

# Human Rights and the Making of a Good Doctor

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Public health professionals are among the most educated and, occasionally, the most respected members of the community. Yet, except when an issue impinges on their particular interest, their impact on government policy is miniscule. . . . By mutual sharing, the good physician becomes part of the body and soul of the person he serves. If that trust and confidence are not abused, and if, with warmth and humility and competency, the doctor proves his worth over time, the bond becomes as durable as love. When people and nations can agree on little else, those common bonds may become the bridge to understanding and peace. There is certainly no reason not to utilize this bridge, especially in the light of the dismal record of standard diplomacy.

Kevin M. Cahill, M.D., *A Bridge to Peace*<sup>1</sup>

THE CENTER for International Health and Cooperation was founded to promote the ethos that the physician in society can, as the above quotation illustrates, be a bridge between politicians and peace, or as an earlier publication put it, if every politician has a doctor, is this not a great “untapped resource,” a resource with the potential to influence for the good? That is assuming, of course, that the doctor in society is prepared for such a role.<sup>2</sup> In *The Untapped Resource* (edited and introduced by Kevin Cahill), Hugh Carey, then a member of the United States Congress, said:

“In fact, a review of our own history will show that when we had **less** we did more proportionately. When we were not so strong, we were more generous to the weak. When we were less well fed, we helped others fend off famine.” He went on prophetically (this was 1971): “If our country is not to act as a policeman of the world and wield the bomb as a club, then perhaps it is in our own interest and in the interest of humanity we might consider ourselves as corpsman to mankind, bearing the balm of healing and helping. Exporting our know-how in health care at relatively little cost to ourselves should be an attractive alternative to some high-cost, low-yield programs of foreign aid that we now support under the name of mutual **security.**”<sup>3</sup>

### THE TRADITIONAL “GOOD DOCTOR”

This book has within its shell three strata of discussion—“foundations, fault lines, and corrections.” The doctor must be seen as indispensable to the “foundations” of any tradition in humanitarian rights, but more importantly, I hope to show that “corrections” are needed, and needed urgently, if the doctor is to fulfill his/her potential in contributing to humanitarian action. In short, the good doctor in today’s world must be versed in human rights, and if this is to happen, the undergraduate student has to be taught the subject.

The doctor in society has been a figure of immense influence since the beginning of time. The physician has been portrayed in literature, music, film, and caricature, not always with kindness, but the status of the physician in society has greatly exceeded that of other professions, probably even exceeding that of the cleric. Many assumptions are made in the portrayal of the doctor, and many commentators fail to acknowledge that a doctor is as susceptible to the failings of humankind as anyone else. Or, as Shaw would have put it: “Doctors, if no better than other men, are certainly no **worse.**”<sup>4</sup>

The good doctor has to be all things to all men. He has to

fulfill the requirements of a taxing undergraduate curriculum; he then has to undergo a postgraduate period of betterment, which, depending on his chosen specialty, can be very arduous; he must then be trusted by his patients; accepted by his peers; fulfill the dictates of the jurisdiction in which he practices; acquiesce with the dictates of his professional bodies so as to gain admission to them; and perhaps, depending on the role he casts for himself, also be a scientist and researcher prepared to write and present on his chosen avocation; be a teacher; head a large department; be an administrator; be capable of communicating with his patients, his colleagues, and scientific peers; be prepared not only to keep himself abreast of advances in an ever-changing discipline, but to have his knowledge and skills assessed regularly; be able to cooperate with colleagues in the delivery of health care and with colleagues abroad in the furtherance of science; be willing to work antisocial hours and to adjust his private life accordingly; he must not contract an illness that might endanger his patients' health; he must be prepared to face the medico-legal consequences for incompetence, real or imaginary; and above all, and most difficultly, he must acknowledge the Socratic dictum, "Know thyself."

Not many, one would think, could be attracted by such a job description, yet, thankfully for society, many are. My advice will add to the burden of the good doctor by calling for a further quality that carries an inevitable demand. In a world faced with humanitarian strife and with large populations in turmoil seeking refuge in stable and more prosperous nations, today's good doctor must be alert to the complex discipline of human rights, which brings the inevitable moral imperative of being aware of the prejudices that doctors, as others in society, inherit through the cultural, religious, and ethnic influences of their formative environment.

