

The Malaysian Medical Association's Position Paper on Human Rights

Part
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The Malaysian Medical Association has as its prime objectives the promotion and maintenance of the honour and interest of the profession of medicine. It

is also concerned with serving as the voice of the profession in educating and directing public opinion on problems of health when it affects the community at large.

There has been a resurgence of interest in human rights in Malaysia as a result of the formation of the Human Rights Commission in the year 2000. The MMA feels it is appropriate at this juncture of much public discourse on this topic as a result of the human rights activities in various parts of the globe for it to stand on these issues. In this context, it must be stated that it remains an apolitical association. The principles enunciated in this paper are fundamental to the maintenance of health in every person in this country and everywhere in the world.

The MMA holds firm and believes in the following rights:

The Right to Life

The MMA believes that all persons have a right to life and that no one shall be arbitrarily deprived of their life. Everyone should be given the opportunity to develop to their fullest potential and there should be no discrimination on ethnic, racial, sexual, religious or social grounds. The government should ensure that constitutionally enshrined rights of every citizen should be protected. The MMA will condemn genocide and holds the view that the perpetrators should be punished under national and international laws.

One of the main achievements of the last century has been the unprecedented increase in human longevity. In the past half century, expectation of life at birth in the world as a whole has increased by about 20 years and the risk of dying in the first year of life has been reduced by nearly two thirds. Nevertheless, these achievements fall short of the much greater improvements that had been anticipated in the World Declaration on Primary Health Care (1978) and the Declaration of Alma-Ata, adopted by the International Conference on Primary Health Care in 1978. There remain entire populations and sizeable population groups in many countries that are still subject to very high rates of morbidity and mortality. Differences linked to socio-economic status or ethnicity is often substantial. In many countries with economies in transition, the infant mortality rate has considerably increased as a result of causes caused by accidents and violence (ICPD).

Complications related to pregnancy and childbirth are among the leading causes of mortality for women of reproductive age in many parts of the developing world. At the global level, it has been estimated that about half a million women die each year from pregnancy-related causes, 99 per cent of them in developing countries. The gap in maternal mortality between developed and developing regions is wide: in the developed regions it ranged from more than 700 per 100,000 live births in the least developed countries to about 26 per 100,000 live births in the developed regions. Rates of 100 or more maternal deaths per 100,000 live births have been reported in several rural areas of Africa,

giving women with many pregnancies a high lifetime risk of death during their reproductive years. According to the World Health Organization, the lifetime risk of dying from pregnancy or childbirth-related causes is 1 in 20 in some developing countries, compared to 1 in 10,000 in some developed countries. The age at which women begin or stop child-bearing, the interval between each birth, the total numbers of lifetime pregnancies and the socio-cultural and economic circumstances in which women live all influence maternal morbidity and mortality. At present, approximately 90 per cent of the countries of the world, representing 96 per cent of the world population, have policies that permit abortion under varying legal conditions to save the life of a woman. However, a significant proportion of the abortions carried out are self-induced or otherwise unsafe, leading to a large fraction of maternal deaths or to permanent injury to the women involved. Maternal deaths have very serious consequences within the family, given the crucial role of the mother for her children's health and welfare. The death of the mother increases the risk to the survival of her young children, especially if the family is not able to provide a substitute for the maternal role. Greater attention to the reproductive health needs of female adolescents and young women could prevent the major share of maternal morbidity and mortality through prevention of unwanted pregnancies and any subsequent poorly managed abortion. Safe motherhood has been accepted in many countries as a strategy to reduce maternal morbidity and mortality (ICPD).

The objectives of the MMA's actions will be to:

- To promote women's health and safe motherhood; to achieve a rapid and substantial reduction in maternal morbidity and mortality and reduce the differences observed between developing and developed countries and within countries. On the basis of a commitment to women's health and well being, to reduce greatly the numbers of deaths and morbidity from unsafe abortions;
 - To improve the health and nutritional status of women, especially of pregnant and nursing women.
- The MMA congratulates the efforts of the government towards its efforts in the area of Safe Motherhood and in making the nation a showcase where much can be done with commitment and determination in a systematic planned method. The MMA advocates greater efforts in narrowing the health differentials between various geographical areas and communities.

2. The Right to Liberty and Security of the Person

The MMA believes that all persons have the right to liberty and security of the person. All persons have the right to be free and enjoy their life within limits of the laws of the country. They must also have due regard to the lives of others. All persons have the right to be free from any medical intervention related to their health save with their full, free and informed consent. All persons have the right to be free from violence and sexual harassment. All persons have the right to be free from externally imposed fear, shame, guilt, beliefs based on myths and other psychological factors which may impair their health. All persons have the right to be free from forced pregnancy, sterilization and abortion.

