MEDICAL ETHICS AND HUMANITARIAN WORK REPORT

HAP & WHO
Roundtable Discussion
August 29-30

INTRODUCTION

On August 29 and 30, the Humanitarian Accountability Project (HAP) and the World Health Organisation (WHO) organised a round table discussion on the relevance of medical ethics to humanitarian actions. To facilitate the discussion, the HAP had commissioned a study on medical ethics and humanitarian interventions, undertaken by four researchers at the Harvard School of Public Health: Jennifer Leaning, Dan Wikler, Richard Cash, and Tracy Rabin.

Over the years, health agencies or those with a medical mandate\(^1\) have become key players in the humanitarian sector, reflecting their crucial role in alleviating suffering, and ensuring that the worst aspects of an emergency situation are controlled. The HAP was especially interested in their work because it considered medical work, and its long tradition of medical ethics, health law and professional accountability, as crucial vectors for a better conceptual and operational understanding of accountability mechanisms. For the WHO, the question of ethics and medical work relates closely to ongoing work and a new WHO initiative on the ethics of health research in complex emergencies.

The main objectives for the round-table therefore included:

- To discuss to what extent are medical ethics, public health ethics, resource allocation, justice, human rights and international humanitarian law applicable to humanitarian interventions;
- To contribute to a better understanding among participants of these areas and approaches;
- To encourage and facilitate sharing of experiences and perspectives; and in particular to raise and discuss ethical and operational dilemmas,
- To consider how such different ethical or legal approaches could be operationalised.

The roundtable discussion was organized around a series of presentations and working groups. The themes for the working groups were: (i) standards of care, (ii) weighing population interests versus individual interests, and (iii) resource allocation in resource constrained settings.

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\(^1\) Health assistance in the context of an emergency may include a wide range of curative and preventive interventions, for example surgical interventions, medical screening, programs of immunization, dealing with malnutrition, controlling communicable disease, addressing sanitation problems, etc.
Intended to be for 25 participants, the meeting was well attended by around 40 participants including representatives of NGOs and UN agencies, public health and academic institutes, and donor agencies. Preparatory work and the round table itself demonstrated the importance and complexity of the issue. The discussion also showed the keen interest within the sector to pursue the topic and foster better understanding around ethics and its application in an emergency context. The participants reported that the discussions had been thought provoking, and that it shed new light on a number of known dilemmas.

In terms of immediate follow-up, the HAP, WHO and Harvard University have proposed to do the following:

- Professors Jennifer Leaning, Richard Cash and Dan Wikley will revise the background paper;
- HAP/WHO will prepare and circulate the report of the meeting;
- HAP and WHO will make proposals on how to take this material to the field, and to ensure Southern stakeholders contribution in the debate.
- HAP is planning to organize a meeting on medical ethics and humanitarian actions in the context of its third field trial in Cambodia;
- WHO will use the outcomes of the meeting as input to the planned work on ethics of research and data collection in emergencies. A meeting to plan for this will be organised in partnerships with TDR, RPC, SCRIHS and the new WHO ethics and health unit.
- Richard Cash will explore the possibility of setting up a web page for participants to the round table for follow up and discussion on specific ethical dilemmas.

This report is part of the proposed follow-up. It begins with a brief review of preliminary findings, based on the final overview by Jennifer Leaning’s, Richard Cash, and Dan Wikler. This report then goes on to summarize all presentations and working-group reporting. Its last part reviews various issues and points raised during the plenary discussions. We hope you will find this report reflects well the rich and interesting discussion.

The HAP and WHO wish to thank all of those who participated to the meeting. Their contribution, energy and commitment, made this round table a success and generated many conceptual, policy, and practical opportunities and prospects. It is the hope of the organizers that the August discussion and exchange were only a beginning and that many more will follow.

Agnès Callamard, Humanitarian Accountability Project & André Griekspoor, World Health Organization.
I - PRELIMINARY FINDINGS

There are four main sources that can assist in good practice, in addressing ethical dilemma: (i) the tradition of medical ethics; (ii) the tradition of public health ethics; (iii) ethics & resource allocation; (iv) human rights.

When looking across history and cultures, there are some universal traditions, ‘principles or presumptions’ that could be used to guide the thinking process to address dilemmas and/or hard choices. These principles can be used in a transparent, structured dialogue between the relevant stakeholders to come to a consensus on what could best be done given the circumstances. They are:

1. The primacy of the patient / Self-determination of the patient
2. Confidentiality
3. Non Discrimination
4. Informed consent
5. Standards of care
6. Do no harm
7. Risk and benefit ratio
8. Resource allocation and distributive justice

In addition, there are three obligations that fall upon the medical practitioners, its employers, and the medical sector as a whole. History has shown that good intentions from well-educated people are not always enough to warrant the trust that they will do the right things. The Nuremberg tribunals showed that high-minded people can do very wrong things.