I suspect more has been written on the making of a good doctor than what makes, for example, a good solicitor, fireman, or accountant. Apart from numerous books, there are university

courses devoted to the topic; for example, the Northeastern Ohio Universities College of Medicine offers a course over **two** months entitled, “In search of the Good **Doctor.**”<sup>5</sup> The *British Medical Journal* saw the subject **as** one of such importance as to merit an issue devoted to “What’s a good doctor and how do you make **one?**”<sup>6</sup> The editor accepted at the outset that his journal faced an impossible task, but one that nonetheless was worth undertaking. This in-depth analysis, running to some 50,000 words, discusses, among other relevant issues, the making of a good doctor as seen from the perspective of the patients, nurses, medical students, women, and doctors; it assesses the expectations of society, governing bodies, and the health services; and considers the necessity for the good doctor to be able to communicate, to remain knowledgeable and skilled, and to be subject to assessment of competency. However, only in the correspondence columns (a letter from Khartoum Hospital) can any reference be found to the need for a good doctor to be aware of human rights issues: “In the developing world with its deficient facilities and patients who need to eat before they need medical care, the medical profession needs input from a belief in humanity and the ethics of the job more than scientific professionalism.”

The journalist, Polly Toynbee, reviewing the qualities that the General Medical Council sees as necessary in the making of a good doctor, had this to say:

**What makes the perfect modern doctor? The General Medical Council has drawn up new guidance for medical schools as a framework on which to base their curriculums and assessments. *Tomorrow’s Doctors* is an idealistic compendium of the best qualities every new doctor should acquire. If medical schools could, indeed, turn out doctors molded to this template, then we should expect a new generation of scholar saints and gentle scientists—wise, knowledgeable, sensitive, collegiate, humble, and good beyond **imagining.****<sup>8</sup>

In short, the traditional **good** doctor as epitomized by Luke Fildes in his famous Victorian painting, *The Doctor.*<sup>9</sup>

## THE HUMANITIES IN THE MAKING OF A GOOD DOCTOR

If human rights and humanitarian affairs seem to be neglected in the making of a good doctor, it does not seem to be the case with the teaching of the humanities, which has seen a remarkable resurgence in the last few decades, especially in the U.S. The Internet provides a truly remarkable compilation of curricula, such as the New York University on-line syllabi of courses in medical humanities,<sup>10</sup> or the U.K. equivalent “Medical Humanities Resource Database,” compiled by the Centre for Health Informatics in Multiprofessional Education, University College London.<sup>11</sup> The importance of this is not so much the relevance of the humanities to human rights, but rather that an awareness of the former serves as a means of bringing students close to the moral dilemmas of medicine. An acquaintance with the humanities, especially literature, imparts an appreciation of the profundity of human existence and a deeper realization of the human condition. Literature is not only enjoyable, but when it enables us to discover how great writers view illness, suffering, and death, it becomes an enriching formative experience.

Take, as an example, Samuel Beckett writing on the humanitarian tragedy of Saint Lô, the small town in Normandy that was devastated in one night by an allied bombing blitz that left hardly a house **standing**,<sup>12</sup> and the efforts of a bewildered group of Irish physicians grappling with all that **was** so foreign to them:

And yet the whole enterprise turned from the beginning on the establishing **of** a relation in the light of which the therapeutic relation faded to the merest of pretexts. **What** was important **was** not our having penicillin when they had none, nor the unregarding munificence of the French Ministry of Reconstruction, . . . but the occasional glimpse obtained, by us in them and, who knows, by them in us (for they are an imaginative people), of that smile at the human condition as little to be extinguished by bombs as to be broadened by the elixirs **of** Burroughes and Welcome, the smile deriding, among other things, the having and not having, the giving and the taking, sickness and health. . . . I suspect that

our pains were those inherent in the simple and necessary and yet so unattainable proposition that their way of being we, was not our way and that our way of being they, was not their way. It is only fair to say that many of us had never been abroad **before**.<sup>13</sup>

Or if one moves forward to read of a unique tribute paid by maestro Leonard Bernstein to his physician:

