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### Human Rights and Health - The Universal Declaration of Human Rights at 50

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*Editorials***SHOULD INTRACRANIAL ANEURYSMS BE TREATED BEFORE THEY RUPTURE?**

**M**ODERN diagnostic techniques allow the detection of many potentially dangerous conditions before patients get sick, often before symptoms occur. The ability to detect four such conditions — asymptomatic carotid-artery stenosis,<sup>1</sup> atrial fibrillation without brain embolism,<sup>2</sup> vascular malformations in the brain,<sup>3,4</sup> and cerebral aneurysms<sup>5-7</sup> — has led to controversy about preventive treatment. All four are serious disorders that can cause disabling or fatal brain infarction or hemorrhage. Treatment of these conditions — surgery in patients with carotid artery disease, aneurysms, or vascular malformations and anticoagulant therapy in elderly persons with atrial fibrillation — carries considerable risks as well as potential benefits. Physicians are schooled in the tradition of *primum non nocere*, and many physicians as well as patients endorse the adage, “If it ain’t broke, don’t fix it,” and note that you cannot make an asymptomatic person feel better. Other doctors, however, want to repair any lesion that exists. The issues raised are broad, and they hinge on the question: How do doctors decide to treat individual patients?

Choosing surgery for patients with an unruptured intracranial aneurysm involves weighing the risk of intracranial hemorrhage against the risks associated with brain surgery. In this issue of the *Journal*, the findings of the International Study of Unruptured Intracranial Aneurysms are reported.<sup>7</sup> The investigators retrospectively analyzed the frequency of rupture among 1449 patients with unruptured intracranial aneurysms, some of which were discovered during the treatment of subarachnoid hemorrhage caused by the rupture of other aneurysms.

Size, location, and previous subarachnoid hemorrhage were the most important features that predicted aneurysmal rupture. As in other circumstances, biologic characteristics proved to be very important. Patients with previously ruptured aneurysms had 11 times the rate of rupture of patients without prior hemorrhage. The size of the aneurysm was prognostically important. Aneurysms that were less than 10 mm in diameter had a very low rate of rupture. Location was also important. Aneurysms at the junction of the internal carotid and posterior communicating arteries and aneurysms within the vertebrobasilar system, especially those at the rostral basilar-artery bifurcation, had a higher rate of rupture than other aneurysms.

The study also analyzed surgery-related morbidity and mortality among 1172 patients with newly diagnosed, unruptured intracranial aneurysms. The outcome of surgery depended heavily on age. The combined rate of surgery-related morbidity and mortality at one year for patients without prior subarachnoid hemorrhage was 6.5 percent for those younger than 45 years, 14.4 percent for those between 45 and 64 years, and 32 percent for those over 64. The authors concluded that the risks of surgery outweighed the benefits in patients without previous subarachnoid bleeding who had aneurysms that were less than 10 mm in diameter.

Previous studies performed at the Mayo Clinic also emphasized size as the main prognostic feature. In a study of 65 patients with 81 unruptured aneurysms, reported in 1981, none of the 44 aneurysms that were 10 mm in diameter or less ruptured, as compared with 8 of 29 aneurysms that were larger than 10 mm.<sup>8</sup> In a study of 130 patients with 161 unruptured aneurysms, reported in 1987, saccular aneurysms that were less than 10 mm in diameter had a very low rate of rupture; the mean diameter of the ruptured aneurysms was 21.3 mm.<sup>9</sup> The mean diameter of ruptured aneurysms at the Mayo Clinic during this period was 7.5 mm.<sup>9</sup> Other large studies have shown that small aneurysms may cause subarachnoid hemorrhage, however. In the Co-operative Study of Intracranial Aneurysms and Subarachnoid Hemorrhage, which involved 6038 ruptured aneurysms, the critical size for rupture was between 7 and 10 mm.<sup>10</sup> In another study, involving 650 patients with aneurysmal rupture, the average size of ruptured aneurysms was 8 mm.<sup>11</sup>

Intracranial aneurysms cause symptoms other than clinically recognized subarachnoid hemorrhage. Episodes of minor bleeding, often referred to as sentinel hemorrhages or “warning leaks,” occur often and are frequently undetected.<sup>12</sup> Some aneurysms produce pressure on cranial nerves and brain structures, causing headache and neurologic symptoms and signs. Aneurysms can harbor thrombi that embolize distally, causing episodes of brain ischemia.<sup>13,14</sup> The frequency of symptoms other than recognized rupture was 21 percent in the present series.<sup>7</sup>