1. The professional obligation of the individual medical practitioners to maintain knowledge, to train and teach, and to tell the truth.
2. The obligations of the organization: There are strong obligations to maintain an adequate monitoring system for the character and the knowledge of the people being recruited. Recruitment, assessment of who this person is, on-going monitoring and periodic peer review. Checking what is on a CV, a person’s credentials, should be mandatory.
3. The obligation of self-regulation. Central to medical care is the trust that patients have in doctors. This trust is essential but comes with high levels of responsibility for doctors. Systems of self-regulation are the public acceptance of these responsibilities and can be seen as a privilege. Peer review constitutes a particularly important mechanism of quality.
II - OVERVIEW OF PRESENTATIONS

DAN WIKLER: MEDICAL ETHICS

There is no general code based on medical ethics that can be applied universally. Codes are context specific and even within one context they will develop and change over time. Nevertheless, when looking across history and cultures, there are some universal traditions:

First, the primacy of the patient’s interest. This reflects the doctor’s dedication to make decisions that are best for the patient, above the doctor’s own interests.

Second, the concept of medical neutrality. Based on this, doctors see their patients as persons with medical needs, regardless of their origin, social status, ethnicity, merit, etc.

Thirdly, the notion of self-regulation. As medical care has become highly specialized, only doctors can make informed judgments on the basis of good practice norms. Central to medical care is therefore the trust that patients have in doctors. This trust is essential but comes with high levels of responsibility for doctors. Systems of self-regulation are the public acceptance of these responsibilities. History has shown that good intentions from well-educated people are not always enough to warrant the trust that they will do the right things. The Nuremberg tribunals demonstrated that high-minded people can do very wrong things. This led to the necessary codifications, laws, and processes of peer review.

JENNIFER LEANING: MEDICAL ETHICS AND HUMAN RIGHTS

The discussion on human rights and medical ethics is young but is rapidly being recognised as important.

Professionalism and ethics in field practice require that dilemmas are anticipated and possible options defined beforehand. Rather than being problem-solvers on the spot, health workers need to be trained to define problems by categories, to recognise patterns. If not they can take very wrong decisions. We have to insist on very strong systems of inquiry, reflection, telling the truth and training. Good physicians teach and train others: at leadership level, the responsibility is to train and teach your staff, and in their turn they have the responsibility to teach and train the people they work with at the field level.

We have to insist on the virtue of the position of the health worker. Through personal integrity one sets standards of behaviour. We have to be careful how we use the power given to us. At leadership level, this leads to the question of how field staff is supported and monitored.

Within the Human Rights tradition there are three main concepts: dignity, equity and state system. Dignity is the recognition of the other, looking into the meaning and power of the other. Everybody is equally important to themselves, so they have to be equally important to you. Dignity is not that strong in medical ethics and equity is difficult to operationalise.

International Humanitarian Law emphasises the imperative of civilian protection from the impact of war. The role for humanitarian workers is to do everything to protect civilians: you are not only medical staff, you are part of the humanitarian mission to support civilian assets. Furthermore, the importance of medical neutrality is emphasised. This for example leads to
refusing arms in medical convoys. Lastly, the imperative to protect what it is to be human: people their history, their ecology, and their culture.

**RICHARD CASH: STANDARDS OF CARE**

There is one particular issue that has been raised and that you deal with all the time: standards of care. *What standards of care do we use in humanitarian situations?*

Do we use the best there is?
Do we use the standards of the country in which care is provided?
Do we use standards that are locally available?
Or do we use the most effective, attainable and sustainable level of care?
Is it ethical to begin a treatment to treat long-term conditions if the therapy and the drugs are not available after the humanitarian intervention comes to an end?
Should only those therapies be used that are expected to be available after the humanitarian agencies have left?
How long should such intervention last?
What happens when a humanitarian NGO sets up a clinic in an area serving both refugee and host population as there was no available health care for either?
Is there an ethical and moral imperative to keep it going beyond the life of the camp and if not, what provisions need to be made?

Different people may come up with very different conclusions and much of these questions are particularly relevant to those who come from outside the affected country.