It is hard not to love Kevin; it is equally hard to know which Kevin you are loving. He is that complicated creature once called a "Medicine Man," a term that presents us with a host of dualities: pillar of society/leprechaun; medieval alchemist/medical master; shaman/clinician; witchdoctor/psychologist; juggler/saint. I have observed him in all three phases, I think; I have appeared at his office in despair, begging for some magic pill, only to leave like Fred Astaire, lighter than air, with not even a placebo to con me on my way. How does this happen? What went on in there during that hour or more, aside from a cardiogram, some palpation, and what I think of as the *Stethoscopic Follies*, the shortest show in New York. Oh, yes, the prerequisite blood sample; but all that surely didn't take an hour plus. Of course not; we *talked*.<sup>14</sup>

These quotations from a rich literary archive are chosen merely to suggest that the humanities can at least prepare the intellectual soul of the doctor-in-the-making for the tougher stuff of human rights. The artist can hone the sensitivities, kindle a desire to participate, even contribute toward the betterment of the panorama of living and dying in which the doctor is always center-stage. The arts cannot teach **us** to be good human beings but they can kindle in **us** a desire to **try** to be more humane, to banish prejudice, to be kinder and more considerate of the foibles and irritations that constitute the non-medical presentation of all clinical dilemmas. Put another way, medicine demands compassion and feeling, or such, at least, would be the public's perception of the good doctor. Paradoxically, the practice of medicine makes the exclusion of sentiment a prerequisite for the survival of self, and the process, begun in early studentship, soon becomes so integral a part of the scientific persona that the dissipated gems of idealism, among which, of course, may be found

compassion, become unrecognizable. The years of training so carefully constructed by our institutions initially blunt and, finally, pervert the purity of avocation and the sensibility of youth, essences to be found in most medical students but so few doctors. It is chastening but not necessarily a balm to existence, to have this protective wall around one annihilated. At least being aware of the contradictory influences that will confront the doctor in society places the medical student at an advantage in choosing the correct moral stance.

### HUMAN RIGHTS AND THE UNDERGRADUATE CURRICULUM

The need for the teaching of human rights in medical schools has been long recognized. For example, in 1992, the British Medical Association (BMA) declared: "We recommend that all medical schools incorporate medical ethics into the core curriculum and that all medical graduates make a commitment, by means of an affirmation, to observe an ethical code such as the WMA's (World Medical Association) International Code of Medical Ethics." In 1993, the General Medical Council in the U.K. stated that a core-objective of the undergraduate degree in medicine included a "knowledge and understanding of . . . ethical and legal issues relevant to the practice of medicine," as well as an "awareness of the moral and ethical responsibilities involved in individual patient care."<sup>16</sup> In 1999, the World Medical Association resolved that in so far as medical ethics and human rights form an integral part of the work and culture of the medical profession, and of the history, structure, and objectives of the World Medical Association, "it is hereby resolved that the WMA strongly recommends to Medical Schools worldwide that the teaching of Medical Ethics and Human Rights be included as an obligatory course in their curricula."<sup>17</sup> Moreover, the United Nations has published, among other documents relating to the topic, *Guidelines for National Plans of Action for Human Rights Education*, in which it envisages human rights education as being part

of the education of “pre-school and primary, secondary, university, and other institutions of higher learning levels of education.”<sup>18</sup> The many international declarations and standards on medical ethics and human rights are available in a number of compilations.<sup>19,20</sup> However, these recommendations have fallen largely on deaf ears. Despite these prestigious and authoritative mandates for the teaching of human rights to medical undergraduates, there appears to be no systematic human rights education within the curricula of the U.K.’s twenty-seven medical schools.<sup>21</sup>

### DOCTORS AND PREJUDICE

Why should doctors, particularly those living in affluent, stable societies, have to concern themselves with humanitarian issues? The *New Dictionary of Medical Ethics* has postulated four reasons:

First, as citizens of the modern world, they should know about the most dynamic, complex, and challenging modern movement; after all, their own rights and dignity as well as those of their patients are at issue. Second, health policies, programs and practices, and clinical research may inadvertently violate human rights. Thirdly, violations of each of the rights have important adverse health effects on individuals and groups. Finally, promoting human rights is now understood as an essential part of the efforts to promote and protect public health.<sup>22</sup>

No one can disagree with these recommendations, but do they go far enough?