There are many characteristics that prudent physicians must weigh in each individual case. The size and location of the aneurysm and the presence or absence of a history of ruptured aneurysms are important. The patient’s symptoms should also be considered. Major compressive symptoms should lead to the consideration of surgery. Coexisting medical problems are common in patients with aneurysms. Hypertension increases the risk of bleeding. Poorly controlled hypertension, especially in patients known to be non-compliant with treatment, is therefore a factor that favors surgery. Severe cardiac, pulmonary, or renal disease or cancer weighs against prophylactic surgery.

Factors related to surgery are also critical. The location of some aneurysms makes surgery particularly difficult and hazardous. The morphologic features of the aneurysm — for example, whether it has a neck that can be clipped — also influence the outcome of surgery. And of course, some surgeons have better results with respect to morbidity and mortality than others.

There are also many patient-related factors. Age is very important. Surgery seems more reasonable in young patients, who face many years at risk, than in older patients. The patient's feelings, experiences, biases, and personal preferences are also important. Many patients will not accept the immediate risk of death or disability associated with surgery to prevent the possibility of rupture at some time in the future. On the other hand, some patients are so frightened by knowing that they have an aneurysm (“a time bomb ticking in my head”) that they cannot function until it is repaired.

How do physicians make such difficult therapeutic decisions? Evidence-based medicine emphasizes the importance of relying on data from randomized therapeutic trials. But many conditions are not suitable for a randomized trial, which requires that the condition be common, with clear end points that occur within a relatively short period. There have been no such trials of patients with unruptured aneurysms. Even when information from trials is available, it may not be useful in individual cases. To acquire samples large enough to yield statistically significant results, investigators often combine various subgroups of patients. The results are generally valid but not necessarily easily applied to particular patients. Patients who are old or frail, those with coexisting conditions, and women of childbearing age are frequently excluded. (Almost three quarters of the patients with unruptured aneurysms in the current study were women.<sup>7</sup>) But the excluded patients are often representative of those who turn up in doctors' offices. In addition, patients in trials often receive treatment in academic hospitals, and the surgeons chosen to participate in the trials have records of very low mortality and morbidity rates. Patients in trials receive specialized attention. The same may not be true in the community, where many patients are treated.

A decision whether to treat an unruptured intracranial aneurysm surgically, like many other difficult therapeutic decisions, requires the wisdom of Solomon. Physicians should review all the relevant data from trials and natural-history studies. They must also get to know their patients and their particular conditions, coexisting disorders, and desires. Some patients welcome statistical data and choose therapies logically on the basis of such data. Others eschew “science” and rely on alternative therapies. Decisions take time, patience, experience, and repeated visits with patients. But these key ingredients are not valued highly in our money-driven system of medical

care. Yes, the size of unruptured aneurysms matters a great deal, but so do a lot of other things.

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## RhD HEMOLYTIC DISEASE OF THE NEWBORN

**H**EMOLYTIC disease of the fetus and newborn was first described in 1609 in a set of twins by a French midwife: the first twin was hydropic and stillborn, and the second was deeply jaundiced and subsequently died of what we now call kernicterus. The two conditions were not associated again until 1932, when Diamond et al. demonstrated that hydrops and kernicterus were two aspects of the same disease in which hemolysis of the red cells of fetuses and neonates resulted in extramedullary erythropoiesis, causing hepatosplenomegaly and an outpouring of erythroblasts into the circulation, a condition they termed erythroblastosis fetalis.<sup>1</sup> Kernicterus was subsequently shown to be due to the deposition of unconjugated bilirubin in the brain. It is usually fatal; the 10 percent of affected infants who survive have spastic choreoathetosis, deafness, and mental retardation.

The identification of the cause of the hemolysis had to await the discovery of the Rh system in 1940 and the determination soon thereafter that hemolytic disease of the fetus occurred in an RhD-positive fetus carried by an RhD-negative woman who had been immunized by transplacental passage of RhD-positive red cells during a prior pregnancy.<sup>2</sup> Maternal IgG antibodies to RhD traverse the placenta, coating and destroying the RhD-positive fetal red cells and initiating the chain of events that leads to death from hydrops in 25 percent of affected fetuses and death from kernicterus in 25 percent of affected neonates.