Most of the people around this table represent the West, bringing external interventions in humanitarian crises. However, a substantial contribution to humanitarian assistance comes from the country’s own national organisations. A good example of this was the earthquake in Gujarat. This type of aid will be sustainable and attainable because it is linked to the capacity of national organizations. These however are not represented around the table here and they would have different questions and different answers to the issue of standards of care.

**LUCY BLOK, MSF HOLLAND**

A relation between a humanitarian worker and a victim is quite similar to the relation between doctors and patients, with similar power relationship. Medical ethics provide therefore great value to humanitarian work.

MSF decided to withdraw from Korea because although some people benefited from humanitarian aid, agencies were unable to reach those who were in most need. By staying, one would have legitimised this policy. In Sudan, the under fives were most in need, but the elders preferred that humanitarian aid focus their efforts on 15 year old boys as these were responsible to tend the cattle, that is the community’s livelihood.

There are cultural and moral differences among people. The dilemma is how to value groups of people, how to choose? What is justice? What do you do? Above all, it first has to be made clear what the dilemmas are and for whom.
**High standards:** It is better to reach for the most attainable standard and later on face the difficulties or dilemmas of implementation and maintenance, rather than to lower standards from the start.

**Right of autonomy, principles of beneficence, non-maleficence and justice:** they constitute a very useful framework. They give you a way of understanding dilemma and negotiating approaches and help to define best practice given the specific circumstances They cannot be used, however, to set a general standards.

**Distributive justice:** what is just? A utilitarian approach is probably best when needs are overwhelming. That is to save the most people that can survive. But then when feasible, we should adopt aN egalitarian approach. That is the obligation to assist people who are left out.

**Principle of non-maleficence:** It may have paralysed humanitarian health workers. We should allow humanitarian health workers to do new things on the basis of ethically-sound judgment.

**Sustainability** issue: there is obligation to assist people even if sustainability is not ensured.

### KATE BURNS – UNHCR

To what degree are medical ethics applied in the South?

Goals to reduce mortality and morbidity have been set and certain principles have followed from these such as: local host as a benchmark, host country protocols and drugs, primary health care as benchmark.

The UNHCR is trying to finalize a code of conduct. Previously, there were no rules or regulations.

What are the responsibilities of the donors to hold their partners accountable?

How do you apply the principles to all health humanitarian workers?

What do you do with those that do not follow the code of conduct or the principles?

**Standards of care: Who provides health care and to whom?**

- Direct clinical care is provided by non-Western
- International staff: management.
- To whom: I know of no places where we are forbidden to provide care to local populations.
- Professional Competency: If you don’t have competent people in the field, they should leave the field.
- Unfortunately, there is insufficient monitoring of competency.
- There are too many humanitarian workers that do not believe that we are here to serve.

**Confidentiality:**

- There is insufficient understanding of this subject
- The issue of “shared confidentiality”, ex in HIV/AIDS
- Confidentiality is very important to establish clinical guidelines for survivors of rape: the UNHCR has included an Informed Consent Form in its most recent guidelines on how to treat victims of sexual violence.
Medical ethics:
- We do not monitor enough;
- Peer review is insufficient;
- There is still a long way to go before we get to setting up a “consumer group”. We just started a Beneficiary Perception Survey.

Recommendations:
- We have a responsibility to take these principles to our team and share and train. This responsibility could be included in contractual agreements: MSF with local doctors to build a formal mechanism to ensure compliance.
- Guidelines, procedures, and standards should be developed at a micro and macro level.

NAN BUZARD, SPHERE

Sphere is not necessarily focused on medical ethics but very much on humanitarian law, human rights law and NGO/Red Cross/Red Crescent code of conduct. We attempt to operationalize ethics and principles of humanitarian work.

The right to life with dignity is the number one human right. Sphere has tried to operationalize, quantify and qualify very general/vague human rights principles such as the right to health, or the right to sufficient water.

There is an increased engagement on behalf of NGOs, UN agencies and governments. States should take the responsibility to provide for people who are affected by disasters. They should look to put the guiding principles on IDPs and some of the Sphere minimum standards into their own national legislations and to hold themselves accountable. Many governments are interested in this debate and there is beginning to be an entry point into realizing these principles of accountability.

The importance of training and preparation: we have created a training program which is also available in about eight languages.

There are two important modules to talk about:
1) The module on the humanitarian charter, which tries to introduce to humanitarian workers, the concepts of IHL, human rights law and participation. It also tries to explore what individuals and organizations should do with hard choices or dilemmas. Those of us involved with Sphere will agree that there is value to be found in historical experience, identifying the organization’s mission and mandate, and identifying your own ethics before you are faced with a hard choice or dilemma. Being better informed about the legal instruments and about principles really can make a difference in terms of how we do our actions.
2) The module on context, that focuses on how you think about universal standards and whether they are relevant when there are so many different kinds of operational environments. It is critical to explore the proper role of assessment and indicators can be very useful in thinking about a problem and the context of the problem.