To me, there would seem to be at least three other reasons why aspiring doctors should be taught human rights. The first is that young doctors (and some old ones) are fundamentally good and even better than good, they are idealists who are often anxious to give back some of what society (or parental affluence) has given to them. Or as Shaw (who said *so* much *so* well nearly a century ago) put it: “Unless a man is led to medicine or surgery through a very exceptional technical aptitude, or because doctor-



ing is a family tradition, or because he regards it unintelligently as a lucrative and gentlemanly profession, his motives in choosing the career of a healer are clearly generous. However, actual practice may disillusion and corrupt him, his selection in the first instance is not a selection of a base character.”<sup>23</sup> If the idealism of the young doctor is not exposed, at least in theory, to the calamities of humanitarian crises in the world and the means of alleviating them, the fire of youthful idealism is denied.

A second more practical reason is that the movement of populations is such today that the doctor practicing even in the most settled and affluent of societies is likely to be called upon to care for displaced people. Or as a group of bodies involved in human rights expressed it:

Throughout history, society has charged healers with the duty of understanding and alleviating causes of human suffering. In the past century, the world has witnessed ongoing epidemics of armed conflicts and violations of international human rights, epidemics that have devastated and continue to devastate the health and well being of humanity. **AS** we enter the twenty-first century, the nature and extent of human suffering have compelled health providers to redefine their understanding of health and the scope of their professional interests and responsibilities.<sup>24</sup>

Finally, and most importantly, the teaching of human rights should serve as a means of dispelling, or at least of bringing into focus, the prejudices that are present in us all, and which can lead to discrimination at many levels of health care. A report to the UN Committee on Economic, Social, and Cultural Rights presented alarming evidence that decisions about access to investigations and treatment in the U.K. are sometimes motivated by who the patients are rather than by their health care needs. The report highlights serious shortcomings in protecting the international right to the highest attainable standard of health as a consequence of which some doctors discriminate against vulnerable groups, such as the elderly, prisoners, patients with HIV/AIDS, people with learning disabilities, and, surprisingly, women with

coronary heart disease are denied the treatment facilities afforded to **men**.<sup>25</sup>

At an international level, the former High Commissioner for Human Rights, Mary Robinson, has identified discrimination and stigmatization as important impediments in the global battle against HIV and AIDS. "HIV/AIDS is one of the greatest human rights and health challenges facing the world today. HIV/AIDS-related stigma and discrimination—including discrimination in health care settings—continue to be the primary driving forces behind the epidemic by undermining prevention, treatment, care, and support . . . Health care professionals have a crucial role to play in ensuring respect for human rights, and the right to health and to nondiscrimination in **particular**."<sup>26</sup> Indeed the issue of discrimination in medicine is one of considerable concern globally, and is evident not only in the U.K. but also in the **U.S.**,<sup>27</sup> in **India**,<sup>28</sup> and no doubt in any country that cares to examine the issue.

What many doctors will not know, simply because they have never been told, is that discrimination contravenes a number of ethical codes. First, it violates the Hippocratic Oath, which anticipated the Universal Declaration of Human Rights by nearly 2.5 millennia, and which is just as relevant to contemporary international law today as it was in 400 **B.C.**<sup>29</sup> Second, it violates one of the six nonderogable obligations within Article **12** of the International Covenant on Economic, Social, and Cultural Rights, which asserts the human right of each individual to the highest attainable standard of **health**.<sup>30</sup>

However, there are some promising happenings that augur well for dealing with the problem of stigmatization in medicine. The appointment of Paul Hunt from the Human Rights Centre of the University of Essex as Special Rapporteur on The Right to Health to the UN Commission on Human Rights, whose overall brief is to "promote and protect the international right to health," suggests that after a long period of neglect, "the human rights system, WHO, and other members of the UN family are beginning to treat seriously the international right to health . . .

Nobody can be sure of the implications of the renewed international interest in the right to health. But I suspect the implications are long-term and, at least for some countries, far-reaching.”<sup>31</sup> The impressive Publications Program of the Office of the United Nations High Commissioner for Human Rights (OHCHR), which addresses training and education in human rights for “indigenous peoples, minorities, professional groups, and educational institutions,” is another welcome move.<sup>32</sup> The launch of a global campaign to integrate health and human rights in undergraduate and postgraduate medical training in an effort to “expunge stigmatization from medical practice” can be seen as another step in the right direction.<sup>33</sup> All the more reason, therefore, for the medical schools of the world to join in and play their crucial role in the international move to establish a right to health for all.

