she knows about EC; studies have shown that only one-fourth of reproductive age women in the United States have even heard of it [8]. If Theresa lived in California, Washington, New Mexico, or Alaska, she could obtain the EC medication over the counter, and if she lived in Hawaii a pharmacist could prescribe it for her. Other states are considering similar legislation to increase EC availability.

Women—and especially teens—need accurate information, access to contraceptive services, and readily available EC, with backup medical or surgical abortion if necessary. Residency programs should implement the ACGME requirement that, barring a deeply held moral objection, all residents participate in abortion training. Medical abortion protocols should be instituted in more clinics and physicians' offices. The American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Pediatrics all support over-the-counter availability of EC. It is crucial in these politicized debates that physicians stand up for sound science and for the rights of patients to receive safe and effective care. Until EC can be obtained without a prescription, physicians should provide all women of reproductive age with instructions and prescriptions for EC at every office visit.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

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Clinical Cases

Caring for the Poor - What Can One Doctor Do?

Physicians who are interested providing care to uninsured patients can consider a number of options to balance his altruistic desires with his personal needs.

Commentary by Jaro Kotalik, MD

Dr. Mark Bernard's private internal medicine practice on Manhattan's Upper West Side serves mostly affluent patients. One afternoon, Dr. Bernard noticed that Luis, the hotdog vendor whom he regularly patronized, was wheezing. Dr. Bernard commented on Luis's labored breathing and invited him to come by the clinic after work.

At the office that evening Dr. Bernard confirmed his suspicion: Luis had asthma. After taking Luis's peak flow meter reading, Dr. Bernard gave him a free sample of a combined beta-agonist and steroid inhaler. Luis was otherwise healthy but said he had no medical insurance, so he had not sought treatment when he started feeling short of breath. He was grateful for Dr. Bernard's help.

Over the next several days, Dr. Bernard stopped by to see Luis and saw that his breathing had improved significantly. Luis thanked him profusely, and Dr. Bernard was glad to have helped. Going through medical school in the late 1960s, he had admittedly idealistic aspirations of serving patients like Luis. Now he sometimes asked himself how he ended up serving the population he did.

"Come back when your inhaler runs out," Dr. Bernard told Luis.

The next month Dr. Bernard gave Luis another free sample. Then a few more disadvantaged people from the area began showing up at Dr. Bernard's office; clearly, Luis had told some of his friends about Dr. Bernard. At first Dr. Bernard fit them in between appointments and sometimes during lunch. He provided free care and distributed samples when he had some available. For those who needed medication that Dr. Bernard did not have on hand, he wrote prescriptions, hoping they could afford to have them filled. There was nothing he could do for patients who needed drugs that he did not have available or care he could not provide, so he referred them to a local free clinic, which was notoriously inefficient and difficult to access. Dr. Bernard did not pry into why these patients were uninsured or not on Medicaid rolls. He surmised that some of them were undocumented immigrants. While Dr. Bernard could not provide appropriate care for all his drop-in patients, on the whole he felt his help was making a difference.

Two months after first helping Luis, however, Dr. Bernard had unscheduled patients coming to his office every day. He asked Luis not to tell anyone else about his practice, but that did little to stem the flow of needy patients. Although he wanted to help them as much as he could, he simply did not have enough time, and some of his paying patients had remarked to him about the noticeably different clientele that now gathered in his waiting room. Dr. Bernard wanted to continue caring for his indigent patients, especially the children among them, but it was becoming unsustainable.

Commentary

It seems that Mark Bernard is experiencing a moral awakening. The decisions he undertakes at this crossroad will certainly affect his professional life as well as his future personal happiness. To assist him in making a wise decision it

would be prudent for him to first clearly understand what it means to be a physician and then to reflect carefully on his personal situation.

The Nature of the Medical Profession

A physician is a professional who "professes" the willingness to use his or her specialized knowledge and skills, not for his or her own purposes, but for the benefit of others, especially the sick and suffering. This is the basic moral meaning and commitment of the vocation. This professional commitment remains—as in ancient times—a fundamental value because the human condition of fragility and the need for a healing relationship between patient and caregiver has not changed in spite of all the social and technological advances of modernity. This means that after being asked to provide medical services, the physician is expected to base a response primarily on the patient's probable (impending) needs and on his or her ability to provide them, and not on the patient's ability to pay. It has been the physician's attitude of altruism and compassion toward those in need that has earned society's high esteem and trust [1]. This is also what motivates many young people to enter the medical profession.

At the same time, it is understood that the physician is entitled to make a living from his or her practice. Even if all patients deserve the same effort and the same attention, the physician will be mindful of their differing ability to pay for time and services received. For centuries, most physicians provided for themselves and their families by a custom of variable billing: they would charge full fees to the rich, expect less remuneration from the middle class, and treat the poor with little or no expectation of being paid. Only during the past 100 years has a different system emerged. Physicians now have more or less standard fees, and the patients have an insurer who pays these fees on their behalf. Those who pay the physician directly are either the very rich (who do not need insurance) or those who, for a variety of reasons, are unable to purchase insurance. In places where affluence is prevalent, it may seem that a physician can expect payment for every patient for every service and not need to work without compensation. Yet, this is an illusion; there are always people with unmet medical needs who are unable to access regular practitioners. They could be helped by a physician who would provide what the legal profession calls pro bono services.

A Fundamental Professional Commitment

The fact is that people who are socially and economically most disadvantaged are least likely to have satisfactory insurance coverage or regular medical care; hence, they have many illnesses and disabilities that are in need of medical care. For this reason, the *Code of Medical Ethics* of the American Medical Association states, "each physician has an obligation to share in providing care to the indigent" [2]. The code does not specify how much of one's professional time should be devoted to this purpose, whereas some associations of lawyers have indicated to their members that they expect at least 50 hours of pro bono work per year. Consequently, for many physicians, the right amount of time and the recipients of uncompensated care are matters of personal decision.

In his dealings with patients, Dr. Bernard certainly exhibits an attitude of compassion leading to altruistic behaviour, and in this respect he is fulfilling a fundamental professional commitment. He now needs to determine some boundaries; how much time can be devoted to uncompensated care? And, how many patients can be seen within the allotted time?

Dr. Bernard's Many Options

There are several possibilities open to Dr. Bernard. If he is quite wealthy, he may reflect that a high income is no longer that important to him. In that case, he could decide to transfer care of his affluent patients to his colleagues while he embraces the vocation of providing service to those who need it most but can least afford it. He may see this action as a glorious final part of his professional career and the fulfillment of his idealistic aspirations of earlier years. A practice devoted totally to underprivileged patients may give him a great deal of satisfaction, but he needs to be prepared for some unpleasant consequences, like the need to move out of his comfortable and expensive office and move to a more humble working space.

Alternatively, Dr. Bernard may realize that, given his current personal and family situation, he cannot afford to serve

only indigent patients but he can accept some reduction in his income. In this case he can work out a formula that will provide a sustainable balance of both types of clientele. For example, he may reserve one day a week for booking patients who are uninsured or have Medicaid. Certainly, a disruption of his schedule by people who walk in can be avoided. He is no more obligated to see an indigent patient who did not obtain an appointment than to see any other patient whose problem does not require urgent attention. Alternatively, Dr. Bernard may also choose to work one day a week for an agency or clinic that serves such populations; this way he is volunteering his own time but not the time of his staff. He may even work at improving the efficiency of the local free clinic.

Yet Dr. Bernard may instead determine that his 2 months of work for the underprivileged patients were too costly for him. Even if he has a strong desire to serve the poor, he may not, at the present time, be able to devote much time to this pursuit. He may plan to get some financial stability, reduce his expenses, and then resume his altruistic work with uninsured poor patients.

In the interim, he does not have to ignore the voice of his conscience, because there are many other things he can do. He may convince another colleague, perhaps someone planning to retire, to accept his low-compensation patients, or he may decide to advocate with his local medical society or his local government for better access to services for uninsured or underinsured patients.

The avenue that Dr. Bernard chooses can be ethically right and proper for him, providing that he reflects on his professional responsibility, pays attention to his conscience, searches his own heart for his innermost needs and aspirations, and considers his personal situation.

We hope that Dr. Bernard will arrive at a satisfactory resolution without forgoing his resolve to help. His impending dilemma is a needed reminder to us all that altruistic behaviour born of compassion requires not only an open heart but also some resolute and intelligent planning. It is at this junction that altruistic behaviour can be understood and undertaken as a freely chosen moral obligation resulting in personal fulfillment.

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Journal Discussion

Agents of a Rogue State? Physicians' Participation in State-Sponsored Torture

The participation of physicians in torture around the world exposes the ineffectiveness of international declarations that condemn the practice.

Meme Wang, MPH

Reis C, Ahmed AT, Amowitz LL, Kushner AL, Elahi M, Iacopino V. Physician participation in human rights abuses in southern Iraq. JAMA. 2004 291:1480-1486 (Erratum, JAMA. 2004;291:2316).

As reports of conditions in prewar Iraq remind us, state-sponsored human rights abuses still occur in many parts of the world. Torture continues to be employed by more than 100 governments and by non-state players such as armed militia in 40 countries [1]. A recent study, "Physician Participation in Human Rights Abuses in Southern Iraq" [2], by Physicians for Human Rights (PHR) seeks to clarify the nature and extent of physician complicity with state-sponsored torture during Saddam Hussein's reign in Iraq The authors' findings should be read in the context of the medical community's long and complicated history with torture.