We need to promote an environment for humanitarian aid workers where asking questions and demanding results are ok. Obligation of means vs. Obligation of results. It is important to extrapolate and demand results.
Without indicators, we cannot measure human rights. Sphere provides us with a baseline for a debate about what we should be doing and how we look at the impact of what we are doing.

**KATE GILMORE, AMNESTY INTERNATIONAL**

Amnesty International looks at medical ethics through a human rights lens. Dignity is the end game of human rights. But Human Rights is an unfinished project.

**Assumptions:** moral dispositions, ethics and human rights. These spaces are permeable and affect each other. From a human rights perspective, it is important to understand the connectedness of moral dispositions, ethics and human rights. Human rights principles without the general intention of having moral dispositions are worthless. Human rights is taking different directions.

**Obligations:** Human Rights are not a supermarket; you cannot just select elements that are comfortable or pragmatic for the moment. There are large issues settled within the human rights paradigm.

**The therapeutic event:** It is shaped by ethics and moral dispositions, and human resources. It is anchored unequivocally and irretrievably in human rights. There is no health project that does not invoke human rights. Human rights constructs the therapeutic event: in order to truly be a therapeutic event, it must be without discrimination; its application must be from a place of impartiality and neutrality and has to invoke questions of consent, and be applied with diligence and scrutiny.

**Health intervention:** It includes

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**The recipient:** treat the mind and the body as indivisible so that you do not destroy the human spirit through bodily harm. The body is a textualized, not just contextualized space; it is a space that is individualized and codified.

**The self** (which is composed of mind and body) is contextualized, clamorous, willful, active, and its agency is very important for the end game of human dignity.

**The provider:** we have to take into account that the providers also have human rights (to practice with fear or intimidation), and they have obligations and duties in terms of how they approach the body of the other.

**The organization:** has stewardship for the therapeutic event, it has accountability in the act, responsibilities, obligation, duties.

Human rights standards are always present and have universal applications. The practical implications of this analysis from the human rights perspective is that there is not act or decision
that can be placed beyond the reach of human rights, international law, responsibility or accountability. The reach of human rights is essential and inefficient.

**Due Diligence** is the principle of progressive realization: monitoring the current situation and comparing it to that of another time period; human rights invites us to attain/practice the highest standards of health.

We need to establish policies and action plans that will lead to available and accessible health care for all in the shortest possible time.

**Conclusion:** we need to find a framework that brings these principles together, and within that framework, try to provide practice standards at the individual practitioner level, the organizational level, and at the sector level. They must be coherent enough that we know about human dignity and are open to assessment. **It is only through scrutiny that human rights become the verb of action, and not just the noun of aspiration.**

We are in a place in which much of the implications are un-chartered. Twenty years ago, for the Covenant on civil and political rights and the Convention against Torture, we would have sat in a room with police officers, prison guards, police constables, and attorneys telling us that our goals are far too inspirational and completely unrealistic. Yet, what happened to that sector? It built in a response to distance in praxis terms between principle and practice, a response on behalf of the service providers (police, prison guards, lawyers), a response that involves advocacy and political activism to change the state. I would put to you that was has been missing is that unlike prison guards, police and lawyers, health professionals have not been good activists. I know I am being provocative, but it is the only possible way in which you will walk away from this toppling position in which we seem to find ourselves putting up, as if in context, principle against practice implications. We have not sought to explore the interface with the body, the self, the clamorous self and its implications for the provider, the organization and the state. It is undone work that needs doing.

**WORKING GROUP ONE: STANDARDS OF CARE**

**Key questions**

The working group considered how to determine the most appropriate standard of care. When dealing with long-term expensive continuous treatments like HIV/AIDS, should we implement them even if uncertain about the ability to continue the treatment? We should not use antiretroviral treatments in resource poor settings if you cannot maintain them.

Issue of expired drugs: should we use them for populations in great need? Is treatment using (just) expired drugs better than no treatment at all? No, expired drugs should not be used.

In Kosovo, 50 USD were made available per person; in Sierra Leone only 2USD per person. Should aid workers not also have 50 USD per person in Sierra Leone?