#### WHAT SHOULD MEDICAL STUDENTS BE TAUGHT ON HUMAN RIGHTS?

Human rights is a complex discipline in its own stead, but not one that has yet developed into a specialty in the traditional manner in medicine, whereby an expert becomes a head of a department attracting others with a kindred interest to devise a suitable curriculum for undergraduate teaching. *So*, at least for the immediate future, even if the deans of medical schools were prepared to introduce the subject into the undergraduate curricula, most universities would simply not have the staff with the necessary interest or expertise in the subject to prepare and teach its many complexities. The British Medical Association (BMA) has examined the issue in detail by concentrating on: (1) the composition and scope of ethics and human rights training; (2) what doctors need to know; (3) how they can obtain that knowledge, and (4) how they can use that knowledge effectively.<sup>34</sup>

As all medical schools have a course on medical ethics, the BMA begins logically by examining the mutually complimentary

roles of ethics and human rights. Ethics helps students to understand *why* abuse should be resisted, and human rights should help them discover *what* should be done and *how* to resist abuse. Though there is considerable overlap between ethics and human rights, “ethics teaching needs to be supplemented by human rights **guidance.**”<sup>35</sup> Medical ethics has been taught in medical schools for many years in most countries of the world, but the quality of the courses available varies greatly and herein lies a further caveat for the teaching of human rights; the content and standard of the courses are related to the availability of teachers with the knowledge and enthusiasm to inspire their students, and various bodies have responded by producing case-based teaching packs, evaluated through

Three conclusions that may be drawn from the comprehensive BMA review relating to medical ethics are: (1) many of the current courses on medical ethics are in need of revision; (2) the teaching of medical ethics and human rights should go hand-in-hand, but be designed in unison *so* as to avoid the repetition that seems inevitable if they are designed in isolation; and (3) the achievement of the later objective would serve as an ideal opportunity for effecting the former.

At first glance there appears to be a wealth of teaching material available for the teaching of human rights to medical students, but more careful assessment shows that the material is fragmented and lacking the collaborative cohesion that should be possible with contemporary distance learning techniques, which is likely to be the key to success. Moreover, it must be borne in mind that the teaching of medical ethics and human rights on an international scale must be sufficiently flexible to take account of the political, religious, and social mores that will to some extent govern the national attitude to human rights issues, though this should not be taken as implying that international principles governing human rights can be compromised, but rather be seen as a means of influencing doctors within the sensitivities of the environment in which they will later practice and face abuses to human rights.

The range of material available for human rights education extends from that which medical organizations produce for doctors practicing in societies in which particular human rights abuses occur, for example, the International Rehabilitation Council for Torture Victims (IRCTV) based in Denmark has established training programs dealing with the rehabilitation and care of torture survivors in Asia, Africa, the Balkans, and Latin America. Likewise the Asia-Pacific Forum runs teaching programs and rehabilitation services in Australia, Bangladesh, India, Indonesia, Nepal, New Guinea, New Zealand, Pakistan, Papua, the Philippines, and Sri Lanka. Specific programs in ethics and human rights for prison officers have been established in the former Soviet Union and Southeast Asia by the International Committee of the Red Cross. The organization International Physicians for the Prevention of Nuclear War (IPPNW) works closely with the International Federation of Medical Students concentrating on human rights issues from the perspective of conflict prevention. Another medical student initiative, Human Rights Union for Medical Action (HURUMA), grew out of the work undertaken in Africa by the International Federation of Medical Students and African student groups.<sup>37,38</sup> The Commonwealth Medical Association (CMA) has developed an ethics training manual for developing countries,<sup>39</sup> which integrates ethical principles and extracts from human rights conventions with the aim of making it necessary for all health professionals to attend one training module annually as part of the requirements for renewal of the license to practice.<sup>40</sup> Moreover, the CMA has taken the innovative step of linking each statement of ethics to the provisions of the various UN human rights conventions and declarations, thereby allowing that while doctors in developing countries would not necessarily share the same cultural standards or views about medical ethics, they should nevertheless be aware of an obligation to respect the health-related human rights specified in international instruments that their governments have legally ratified.<sup>41</sup>