According to physician and ethicist Giovanni Maio, the medical establishment's involvement in torture dates back to ancient Greece [3]. The first official reference to medical activity in the practice is in the Constitutio Criminalis Carolina of 1532 in the time of Charles V, emperor of the Holy Roman Empire, which established the European legal roots of the physician's presence during torture [4]. Torture was thought of as necessary to prevent criminal activity, so it was enshrined in the legal system and widely acknowledged.

As representatives of the state, physicians were expected to carry out the law. Their cooperation was not a consequence of coercion or fear of reprisal. Surprisingly, in light of this legal situation, much of the criticism of torture beginning in the 16th century came from the very physicians who participated in it. Doctors did not at first argue on moral or ethical grounds, condemning the cruelty of torment or the infliction of pain. Rather, Maio contends, they questioned the reliability of the testimony given under torture by those who were persecuted.

Still, physicians provided medical certificates that documented the defendant's state of health and mind and his or her ability to survive torture. If the accused was weak or ill, doctors recommended different methods of torment that could be endured. Physicians also determined when the pain had to be stopped in order to prevent sudden death, assessed whether the accused was truly unconscious or not, and treated injuries to allow the persecution to continue. But, Maio concludes that prior to the 20th century, the physician's role in torture was always passive. Medical doctors never took an active part in the ordeal. By contrast, he contends that as modern torture became progressively more scientific, physicians became actively involved by inventing new technical possibilities and by administering, for example, psychiatric-pharmacological and psychological forms of torture. Even as their participation went from passive to active, physicians paradoxically became unwilling to endorse the practice the way their early counterparts had done—a difference that reflects the change in society's attitude toward torture over the centuries.

It was the questionable reliability of testimony made under torture that prompted the first ban of the practice in Austria in 1776 [5]. Torture was eventually repudiated by most "civilized" societies, exiled to isolated torture chambers, denied and suppressed. International declarations and statements forbidding torture were established first after the

French Revolution and again after World War II [6]. And international declarations condemning medical personnel's participation in torture began to appear. Among the most important of these are the Declaration of Geneva and the Declaration of Tokyo, which were adopted by the World Medical Association in 1968 and 1975, respectively. These declarations state that physicians must maintain the "utmost respect for human life" even under threat [7], and any medical participation in torture is proscribed. Similarly, the United Nations' resolution on Principles of Medical Ethics, 1983, forbids physician abuse of the patient-doctor relationship to aid in torture or interrogation of suspects [8].

The current participation of physicians in torture around the world exposes the ineffectiveness of such codes. During Saddam Hussein's reign in Iraq from 1979-2003, his regime systematically inflicted widespread human rights violations. The nature and scope of physician participation in these abuses are ambiguous. On the belief that identifying and confronting past evils will prevent history from repeating itself and is crucial for the successful reconstruction of Iraq, Physicians for Human Rights (PHR) conducted a self-administered survey of medical doctors in 2 major cities in southern Iraq. Its three objectives were: (1) to outline the system of physician participation in state-sponsored torture; (2) to ascertain structural factors that aided doctors' involvement in the abuses; and (3) to assess physician attitudes toward human rights violations and identify actions for preventing future compliance [9].

The study's findings indicate that Iraqi medical doctors performed partial or complete amputation of ears as a form of punishment, falsified medical and legal reports of alleged torture, and misrepresented or fabricated death certificates. These practices breach internationally accepted declarations like those made by the World Medical Association, as well as international codes or principles of medical ethics. Iraq is a party to The International Covenant on Civil and Political Rights, which bans torture. Although the Baath regime decreed participation of physicians in human rights abuses, these acts also violated Iraq's Interim Constitution of 1990 and the Iraqi Penal Code [10]. Despite the ethical ideals and legal measures, physicians assisted in carrying out orders of violence and cruelty of the state.

The absolute control wielded by the Baath regime must be taken into consideration when attempting to understand the medical community's obedience in executing torture, Reis et al argue. Repressive regimes generally involve physicians to spread fear, permit officials to deny responsibility, and allow perpetrators to detach themselves morally. The physicians' complicity in the state's system of oppression in turn, encourages them to support the regime. Their widely known complicity undermines not only patient trust but also trust among the physicians themselves. The survey findings suggest that the web of involvement and cover-up ensures that physicians will continue to comply with the wishes of the authorities. This explains why no independent national medical institutions were able to develop and become powerful enough to speak out against the government and protect individual physicians and their families from harm. The authors further assert that Iraqi physicians who unwillingly performed human rights violations may themselves be viewed as survivors of the regime and should not be judged in the same manner as their willing peers.

The authors advise that reforming the Iraqi legal system, restructuring and strengthening medical institutions and associations, and establishing the medical community's independence from state authorities are crucial steps toward the goal of averting future physician involvement in violence, cruelty, and persecution by the state. Effective monitoring of the authorities' compliance with civil liberties and constitutional rights is necessary to achieving that goal. Ethics education for medical professionals should be designed to promote awareness and understanding of the devastating effects of torture and to explore the roles doctors commonly play in oppressive authoritarian systems. Finally, physicians must be given strategies for dealing with the threatening situations in which they find themselves if they do not comply in executing torture. These include the use of established networks or arrangements with international governments that can then exert external pressures on the abusive regime.

As it rebuilds, Iraq's success as a democratic state will depend on its readiness to confront its past evils and take actions to prevent their recurrence. However, as Vincent Iacopino, Director of Research for Physicians for Human Rights (PHR), writes, "torture is a profound concern for the world community. It concerns all members of the human family because it impugns the very meaning of our existence and our hopes for a brighter future" [11].

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Questions for Discussion

1. Why should physicians care about state-sponsored torture employed in different parts of the world? What are possible implications of not taking a collective stand against torture and not protecting physicians from being forced to participate?
2. How can a physician in a regime that employs torture and abuse confront the government's demand to participate in these practices? What lessons can be learned from the study of Iraqi doctors by physicians in other countries?

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Medical Education

Integrating Human Rights into Medical Education

Educating medical students, residents, and practicing physicians about human rights can help them become more effective advocates for patients.

Kari Hannibal, MA, Carola Eisenberg and H. Kristian Heggenhougen, PhD

An understanding of human rights principles and the connection between health and human rights should begin in the first year of medical school. In this essay we examine the connections between health and human rights and the ways that faculty and students can introduce a human rights perspective into medical training.

Connecting Health and Human Rights

We believe the right to health care is a human right, closely linked to the realization of many other human rights, from the rights to food, housing, and work to the right of access to information and freedom of association [1].

Physicians around the world are called upon to provide health care to persons who have suffered the physical and psychological consequences of torture, imprisonment without trial, and cruel and inhuman treatment. In the past 3 decades, a new field of medical specialization has evolved for the care of persons who have experienced trauma at the hands of governments or individuals. In the United States alone, there are more than 30 treatment centers dedicated to assisting the more than 500,000 torture survivors who live in this country [2].

Human rights abuses also challenge the ethical practice of medicine, from the Nazi doctors to the current situation in Guantanamo Bay. The United Nations and nongovernmental organizations (NGOs) have documented these challenges and provided guidance for physicians in the form of codes of conduct [3,4]. Yet most US medical schools ignore the important intellectual and practical aspects of the human rights movement in teaching medical students.

The consequences of such human rights abuses as direct violence and gender and racial discrimination are reflected in epidemiological data as well as in poorer health care services. On a systems level, moreover, structural violence (the application of force to maintain disparities between social classes) leads to abuses of human rights and a tremendous illness burden among the poor [5,6].

If properly trained, physicians can assist victims medically, legally, and socially by documenting and publicizing abuses. They can work with asylum seekers, testify in court, and provide patients with specialized services or connect them to agencies that are sensitive to the political, cultural, and social dimensions of their suffering. As professionals, physicians are influential political and social actors who can advocate for change in inequitable or harmful social policies and practices.

Human Rights in Medical Education

A rights-based approach to medicine provides a moral framework that enables doctors, from family physicians to medical policy makers, to address injustice in health care locally, nationally, and globally [7]. International efforts to protect health by promoting human rights, assisting victims of abuse, and recognizing the many determinants of health have been evolving for more than half a century.

Human rights education in US medical schools can take place in many forums. Medical student groups that focus on human rights already exist in more than 60 medical schools, according to figures from Physicians for Human Rights [8]. These groups involve the student body in discussing and debating concepts of human rights, equity, and health as phenomena that go beyond biomedicine.

At the least, medical schools should organize periodic lectures and grand rounds for students, residents, faculty, and staff where physicians who are experts or activists in human rights speak about the ways they integrate a human rights viewpoint into their practice of medicine.

Ideally, faculty should begin to incorporate human rights principles into existing medical school classes. Some likely prospects are classes on international health, violence and trauma, health disparities, or patient-doctor relationships. Teaching methods and materials may include the use of case studies, experiential fellowships or internships, reference to international health and human rights norms, and health and human rights reports of the United Nations and well-known NGOs. The medical literature contains rich resources on health and human rights topics, and several NGOs maintain excellent bibliographies (see Suggested Readings, below).

At Harvard Medical School, we have offered a course entitled Medicine, Human Rights, and the Physician as an elective since 1996. It consists of a series of lectures by invited speakers, primarily physicians who live in or are visiting the Boston area, complemented by public health and legal experts. The speakers present both domestic and international situations where health and human rights concerns converge. Students also investigate and present human rights topics to the class. Last year, for example, students presented on the role of physicians in refugee camps, and health and human rights in El Salvador and Cambodia.

Continuing medical education courses in health and human rights, such as those offered by the Francois Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health and by Physicians for Human Rights, can reach residents and practicing physicians. These provide a good orientation to basic principles and current practices in the health and human rights field and introduce attendees to experts both nationally and internationally.

In addition, human rights principles can be mindfully incorporated into residency training programs, such as the Global Health Fellowship program in the Department of Medicine, recently developed at the Brigham and Women's Hospital in Boston [7].