3. The Right to Equality, and to be Free from all Forms of Discrimination

The MMA believes that all human beings are born free and equal in dignity and rights. One should not ideally be discriminated against by way of legislation, regulation, customs and practices as well as social and

cultural patterns of conduct such that health is affected.

All persons have the right to equal access to education and information to ensure their health and well-being, including access to services relating to their health irrespective of race, colour, poverty, sex, marital status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status.

All persons have the right to appropriate nutrition and care throughout their life span and to be free from prejudicial, customary and all other practices which are based on the idea of inferiority or stereotyped roles for men or women.

All persons have the right to protection from all forms of violence caused by reason of their race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Since in all societies discrimination on the basis of sex often starts at the earliest stages of life, greater equality for the girl child is a necessary first step in ensuring that women realize their full potential and become equal partners in development. In a number of countries, the practice of prenatal sex selection, higher rates of mortality among very young girls, and lower rates of school enrolment for girls as compared with boys, suggest that "son preference" is curtailing the access of girl children to food, education and health care. This is often compounded by the increasing use of technologies to determine foetal sex, resulting in abortion of female foetuses. Investments made in the girl child's health, nutrition and education, from infancy through adolescence, are critical.

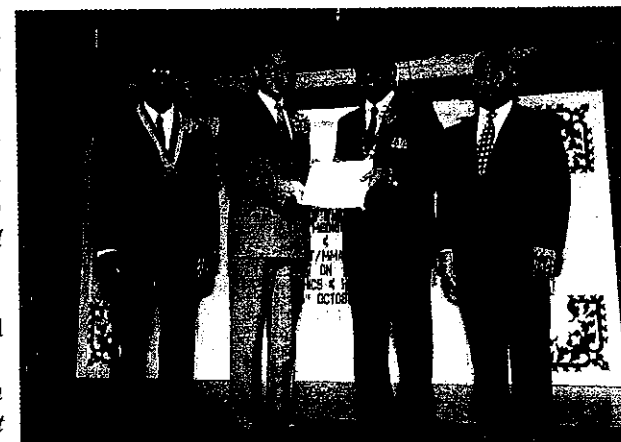
The objectives of the MMA's actions will be to:

- To eliminate all forms of discrimination against the girl child and the root causes of son preference, which results in harmful and unethical practices regarding female infanticide and prenatal sex selection;
- To increase public awareness of the value of the girl child, and concurrently, to strengthen the girl child's self-image, self-esteem and status;
- To improve the welfare of the girl child, especially in regard to health, nutrition and education.

Actions to be taken:-

By Governments, employers, employees, trade unions and women's organizations:

- Enact and enforce laws and introduce implementing measures, including means of redress and access to justice in cases of non-compliance, to prohibit direct and indirect discrimination on grounds of sex, including by reference to marital or family status, in relation to



The launch of the "MMA Human Rights" Position Paper

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access to employment, conditions of employment, including training, promotion, health and safety, as well as termination of employment and social security or workers, including legal protection against sexual and racial harassment;

By Governments:

(c) Ensure, through legislation, incentives and/or encouragement, opportunities for women and men to take job-protected parental leave and to have parental benefits; promote the equal sharing of responsibilities family by men and women, including through appropriate legislation, incentives and/or encouragement, and also promote the facilitation of breast-feeding for working mothers;

By Governments and, as appropriate, international and non-governmental organizations:

(d) Enact and enforce legislation protecting girls from all forms of violence, including female infanticide and prenatal sex selection, genital mutilation, incest, sexual abuse, sexual exploitation, child prostitution and child pornography, and develop age-appropriate safe and confidential programmes and medical, social and psychological support services to assist girls who are subjected to violence.

The MMA congratulates the government for its leadership role in promulgating the rights and privileges of women through its legislative actions.

4. The Right to Privacy

The MMA believes that all persons have the right not to be subject to arbitrary interference with their privacy, family, home or correspondence.

All health care services should provide clients with privacy and ensure that personal information given will remain confidential.

Recognizing the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capacities of the adolescent, appropriate direction and guidance in sexual and reproductive matters, countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse. In doing so, and in order to, inter alia, address sexual abuse; these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents.