After the fall of the Marcos regime in the Philippines in 1986,

the new government **made** a strong commitment to promote human rights through education, and this resulted in a framework for human rights education that “has been seen by some commentators as a useful model of who should be involved and what can be **achieved**.”<sup>42</sup> The Consortium for Health and Human Rights, with a mandate to carry out education, research, and advocacy work, consists of the François-Xavier Bagnoud Center for Health and Human Rights, Global Lawyers and Physicians, Physicians for Human Rights, and International Physicians for the Prevention of Nuclear War. Each of the constituent bodies of the Consortium has produced training courses in various aspects of health care and human **rights**.<sup>43</sup> In the Netherlands, the Johannes Wier Foundation has produced a teaching module designed for doctors, nurses, and paramedics, which, using a case study approach, places students in “real life” situations with victims of violent crime, torture and death in custody, rape in wartime, forensic anthropology, and the administration of **justice**.<sup>44</sup>

Most of the material I refer to is designed for specific groups, or for doctors working in areas where human rights abuse is likely to occur. What is happening in the medical schools? A survey of medical schools in the **U.K.** and **U.S.** showed a willingness to consider human rights in the curriculum, but there was considerable confusion between what constituted medical ethics and human rights, and overall these surveys revealed that, in reality, little was being taught on human **rights**.<sup>45</sup> Indeed, there is some evidence that in countries in which human rights abuses occur, the medical schools and medical organizations are active in teaching awareness of human rights, examples being Turkey, India, the Philippines, Indonesia, Malaysia, and **Nepal**.<sup>46</sup> Increasingly, the pressure and impetus for the teaching of human rights has come from medical students’ organizations even though they, like their deans, are very conscious of the demands being made for more subjects to be compressed into an already overloaded **curriculum**.<sup>47</sup> In many medical schools, the students organize work experience in areas of need and deprivation, which may impart more about human rights than didactic teaching.

In the U.K., Physicians for Human Rights,<sup>48</sup> in conjunction with Rachel Maxwell and Derrick Pounder, has developed a cross-disciplinary course entitled, "Medicine and Human Rights," which is available free on the Internet and has been adopted by the University of Dundee as part of the undergraduate curriculum, and has now been taken up by other medical schools in the U.K.<sup>49</sup> This module on the Internet is designed "for those with no prior knowledge about human rights as they impact on the practice of medicine." It deals with issues that include medical involvement in torture, the diagnosis and rehabilitation of torture victims, doctors' involvement in the death penalty, human rights and public health, women's rights and rape in war, mechanisms of redress for human rights abuses in member states of the European Community, and seeking asylum.<sup>50</sup> The module had been used in Russia, India, and Israel to teach human rights to lawyers and scientists, as well as to medical students. It has also been incorporated by the Centre for Enquiry into Health and Allied Themes (CEHAT) into a one-year diploma in the Civics and Politics Department of Bombay University,<sup>51</sup> and into an intercalated BSc in International Health at the University College London.<sup>52</sup>

Another initiative that differs from other available options is one that cuts across the boundaries of academe and makes no distinction between undergraduate and postgraduate status, the younger or older participant, but seeks rather to educate those working, or contemplating work, in the field of humanitarian crisis relief. The International Diploma in Humanitarian Assistance, which is conferred by the Center for International Health and Cooperation at Fordham University, the Royal College of Surgeons in Ireland, and the University of Geneva, has been conferred on more than 400 graduates from over eighty nations. The one-month intensive residential course has a distinguished faculty that comprehensively covers the ethical and human rights aspects of humanitarian assistance including, among many topics, the historical background to humanitarian assistance, coping with humanitarian crises and protecting human rights, interna-

tional law and human rights, planning and management of humanitarian relief in strife-torn communities, preventive diplomacy, law and ethics, environmental health, torture, land mines and trauma, sexual violence and rape, the military aspects to humanitarian crisis, the role of the media, and the psychological and personal health of international relief workers.<sup>53</sup>

If the growing imperative for teaching human rights to medical students is to be achieved, rhetoric and the passing of international resolutions will not solve the problem. The biggest difficulty for the deans of medical schools will not be any lack of acknowledgement of the importance of human rights for the doctors graduating from their medical schools, or, indeed, of willingness to introduce the subject, but rather the impossibility of implementing a meaningful and well-structured course without having suitable teachers. In this regard, medical schools would do well to take heed of what has been achieved in the Open University with distance learning, and the international experts in human rights would do well to pool their expertise in producing electronic learning modules in medical ethics and human rights for incorporation into the undergraduate curricula of medical schools across the world. In this regard, it is of relevance to note that European Biomed funding was obtained in **1996** to produce distance-learning workbooks on core themes in medical ethics for use across Europe. This project, known as the European Biomedical Ethics Practitioner Education (EBEPE) project, was co-coordinated by the Imperial College School of Medicine in London in partnership with the Instituut voor Gezondheidsethiek in Maastricht, the Instituto Psicoanalitico per la Ricerca Sociale in Rome, the Zentrum für Ethik in der Medizin in Freiburg, and the Department of Philosophy at the University of Turku in Finland. The training pack was published in **1999** with the objective of encouraging health professionals to assess differing approaches to resolving dilemmas by illustrating how the same ethical challenges are handled in different European