Authors ' note: The views presented here are solely those of the authors and not that of Harvard Medical School.

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Suggested Readings

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Clinical Pearl

Medical Evaluations of Asylum Seekers

Health workers can provide important medical documentation for individuals who are seeking political asylum in the United States.

Vincent Iacopino, MD, PhD

Identify important considerations in conducting a medical evaluation of asylum seekers.

Identify physical and psychological evidence of torture and ill treatment.

Each year, thousands of people who have suffered torture and ill treatment at the hands of government officials flee their countries of origin and seek asylum in the United States. Health professionals can provide critical documentation of torture and ill treatment in asylum proceedings. Such evaluations are often conducted through the Asylum Network of Physicians for Human Rights and specialized treatment centers for survivors [1,2].

Purpose of the Medical Evaluation

The purpose of the medical evaluation of asylum applicants is to provide expert opinion on the degree to which medical findings correlate with the applicant's allegation of abuse and to effectively communicate the clinician's medical findings and interpretations to the judiciary or other appropriate authorities. In addition, medical testimony often serves to educate the judiciary, other government officials, and the local and international community on the physical and psychological sequelae of torture.

Medical evaluations require a careful and thorough clinical history and examination of physical and psychological evidence by clinicians who are sensitive to cross-cultural issues and interpersonal dynamics between traumatized individuals and persons in positions of authority. Clinicians must be knowledgeable about the medical and psychosocial consequences of torture [3-7] and the established guidelines for effective documentation [3-5].

Torture Definition and Methods

Torture and ill treatment are generally defined as the intentional and systematic infliction of pain and suffering by public officials upon an individual for some purpose [8]. There is no limit to the number of forms that torture and ill treatment can take. This is precisely why all forms of torture and ill treatment are equally prohibited by international human rights law. Further elaboration on possible forms of torture and ill treatment is included in the *United Nations Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (Istanbul Protocol), which contains international standards for effective investigation and documentation of torture and ill-treatment [3].

Health Consequences

While torture can have devastating health consequences, it is important to recognize that there is individual variability in physical and psychological findings. Individuals respond to and recover from traumatic events, including torture, in a variety of ways. In some cases, physical evidence may not be detectable because most medical evaluations are

conducted after the resolution of acute signs and symptoms of physical injury. Psychological symptoms, on the other hand, are often enduring in nature and also can play a critical role in documenting evidence of torture.

Physical Evidence

Physical manifestations of torture may involve all organ systems. Some effects are typically acute while other may be chronic. Symptoms and physical findings will vary in a given organ system over time, though psychosomatic and neurologic symptoms are typically chronic findings. Musculoskeletal symptoms are commonly present in both acute and chronic phases. A particular method of torture, its severity, and the anatomical location of injury often indicate the likelihood of specific physical findings. For example:

- Beating the soles of the feet (falanga) may result in subcutaneous fibrosis and a compartment syndrome of the feet.
- The use of electricity and various methods of burning may also leave highly characteristic skin changes.
- Whipping may also produce a highly characteristic pattern of scars.
- Different forms of body suspension and stretching of limbs may result in characteristic musculoskeletal and nerve injuries.
- Other forms of torture may not produce physical findings, but are strongly associated with other conditions. For example, beatings to the head that result in loss of consciousness are particularly important to the clinical diagnosis of organic brain dysfunction. Also, trauma to the genitals is often associated with subsequent sexual dysfunction.

Psychological Evidence
Although there may be considerable variability in psychological effect, torture and ill treatment often result in profound, long-term psychological trauma. According to the Istanbul Protocol, the most common psychological problems are posttraumatic stress disorder (PTSD) and major depression, but may include the following:

- Re-experiencing the trauma
- Avoidance and emotional numbing
- Hyperarousal symptoms
- Symptoms of depression
- Damaged self-concept and foreshortened future
- Dissociation, depersonalization, and atypical behavior
- Somatic complaints
- Sexual dysfunction
- Psychosis
- Substance abuse
- Neuropsychological impairment

Such psychological symptoms and disabilities can last many years or even a lifetime. It is important to realize that the severity of psychological reactions depends on the unique cultural, social, and political meanings that torture and ill treatment have for each individual, and significant ill effects do not require extreme physical harm. Seemingly benign forms of ill treatment can and do have marked, long-term psychological effects.

General Interview Considerations

Clinicians should be aware of the following considerations in the course of conducting their medical evaluations:

Informed Consent: Clinicians must ensure that applicants understand the potential benefits and potential adverse consequences of an evaluation and that the applicant has the right to refuse the evaluation.

Confidentiality: Clinicians and interpreters have a duty to maintain confidentiality of information and to disclose information only with the applicant's consent.

Setting: The location of the interview and examination should be as safe and comfortable as possible, including access to toilet facilities. Sufficient time should be allotted to conduct a detailed interview and examination.

Control: Let the applicant know it's all right to take a break if needed or to choose not to respond to any question he or she may not wish to.

Earning Trust: Trust is an essential component of eliciting an accurate account of abuse. Earning the trust of one who has experienced torture and other forms of abuse requires active listening, meticulous communication, courtesy, and genuine empathy and honesty.

Translators: Professional, bicultural interpreters are often preferred, but may not be available.

Preparation for the Interview: Clinicians should read relevant material in order to understand the context of the alleged abuse and to anticipate regional torture practices.

Interview Techniques: Initially, questions should be open-ended, allowing a narration of the trauma without many interruptions. Closed questions are often used to add clarity to a narrative account or to carefully redirect the interview if the applicant wanders off the subject.

Medical History: Obtain a complete medical history, including prior medical, surgical, or psychiatric problems. Be sure to document any history of injuries before the period of detention or abuse, and note any possible after-effects. Avoid leading questions. Structure inquiries to elicit a chronological account of the events experienced during detention. Specific historical information may be useful in corroborating accounts of abuse. For example, a detailed account of the applicant's observations of acute lesions—and the subsequent healing process—often represents an important source of evidence in corroborating specific allegations of torture or ill treatment. Also, historical information may help to correlate individual accounts of abuse with established regional practices. Useful information may include descriptions of torture devices, body positions, and methods of restraint; descriptions of acute and chronic wounds and disabilities; and information about perpetrators' identities and place(s) of detention.

Pursuit of Inconsistencies: An applicant's testimony may, at first, appear inconsistent unless further information is gathered. Factors that may interfere with an accurate recounting of past events may include: blindfolding, disorientation, lapses in consciousness, organic brain damage, psychological sequelae of abuse, fear of personal risk or risk to others, and lack of trust in the examining clinician.

Nonverbal Information: Include observations of nonverbal information such as affect and emotional reactions in the course of the trauma history and note the significance of such information.

Transference and Countertransference Reactions: Clinicians who conduct medical evaluations should be aware of the potential emotional reactions that evaluations of trauma may elicit in the interviewee and interviewer. These emotional reactions are known as transference and countertransference. For example, mistrust, fear, shame, rage, and guilt are among the typical transference reactions that torture survivors experience, particularly when asked to recount and remember details of their trauma history. In addition, the clinician's emotional responses to the torture survivor, known as countertransference (eg, horror, disbelief, depression, anger, over-identification, nightmares, avoidance, emotional numbing, and feelings of helplessness and hopelessness), may affect the psychological evaluation. Considering survivors' extreme vulnerability and propensity to re-experience their trauma when it is either recognized or treated, it is critical that health professionals maintain a clear perspective of a healing relationship. Such vicarious or secondary trauma to the clinician can be minimized by discussions with other colleagues after the interview. Effective documentation of torture and other forms of ill-treatment requires significant understanding of the motivations for working in this area. It is important that a clinician not use the population to work out unresolved issues in himself or herself, inasmuch as these issues can clearly hamper effectiveness.

Examination

The examiner should note all pertinent positive and negative findings, using body diagrams to record the location and

nature of all injuries. Torture victims may display injuries that are substantially different from other forms of trauma. Although acute lesions may be characteristic of the alleged injuries, most lesions heal within about 6 weeks of torture leaving no scars or nonspecific scars.

Interpretation of Findings and Referrals

The clinician should correlate allegations of abuse with the findings of the medical evaluation and indicate his or her level of confidence in the correlations (eg, inconsistent / consistent with / highly consistent with / pathognomonic). A final statement of opinion regarding all sources of evidence (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and the possibility of torture should be included. The clinician also should provide any referrals or recommendations for further evaluation and care for the asylum applicant.

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Health Law

Medicating Death Row Inmates so They Qualify for Execution

Ethical questions arise when physicians are asked to medicate death row inmates so that they qualify for execution.

Leah Eisenberg

Charles Singleton was convicted of murder and sentenced to death in 1979 [1]. Once on death row, he began taking psychotropic medications to alleviate anxiety and depression. His mental health began to deteriorate further around 1987, at which time he came to believe that his cell was inhabited by demons and that his thoughts were being stolen from him. Singleton was subsequently diagnosed with schizophrenia and given antipsychotic medication. Over the next several years, he sometimes agreed to take the medication; at other times, it had to be administered forcibly. When he went off the medication, the paranoid and delusional behaviors—including the belief that he was on a mission to kill the president and that he had already been executed—returned. At this point, antipsychotic medication was deemed medically necessary, so, starting in 1997, the prison placed Singleton on an involuntary medication regime, subject to an annual review. The precedent for doing so was the 1990 US Supreme Court decision in *Washington v Harper* [2]. Harper was a psychotic inmate with a history of violent outbursts, who became unwilling to take antipsychotic medication while in prison. The Court decided that the State could medicate such an individual against his will only if "the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest" [3].