The Platform for Action recognizes that women face barriers to full equality and advancement because of such factors as their race, age, language, ethnicity, culture, religion or disability, because they are indigenous women or because of other status. Many women encounter specific obstacles related to their family status, particularly as single parents; and to their socio-economic status, including their living conditions in rural, isolated or impoverished areas. Additional barriers also exist for refugee women, other displaced women, including internally displaced women as well as for immigrant women and migrant women, including women migrant workers. Many women are also particularly affected by environmental disasters, serious and infectious diseases and various forms of violence against women.

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

5. The Right to Freedom of Thought

The MMA believes that all persons have the right to freedom of thought, conscience and religion; that the right to freedom of opinion and expression includes the right to hold opinions without interference and to seek, receive and impart information and ideas via any media. In this context, the MMA recognizes that governments may have to impose restrictions for the greater good of the community. The MMA will nevertheless engage in constructive dialogue with the government if health of the community or individual is affected.

Standard from the International Covenant on Civil and Political Rights (ICCPR); 1996

Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching. (Article 18, ICCPR)

Standard from the World Conference on Human Rights (WCHR); 1993

All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms. (Paragraph 5, Vienna Declaration and Programme of Action, adopted by the WCHR).

Standards from the World Medical Assembly (WMA) Declaration of Oslo; 1970

If the doctor considers that his convictions do not allow him to advise or perform an abortion, he may withdraw while ensuring the continuity of (medical) care by a qualified colleague. (Paragraph 6, Statement on Therapeutic Abortion, adopted by the WMA, 1970)

6. The Right to Information and Education

The MMA believes that all persons have the right to education and in particular, specific educational information to ensure the health and well being of persons and families.

Standards from the Programme of Action of the United Nations International Conference on Population and Development (ICPD): Cairo, Egypt 5-13 September 1994

Beyond the achievement of the goal of universal primary education in all countries before the year 2015, all countries are urged to ensure the widest and earliest possible access by girls and women to secondary and higher levels of education, as well as to vocational education and technical training, bearing in mind the need to improve the quality and relevance of that education. (ICPD)

Specifically, Governments should make it easier for couples and individuals to take responsibility for their own reproductive health by removing unnecessary legal, medical, clinical and regulatory barriers to information and to access to family-planning services and methods. (ICPD)

Support should be given to integral sexual education and services for young people, with the support and guidance of their parents and in line with the Convention on the Rights of the Child, that stress responsibility of males for their own sexual health and fertility and that help them exercise those responsibilities. Educational efforts should begin within the family unit, in the community and in the schools at an appropriate age, but must also reach adults, in particular men, through non-formal education

and a variety of community-based efforts.

In the light of the urgent need to address unwanted pregnancies, the rapid spread of other sexually transmitted diseases, and the prevalence of sexual abuse and violence, Governments should develop national policies on a better understanding of responsible human sexuality and the current sexual behaviour. (ICPD)

Governments, in collaboration with non-governmental organizations, are urged to address the special needs of adolescents and to establish programmes to respond to those needs. Such programmes should include support mechanisms for education and counselling of adolescents in gender relations and equality, violence against adolescents, responsible sexual behaviour, family-planning practice, family life, reproductive health, sexually transmitted disease, HIV and AIDS prevention. Programmes for the prevention of sexual abuse and incest should be provided. Reproductive health services should be provided. Such programmes should provide information to adolescents and make a conscious effort to strengthen their social and cultural values. Sexually active adolescents will require special family-planning information, counselling and services, and those who become pregnant will require special support from the family and community during pregnancy and early childbirth. Adolescents must be fully involved in the implementation and evaluation of such information services with proper regard for parental guidance responsibilities. (ICPD)

Standards from the Platform for Action of the United Nations Fourth World Conference on Women (FWCW): Beijing, China; 4-15 September 1995

Actions to be taken

By Government, in cooperation with non-governmental organizations, the mass media, the private sector and relevant international organizations, including United Nations bodies, as appropriate:

(e) Prepare and disseminate accessible information through public health campaigns, the media, counselling and the education system, designed to ensure that women and men, particularly young people, can acquire knowledge about their health, reproductive information on sexuality and reproduction, take account of the rights of the child to access information, privacy, confidentiality, respect and informed consent, as well as the responsibilities of parents and legal guardians to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise of the rights recognized in the Convention on the Rights of the Child, and in conformity with the Convention on the Elimination of All Forms of Discrimination against Women; ensure that the best interests of children are a primary consideration; (FWCW).