It is helpful to have **absolute** standards to be used in all countries, like those in the Sphere handbook, to address excess morbidity. But the interpretation of what is in excess is relevant to what is **normal** in that context. The group did not reach consensus on sustainability, whether to focus on the here and now or always to take into account the future. Dialogue was emphasised as
the mechanism to find the most optimal answer in that situation. But how, whom to invite to the
dialogue. And how to avoid delay necessary action.

**TB treatment: Should we treat TB?**

- Often the answer is no, because of the technical arguments (could create harm, resistance and no
  sustainability: Treatments take at least 6 months to carry through completely.
  But the fear not to do harm, may have prevented to do good - Even treatment that lasts 3 months
  is a benefit for that individual and in highly concentrated populations this also reduces transmission.

- Different organisations will take different positions. For instance, WHO focuses on TB control.
  There is a doctrine that says that you should only treat if you can control TB
- What is the value of treating one person? Is a public health approach to benefit the population
  better than one that treats individuals? Is treating certain groups and not giving others the benefit
  of treatments, discriminatory?

- People working in this field are so fearful of doing harm by using TB treatments, that they are
  paralyzed from moving in that direction; they would rather be passive than take the risk of doing
  harm. (Hesitancy of doing harm)

It was suggested to take TB treatment in emergency situations as a case study to debate the
ethical implications and how these could assist to reach the best solution.

**WORKING GROUP TWO: INDIVIDUALS VS. POPULATIONS INTERESTS**

Rapid medical ethics and health human rights assessment:

1. What is the nature of the local health worker/patient relationship? Research
   local ethical guidelines: investigate references in countries
2. Religion
3. How do you assess how local people and providers value life, pain, dignity,
   equity, consent, confidentiality, consent?
4. Discrimination
5. How does the state relate to persons? What is the nature of state authorities
   with respect to the humanitarian/health workers?

Integrate human rights and IHL within the framework of rapid assessment (adapt programs to
protect needs; requires training and tools).

MdM Protection Offices: Their mandate include:

(i) Advise program Heads of Mission and coordination;
(ii) Do advocacy work
(iii) Training local staff
(iv) Conduct research to ensure our patients have equal access to our services,
    to ensure we don’t engage in malpractice or discrimination

**WORKING GROUP THREE: RESOURCE ALLOCATION**

*Dilemma:* There are 100 patients. 50 need 1 pill to survive, and 50 need 2 pills to survive. What
would you do if you only have 50 pills?
Be most cost effective? give all pills to those who need only one: you save 50 lives
Give every one an equal chance at survival? Distribute at random and give each selected patient
the amount of pills to survive: yo save 32-34 people
Let the people decide? however, what if they fight among themselves?

What criteria would contribute to the final decision?
1. Cost effectiveness- allocate so that the maximum benefit be achieved
2. Based on need-reach the most vulnerable
3. Based on consultation with target groups (provided meaningful participating mechanisms are there)
4. The capacity of the agency or the organization- do they have the expertise, the human resources, equipment, time etc
5. the mandate, charter of the organisation
6. Pre-decided criteria, guidelines and lessons learned
7. Ad hoc, guts feeling done on the ground, do what you can

Extrapolating from this dilemma:
- Should we provide humanitarian assistance if we cannot monitor or evaluate it?
- Sustainability: do you give treatment if you know that you cannot sustain it? (not sustainability of humanitarian action, but sustainability that builds capacity of local structures to sustain themselves)
- Cost effectiveness: Humanitarian aid is not necessarily cost effective, there is also value in showing that you care.
- Sometimes the donors already have an idea of how they want their money to be used. However, if you chose the most cost-effective solution, you might get more donations in the future
- Constraints in resources are not only a matter of goods, but also a matter of time and coverage
- If you try to salvage patients in the direst situations with the highest needs, knowing that you will not be able to have sufficient coverage, you are not necessarily doing the most good. It might be better to try to salvage those with lesser needs but with better chances of survival. Triage as a way to maximise the use of limited resources.
- Selection or choices based on community priorities may be taken into account. However, humanitarian workers must have their priorities and senior officers with the most experience must make decisions.
- Perhaps families are in a better position to make decisions because they are more familiar with the circumstances and they have to survive as a unit. Problem with letting families decide: they might not give an objective point of view. Perhaps there are cultural, ethnical factors that contribute to discrimination within the families. Humanitarian workers are there to stop this type of discrimination, to bear witness and offer solutions; therefore, giving families this big responsibility is not always constructive.
- However, you must involve the community in some way—the problem is that many humanitarian officers want to “play God”
PRELIMINARY CONCLUSION – JENNIFER LEANING, RICHARD CASH, DAN WIKLER

There are 9 ‘principles or presumptions’ that could be used to guide the thinking process to address good practice, dilemmas and/or hard choices. These cannot give absolute right answers, as different stakeholders might come to different conclusions on an individual basis at different times.