Under the involuntary medication regime, Singleton's symptoms abated, and the State of Arkansas scheduled his execution for March 2000. Singleton subsequently filed a petition for habeas corpus, a judicial mandate ordering that a prisoner be brought before the court to determine whether or not he is being held unlawfully. Singleton contended that he was only competent because of the antipsychotic medication he was taking and that it was unconstitutional for the court to render him competent for execution by forcibly medicating him. The 8th Circuit Court of Appeals was faced with deciding whether the state can execute someone who is involuntarily medicated to meet competency requirements for execution.

The 8th Circuit Court was guided in its deliberation by several landmark cases concerning mentally ill prisoners. The US Supreme Court first addressed the question of whether the Constitution allows the mentally ill to be executed in 1986, in the case of *Ford v Wainwright* [4]. The court found it unconstitutional, although it could not agree on a single rationale for that decision, citing variously concerns about inhumane treatment and the lack of either deterrent effect or retributive value of such action. In his concurring opinion, Justice Lewis F. Powell, Jr, suggested that, under the Eighth Amendment, prisoners are not competent to be executed if they are "unaware of the punishment they are about to suffer and why they are to suffer it" [5]. This language has become the standard used to evaluate the mental capability of prisoners, and inmates are now judged on their "Ford competence." It is important to note that this refers to the prisoner's level of competence at the time of execution, not at the time that the crime was committed. Neither party in the Ford case disputed the fact that the defendant was mentally competent when he committed the crime and during the trial and sentencing.

Charles Singleton's situation was more complicated than the one described in *Ford v Wainwright*, since the psychosis that caused Singleton's mental incompetence could be diminished, if not eliminated entirely, with psychotropic

medication. And Singleton's case was more complicated than that of Harper because Harper was not on death row. Medicating Harper involuntarily did not mean that he would die as a result.

While the due process clause of the Fourteenth Amendment grants every person the right to liberty, including the liberty to be free from unwanted medication, limits may be imposed upon that liberty in order to meet a legitimate state interest. Although prisoners maintain some constitutional rights, the state has both a right and an obligation to preserve order in prisons, and, in these cases, the state's interests in maintaining a safe prison environment were found to supersede the inmates' right to refuse medication. The *Washington v Harper* court had also decided that it was not necessary to hold a judicial hearing to determine competence prior to imposing an involuntary medication regime on an inmate. The court went on to explain that the ruling did not imply that every prison had the right to medicate a prisoner against his will; rather, it meant that competence did not have to be determined by a judicial decision maker. The hearing by committee that had decided Harper's incompetence—and had included both a psychiatrist and a psychologist—was found to be sufficient to meet Harper's due process rights. In 1992, the Supreme Court again confronted the issue of forcing antipsychotic medication on inmates, and it again ruled that there are times when such action may be appropriate, so long as the treatment is shown to be essential for the defendant's safety or the safety of others [6].

How do these decisions impact the Singleton case? The 8th Circuit Court reviewed these cases when deciding Charles Singleton's fate, and, while the precedents were instructive, none of them addressed the specific issue of whether it was constitutional to force a psychotic prisoner who has been condemned to death to take medication that makes him competent and, hence, eligible for execution. Singleton argued that once an execution date was set, it was no longer in his best medical interest to be medicated, since by rendering him competent, the medication also made him eligible for execution. On the other hand, whenever Singleton went off his medication, he quickly reverted to psychosis, and being in a psychotic and delusional state was not in his best medical interest either. The court found that since the medication controlled Singleton's mental illness, and since Singleton himself admitted to feeling better while on it, the only unwanted side effect of forcing him to take antipsychotic medication was the fact that it would make him eligible for execution, a sentence that was lawfully imposed upon him for a crime he was found to have committed. The state always has an essential interest in making sure that lawfully imposed sentences are carried out. Therefore, the 8th Circuit Court decided that Singleton was to continue to receive the medication regardless of the fact that an execution date had been set, because it was still in his best medical interest. On January 6, 2004, after spending a record length of time on Arkansas' death row, Charles Singleton was put to death.

Implications for Physicians

The case of Charles Singleton forces physicians to make a number of difficult ethical decisions, inasmuch as there is no treatment plan that is clearly in the patient's *overall* best interest. Under normal conditions, principles of patient autonomy require that a patient be allowed to make his or her own treatment decisions; however, an incarcerated prisoner—and one who is declared incompetent to make medical decision—does not have the same autonomy as a competent individual living independently.

The AMA *Code of Medical Ethics* has 2 opinions that offer guidance on physician participation in cases like Singleton's—the opinion on court-ordered medical treatment and the opinion on capital punishment. As it turns out, the latter is more to the point. The former, Opinion 2.065 concerning court-ordered medication, states that it is ethical for a physician to provide such treatment as long as the treatment is "therapeutically efficacious and…not a form of punishment or solely a mechanism of social control" [7]. A physician, and not the court, must make the diagnosis, and if the physician who is to treat the inmate makes the diagnosis, it must be confirmed by an independent physician or panel of physicians not responsible to the state.

There is no dispute that the antipsychotic medication effectively controlled Singleton's schizophrenia. However, this opinion concerns itself chiefly with court-ordered treatments to which the prisoner is likely to consent. Thus, it states that "the physician must be able to conclude, in good conscience…that the informed consent was given voluntarily to the extent possible, recognizing the element of coercion that is inevitably present," and that in the case of pharmacological treatments, "an independent physician or panel of physicians not responsible to the state should confirm that the informed consent was given" [7]. Though physician permission to participate in court-ordered

medication applies to the Singleton case, "with patient consent only" clearly does not. Should a physician then refuse to provide court-ordered treatment to which the patient does not consent? There is no clear answer. The report drafted by the AMA's Council on Ethical and Judicial Affairs (CEJA) from which Opinion 2.065 was derived remarked that each state has the authority to determine whether or not it will allow the courts to mandate medical procedures, but that a physician who treats a patient against his will, in violation of the principles of informed consent, may be liable for medical malpractice or battery [8]. Even if the physician were not held liable, the council expressed concern that such action would damage the integrity of the medical profession by making physicians agents of the state rather than providers of care.

The question of whether Charles Singleton's physicians ought to comply with a forced medication regime is further complicated by his death sentence, and, therefore, the *Code's* opinion on physician participation in capital punishment (Opinion 2.06) offers more guidance in the dilemma. By giving medication that would restore Singleton to competence and render him eligible for execution, the physician would be incidentally participating in his execution, and the *Code of Medical Ethics* states unequivocally that "a physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution" [9]. The *Code* goes on to say that a physician should not treat a condemned prisoner for the purpose of restoring competence, unless a commutation order is in place before treatment begins, but that "if the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible" [9]. Without medication, Charles Singleton suffered from psychosis and delusions, and, since the medication alleviated those symptoms, a physician could be justified in giving it to him if the commutation issue was first addressed.

The *Code of Medical Ethics* declares that a physician should never be "compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs" [9]. However, regardless of whether a physician decides to participate, or to transfer the patient's care to another physician, issues like those presented by the Singleton case leave all doctors between a rock and a hard place. Is it better to provide care for such patients, because everyone deserves competent care and protection from needless suffering, or does it devalue the healing profession to use one's clinical skills to prepare a person for execution? Suppose all physicians agreed that the profession's ethical code forbade medicating a death row inmate if doing so would result in his being executed. Must the prisoner then live out the remainder of his days tortured by psychosis?

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Policy Forum

Choice in Planning and Experiencing Childbirth

Physicians should play a critical role in expanding access to reproductive health choices for women, including the choice to give birth under the care of a midwife.

Lynn P. Freedman, JD, MPH, Rana E. Barar and Ann Drobnick, MPH

"Choice" is a central concept in the struggle for reproductive freedom around the world. Yet one of the most damaging consequences of our bruising abortion debates is the gutting of choice itself. In US political discourse, "choice" has come to be identified almost exclusively with the right to choose an abortion, and "reproductive rights" has been conflated with this narrow, legalistic notion of choice.

But for many women, reproduction includes both the prevention of unwanted pregnancy *and* the process of carrying a pregnancy, progressing through labor, and giving birth to a child. Wherever a woman finds herself on that spectrum, her experience of reproductive choice is not just a yes-or-no decision protected in law; rather, the experience of reproductive freedom is profoundly influenced by her interactions with the health system. Thus access to health care must be a core element of choice. Moreover, access ultimately means more than getting in the door. In a system that respects, upholds, and values reproductive freedom, access implies entrée to health care practices that acknowledge the complexity of the reproductive experience for women—its social, psychological, and political dimensions—and that honor the different choices women make throughout that experience.

US law is a particularly blunt instrument for the advancement of these ideas about reproductive freedom. Here, in both law and political discourse, rights are conceptualized almost exclusively as entitlements of the individual, and analysis centers on violations of those individual rights. The question of what social and institutional conditions are necessary for the individual to exercise and fully enjoy her rights is usually deemed a public policy or even a private issue, beyond the scope of rights analysis. Thus US law guarantees a right to choose between terminating and continuing a pregnancy, but stops short of ensuring the conditions that would enable women actually to exercise the choices they make. At one end of the reproductive spectrum, the classic statement of this distinction is the Supreme Court opinion in *Harris v McRae*, holding that although all women have an equal right to choose abortion, Medicaid is not constitutionally required to pay for it, even if that effectively closes off the option for poor women [1]. At the other end, in the conditions surrounding childbirth, women's choices have also been constricted by laws, practices, and the powerful social and intellectual constructions that underpin them, as we demonstrate below.