7. The Right to Choose Whether or Not to Found and Plan a Family

Governments should strictly enforce laws to ensure that marriage is entered into only with the free and informed consent of the intending spouses. In enforcing these laws, Governments should strictly enforce laws on the minimum legal age of consent and the minimum age at marriage and should raise the minimum age at marriage where necessary. Governments should support the enforcement of laws on the minimum legal age at marriage, in particular by providing educational and employment opportunities. (FWCW)

The MMA congratulates the government for its actions in this regard. MMA

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8. The Right to Decide, Whether or When to Have Children

The MMA believes that the right to decide whether or when to have children is

9. The Right to Health Care and Health Protection
All persons have the right to the enjoyment of the highest attainable standard of physical and mental health.

10. The Right to the Benefits of Scientific Progress
All persons have the right to enjoy the benefits of scientific progress and its applications. Moral and ethical guidelines are essential cornerstones of scientific research.

Standards from the Programme of Action of the United Nations International Conference on Population and Development (ICPD): Cairo, Egypt; 5-13 September; 1994

Governments, assisted by the international community and donor agencies, the private sector, non-governmental organizations and the academic community, should increase support for basic and applied biomedical, technological, clinical, epidemiological and social science research to strengthen reproductive health services, including the improvement of existing and the development of new methods for regulation of fertility that meet users' needs and are acceptable, easy to use, safe, free of long- and short-term side effects and suitable for different age and cultural groups and for different phases of the reproductive cycle. Testing and introduction of all new technologies should be continually monitored to avoid potential abuse. Specifically, areas that need increased attention should include barrier methods, both male and female, for fertility control and the prevention of sexually transmitted diseases, including HIV/AIDS, as well as microbicides and virucides, which may or may not prevent pregnancy. (ICPD)

High priority should be given to the development of new methods for regulation of fertility for men. Special research should be undertaken on factors inhibiting male participation in order to enhance male involvement and responsibility in family planning. In conducting sexual and reproductive health research, special attention should be given to the needs of adolescents in order to develop suitable policies and programmes and appropriate technologies to meet their health needs. Special priority should be given to research on sexually transmitted diseases, including HIV/AIDS, and research on infertility. (ICPD)

To expedite the availability of improved and new methods for regulation of fertility, efforts must be made to increase the involvement of industry, including industry in developing countries and countries with economies in transition. A new type of partnership between the public and private sectors, including women and consumer groups, is needed to mobilize the experience and resources of industry while protecting the public interest. National drug and device regulatory agencies should be actively involved in all stages of the development process to ensure that all legal and ethical standards are met. Developed countries with economies in transition with their knowledge, experience and technical expertise and promote the transfer of appropriate technologies to them. The international community should facilitate the establishment of manufacturing capacities for contraceptive commodities in developing countries, particularly the least developed among them, and countries with economies in transition. (ICPD)

Standards from the Platform for Action of the United Nations Fourth World Conference on Women (FWCW): Beijing, China; 4-15 September 1995

In most countries, the neglect of women's reproductive health severely limits their opportunities in public and private life, including opportunities for education and economic and political empowerment. The ability of women to control their own fertility forms an important basis for the enjoyment of other rights. Shared responsibilities between women and men in matters related to sexual and reproductive behaviour is also essential to improving women's health. (FWCW)

Standards from the World Conference on Human Rights (WCHR); 1993

Everyone has the right to enjoy the benefits of scientific progress and its applications. The World Conference on Human Rights notes that certain advances, notably in the biomedical and life sciences as well as in information technology, may have potentially adverse consequences for the integrity, dignity and human rights of the individual, and calls for international cooperation to ensure that human rights and dignity are fully respected in this area of universal concern. (Paragraph 11, Vienna Declaration and Programme of action; WCHR)

11. The Right to be Free from Torture and I II Treatment

The MMA believes that all persons have the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment and not to be subjected to medical or scientific treatment without free and informed consent.

Standards from the Programme of Action of the United Nations International Conference on Population and Development (ICPD): Cairo Egypt; 5-13 September 1994

Countries should take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and children. This implies both preventive actions and rehabilitation of victims. Countries should prohibit degrading practices, such as trafficking in women, adolescents and children and exploitation through prostitution, and pay special attention to protecting the rights and safety of those who suffer from these crimes and those in potentially exploitable situations, such as migrant women, women in domestic service and schoolgirls. In this regard, international safeguards and mechanisms for cooperation should be put in place to ensure that these measures are implemented. (ICPD)

Countries are urged to identify and condemn the systematic practice of rape and other forms of inhuman and degrading treatment of women as a deliberate instrument of war and ethnic cleansing and take steps to assure that full assistance is provided to the victims of such abuse for their physical and mental rehabilitation. (ICPD)

