MEDICAL ETHICS LECTURE SERIES

Lecture 2

Human Rights and the Law

Department of Psychiatry • Jordan University Hospital
Psychiatry Residency Training Program

Duration: 40 minutes

LECTURE OVERVIEW

Learning Objectives

- Identify the key international human rights instruments relevant to medicine
- Explain the right to health and distinguish it from a right to be healthy
- Differentiate legal obligations from ethical obligations, and recognise when they conflict
- Describe physicians' absolute duties regarding torture and dual loyalty situations
- Apply human-rights principles to vulnerable populations: prisoners, detainees, refugees

LET'S BEGIN WITH A SCENARIO

Case Study

CASE VIGNETTE

A physician working in a detention facility is asked by security personnel to examine a detainee and sign a form certifying him “fit for interrogation.” The physician notices bruising on the detainee's wrists and torso, inconsistent with the explanation given. The facility commander reminds the physician that his contract is with the ministry, and that cooperation is expected.

Discussion: Whose interests does this physician actually serve — the state, the institution, or the patient? Hold this question; we will return to it.

This scenario is a textbook case of ‘dual loyalty’ — a central theme of this lecture.

FOUNDATIONS

Why Human Rights Matter in Medicine

> *"Human rights are entitlements that belong to every person, simply by virtue of being human — inherent, inalienable, and universal."*
>
> — Universal Declaration of Human Rights, 1948[1]

Medicine engages human rights directly: bodily integrity, privacy, non-discrimination, and access to care all have both an ethical and a legal dimension.

Where physicians encounter human rights daily:

Bodily integrity

Consent to examination and treatment; freedom from non-consensual intervention.

Non-discrimination

Equal access to care regardless of race, religion, gender, or political belief.

Freedom from torture

An absolute right — no exceptions, no balancing against other interests.

THE LEGAL ARCHITECTURE

Key Human Rights Instruments

1948

UDHR

Universal Declaration of Human Rights — the foundational statement of universal rights.[1]

1966

ICCPR

International Covenant on Civil and Political Rights — binding treaty, incl. freedom from torture.[2]

1966

ICESCR

International Covenant on Economic, Social and Cultural Rights — Art. 12, right to health.[3]

1975/2016

Declaration of Tokyo

WMA guidance for physicians on torture and detention.[4]

2017

Declaration of Malta

WMA guidance on hunger strikers' rights and physician duties.[5]

The Right to Health

Not a right to be healthy

No instrument guarantees perfect health — that is biologically impossible to promise. Genetics, environment, and chance all play a role no legal system can eliminate.

A right to the conditions for health

ICESCR Art. 12 obliges states to progressively ensure: available and accessible health facilities, medical care in illness, healthy environmental conditions, and non-discriminatory access.[3]

HOW THEY RELATE

Human Rights and the Law

Rights as legal claims

When ratified, human rights instruments create binding obligations on states — enforceable, at least in principle, through courts and treaty bodies.

Rights as ethical claims

Even where enforcement is weak, human rights carry independent moral force — physicians are bound by them ethically regardless of local enforcement.

National vs. international law

National law may fall short of international human rights standards — physicians must know both, and where they diverge.

When they conflict

A physician may face a local law or order that violates international human rights norms — professional ethics does not yield automatically to local law.

THREE CORNERSTONE DOCUMENTS

WMA Declarations Protecting Human Rights

Declaration of Tokyo

Absolute prohibition on physician participation in torture or degrading treatment, even under orders.[4]

Declaration of Malta

Guidance on respecting the autonomy of hunger strikers — no force-feeding of a capable, informed refuser.[5]

Declaration of Lisbon

Sets out fundamental rights of the patient: information, consent, dignity, confidentiality.[6]

NO EXCEPTIONS, NO JUSTIFICATIONS

Torture: An Absolute Prohibition

"The physician shall not countenance, condone, or participate in the practice of torture or other forms of cruel, inhuman, or degrading procedures."[4]

This means, concretely:

- No certifying a detainee "fit" for interrogation methods that could cause harm
- No providing knowledge, instruments, or presence that facilitates torture
- A duty to document injuries objectively — per the Istanbul Protocol standard[7]
- This obligation holds even under direct orders from a superior or the state

[7] *UN Office of the High Commissioner for Human Rights. Istanbul Protocol. 1999 (rev. 2022).*

WHEN DUTIES COMPETE

Dual Loyalty

"Dual loyalty" describes the conflict a physician faces when obligations to an employer, the state, or a third party pull against the primary duty owed to the patient.[8]

Military & prison medicine

Physicians employed by security services may be pressured to prioritise institutional over patient interests.

Occupational medicine

Company-employed physicians can face pressure to minimise findings that are costly to the employer.

Insurance & utilisation review

Physicians reviewing claims may face incentives that conflict with a patient's actual clinical need.