In concluding, it would not be unreasonable to ask skeptically



if there is any evidence **that** the teaching of human rights to medical students makes them better doctors. Intuitively my response would be affirmative, but we live in a world where evidence is demanded for all statements, and to be fair, the incorporation of human rights in the medical school curricula, as I have stressed, is not one to be undertaken lightly. A few international surveys have indeed shown that the teaching of human rights to medical students does increase awareness by allowing doctors to detach themselves from the prejudicial influences of their social background, but where doctors are faced with human rights abuse education alone will not solve their dilemmas, and the need for collegiate support then becomes **necessary**.<sup>55</sup> More evidence on the value of teaching human rights is clearly needed but in fairness may be difficult to obtain, at least until the teaching of the subject is standardized to internationally accepted minimum standards.

If medicine, with its long-established tradition of caring, has been slow in acknowledging human rights, I hope I have not *so* much excused the profession for its shortcomings in this regard, but rather enunciated the real difficulties it faces in achieving what it recognizes as an urgent imperative. The symposium, "Traditions, Values, and Humanitarian Action," has served as a timely stimulus to assess the place of humanitarian action within the tradition of medicine, not merely as an audit of the current state of affairs within the undergraduate curriculum, but as the impetus to develop structures for the future implementation of human rights in the training of doctors. The teaching of human rights will not, of course, abolish the worldwide abuse of human rights, but it is an essential component in the fight to make the world a better place for all to live.

**NOTES TO CHAPTER EIGHT**  
**HUMAN RIGHTS AND THE MAKING OF A GOOD DOCTOR**

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1. K. Cahill, *A Bridge to Peace* (New York: Haymarket Doyma Inc., 1988), 18.
2. K. M. Cahill, "Medicine and Diplomacy: An Introduction," in *The Untapped Resource: Medicine and Diplomacy*, ed. Kevin Cahill (New York: Orbis Books, 1971), 2.
3. H. L. Carey, "A War We *Can* Win: Health as a Vector of Foreign Policy," in *The Untapped Resource: Medicine and Diplomacy*, ed. Kevin Cahill (New York: Orbis Books, 1971), 96, 103.
4. G. B. Shaw, "Preface," in *The Doctor's Dilemma* (London: Penguin, 2002).
5. <http://mchip00.med.nyu.edu/lit-med/syllabi.for.web/syllabi.menu.page.html>
6. "What's a Good Doctor and How Do You Make One?" *BMJ* 32 (2002).
7. M. A. Elgizouli, "Medical Profession Needs Input from Belief in Humanity and Ethics," *BMJ* 325 (2002): 713.
8. P. Toynbee, "Between Aspiration and Reality," *BMJ* 325 (2002) 718-19.
9. C. Douglas, "Doing Better; Looking Worse: The Portrayal of Doctors in Art, Literature and Television," *BMJ* 325 (2002): 720.
10. <http://mchip00.med.nyu.edu/lit-med/syllabi.for.web/syllabi.by.topic.html>
11. <http://www.mhrd.ucl.ac.uk/>
12. E. O'Brien, *The Beckett Country: Samuel Beckett's Ireland* (Dublin: The Black Cat Press & Faber and Faber, 1986), 315-44.
13. E. O'Brien, "Samuel Beckett and the Weight of Compassion," *The Recorder* 10 (1997): 154-65.
14. L. Bernstein, "A View of the Author: The Medicine Man," in *Bridge to Peace*, ed. K. Cahill (New York: Haymarket Doyma Inc., 1988) 98.
15. British Medical Association, *Medicine Betrayed* (London: Zed Books, 1992), Recommendation 19.
16. *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education*. (London: The General Medical Council, 1993), 14-15.
17. British Medical Association, "Teaching and Human Ethics," in

*The Medical Profession and Human Rights: Handbook for a Changing Agenda* (London and New York Zed Books, 2001), 483. Web site address: [www.wma.net/e/policy/20-4-99\\_e.html](http://www.wma.net/e/policy/20-4-99_e.html)

18. *Guidelines for National Plans of Action for Human Rights Education*. Human Rights Questions, including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms. United Nations Decade for Human Rights Education (1995–2004) and public information activities in the field of human rights. Report of the Secretary-General.