Standards from the Programme of Action of the United Nations World Summit for Social Development (WSSD): Copenhagen, Denmark; 6-12 March 1995

International support for national efforts to promote a favourable political and legal environment must be in conformity with the Charter of the United Nations and principles of international law and consistent with the Declaration and Principles of International law concerning Friendly Relations and Cooperation among States in accordance with the Charter of the United Nations. Support calls for the following actions:

Coordinating policies, actions and legal instruments and/or measures to combat terrorism, all forms of extremist violent, illicit arms trafficking, organized crime and illicit drug problems, money laundering and related crimes, trafficking in women, adolescents, children, migrants, and human organs, and other activities contrary to human rights and human dignity; (WSSD)

Addressing the problem created by violence to eliminate all forms of exploitation, abuse, harassment and violence against women, in particular domestic violence and rape. Special attention should be given to

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violence resulting from harmful traditional or customary practices and all forms of extremism, which implies both preventive actions and the rehabilitation of victims; (WSSD)

Standards from the Platform for Action of the United Nations Fourth World Conference on Women (FWCW): Beijing, China; 4-15 September 1995

By Government of countries of origin, transit and destination, regional and international organizations, as appropriate:

Take appropriate measures to address the root factors, including external factors, that encourage trafficking in women and girls for prostitution and other forms of commercialised sex, forced marriages and forced labour in order to eliminate trafficking in women, including by strengthening existing legislation with a view to providing better protection of the rights of women and girls and to punishing the perpetrators, through both criminal and civil measures. (FWVW)

12. The Right to care for disadvantaged groups

The MMA believes that the disadvantaged and vulnerable groups have the right to medical care. The obligation of the physician to provide medical care for disadvantaged and vulnerable groups must be upheld. Physicians should endeavour to identify causes of ill health in such groups and should draw attention to the need to alleviate them.

All sick or disabled persons are vulnerable insofar as they are likely to be unduly susceptible to suggestions, which offer them relief from pain and suffering and a cure of their condition. Physicians must constantly bear this in mind and be careful not to take unreasonable advantage of it. Health professionals should accept that they have a responsibility to identify those members of the community who are deprived of adequate access to health care or who have difficulty in making their requirements known, having regard to the fact that they are at high risk of exploitation, violence and abuse. Health professionals should take account of the special needs of such groups as well as ascertaining the causes of their ill health. The risks are greatest for the following groups in most countries:

Children: Physicians should constantly bear in mind that violence suffered by children is by no means always accidental and that sexual abuse of children may remain undetected for long periods of time. Whenever they become aware of violence to children, from whatever source, physicians should enlist the aid of the social or other supporting services to deal with the problem. The recognition and assessment of signs of violence, particularly sexual abuse, in children requires special skills and health professionals requested by the police to examine such cases should not attempt to do so if more experienced colleagues are available.

In many countries female children are likely to be undernourished as a result of discrimination, which exists in favour of the male children in the family. This may result in delayed physical development and difficulties with future childbearing. The female child is also less likely to receive adequate schooling and may often be required to carry out an unfair share of heavy physical work in the family home which can damage her health. As the HIV/AIDS pandemic spreads amongst the heterosexual population in developing countries, increasing number of children will lose their parents, and become orphans. Child labour e.g. in the fields, is a common hazard to the health of children in such countries even though it is usually proscribed by law.

Other hazards to the health of the female child include adverse tradition practices such as genital mutilation. Physicians should endeavour to expose the dangers of such practices with the aim of changing the beliefs and attitudes which support them.

Adolescents: Adolescent girls are exposed to special health risks in developing countries as a result of gender discrimination and of being forced into marriage at too young an age. Where additional earning power is needed for the family, or where their parents become sick, e.g. from AIDS, the girls in the family rather than boys will be the first to be taken away from school.

They may be forced to leave school prematurely as a result of becoming pregnant, following which they will earn money from available sources, which may be limited to commercial sex, drug peddling or other occupations hazardous to their health. Too often their only recourse in pregnancy is to unsafe abortion. Physicians should try to help girls to avoid these adverse consequences by providing them with family planning counselling and services whenever necessary and with safe termination of pregnancy whenever it is appropriate and permitted by law.

Health professionals should take account of the fact that it may take some time for adolescents to come to the point during a consultation and that their main concern is that the health professionals may not observe confidentiality. They should therefore be given assurances that the consultation is confidential, especially where their sexual or reproductive health problems are involved.