In the early 1940s in Canada, when the perinatal death rate was 40 per 1000 births, 10 percent of the deaths were due to hemolytic disease of the newborn. In Manitoba there were 90 to 100 such deaths annually. The introduction in 1946 of neonatal exchange transfusion,<sup>3</sup> in which an infant's RhD-positive red cells are replaced by red cells from an RhD-negative donor, offered a means of preventing hemolysis and kernicterus and of cutting the mortality rate of hemolytic disease of the newborn in half.

The remaining problem was hydrops fetalis: half of the cases occurred at or before 34 weeks' gestation and half afterward. The induction of labor or delivery by cesarean section at or after 32 weeks' gestation, which substituted the lesser risks posed by prematurity for the greater risks associated with hydrops, substantially reduced perinatal mortality. However, the accuracy of the diagnosis of hemolytic disease in utero was poor, which meant that some prematurely delivered babies were unaffected or only mildly affected and died of prematurity and that others were left in utero and became hydropic.

In 1961, the introduction of the spectrophotometric measurement of bilirubin in amniotic fluid as an index of hemolysis increased the accuracy of the estimation of the severity of fetal hemolytic disease.<sup>4</sup> By 1964, the death rate from hemolytic disease of the newborn in Manitoba had been reduced from 25 percent of all affected infants to 16 percent. The introduction of fetal ultrasonography in the late 1970s and of fetal-blood sampling in the early 1980s further improved the accuracy of fetal diagnosis. The introduction of intraperitoneal fetal transfusion<sup>5</sup> and of intravascular fetal transfusion<sup>6</sup> further lowered the death rate to 2 percent in Manitoba in the 10-year period from 1986 to 1995.

When the father of a fetus being carried by a sensitized RhD-negative woman is heterozygous for RhD, as more than 50 percent of people are, the clinician is on the horns of a dilemma. Half the fetuses will be RhD-negative and therefore require no treatment. The others will be RhD-positive and require sophisticated investigative measures and treatments. The RhD status of the fetus can usually be determined by serial measurements of bilirubin in amniotic fluid or by measuring the hemoglobin concen-

tration in fetal blood. Both these approaches are invasive and carry some risk of fetal trauma and of fetomaternal transfer of blood, which will increase the titer of antibodies to RhD if the fetus is RhD-positive. Unfortunately, ultrasonography to determine the size of the placenta and the size of the fetal liver may fail to identify an RhD-positive fetus until hydrops has occurred.

Analysis of amniotic fluid DNA by the polymerase chain reaction (PCR) to determine the fetal RhD status, introduced in 1993,<sup>7</sup> is very accurate but is also invasive. The use of PCR analysis to detect fetal nucleated erythroid precursors in maternal blood proved to be frequently but not always accurate as well as time consuming, technically demanding, and expensive.<sup>8</sup>

In this issue of the *Journal*, Lo et al. describe a noninvasive method of determining fetal RhD status by analyzing maternal plasma.<sup>9</sup> Using a fluorescence-based PCR assay that was sensitive enough to detect the amount of RhD DNA found in a single cell, these researchers determined the RhD status of singleton fetuses from 57 RhD-negative women whose partners were heterozygous for the *RhD* gene. This method correctly identified the RhD status of 10 of 12 fetuses whose mothers were in their first trimester of pregnancy, that of all 30 fetuses whose mothers were in their second trimester, and that of all 15 fetuses whose mothers were in their third trimester. The method they describe is rapid, providing results within one day, and represents a major advance in fetal RhD genotyping.

It is a cliché but nevertheless true that one can eliminate the risk of death from a disease only if one can prevent it. In 1900 passive administration of antibodies to the mother was found to prevent active immunization, and in 1960, 20 years after the discovery of the Rh blood-group system, experiments and subsequent clinical trials established that Rh isoimmunization could be prevented by the administration of an immune globulin — Rh<sub>0</sub>(D) immune globulin — containing antibodies to RhD. The product was licensed for administration in North America in 1968. Today, the standard dose is 300  $\mu$ g in the United States and 100 to 125  $\mu$ g elsewhere.