Can human rights be used to break open these constraining forces and foster new understanding of reproductive freedom and choice? Following the model of US civil rights law, traditional approaches to international human rights law have focused heavily on civil and political rights—issues such as torture, prisoner abuse, discrimination—with an emphasis on identification of violations and punishment of violators. But human rights also includes another branch of international law, social and economic rights (such as the rights to health and to health care), which brings the challenge of "enabling conditions" out of the private or the policy sphere, and into the domain of rights analysis [2]. These social and economic rights are not recognized as enforceable rights in US law. But the principles that underlie them (and civil and political rights as well) are increasingly used in global health work, not just to mark the boundaries of behavior, but also to shape the way problems are analyzed, solutions are crafted, and professional responsibility is approached.

This evolving use of the principles of human rights to shape all aspects of professional practice is termed a "rights-based approach" [3,4]. We believe it can be a valuable way to analyze the role and obligations of physicians in promoting reproductive freedom for women in this country as well as in countries where maternal mortality is high and death in childbirth is a real danger for every woman.

What should physicians do to promote this fullest sense of choice and reproductive freedom? We recognize that the health system has become a massively complex edifice with myriad competing interests, often perverse incentive structures, and proliferating restrictions on the physician's own freedom to set the terms of his or her practice. Still, physicians as individuals and members of a professional community remain powerful arbiters of ideas about health care and the ways in which those ideas translate into public policies and ultimately into health care choices available for women. The influence that the medical profession has had over the conditions under which women give birth in a range of different settings globally serves to illustrate our point.

Accounting for Risk

Pregnancy and childbirth are, of course, normal and natural parts of life, experienced by most women without physical complications. But in every setting, no matter how technologically advanced, pregnancy and childbirth also pose risks. A routine delivery can quickly and unexpectedly turn into a life-threatening situation. Where access to emergency obstetric care is nearly universal, few women die from obstetric complications. However, in many countries, especially in South Asia and sub-Saharan Africa, health systems are in a state of collapse. Unmet need for emergency obstetric care often climbs to over 90 percent and, in such settings, maternal mortality is shockingly high [5]. A comparison of lifetime risk makes the point starkly: In Africa, a woman has a 1 in 16 chance of dying in pregnancy or childbirth, while in North America her lifetime risk is only 1 in 3500 [6].

These data describe only 1 aspect of reproductive risk. In every society, reproduction has many kinds of social, economic, cultural, and emotional significance for both individuals and the society [7]. These meanings influence the way that childbirth and its risks are actually experienced by women, how they are managed by the health system, and, ultimately, how they are regulated by the legal system. It is useful, therefore, to distinguish among 3 levels of risk [7]. At the *population level*, risk is quantified through epidemiological data correlating risk factors and outcomes across a society as a whole. At the *clinical level*, epidemiological data and the characteristics of the individual patient inform the assessment of risk that a clinician uses in counseling and treating a specific person. Finally, at the *individual, subjective level*, a woman processes, understands, and acts on statistical information she is given, taking into account the entire, multi-dimensional context of her life—a concept that has been called *lived risk* [8].

When the clinical model of risk eclipses all other models and controls childbirth policies across the whole health system, women's choices shrink. For example, Western medicine's notions of safety and risk have been used to justify "scope-of-practice" rules that unduly restrict the role of midwives, with negative impact not only on the efficiency and functioning of the health system [9], but also on the rights of pregnant and laboring women.

In the United States, the troubled relationship between physicians (especially obstetricians) and midwives goes back more than a century, with the struggle to capture social and legal authority over childbirth and to dominate the market for childbirth services. Economic aspects of this struggle have been well documented [10]. But, in the medical and public health literature, the debate has been dominated by questions of risk and safety.

The current paradigm of childbirth in America pits 2 contrasting models against one another. The medical model, based on notions of clinical level risk, approaches every birth as potentially pathological and intervenes medically to cut the risk of anything going wrong. The medical profession's involvement in routine pregnancy and labor began with the well-intentioned goal of reducing the pain and risk involved in bearing children and has progressed to the point that, for women who want it, childbirth can be made virtually pain free and even predictably timed.

The midwifery model, by contrast, approaches childbirth as a normal, natural event, although it does not deny the occasional need for emergency medical intervention. Midwifery care often represents a more holistic, female-centered, and less medicalized way of giving birth. Midwives approach every birth as a potentially powerful experience for the woman, facilitating her ability to maintain control over the process. Women seeking this kind of care see the

medicalization of childbirth as a disempowering cycle in which one medical intervention leads to another, leads to another, eventually ending in, at best, a harried, frightening experience and, at worst, an unwanted and possibly avoidable caesarian section.

From a human rights perspective, this uniquely American battle—however honestly and fervently it is waged—misses the point. By pitting the 2 models against each other, it fails to give meaningful weight to either population level risks or lived risks—and the values of access and choice that flow from each.

First, we should put the safety issue to rest. The United States stands virtually alone among industrialized nations in its lack of support for midwife-attended births. For example, midwives attend 90 percent of normal births in Germany and virtually all normal births in Denmark and France. In Austria, the law actually requires all births to be attended by a midwife [11]. In contrast, in 2002 (the last year for which data is available), midwives attended only 7.6 percent of births in the United States [12]. Although European countries rely heavily on midwives for routine births, and support them to practice with varying degrees of autonomy, they also ensure that women have universal access to emergency obstetric care in high quality health facilities in the event they experience complications. As a result, these countries have low maternal mortality, low perinatal mortality, and low rates of medical interventions, such as episiotomies and caesarian sections—indeed, on all counts lower than the United States [11]. Clearly, it is possible to organize the health system around a model of care that values the strengths of both midwives and doctors to achieve the best results for women without any trade-off in safety.

In some high-mortality countries, midwives are the backbone of the maternal health care system. But in many others, the medical profession has enormous influence over health policy, and the interests and clinical perspectives of physicians have determined scope-of-practice regulations that severely restrict the procedures that skilled, professional midwives (as distinct from traditional birth attendants) are permitted to perform [13]. In these settings, when safety debates framed as "midwives versus physicians" are allowed to obscure issues of access to basic life-saving care, the consequences are nothing short of tragic. Every year, half a million women worldwide die in pregnancy and childbirth. The single most important reason for these deaths is the lack of emergency obstetric care that women can access when life-threatening complications strike. The desperate shortage of trained, professional providers (midwives, nurses, and doctors), especially in rural areas, is both a fundamental part of the problem and an indispensable part of the solution [14]. A human rights approach that takes population level risk as seriously as clinical risk, that emphasizes equitable access to life-saving care, and analyzes the situation from a structural, public health perspective will yield policies that strongly support an expanded role for nonmedical providers, including midwives [15]. But such policies have little chance unless and until the medical profession changes its stance on scope-of-practice regulations and supports the training and deployment of midwives as safe and effective providers of emergency obstetric care.

Physicians' Role in Promoting Reproductive Rights by Expanding Choice

Of course, it takes more than the good will of physicians to make midwifery care a viable option for women. Political choices that determine the structure and functioning of the health system are key. In New York City, for example, the percentage of births attended by midwives is actually decreasing as access constricts [16]. Malpractice insurance premiums, skyrocketing for all providers of maternal care, have become completely untenable for midwives, rising as much as 1000 percent in the last year [17]. In September 2003, New York's Elizabeth Seton Birth Center, the first freestanding birth center in the country, was unable to afford insurance and forced to close its doors. Hospital-based midwifery care has fared little better. Medicaid, for example, only reimburses midwives 65 percent of the physician fee schedule [17]. As a result, hospitals around the country, including Columbia Presbyterian in New York City, are shutting down their midwifery services, citing economic considerations.

Other barriers relate more directly to the physician-midwife relationship. Some states require that midwives partner with physicians in providing care to patients. While these laws prohibit midwives from practicing without the partnership of a doctor, they do not require doctors to work with midwives. Midwives often face serious difficulty in finding doctors who are willing to practice with them on terms of respect and trust in a truly collaborative, nonhierarchical relationship.

At a social level, the barriers are more profound: In the United States, unlike in Europe and many other countries, the

choice of medicine versus midwifery is laden with value judgments, which the medical profession has done little to dispel. The woman who, based on her own lived risk, chooses a midwife to attend her pregnancy and delivery is often denigrated and marginalized, pushed out of, rather than embraced by, the health system.

A New Vision

A new vision of care in pregnancy and childbirth is urgently needed. The World Health Organization—joined by the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO)—has now made professional midwifery skills a central plank in its strategic platform for reducing maternal mortality in developing countries [18]. In the United States, a 1998 report of an expert commission on health professions called for dramatic change in the American system as well, stating: "[T]he midwifery model of care is an essential element of comprehensive health care for women and their families that should be embraced by, and incorporated into, the health care system and made available to all women" [9]. A resolution passed by The American Public Health Association takes a similar position [19].

The US medical community—perhaps locked in too narrow a vision of reproductive risk—has lagged far behind. Physicians, obstetricians in particular, have a critical role to play in expanding access by recognizing and supporting the range of reproductive health choices that women make, including the choice to give birth under the care of a midwife.

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Medicine and Society

Physicians' Obligation to Speak out for Prisoners' Health

Physicians have a duty as advocates for human rights to speak out for the rights of prisoners, who often suffer both physically and psychologically.

Daryl Matthews, MD

As this is written, military review hearings at the US detention center at Guantánamo Bay, Cuba, are under way to determine whether any of the individual detainees has been wrongly classified as an "illegal combatant" by the Department of Defense, and is, thus, eligible for repatriation. The men facing these hearings have been held, often in solitary confinement, for up to 2½ years and have not had access to legal counsel. It appears from news reports that a majority of detainees are refusing to participate in the hearings.