Women: Women in developing countries suffer disproportionately from ill health including many illnesses that are life threatening. Violence is usually identified as the health issue about which they are most concerned. Women who have been assaulted by their partners often claim that their injuries were the result of an accident. In deciding whether to report such cases to the police health professionals should weigh the consequences to the woman and her children if her partner is imprisoned against the risk of her being the victim of more serious attacks if no action is taken.

Women are often denied access to means of controlling their fertility. Reliable information about the prevention of disease may never reach them because of the high incidence of functional illiteracy. The high maternal mortality rate in such countries is largely avoidable.

The associated morbidity from pregnancy related causes includes fistula formation which will often lead to the affected woman being evicted from her home and left with no means of support. Physicians should do all they can to promote the services that can help women avoid these adverse consequences to their health, whilst taking care not to expose them to non-essential intrusive procedures.

Elderly: the dependence of the elderly on others for their care renders them susceptible to exploitation. The capacity of the extended family to care for the elderly has been seriously compromised in many developing countries by the effects of the HIV/AIDS pandemic that has reduced the number of family members available to look after them. Physicians must be alert to the signs of violence and neglect in the elderly and do all that is possible to provide them with the support which is necessary to protect their health.

Other high risk groups: Physicians should be aware of the special needs of refugees, asylum seekers, minority ethnic groups, indigenous peoples etc. and should recognise that their access to health care is often limited. Refugee status is not conducive to health and refugee women may sometimes be subjected to sexual abuse. Persons suffering from severe physical or mental incapacity are often at risk of abuse, maltreatment or neglect by their families or by the institutions in which they have been placed. Physicians attending these vulnerable and disadvantaged groups must be vigilant

in detecting any suspicious signs of violence or neglect and must be sure to alert the appropriate authorities promptly.

13. The right to care for prisoners

The MMA believes that attendance by physicians on persons in custody, prison and those held in detention must always be conducted in the best interests of their health

Prison conditions in many countries are damaging both physical and mental health as a result of overcrowding, inadequate nutrition, bad sanitation, lack of adequate medical care, confinement, abuse of various kinds and many other disadvantages of having to live in a dehumanising environment. Physicians working in prisons must draw the attention of the prison authorities to unhealthy conditions that must be remedied. If the prison authorities refuse to take necessary action the appropriate higher authority must be informed.

Physicians attending prisoners should take all possible steps to preserve the dignity of detainees by insisting wherever possible that medical examinations are carried out in private, that the ethical requirements of consent and confidentiality are respected, and that treatment is carried out in a humane manner. They should ensure compliance with United Nations human rights instruments relevant to the care of prisoners and other detainees, particularly those concerned with juvenile detainees.

Body searches: When law enforcement, prison or other detaining authorities decide that an intimate body search should be carried out and if the physician is convinced that it is necessary, e.g. where there is reason to believe that dangerous substances may be concealed in body cavities, consent should always be sought by the examining physician from the prisoner before the examination is carried out. If consent is withheld, it should be made clear to the prisoner that the examination may have to be carried out by someone without medical qualifications and experience e.g. a prison officer.

Signs of violence: Physicians should be vigilant for signs of violence, particularly those resulting from torture or other degrading and inhuman practices. They must report the matter to the appropriate authorities, and make a comprehensive note of their findings at the time. Any failure of the authorities to take appropriate action should be reported to the medical licensing or registration body (i.e. MMC) or to the national medical association (i.e. MMA).

Physicians must never falsify their medical reports on prisoners at the request of prison authorities nor must they acquiesce in the concealment of any signs of violence that may be disclosed at postmortem examination of prisoners. Drugs or medication (including psychoactive drugs) should never be prescribed or administered to prisoners other than for purposes of medical treatment.

Hunger strikes: Physicians requested to attend hunger strikes must first determine whether the prisoner is capable of forming the necessary intent to refuse food and/or whether there is coercion by others. This will include informing the prisoner of the injurious effects on health if food is refused beyond a certain stage. Prisoners who fully understand the implications of their choice should not be forcibly fed. Physicians should insist that only they, and not the prison or other detaining authorities must decide whether compulsory feeding is appropriate e.g. where the prisoner's physical demands have been met, but he or she has no longer the mental capacity to take a decision.

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ness of overkill and mutual assured destruction was so deeply entrenched that the entire system were able to break down.

Security, based on nuclear deterrence, is a illusion. Despite the safeguards and crisis management during the Cold War, documented evidence of more and more nuclear weapons as well as the alarms that came very close to a nuclear war that would have been more destructive than Hiroshima. Now that the United States and the Soviet Union are no longer enemies, can we go back on the Cold War and just take them were taken with the strategy of nuclear destruction?