These principles should be used in a transparent, structured dialogue between the relevant stakeholders to come to a consensus on what could best be done given the circumstances.

They can also assist agencies in explaining why and how they have arrived at a certain conclusion and difficult choice. We need to learn to think in advance to avoid moral regret: if I had known at the time…

The principles are:

1) The primacy of the patient: 1. the patient in front of you: putting the patient as a priority, before your own interests is very important; there is a responsibility of the health care professional not to exploit the vulnerability of the patient. 2. To populations: fairness of distribution, respect for the dignity and rights of the individuals, everyone matters.

2) Self-determination: the link between dignity and self-determination is close; For individuals: the ability to make your own rational decisions. For populations this is different: Quarantine, isolation of TB patients, immunisation, chlorinated water. Then choices made by elected authorities, or by humanitarian agencies.

3) Confidentiality. With present ease of dissemination of information and loss of control over information, this puts high responsibility to the professional care taker. There are exceptions, when someone is contagious, or child abuse. Risk of stigmatisation.

4) Informed consent: The value of informed consent from individuals and communities—self-determination is not possible without this. Sign of respect that recognizes the dignity of individuals and communities. Informed consent involves telling people the procedures, the benefits, risks and explaining that they have a right to decline and to request an alternative. This process is more complicated for populations (getting consent of the pop); in research solutions are found through polls, focus groups, or consultation of community leaders. You must, however, recognize when consent is possible and when it matters, and when it can be waived (ex- in crisis situations when you need to act fast).

5) Standards of care: The most appropriate level of care must be determined. You should move away from the best in the world towards what is most reasonable in that particular local society. Whatever standard we use, we must use resources to the fullest extent. Also, effectiveness and sustainability needs to be considered.

6) Do no harm: It does not mean never take a risk. It means do not do avoidable harm. Do not engage when the risk to do harm is too high.
7) **Risk and benefit analysis**: consideration of the ratio between risk and benefit in each situation. The patient has to define this for you, informed consent. Perceptions of risks and benefits are different in different cultures, and individuals may have differing attitudes.

8) **Resource allocation and distributive justice**: factors on which to base resource allocation include: (i) Needs, (ii) Vulnerability, (iii) Urgency, (iv) Priority to the worst off. Cost-effectiveness only may result in unacceptable or unjust choices.

9) **Professional responsibilities**: Maintaining knowledge, character, evidence of competence, habit of learning, discipline to remain competent. The ethical obligation to teach and train: in order to teach, you must have confidence, a habit of learning, the discipline to become and remain competent. There is an obligation to transmit knowledge. The obligation is to be virtuous, honest because health care is achieved through the transmission of information. The need to engage in data gathering, to do research. It is better to say “I don’t know” than to lie or make up answers.

**Individual obligations**:
- Obligation of the professional to behave in a certain kind of way and to be a certain kind of person.
- Obligation of a provider or a health care worker of maintaining knowledge: one has to provide evidence of competence. You have gone through a training program and you can prove it, you have a habit of learning, you keep learning, you are disciplined, you are competent.
- Obligation to transmit knowledge; a physician is an educator, not just to the patient, but with his peers and junior doctors.
- Obligation to be a good person, to be virtuous and the most fundamental aspect of this is to tell the truth. That does not mean you always tell the whole truth to patients, you try to learn to accommodate. Telling the truth is not a simple kind of checklist. Vis-à-vis peers however truth telling is important: you say everything that you know in the most clear, accurate and specific way you can. Healthcare is accomplished through the transmission of information. If you lie, you commit a grave error in terms of medical ethics. The one who lies is very dangerous.

**Organisational obligations**:
- Sexual relations with minors and with patients, or as aid provider with recipient population, is totally unacceptable.
- There are strong obligations to maintain an adequate monitoring system for the character and the knowledge of the people you have. Recruitment, assessment of who this person is, on-going monitoring and periodic peer review. Not checking credentials at recruitment, what is on a CV, is a grave error.
- It is important for a humanitarian organisation to establish the capacity for peer review.
- Not every one is a researcher and not every organisation has that capacity. Periodically you should be interested in asking to your health care workers “what are the critical key dilemmas or questions that you face?” That is part of learning and enquiring organisation, a good professional organisation encourage to have their eyes open to problems and questions.
- Next step is sharing of information and coordination. There is the need to engage together in data gathering planning, evaluation and probably research. Pay attention to the research ethics issues and try to figure out the answers. You will sometimes do it collectively or individually but you must share the results.
Peer Review:
- One of the things a peer review committee could consider is a situation where there is an allegation of a physician operating outside the standards of care, or of a violation of understood principles. The most egregious is the commission of harm, when it turns out that the physician was either ignorant or negligent. This peer review committee is an extremely important one.