On the face of it, this would seem altogether irrational. Some detainees may be released as a result of the military review hearings, so there would appear to be no downside to participating. Only a few detainees currently face charges that will result in their being tried before military commissions, so those refusing the military review hearing process may still be held indefinitely without trial. And these review hearings are not the habeas corpus proceedings mandated by the US Supreme Court in its recent decisions on the Guantánamo detentions; thus, participation in them would not preclude participation in judicial hearings later on. Still, it appears that many detainees are refusing to attend.

Are those who are refusing doing so to protest their detention and the unfairness of their legal situation and because they see the classification review hearings as sham justice? Possibly this applies to some or many. But might not other detainees be abstaining due to hopelessness, despair, demoralization, and depression—mental states that can be induced or exacerbated by incarceration of the type experienced by Guantánamo detainees [1]? Individual Guantánamo detainees have asserted the presence of these conditions in recent legal pleadings [2]. These mental states, and more serious aberrations rising to the level of psychosis, induced by conditions of confinement, have been widely described in the psychiatric literature since the 19th century [3].

These conditions may constitute mental disorders sufficiently severe to impair or negate individuals' ability to competently waive or assist their attorneys or to participate unrepresented in the process. While these conditions are prevalent among US prisoners as well, the Guantanamo detainees' conditions, beyond the human suffering involved, may actually preclude their exercising the few legal rights they possess.

Surprisingly few mental health or medical professionals speak or write on the Guantánamo detentions or military commission process. It has fallen to others—attorneys, journalists, and human rights advocates and organizations, to bring news and warnings to the public about the psychiatric and psycho-legal impact of the detentions. Still, there is ample reason for medical and mental health professionals To join the public debate on the detentions and their mental health consequences.

While a host of professional ethical codes would support involvement in the debate over the detentions, one need go no further than the *Declaration of Professional Responsibility: Medicine's Social Contract with Humanity*, adopted by the AMA House of Delegates in December, 2002 [4], and by a host of other professional organizations. Physicians are enjoined to "use their skills beyond the bounds of the traditional patient-physician relationship in responding to

exceptional global conditions and need for care. . . .The duties the declaration imposes transcend physician roles and specialties, professional associations, geographic boundaries, and political divides" [4].

The declaration calls upon us to "respect the dignity of every individual" and to "refrain from supporting or committing crimes against humanity and condemn all such acts." We are also asked to "advocate for . . . political changes that ameliorate suffering and contribute to human well-being" [4].

The global political changes that might be made in service of these goals are limitless and many would be difficult or impossible to achieve. However, in the area of US treatment of alleged "illegal combatants," change may be possible. The Department of Defense has yielded to political pressure in many ways as it has gradually altered the military commission rules, released groups of detainees from particular nations, introduced a review hearings procedure, and opened Guantánamo itself to journalistic scrutiny.

Medical and mental health professionals are in a unique position to advocate for humane conditions of detention, fair legal processes, adequate psychiatric care, and appropriate psycho-legal evaluations. The Guantánamo detainees, exposed to a host of potential mental health risks, are hidden from professional and public scrutiny to an extent unparalleled by a correctional population in recent US history. Professional societies have avoided the controversies posed by the Guantánamo detentions; only human rights organizations have come forward to express concern about the detainees' mental health: The International Committee of the Red Cross, Amnesty International, Human Rights Watch, and Physicians for Human Rights, to name a few. Perhaps our professions are so silent because we have become accustomed to maintaining silence about the massive human rights violations so prevalent in US jails and prisons [5]. However, public examination and discussion of the Guantánamo situation may also help us take a clearer look at our responsibilities at home.

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The Living Code

Physician-Scientists and Social Responsibility

A new AMA policy provide guidance for physician-scientists on dual-use research issues and reinforces the message that ethical conduct in scientific research ultimately rests with the individual researcher.

Shane K. Green, PhD

Physician-scientists, like all physicians, have duties that extend beyond realizing the medical and scientific possibilities of their field. Among these duties are moral and professional obligations to individual patients and their families, as well as responsibilities to employers, governments, and society as a whole. Their various responsibilities may give rise to significant tension if and when physicians are asked—or are ethically bound—to choose between them.

A major role of the AMA's *Code of Medical Ethics* is to provide guidance for physicians in balancing these responsibilities when conflicts arise. For example, the potential for physicians' skills to be put to use that contravenes the profession's fundamental respect for human rights [1] is at the heart of existing opinions within the *Code* concerning physician involvement in torture [2], capital punishment [3], and court-initiated medical treatment in criminal cases [4].

Recent articles exploring potential pressures on physicians in the military to collude with inappropriate treatment of political detainees and prisoners of war [5] demonstrate the need for additional guidance in this area. With a "war on terror" abroad and efforts underway to prevent, or at least prepare for, possible future terrorist attacks at home, the conflicting obligations faced by physicians in the post-9/11 US are plentiful, and their ethical resolution critical to the well-being of society.

The threat of bioterrorism, for example, has placed renewed importance on the need for physician-scientists engaged in clinical or preclinical (ie, laboratory-based) research to balance their obligations to the advancement of science and medicine against the risk for nefarious application of their research findings. Consistent with its dedication to upholding medicine's social contract with humanity, the AMA has adopted a new policy to address this issue.

Science and Social Responsibility

The notion that scientific inquiry is objective and therefore morally neutral—while still held by some—is no longer as entrenched as it once was. The power of science to change the nature of the world in which we live is increasingly taken as cause for moral reflection. Indeed, there is a growing acceptance within and beyond the scientific community that scientists have a responsibility to conduct research with the aim of improving, or at minimum preserving, the general welfare of society [6].

In furtherance of that aim, scientists must give due consideration to and accept responsibility, at least in part, for all foreseeable applications of their research and the potentially disastrous consequences thereof. Never has this been acknowledged more powerfully than by one of the scientists involved in the creation of the atomic bomb, J. Robert Oppenheimer, who reflected ruefully on his role in the Manhattan Project by paraphrasing the Bhagavad-Gita: "I am become Death, the destroyer of worlds" [7].

The destructive potential of scientific knowledge is by no means unique to atomic energy research. Research in many biomedical science disciplines (eg, microbiology, genetics, and immunology) can generate knowledge with the potential for malevolent application. The possibility that terrorists may take advantage of this "dual-use" nature of biomedical research to develop biological weapons (BW) recently led the US National Research Council to issue a report calling for increased reflection upon and oversight of potentially corruptible research [8].

Similarly, it was the threat of bioterrorism, and the potential for physician-scientists engaged in dual-use research to act as unwitting facilitators for such acts, that compelled the stewards of the *Code*, the AMA Council on Ethical and Judicial Affairs (CEJA), to elucidate physicians' social responsibilities with respect to their research endeavors.

The AMA on Biological Weapons and Dual-Use Research

In retrospect, it seems somewhat prophetic that biological weapons were on the AMA's radar, so to speak, before acts of terrorism in the US prompted national concerns over their future use. In May 2000, the AMA chose BW as the focal point for the Scientific Session of the 54th General Assembly of the World Medical Association (WMA), which was held in Washington, DC, in 2002. There, the AMA presented a policy statement to the WMA, delineating the medical profession's roles and responsibilities with respect to the threat of BW. Adopted as the WMA Declaration of Washington on Biological Weapons, the policy includes a section devoted to bioweapons research and medical ethics, in which it states: "Physicians who participate in biomedical research have a moral and ethical obligation to consider the implications of possible malicious use of their findings" [9].

In the interim, the US was victimized by the terrorist attacks of September 11, 2001, and by the postal dissemination of anthrax shortly thereafter. In the immediate wake of these attacks, in October 2001, CEJA initiated discussion on a report to address some of the unique ethical issues that physicians face with respect to bioterrorism. Later that same year, the AMA's House of Delegates (HOD) adopted the *Declaration of Professional Responsibility: Medicine's Social Contract with Humanity*, which cited terrorism and the dual-use potential of medical research, among other factors, as inducements for its formal reaffirmation of physicians' social responsibilities [10].

In June 2002, members of CEJA agreed to develop a report on the responsibilities of physicians engaged in biomedical research with the potential to endanger public health and safety [11]. Two years later, in June 2004, the HOD adopted as AMA policy the recommendations of the ensuing CEJA report, entitled Guidelines to Prevent Malevolent Use of Biomedical Research [12].

Extending the Code

This new policy is not the AMA's first to direct physician-scientists' attention to their social responsibilities; a *Code* opinion issued in 2001 to guide physician-researchers experimenting with xenotransplantation, for example, compelled them to consider the uncertain risks posed by this new technology [13]. The new policy, however, broadens this guidance by applying the same standard—balancing the promise of benefit against potential harms—to *all* research endeavors, irrespective of their focus.

In doing so, this policy, when officially incorporated into the *Code*, will represent the *Code*'s most comprehensive commentary on preclinical research activities to date. Most *Code* opinions aimed at physician-scientists concern research involving human subjects [14-21]. Among those opinions that don't relate to human subjects research, each deals with a specific type of preclinical research (eg, cloning for biomedical research) and its likely clinical applications [22-24]. The inclusiveness of the new guidelines is essential; it is imperative that *all* research—basic and clinical—be assessed for dual-use potential because the possible harmful applications of any scientific inquiry or innovation are not always obvious on the face of it. Knowledge gained through basic research on the human immune system, for example, could conceivably be utilized to design uniquely infectious pathogens for use in BW.

The new policy reiterates (though not in so many words) provisions found within existing clinical research guidelines in the *Code* [14], that ethical conduct in scientific research ultimately rests with the individual researcher. But, again paralleling a previous *Code* opinion [13], it also suggests that physician-scientists be involved in the development and implementation of guidelines and oversight for potentially risky research. This calls upon physicians to broaden their

understanding of social responsibilities beyond monitoring their own research to setting standards for the actions of other researchers as well.