Nuclear Futures

Since the end of the Cold War, public opinion that the nuclear arms race is over and that nuclear war have passed. However, in 1998, Pakistan gave the international community they carried out nuclear tests, which themselves nuclear weapon states. India and Pakistan have themselves threatened a nuclear attack and their population is at risk of nuclear devastation - hardly a secure future.

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Monitoring judicial punishment in countries, it is a legal requirement that judicial punishment be overseen by a judicial committee. This presents an ethical dilemma for physicians. If they recognise that participating in judicial punishment which can range from flogging to execution of a convicted prisoner in lieu of punishment and disability following judicial punishment) leads a spurious judicial punishment which is contrary to medical practice.

On the other hand the medical profession may allow humane punishment if it is not excessively harsh. It is a balance between less mutilation and less severe punishments - an outcome which is faced with the inevitable. Physicians refuse to participate in judicial punishment may jeopardise the lives of prisoners suffering may be incarcerated, even under protest, and help to perpetuate, an inhumane practice. Neither option is satisfactory.

Whatever are the circumstances, physicians attend or participate in judicial punishment are essential that they are appropriately informed and fully aware of their rights.

National medical associations and internationally, should endeavour to abolish inhumane punishment. Physicians opposed to such a stance are encouraged, and those who participate in judicial punishment are sensitised to the implications of their actions. It is an international quest for the end of judicial punishment and coercive forms of punishment.

It is imperative that medical colleagues ensure that in hospitals, police officers serve as prison doctors and that there has been a clear ethical principles involve in the use of force. The ethical principles needs to start in the medical profession.

The MMC guidelines under the heading of "Conduct of the profession".

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of overkill and mutual assured destruction. The system was so deeply entrenched that very few people in the entire system were able to break free of Cold War thinking.

Security, based on nuclear deterrence, was and still is an illusion. Despite the safeguards built into nuclear weapons and crisis management during the Cold War, there is documented evidence of more than 40 accidents involving nuclear weapons as well as numerous crises and alarms that came very close to triggering a nuclear war - a nuclear war that would have been thousands of times more destructive than Hiroshima; a nuclear war that would have destroyed much of Europe and North America. Now that the United States and the former Soviet Union are no longer enemies, can any sane person today justify the suicidal risks taken with the strategy of mutual assured destruction?

Nuclear Futures

At the end of the Cold War, public perception has been that the nuclear arms race is over and that the dangers of a nuclear war have passed. However, in May 1998, India and Pakistan gave the international community a wake-up call when they carried out nuclear tests and declared themselves nuclear weapon states. By one fell swoop, both India and Pakistan have themselves become prime targets of a nuclear attack and their populations are now exposed to nuclear devastation - hardly an assurance of greater security.

Nuclear proliferation in South Asia has underlined the potential for proliferation by non-nuclear weapon states and has hardened the resolve of the five main nuclear powers to retain their nuclear arsenals indefinitely.

Achieving the elimination of nuclear weapons depends mainly on the United States, the circuit breaker, the only state that can free the world of its nuclear weapons. But instead, the US is committed to a first-use policy and is engaged in upgrading its nuclear forces and developing new nuclear weapons for meeting perceived regional threats from so-called 'rogue' states.

In addition, the US Senate has rejected the Comprehensive Test Ban Treaty (CTBT) and the Bush administration has announced its intention to kill the CTBT and possibly resume nuclear testing.

Another setback has been the proposal to build a national missile defence system, which would violate the 1972 Anti-Ballistic Missile (ABM) Treaty, destabilize arms control and ignite a second nuclear arms race. Missile defence is opposed by Russia and China and does not have the support of American allies and friends, except Australia and India.

The damage to the CTBT and the possible loss of the ABM Treaty are serious blows to arms control and disarmament.

Perhaps the most troubling aspect is the trend towards the

development of new nuclear weapons, whether by the US or Britain or France. Designed as low-yield weapons for conflicts in the Third World, with specific functions, such as deep penetration to destroy buried targets, these new nuclear weapons could be rationalised as being more 'useable', particularly in 'small nuclear wars in far-off places', where recalcitrant Third World countries defiantly resist American hegemony.

From that disturbing account of current trends, we have to conclude that there is no unequivocal commitment to the elimination of nuclear weapons and at present no sign of movement in that direction. If anything, the trend is in the opposite direction.