Relations with the state:
- We would like to identify the very challenging relationship that professionals in health have with the State. When you have an ineffective State authority, there is a space in which you as professionals and as a group have a great deal of power and autonomy. Where the state does not function or does not interfere, you become that authority and with that comes an obligation for a form of self-regulation. Professionals should not act as the arm of the state, but retain a certain degree of independence. There is an independent responsibility to consider what is proper medical and public health practice.
- There are many situations that happen across the world, in the context of torture, where the State is in charge, the State says “do something”; the doctor has to decide whether or not he/she is going to, and his/her association must be positioned to protect him/her if that person is making the ethical decision.

III - DISCUSSION – SAMPLE OF ISSUES RAISED

Ethics and Politics:
How to deal with a group of people politically affiliated, as in Goma?
How to handle the fact that we have political famines, when political motives created situations of decreased food security? Should agencies turn a blind eye to the politics of famine?

Code of Conduct:
Scepticism about establishing a code of conduct based on ethics. In Korea agencies signed on to a code of conduct but they could not assess needs in many parts of the country. Is it then unethical to remain? What are the responsibilities of the humanitarian organizations in these situations? The question is why should we establish a code of conduct and for what? We have codes of conduct, but they are not being respected. Codes of conduct may be mainly useful as a reflection tool.

There is a need for more consequence based thinking, rather than codes. Medical ethics need to be contextualised and used case-by-case to identify a set of rules to deal with a specific dilemma. The process is what is important.

Neutrality and Impartiality:
The concept of medical neutrality is confusing and neutrality itself is a debatable principle. Neutrality comes from establishing a zone of protection for civilians from war related activities. Impartiality is a more practical concept and closer to what we do.

Confidentiality:
Example of confidentiality as applied to a group of people. In India, a village elder complained about a survey on HIV/AIDS that was distributed in his community. His complaint was that none of the girls in his village would be able to get married because his community would be tagged as one in which everyone has AIDS. The survey did not respect the confidentiality of the community.

**Transparency**

Transparency may not be the order of the day, but it should be. Each organization must be clear and confident and explain its goals, values and principles. Transparency is extremely important: if you are vague, it makes it difficult to assess the process and whether outcomes/goals have been reached. With transparency, the process of evaluation and assessment will become increasingly easier.

To get transparency, you need to remove stigma: don’t beat up on each other. Be explicit! Remove the stigmata to make transparency easier. Humanitarian organizations have a big part in providing information. We must stop penalizing people who give reports. Example, India lost 2 billion USD when it published its cholera report

**Bad practice:**

What exists in your sector to deal with those that trespass beyond what is considered to be good practice? Is it only the popular press that is the gatekeeper to monitor accountability and confidentiality? Is it civil society that will bring these issues to the floor? Do we have to rely on the local media to show what is happening and take measures to stop the situation?

The media is the gatekeeper. People don’t like speaking out within the aid community! It is a club! If you try to step out of the club and start to challenge the ideas, say that a certain organization acted in a way that is not considered to be in line with the code of conduct, you are alienated. There is no self-regulation.

Could there be some opened forum of discussion? Aid organizations are not open enough to have their own views challenged. Too many aid organizations are too dependent on donor funding. They are not independent enough to be able to separate what they actually think is the best course of action from the actual course of action. Unless you have independence as a prerequisite to being able to act in a way that you would like to act, you are protecting interests; most aid organizations are protecting their own interests. Institutional preservation comes before what we should be trying to achieve.

How do you ensure accountability? What do you do with those who do not follow those codes? Are there ways of disciplining those individuals/groups who do not follow the codes, for example, losing their funding, etc? Is there such a thing or should there be such a thing in your community?

Many times, aid organizations simply do not have the capacity (physical and human resource capacity, money) to do proper monitoring. Monitors don’t have proper experience. Some countries have put forth some licensing programs in which people have to get licenses and be approved before carrying out monitoring activities. For behavioral issues, the watchdog groups, the amnesties, the human rights watches, which lead to media coverage, will probably be the only way to keep us “clean”
Self-regulation:

Self-regulation is not only an obligation, but also one of the privileges of being a doctor.

Transparency may not be the order of the day, but it should be. To get transparency, you need to remove stigma: don’t beat up on each other. Be explicit!