Finally, the new policy states that, in rare cases, there may be types of research that physician-scientists are morally prohibited from participating in, such as research that would *directly* contribute to the development of biological or chemical weapons. Implicit in this statement is an acknowledgment of another set of conflicting obligations that physician-scientists may face, namely duties to society imposed by the profession versus duty to the state (eg, a military research program). By precluding physicians' participation in the development of *offensive* biological weapons, the report echoes the firm tenor of previous opinions on capital punishment [3] and court-initiated medical treatments in criminal cases [4]; it holds that physicians must not, under any circumstances, act in ways that are antithetical to the fundamental principles of medicine.

The majority of the adopted recommendations that make up the new policy, however, do not deal with such direct involvement in unethical acts, focusing instead on the more likely possibility that a physician-scientist may unwittingly aid others in causing harm. In this, the new policy resembles the *Code*'s existing opinion on physician involvement in torture [2], in which the prohibitions are not meant so much to address physicians' direct participation in human rights violations, but their role as *facilitators*, ie, using their medical skills and training to enable torture to take place or continue. Similarly, because the development and use of biological weapons would constitute a gross violation of international policy [25] and basic human rights, physicians are obliged to consider and mitigate, insofar as possible, the potential that their research endeavors be applied to harmful purposes by others.

Overall, the new policy offers timely guidance for physician-scientists, to aid them in recognizing and living up to the social responsibilities shared by all members of the medical profession. War and terrorism do not engender novel societal obligations for physician-scientists—they simply underscore the importance thereof.

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Note: All *Code of Medical Ethics* Opinions, (except references 12 and 24) are also available online via the American Medical Association Web site and its Policyfinder. Go to http://www.ama-assn.org/ama/noindex/category/11760.html.

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Op-Ed

Torture and Human Rights

Participation in acts of torture, despite the approval of a government agency, places physicians in a morally compromised position.

Timothy F. Murphy, PhD, and Peter J. Johnson

In March 2004, the United States captured Khalid Sheikh Mohammed, said to be the al Qaeda operations chief, second-in-command to Osama bin Laden, and the alleged mastermind of the September 2001 terrorist attacks against the United States. The United States holds Sheikh Mohammed in an undisclosed location for interrogation [1]. The United States also holds other detainees (including lesser known al Qaeda leaders and members of the Taliban) while their intelligence value and legal fate is assessed. A key question is whether these detainees have knowledge that could save lives at imminent risk. The interrogation techniques used to obtain information from these parties remain murky and are perhaps willfully ignored by a public uncomfortable with all the details but willing to cut corners when American lives are at stake. A team of administration lawyers advised Defense Secretary Donald Rumsfeld that, in his capacity as commander-in-chief, President Bush could use torture in interrogations [2], even though the Bush administration did also counsel humane treatment of prisoners [3]. In any case, in May 2004, photographic images of US interrogations of Iraqi prisoners at the Abu Ghraib prison forced closer attention to US interrogation techniques. These iconic images show naked and hooded prisoners cowering in palpable fear. The administration called these interrogation techniques "abuses," but the world press did not hesitate to call them torture or possible war crimes. Whether the photographic evidence captures only the aberrant acts of a few or reflects directives issued from on high remains to be seen as investigations and military trials sort through these issues.

It also remains unknown what exact role physicians played at Abu Ghraib, though it is clear that some knew of intentionally inflicted harm [4]. Involvement in torture—before, during, and even afterward—puts physicians in morally compromised positions, no matter whether civil, military, or judicial systems have approved it. If physicians are not present or near at hand during torture, then victims of torture can be put at risk in many ways, including the risk of death. If physicians are present during torture, however, in order to protect against injurious outcomes, they run afoul of ethical advisories from their professional organizations. A physician who resuscitated and treated men and women after torture would face questions about moral complicity if victims were exposed to more torture later.

The exact scope of physician involvement in torture across history is not well studied. Some physicians have been involved with torture in the sense that they have treated its victims, sometimes going to heroic lengths to do so. Physicians who treat torture victims have sometimes suffered retaliation themselves [5]. Other physicians have been maliciously involved [6]. Some physicians have witnessed or committed injurious acts intended to achieve some ulterior goal, to silence political critics, to secure testimony against political enemies, to gain information, to elicit compliance and collaboration, to protect themselves from reprisal, and so on. Some have offered counsel about fitness of victims to undergo torture, monitored victims during torture, and carried out resuscitations after torture in order to make the victims available for further interrogation and abuse. Others have also falsified documents, directly committed acts of violence, or trained others to do so.

Prominent examples of physician involvement in torture are to be found during times of war and political upheaval in, for example, Nazi Germany [7], Japanese-occupied Manchuria [8], the Soviet Union [9], Chile[10], Israel [11], Turkey [12], and Iraq. The participation of medical professionals in torture raises ethical concerns as to whether or not the state or culture in question accepts torture and wants physicians to play a role in it.

International political organizations that have condemned torture have usually done so in categorical ways [13]. Most codes dealing with the matter do not specifically object to torture by physicians because torture itself is usually condemned outright for all [14]. But there are specific prohibitions against physician involvement in torture. In 1975, the World Medical Association adopted the Declaration of Tokyo, which forbids physician participation in torture:

> The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedure is suspected, accused or guilty, and whatever the victim's belief or motives, and in all situations, including armed conflict and civil strife. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment are used or threatened [15].

In 1997, the World Medical Association again specifically denounced torture by physicians, saying: "Physicians are bound by medical ethics to work for the good of their patients. Involvement by a physician in torture, war crimes or crimes against humanity is contrary to medical ethics, human rights, and international law. A physician who perpetrates such crimes is unfit to practice medicine" [16].

In 1999, the American Medical Association adopted a formal position on physician involvement in torture. After defining torture, it went on to say that "Physicians must oppose and must not participate in torture for any reason. Participation in torture includes, but is not limited to, providing or withholding any service, substances, or knowledge to facilitate the practice of torture. Physicians must not be present when torture is used or threatened" [17]. This advisory was not intended to deprive all victims of torture of medical care—quite the contrary. The AMA *Code of Medical Ethics* goes on to say that "Physicians may treat prisoners or detainees if doing so is in their best interest, but physicians should not treat individuals to verify their health so that torture can begin or continue" [17].

Medical Ethics Counsels Resistance, not Acceptance

While many professional medical associations condemn torture outright, they do not have any specific means by which to monitor or enforce their advisories except to expel a member from the group. By itself that expulsion may mean relatively little to a physician since membership is usually voluntary. The World Medical Association recommends that national medical associations work to ensure that physicians entering their countries answer any allegations of torture before they are licensed to practice medicine. It also recommends that these associations report any evidence of involvement in torture to the appropriate authorities. However, it is unclear whether many physicians have answered charges of torture. Physicians might be brought before an international court for involvement in torture, but it is not clear that this has ever happened in the post-World War II era. One US legal expert, attorney George Annas, has recommended the creation of an international tribunal for bioethics—with enforcement powers—to hear cases of physician misconduct, including torture, but this proposal has no political movement behind it [18]. Even without strong legal mechanisms to deal with physician involvement in torture, the AMA counsels physicians to, "whenever possible, strive to change situations in which torture is practiced or the potential for torture is great" [17]. In other words, it is not acceptance of torture but resistance to torture that is the hallmark of medical ethics.

Some physicians do actively work to identify and counteract torture [19,20]. Physicians of the International Red Cross can conduct examinations of certain prisoners and detainees. In this capacity, they do not usually treat, but they do make recommendations about necessary medical treatment and document any evidence of torture. The International Rehabilitation Council for Torture Victims carries out educational programs to train physicians in the medical management of torture victims [21]. In 2002, the United Nations endorsed the Istanbul Protocol, a manual for the effective investigation and documentation of torture.

The ability to identify and deter torture is only as strong as the commitment to do so, and the mistreatment of prisoners at the Iraqi prison, Abu Ghraib, has called the moral commitments of US military medicine into question. Physician and bioethicist Steven H. Miles has called for a specific investigation of the failures of medical personnel to protect human rights, including the falsification of records about prisoners' deaths [22]. Such an investigation should go

forward, and to the extent it is successful it will raise obstacles to future breaches of law and ethics. It is important that the military work with medicine to define procedural safeguards that will keep physicians from complicity in the evils of torture. But it is also to be hoped that physicians in the military, especially those called on to care for prisoners, heed the counsel of their professional organizations and avoid all complicity with torture, even when torture seems desirable—even urgent—in a particular situation. Being a party to the infliction of pain, harm, and death is simply incompatible with the ethics of medicine.

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Op-Ed

Framing Health Care as a Right: Is That the Best Way to Foster Reform?

Lack of access to health care is causing the US to lag behind in the global economy and needs to be tackled with specific policy solutions.

Alan L. Wells, PhD

At the 1992 Republican National Convention in Houston I marched down the main street of the Texas Medical Center with a group chanting "Health care is a right." In those days it seemed as if the US would adopt a universal health plan. Thirty-seven million people were uninsured and millions more lived in danger of losing benefits. Something would happen, surely. But, as Daniel Callahan has reflected, "Surely nothing, it turned out. No plan made it through Congress then—not a single bill, not a single reform. By 1997, the 37 million uninsured had grown to 41 million and only one other bill had been passed; the 2 presidential candidates in 1996 had all but ignored the issue" [1] While no universal coverage came out of Clinton's plan, it inadvertently galvanized the private sector in an unsurpassed way. Today, 12 years and 2 convention seasons later, health care reform seems low on the policy radar in comparison to 1992 and there are 45 million uninsured Americans. Does this mean that it is time to claim health care as a right again? For me, the idealism of marching days are replaced with worry—degrees of separation between me and the problem have narrowed as people close to me lose jobs and benefits, and I wonder how to keep them healthy. For many today, issue-specific discussions are replacing philosophical claims. At the 2004 Republican Convention it is unlikely that there will be a health care rights march.