The exact mechanism whereby Rh<sub>0</sub>(D) immune globulin prevents RhD isoimmunization is unknown. Prevention does not appear to be due simply to clearance of RhD-positive fetal red cells or to binding of the antibody to antigenic sites on the red-cell membrane. To be maximally effective, Rh<sub>0</sub>(D) immune globulin must be given to an RhD-negative woman after she has given birth to an RhD-positive infant. Unless the father of the child is known to be RhD-negative, such women must also receive the immune globulin at 28 weeks' gestation,<sup>10</sup> after abortion or threatened abortion, and after amniocentesis or chorionic-villus sampling or any other invasive intrauterine procedure. In the event of a transplacental hemorrhage of more

than 30 ml of fetal blood (determined by fetal red-cell screening with the Kleihauer–Betke test), which occurs in 1 in 400 pregnancies, the dose of Rh<sub>0</sub>(D) immune globulin must be at least 10  $\mu$ g per milliliter of fetal blood in the maternal circulation. If all aspects of Rh prophylaxis are considered, the prevalence of RhD isoimmunization can be reduced by 96 percent,<sup>10</sup> which in Manitoba translated to a change from a total of 90 to 100 deaths annually in the 1940s to 1 death every two years in the 1990s.

Thus, great strides have been made in the ability to determine fetal RhD status and in the prevention and management of RhD isoimmunization. Nonetheless, since there will always be a small number of RhD-immunized pregnant women and because there are no means of preventing isoimmunization in the case of atypical blood groups (the c and Kell blood groups in particular), there will always be a need to maintain the investigative and fetal-transfusion skills that have been developed in the past 40 years.

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*Sounding Board***HUMAN RIGHTS AND HEALTH —  
THE UNIVERSAL DECLARATION  
OF HUMAN RIGHTS AT 50**

**W**AR, famine, pestilence, and poverty have had obvious and devastating effects on health throughout human history. In recent times, human rights have come to be viewed as essential to freedom and individual development. But it is only since the end of World War II that the link between human rights and these causes of disease and death has been recognized.<sup>1-3</sup> The 50th anniversary of the Universal Declaration of Human Rights — signed on December 10, 1948 — provides an opportunity to review its genesis, to explore the contemporary link between health and human rights, and to develop effective human-rights strategies in order to promote health and prevent and treat disease.

**WAR AND HUMAN RIGHTS**

The modern human-rights movement was born from the devastation of World War II. Nonetheless, appeals to universal human rights are at least as old as government. When Jean Anouilh staged Sophocles' *Antigone* in Nazi-occupied Paris in early 1944, the French audience applauded the performance, identifying *Antigone* with the French resistance. *Antigone* was sentenced to be buried alive for defying King Creon's order not to bury her dead brother (whom the king considered a traitor) but to leave his body to rot in public. The Nazis in the audience also applauded the performance, apparently because they identified with Creon and his difficulty in maintaining law and order in the face of seemingly fanatical resistance.<sup>4</sup>

*Antigone*, which was written more than 2400 years ago, focuses on a central moral question: Is there a higher, universal law to which all humans must answer, or is simply obeying the written law of one's country sufficient? *Antigone* justified her defiance of the king on the basis of an unwritten, higher law:

Nor did I think your edict had such force  
that you, a mere mortal, could override the gods,  
the great unwritten, unshakable traditions.<sup>4</sup>

The source of higher law has varied throughout human history and has included the mythical gods of Olympus, the God of the Old Testament, the God of the New Testament, human reason, and respect for human dignity. The multinational trial of the Nazi war criminals at Nuremberg after World War II was held on the premise that there is a higher law of humanity (derived from rules of "natural law" that are based on an understanding of the essential nature of humans) and that persons may be properly

tried for violating this law. Universal criminal law concerns crimes against humanity, such as state-sanctioned genocide, torture, and slavery.<sup>5</sup> Obeying the orders of superiors is no defense: the state cannot shield its agents from prosecution for crimes against humanity.<sup>5</sup> Another major step toward incorporating human rights into international law was taken when the Universal Declaration of Human Rights was signed in a liberated Paris.<sup>6</sup>

**THE UNITED NATIONS**

The United Nations was formed at the end of World War II as a permanent peace-keeping organization. The charter of the United Nations, signed by the 50 original member nations in San Francisco on June 26, 1945, spells out the organization's goals. The first two goals are "to save succeeding generations from the scourge of war . . . and to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small."<sup>7</sup> After the charter was signed, the adoption of an international bill of rights with legal authority proceeded in three steps: a declaration, a treaty-based covenant, and implementation measures.