There are no ways of ensuring accountability at the present moment. However, the next phase in the reasoning is, can we agree on principles? Yes, we can agree on some fundamental principles like the fact that the justification for humanitarian work is to alleviate human suffering. We just have to adapt rules and regulations to specific situations.

Self-regulation is already occurring, but there is room for improvement. Agencies should be encouraged to monitor their own organizations from an accountability standpoint. The weakest link is in collective responsibility; this may take a much longer time/ it is the highest challenge facing the sector right now. The system is changing, the communities we are working with are becoming more and more sophisticated. There are other actors that are coming up and which are much more inclined to be punitive. It is important that the sector thinks about how it is going to regulate, before others start to impose principles.

Self-regulation is going to be a big challenge because it presupposes some common framework (the same understanding and purpose in the field) among agencies. Some organizations focus on the acts themselves, while others try to take into account the context and the impact of their aid. Self-regulation is a process rather than an outcome.

Peer review:

In medical practice there are forms of retrospective peer reviews. These are not punitive but inquiring. The process is supportive and constructive, and only works if there is a clear understanding of this and high levels of confidentiality. Of interest is that these clinical reviews take place between senior as well as junior staff so they learn from it.

Community of Peers: this is not too idealistic to think about. There might be ways in which this could happen.

Training and practice:

Most of the time the western staff is well educated, trained, and highly motivated. But in the camps they might not be able to apply what they have learnt. Often you cannot work the way you were trained to.

Organisational responsibilities:

It is important to judge what is the purpose of the organization. It has to be very explicit; decision has to be very explicit. Individual ethics flow from organizational ethics; training

Donors’ role:

Donors can bear responsibilities. For instance, some donors now insist that the six principles of the Inter Agency Standing Committee’s code of conduct are included in the funding contracts.
Human Rights:

The body is the textural statement of who the being is; human rights looks at the state fairly warily and yet relies on the existence of a certain kind of institutional capacity to be able to establish the guidelines and to support people who are adhering to the guidelines. Medical ethics and human rights are similar in medical practice; they both rely on an institutional system of rules, regulations, peer review and continued medical education. These aspects hold humanitarian workers together.

Human rights has a short history: 50 years (it is a post-World War II history), while humanitarian action has been around for 150 years (that is, 150 years of conscious humanitarian action, outside of the religious institutions). The emphasis on reflection and scrutiny that Kate Gilmore was emphasizing is a very important one.

The principles we could agree and adhere to are those from Human Rights and International Humanitarian Law. However, they are inadequate for monitoring and they are considered to be too ‘blunt’ as instrument. In the real dilemmas in the field, one needs to think beyond human rights.

It is important to know what types of standards to apply: you can provide a good amount to a few and much less to everybody; you have to decide which of the two options to undertake. Can human rights concepts help make these kinds of decisions? I’m not sure that human rights gives states a good idea of what they owe their citizens. The debate over what the right to health care consists of. The idea of progressive realization can be misleading because you can go back twenty times to a country and see that there are improvements, but just because they are better off today doesn’t mean that there has been a significant positive change. How do you know if you are in compliance with their right to health, if you go and provide them with resources? The notion of the right to health doesn’t give you enough of an analytical power to make trade offs with cost and to set any baselines for knowing whether or not you are providing such a level of service that people’s right to health is being violated.

In the third world, which represents about four-fifths of the world, health is so central to everything that you are very privileged if you say that there are things that can be of a better value than health. Governments don’t always violate human rights, but they often just forget and ignore them. People in the West are in a society that allows them to dismiss health because most of their basic social and economic rights have been realized. A lot of the discussion in the West is more about the realization, violation and neglect of political rights. Today, there is increasing public awareness about rights. Fortunately, we are thrown into the humanitarian world at a time where the human rights discourse is growing, so we have grown up with it. The monitoring mechanisms and the knowledge of the fact that they exist allow there to be progressive realization. The history of human rights is actually a bit older than WWII because the Convention of the Rights of the Child was written by an NGO in 1919 after WWI, and that was the first recognized human rights instruments.

Human rights law takes what we do, humanitarian action, from the arena of charity to the arena of human dignity: there has been a paradigm shift (from top down programs that give food, to participation programs that get the target groups involved). It is not what we can spend, but what the target groups deserve. That is the single most distinguishing factor from medical ethics and human rights. As doctors, we serve people, but we do it out of a spirit of charity, while
humanitarian aid is treated as something that is deserved/inherent. That is a very good basis for a group like this, or any other group, to take it further.