(Paper presented at a public forum on 6 August 2001, in commemoration of Hiroshima Day) MMA

To be continued in next issue

TO: ALL MMI MEMBERS

MALAYSIAN MEDICAL INDEMNITY (MMI) SCHEME

Please be informed that the lead insurer for the above scheme w.e.f. 1/10/2001 is Hong Leong Assurance Berhad. Progressive Insurance Berhad will still be participating in the scheme as a co-insurer.

Kindly make your payment in favour of Hong Leong Assurance Berhad with immediate effect and send the cheque to MMA.

The terms and conditions of the Policy remain unchanged.

Should you have any further queries, please do not hesitate to contact Mr Sarjit Singh or Ms Jennifer Liew at:

AON Insurance Brokers (M) Sdn Bhd
7th Floor, Bangunan Malaysia Re
No. 17, Lorong Dungun
50490 Kuala Lumpur
Tel No : 03-2556628
Fax No: 03-2556618

Alternatively you can contact Miss Uma of MMA at Tel No: 03-40411375.

ENT Specialist required as Assistant

in Specialist Hospital in Ipoh.
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respect for human life should be maintained even under threat, and no use should be made of any medical knowledge contrary to the laws of humanity. The practitioner should 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 procedures is

suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations including armed conflict and civil strife. The practitioner also should 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 MMA is committed to ensuring a continuing dialogue with the government and other interested parties in ensuring the realisation of the full potential of every person with regards to his health. The MMA will use the above rights based platform to guide its actions.

References:

1. Hippocratic Oath
2. International Covenant on Economic, Social and Cultural Rights Article 10 (3).
3. Convention on Rights of the Child Article 32.
4. Convention on all Forms of Discrimination Against Women Article 5 (a).
5. Convention on all Forms of Discrimination Against Women Article 16 (2).
6. Convention on the Rights of the Child Article 16 (1) (e) & (f).
7. Convention on all Forms of Discrimination Against Women Article 12, 14(2)(b) & 16 (1) (e).
8. Declaration on the Rights of Persons Belonging to National or Ethnic, Religious or Linguistic Minorities (UN General Assembly Resolution 47/135, 1992).

9. Convention on the Rights of the Child Article 22 (1).
10. ILO Convention No. 169 Article 25.
11. UN General Assembly Resolution 47/135 1991.
12. UN Economic and Social Council (ECOSOC) Resolutions 663 C 1957 & 2076 1977.
13. UN General Assembly Resolutions 37/194 1982; 39/46 1984; 43/173 1988; 45/113 1990.
14. International Covenant on Economic, Social and Cultural Rights Article 10(3); Convention on Rights of the Child Articles 3(2), 9 and 32-37.
15. IPPF Charter on Sexual & Reproductive Rights; International Planned Parenthood Federation 1996. MMA

Paper presented at the 19th Triennial Conference of the Commonwealth Medical Association and Joint ComMAT/MMA Workshop on Human Rights and Medical Ethics on 19th October 2001.

Monitoring judicial punishments: In many countries, it is a legal requirement that corporal and/or capital punishment be overseen by a physician. This presents an ethical dilemma for physicians. On the one hand, they recognise that participation in such activities can range from flogging chosen by the convicted prisoner in lieu of punishment, to life long mutilation and disability following judicially authorised punishments) lends a spurious respectability to such punishments which is contrary to the accepted goals of medical practice.

On the other hand the mandated presence of a physician may allow humane intervention e.g. if the punishment is excessively harsh. It may also permit less mutilation and less disability following capital amputations - an outcome often desired by victims faced with the inevitability of the sentence. If physicians refuse to participate their active civil disobedience may jeopardise their own lives and the lives of prisoners suffering may be increased. If physicians do participate, even under protest, they may be identified and help to perpetuate, an oppressive and inhuman practice. Neither option is satisfactory.

Whatever are the circumstances under which physicians attend or participate in punishments it is essential that they are appropriately qualified and are fully aware of their rights and obligations.

National medical associations, both nationally and internationally, should exercise their influence to abolish inhumane punishments. Individual physicians opposed to such activities supported and encouraged, and those who participate in them should be sensitised to the implications of their participation, in the international quest for the elimination of degrading punishment and coercive forms of control.

It is imperative that the more senior of our colleagues ensure that in hospitals, where medical practitioners serve as prison doctors, there are clear written guidelines and that there has been a regular discussion of the ethical principles involved. The teaching of these principles needs to start in the medical schools.

The MMC guidelines discuss these principles under the heading of "Conduct derogatory to the reputation of the profession". It states that the utmost

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