Framing the Need for Reform

In the United States health care is not a right. Most Americans access health care through workplace benefits or public sector programs such as Medicare, Medicaid, and the Veterans Administration. There are post World War II Western democracies with state welfare systems that incrementally installed health care as a national right, however they are struggling with difficult decisions determined by technology and inflation as well [1]. Framing a public problem too broadly can inhibit a dialogue for change. Start, for example, with the question: "What is health?" Answers vary from the narrow, such as "the absence of disease," to the very broad, "harmony between a human organism and his or her physical and emotional environment." Now consider "What is health care?" Answers could vary from "systemic delivery of clinical services" to "an essential civil right for all Americans." While the premise that health care is a right can be argued on moral and philosophical grounds, it also has the ability to alienate solution-driven policy action. Equating health care with inalienable rights—that is to say that health care is a part of the pursuit of life, liberty and happiness—runs the risk of instigating a broad dialogue on national culture and individual rights that distracts policy initiatives from immediate problems. What sounds ideally good to some leads others to fear legal mandates encouraging abuse of a system already in crisis. The impetus for health care reform may be better construed on commonsense, rather than philosophical, grounds. When times are tough, experience trumps idealism. Among the many practical reasons why the US must initiate substantial health care reform are (1) to remain economically competitive in a global economy and (2) to maintain essential public infrastructure in emergency services and medical education.

Rising Health Care Costs and Global Competition

The patchwork approach to access is becoming dangerously vulnerable as the United States is forced to compete in a global economy. US job growth is slowing, and the impact of rising health care costs on employers is considered a significant factor. Competition for cheaper labor has extended itself to white collar jobs in the Internet age. The *New York Times* [2] reports that corporate decision makers must factor in health care costs that rise at a pace 3 or 4 times the rate of inflation, and this increases labor costs as wages remain stagnant. In a standoff between health care benefits and wages, health care impacts the entire economic system. As the cost of health care benefits rises, fewer and fewer people have them. US Bureau of Labor Statistics data indicate that, in the last decade, the percentage of employees in private industry enrolled in company health plans has dropped from over 60 percent to just over 40 percent [2]. Couple this with the fact that many Americans are transitionally uninsured if they lose or change jobs, and the numbers rise [3]. If these trends continue, the burden on workplace benefits will drive up both labor costs and ultimately put the US at a competitive disadvantage internationally.

Essential Public Safety

The federal Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) established the right to emergency medical treatment. This is the only common law annexing a right to health care in the US. Consequently, the cost of covering those with no insurance is being shifted to the most vulnerable links in the health care sector—public hospital emergency rooms. Emergency systems all over the US are crashing. In California, 70 hospital emergency rooms have closed since 1990. Dr. Jack Lewin, President of the California Medical Association reports that 500 hospitals in the state are "on the verge of a whole series of unraveling events. Uncompensated health care affects everyone in the system. No place is safe when you have large volumes of people who need care, but there's no one to pay for it" [4]. Every state is facing the burden of charity care, with the ER as a focal point. How then would the country deal with a major emergency? The vulnerability of the health sector is inherently linked to national security. Public sector hospitals are also the backbone of resident training programs. If the country is to keep its vital infrastructure intact, it must move primary care out of the ER.

In summary, the impetus for health care reform has to begin with a commonsense approach to problem solving. Claiming health care as a right is valid philosophically—life, liberty, and happiness are contingent upon health in the abstract. However, US policy problems are specific and should be discussed with particular solutions in mind. As Michael Walzer contends, civil society is a project within projects and the "devil is in the details" [5].

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Medical Humanities

Physicians Speak out for Health and Human Rights at Great Cost

Many physicians assist others at great risk to their personal safety as part of Physicians for Human Rights.

Holly G. Atkinson, MD, and Gina Coplon-Newfield

Across the globe, many physicians face grave dangers simply for performing their professional duties or speaking out against human rights abuses. As punishment for exercising their rights or adhering to medical ethics under their national and international laws, health professionals may be threatened, detained, arrested, tortured, or murdered by their governments or nonstate actors. Particularly during times of armed conflict, health professionals sometimes put themselves at enormous risk merely by practicing ethical, non-discriminatory medicine that does not favor one ethnic or political group over others.

As chief surgeon at Alkhan-Kala Hospital in Chechnya during the Chechen War of the late 1990s and in early 2000, Dr. Khassan Baiev was, for a period, the only doctor serving a population of up to 100 000 people. He sometimes performed as many as 60 surgeries a day to save lives and limbs, often without gas, electricity, running water, or dressings. Dr. Baiev believed it was his medical and ethical obligation to treat all people, though each side of the conflict insisted that he adopt a political approach and aid only its partisans. He was threatened and eventually imprisoned in Russia, and is now a refugee in the United States [1].

On March 18, 2003, the Cuban government launched a massive crackdown on 75 dissidents, arresting independent journalists, human rights defenders, labor unionists, librarians, teachers, and 6 medical doctors. Dr. Marcelo Cano Rodríguez, one of the physicians detained, is national coordinator of the unofficial Colegio Médico Independiente de Cuba (Cuban Independent Medical Association). He is also a member of the unofficial Comisión Cubana de Derechos Humanos y Reconciliación Nacional (Cuban Commission for Human Rights and National Reconciliation). He was arrested on March 25, 2003, as he was investigating the arrest and detention of a fellow physician. He had no previous criminal record. The activities that the prosecution cited against Dr. Cano Rodríguez included visiting prisoners and their families as part of his work with the human rights group and maintaining ties to the organization Doctors without Borders. Yet, he was tried, convicted, and sentenced to 18 years in prison [2].

Dr. Matthys Johannes van Mollendorff, from South Africa's province of Mpumalanga, was discharged from his duties as superintendent of the Rob Ferreira Hospital, Nelspruit, South Africa, in early 2002 for "insubordination" after he allowed the Greater Nelspruit Rape Intervention Project (GRIP) to use space in his facility. GRIP, in cooperation with physicians, provided antiretroviral prophylaxis for rape survivors. Dr. Mollendorff stated that he followed national policy in doing what is best for his patients and followed WHO and UNAIDS guidelines for prophylaxis treatment of rape victims at high risk for HIV. At the time Dr. Mollendorff was fired, the South Africa National Ministry of Health prohibited the use of antiretroviral drugs as a method of prevention and treatment after HIV exposure [3]. International pressure has since convinced the South African government to change this policy.

In 1998, 6 Bulgarian nurses and one Palestinian physician arrived in Libya to provide treatment to Libyans at the Al-Fateh Children's Hospital in Benghazi, northeast of Tripoli. In 1999, these health workers, Kristiana Malinova Valcheva, Nasya Stojcheva Nenova, Valentina Manolova Siropulo, Valya Georgieva Chervenyashka, Snezhanka

Ivanova Dimitrova, all nurses, and Ashraf Ahmad Jum'a, a physician, were arrested and detained by Libyan authorities, charged with having infected more than 400 children at the hospital with HIV. Since that time, some of the 6 detainees maintain that they gave false confessions because they were tortured by Libyan authorities by subjection to electric shocks, suspension from heights by the arms, beatings, and rape. In early May of 2004, these Bulgarian and Palestinian health workers were convicted of the charges and sentenced to death by firing squad, despite a report presented during the trial by Dr. Luc Montagnier, the French co-discoverer of HIV, stating that the infections were probably spread by unsterile hospital practices, rather than by deliberate actions of health workers [4].

Efforts on Behalf of Physicians

The Physicians for Human Rights' Colleagues at Risk Program advocates on behalf of many brave health professionals around the world who attempt to treat all types of patients or speak out on behalf of persecuted groups, often at great personal and professional cost. PHR sends letters to government officials, reaches out to the media, and urges its members and the general public to write letters on behalf of health professionals in danger. In the case of Libya, PHR mobilized 30 prominent physicians and scientists from 10 countries including the United States, several European nations, Iran, Egypt, and the West Bank and Gaza, to sign a letter to Libyan authorities calling for the release of the health workers, who are appealing their sentences at the time of this writing. In 2003, PHR monitored, publicized, and provided advocacy support for colleagues in South Africa, Pakistan, Cuba, Burma, Iran, Malaysia, Azerbeijan, China,Vietnam, Egypt, Colombia, and Turkey.

PHR's efforts have contributed to the dismissal of charges, release from prison, improved treatment, and even saved lives of health professionals, as well as improved government policies on human rights and health. Following advocacy on behalf of Dr. Mollendorff, for example, the South African Department of Health agreed in March of 2003 to pay his back salary and benefits for 12 months and compensate him for his legal costs. The government unconditionally withdrew the charges against Dr. Mollendorff and offered him the opportunity to reclaim his job.

Physicians for Human Rights was also successful in helping Dr. Khassan Baiev safely leave Chechnya in 2000 and gain asylum for himself and his family in the United States. For many other colleagues at risk, however, Physicians for Human Rights and others are still advocating. The more individual health professionals and medical associations that support our Health Professional Colleagues At Risk Program, the larger and louder will be the collective voice we have to help our brave colleagues throughout the world practice medicine and speak their minds safely. It is also through this advocacy that we are able to improve national and international human rights policies, which inevitably affect the health and well-being of all people.

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