The resolving principle: the physician's primary ethical duty remains to the individual patient, regardless of who signs the paycheck.

RIGHTS THAT PERSIST REGARDLESS OF STATUS

Vulnerable Populations

Prisoners & detainees

Retain the right to healthcare of the same quality available to the general population — custody does not suspend medical rights.

Refugees & asylum seekers

Entitled to non-discriminatory access to care regardless of legal or documentation status.

Persons with disabilities

Protected against discrimination and entitled to informed consent, not substituted decision-making by default.

Children & the elderly

Special protections apply, balancing evolving or diminished capacity against the individual's own voice.

EQUAL ACCESS, NO EXCEPTIONS

The Non-Discrimination Principle

"A physician shall owe his/her patients complete loyalty ... regardless of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other factor."[9]

Why this principle is tested most in moments of scarcity or conflict:

- Triage under resource constraints must use clinical criteria, not identity or status
- Treating a patient identified as an enemy combatant or a political opponent still requires full clinical loyalty
- Personal disagreement with a patient's beliefs or conduct never justifies withholding indicated care

DECLARATION OF MALTA[5]

Case in Focus: Hunger Strikers

A competent, informed hunger striker has the right to refuse nutrition, even if this results in death. The physician's duty is to ensure the decision is truly voluntary and informed — not to force-feed to preserve life against the striker's wishes.

Core principles:

- Assess and re-assess mental capacity throughout the strike, not only at the start
- Provide full information on medical risks, without using it as a pressure tactic
- Forced feeding of a capable, informed refuser is a form of inhuman and degrading treatment
- Document the physician's own conscientious objection if asked to force-feed against these principles

Confidentiality as a Human Right

Privacy is protected under ICCPR Art. 17 and echoed in the Declaration of Lisbon: patients have a right to expect that information shared with a physician remains confidential, even after death.[2,6]

Recognised exceptions — narrow, and each independently justified:

Serious risk of harm to an identifiable third party	Duty to warn/protect may override confidentiality in narrowly defined circumstances.
Statutory reporting requirements	E.g., certain communicable diseases, gunshot wounds, child abuse — as defined by national law.
Patient's own informed consent to disclose	The default remains non-disclosure unless the patient authorises it or a clear exception applies.

WHY THESE PROTECTIONS EXIST

Lessons From History

Nazi medical atrocities

Physicians conducted lethal experiments under state authority — directly prompting the Nuremberg Code and Declaration of Geneva.[10]

Documented torture complicity

Physicians in several conflicts certified detainees fit for interrogation methods now recognised as torture — prompting the Declaration of Tokyo.[4]

Apartheid-era medicine

Physicians who treated political prisoners differently from other patients breached the non-discrimination principle directly.[9]

NAVIGATING THE GAP

When Law and Ethics Conflict

Professional ethics does not automatically defer to local law or institutional pressure — especially regarding absolute rights.

1

Recognise the conflict

Notice when an order, policy, or local law would require an act inconsistent with human rights.

2

Consult professional guidance

WMA declarations, national medical council guidance, and colleagues can clarify the ethical position.

3

Refuse participation in violations

Ethical obligations regarding torture and dignity admit no exception — refusal is required, not optional.

4

Document and, where safe, report

Objective documentation (e.g., Istanbul Protocol standards) protects both patient and physician.

5

Seek institutional or legal protection

Conscientious objection provision and professional bodies can offer support against retaliation.

RESOLUTION

Back to the Case Study

The physician must decline to sign the “fit for interrogation” certification. The Declaration of Tokyo makes this an absolute duty — employment by the ministry does not override it. The correct course is to objectively document the injuries observed, decline to certify fitness for any interrogation involving risk of harm, and escalate through professional and, where safe, legal channels.

Why dual loyalty resolves this way:

- The prohibition on facilitating torture is absolute — it is not weighed against employer interests
- The physician's primary duty is to the individual before them, not the institution paying the contract
- Objective documentation protects the detainee and creates an accountable record

KEY TAKEAWAYS

Human Rights and the Law

- Human rights are inherent and universal — medicine engages them through bodily integrity, privacy, and non-discrimination
- The right to health obliges states to provide the conditions for health; it is not a guarantee of being healthy
- Legal and ethical obligations usually align, but professional ethics does not automatically defer to local law when they diverge
- The prohibition on physician participation in torture is absolute, with no exception for orders or employment context
- Dual loyalty conflicts are resolved by keeping the individual patient as the primary duty, whoever else is paying or instructing

SOURCES CITED IN THIS LECTURE

References

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5. World Medical Association. WMA Declaration of Malta on Hunger Strikers. Adopted 1991; revised 2017.

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8. Physicians for Human Rights & University of Cape Town Health Sciences Faculty. Dual Loyalty and Human Rights in Health Professional Practice. 2002.

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