19. Amnesty International, *Ethical Codes and Declarations Relevant to the Health Professions* (London, 1994).

20. S. Fluss, *International Guidelines on Bioethics* (Geneva: Council for International Organizations of Medical Sciences [CROMS], 1999).

21. Physicians for Human Rights–U.K. Response to the U.K. Government’s Fourth Report under the International Covenant on Economic, Social, and Cultural rights, Article 12—The Right to Health. 2002.

22. K. Boyd, R. Higgs, A. Pinching, eds., *The New Dictionary of Medical Ethics* (London: BMJ Publishing, 1997), 126.

23. Shaw, “Preface” in *The Doctor’s Dilemma*.

24. American Association for the Advancement of Science, Physicians for Human Rights, American Nurses Association, Committee for Health in South Africa. *The Legacy of Apartheid* (Washington, D.C., 1998).

25. Physicians for Human Rights–U.K. Response to the U.K. Government’s Fourth Report, Article 12—The Right to Health.

26. Mary Robinson, *Physicians for Human Rights Newsletter* 13, no. 2 (2002): 6.

27. Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: National Academy Press, 2002).

28. S. Bharet, P. Aggleton, P. Tyrer, *India: HIV and AIDS-Related Discrimination, Stigmatization, and Denial* (Geneva: UNAIDS, 2001), 16–24.

29. P. Hall, “Human Rights in the Hippocratic Oath,” presented at the International Federation of Health and Human Rights Organizations Conference, Amersfoort, 2002.

30. Article 12. International Covenant on Economic, Social, and Cultural Rights (CESCR).

31. P. Hunt, “The Right to Health: From the Margins to the Mainstream,” *Lancet* 360 (2002): 1878.

32. <http://193.194.138.190/html/menu6/2/index.htm>

33. P. Hall, "Doctors Urgently Need Education in Human Rights," *Lancet* **360** (2002): 1879.

34. British Medical Association, "Teaching and Human Ethics," in *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, 478–502.

35. *Ibid.*, 492.

36. *Ibid.*, 480.

37. *Ibid.*, 492–94.

38. HURUMA, Makerere Medical School, P.O. Box 16749, Kampala, Uganda. E-mail: [huruma@uga.healthnet.org](mailto:huruma@uga.healthnet.org)

39. Commonwealth Medical Association, *Training Manual on Ethical and Human Rights Standards for Health Care Professionals* (London: BMA, May 1999).

40. "Teaching and Human Ethics," in *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, 494.

41. *Ibid.*, 497–98.

42. R. P. Claude, "Human Rights Education: The Case of the Philippines," *Human Rights Quarterly* **13** (1991): 453–524.

43. "Teaching and Human Ethics," in *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, 494.

44. Johannes Wier Stichting, Postbus 1551, 3800 BN Amersfoort, Netherlands. Web site: [www.johannes-weir.nl](http://www.johannes-weir.nl)

45. "Teaching and Human Ethics," in *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, 481–83.

46. *Ibid.*, 485.

47. *Ibid.*, 483.

48. Physicians for Human Rights (U.K.), The University Department of Forensic Medicine, The Royal Infirmary, Barrack Road, Dundee, Scotland. [phruk@dux.dundee.ac.uk](mailto:phruk@dux.dundee.ac.uk)

49. *Physicians for Human Rights Newsletter* **13**, no. 1 (2002): 4.

50. [www.dundee.ac.uk/med&humanrights/SSM/home.html](http://www.dundee.ac.uk/med&humanrights/SSM/home.html)

51. "Teaching and Human Ethics," in *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, 496.

52. *Physicians for Human Rights Newsletter* **13**, no. 1 (2002): 4.

53. CIHC Headquarters, 850 Fifth Avenue, New York, NY 10021. E-mail: [cihcnyc@aol.com](mailto:cihcnyc@aol.com)

54. "Teaching and Human Ethics," in *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, 497.

55. "Teaching and Human Ethics," in *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, 485–92.