**THE UNIVERSAL DECLARATION  
OF HUMAN RIGHTS**

The Universal Declaration of Human Rights was adopted by the United Nations General Assembly in 1948, with 48 member states voting in favor of adoption and 8 (Saudi Arabia, South Africa, and the Soviet Union together with 5 other countries whose votes it controlled) abstaining.<sup>8</sup> The declaration was adopted as a "common standard for all people and nations."<sup>9</sup> As Steiner notes, "No other document has so caught the historical moment, achieved the same moral and rhetorical force, or exerted so much influence on the human rights movement as a whole."<sup>10</sup> The rights enumerated in the declaration "stem from the cardinal axiom that all human beings are born free and equal, in dignity and rights, and are endowed with reason and conscience. All the rights and freedoms belong to everybody."<sup>6</sup> These points are spelled out in Articles 1 and 2. Nondiscrimination is the overarching principle. Article 7, for example, is explicit: "All are equal before the law and are entitled without any discrimination to equal protection of the law."<sup>8</sup> Other articles prohibit slavery, torture, and arbitrary detention and protect freedom of expression, assembly, and religion, the right to own property, and the right to work and receive an education. Of special importance to health care professionals is Article 25, which states, in part, "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services."<sup>8</sup>

Human rights are primarily rights individuals have in relation to governments. Human rights require governments to refrain from doing certain things, such as torturing persons or limiting freedom of religion, and also require that they take actions to make people's lives better, such as providing education and nutrition programs. The United Nations adopted the Universal Declaration of Human Rights as a statement of aspirations. The legal obligations of governments were to derive from formal treaties that member nations would individually sign and incorporate into domestic law.

### THE TREATIES

Because of the Cold War, with its conflicting ideologies, it took almost 20 years to reach an agreement on the texts of the two human-rights treaties. On December 16, 1966, both the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social, and Cultural Rights were adopted by the General Assembly and offered for signature and ratification by the member nations. The United States ratified the International Covenant on Civil and Political Rights in 1992, but not surprisingly, given our capitalist economic system with its emphasis on private property, we have yet to act on the International Covenant on Economic, Social, and Cultural Rights. The division of human rights into two separate treaties illustrates the tension between liberal states founded on civil and political rights and socialist and communist welfare states founded on solidarity and the government's obligation to meet basic economic and social needs.

The rights spelled out in the International Covenant on Civil and Political Rights include equality, the right to liberty and security of person, and freedom of movement, religion, expression, and association. The International Covenant on Economic, Social, and Cultural Rights focuses on well-being, including the right to work, the right to receive fair wages, the right to make a decent living, the right to work under safe and healthy conditions, the right to be free from hunger, the right to education, and "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

Given the horrors of poverty, disease, and civil wars over the past 50 years, it is easy to dismiss the rights enunciated in these documents as empty gestures. Indeed, Amnesty International, in marking the 50th anniversary of the Universal Declaration of Human Rights, has labeled the rights it articulates "little more than a paper promise" for most people in the world.<sup>11</sup> It is certainly true that unadulterated celebration is not in order, but as Kunz noted almost 50 years ago in writing about the birth of the declaration, "In the field of human rights as in other actual problems of international law it is necessary to avoid

the Scylla of a pessimistic cynicism and the Charybdis of mere wishful thinking and superficial optimism."<sup>6</sup>

### HUMAN RIGHTS AND HEALTH

The Universal Declaration of Human Rights and the two subsequent treaties form a global human-rights framework for action and have a special relevance for global health.<sup>1,3</sup> In recent years, the relation between health and human rights has been most persuasively articulated and tirelessly championed by Dr. Jonathan Mann, the first director of the World Health Organization's Global Program on AIDS, whose life was tragically cut short in the September 1998 crash of Swissair flight 111. The strongest predictor of health is income — that is, poverty is strongly correlated with disease and disability — and one way to attack disease and improve health internationally is to redistribute income.<sup>12</sup> This seems a hopeless goal to most people in developing nations. Reliance on income redistribution as a single or primary strategy can lead to pessimism about the possibility that anything can be done or cynicism about the likelihood that anything will be done.<sup>12,13</sup> Equality of income may be unattainable. But it is not unreasonable to expect the rich to share their wealth with the poor, and thereby help create the conditions necessary for good health for all. The United Nations has noted, for example, that the cost of universal access to basic education, health care, food, and clean water is only \$40 billion a year — less than 4 percent of the combined wealth of the 225 richest people in the world.<sup>14</sup> This figure seems too low (if 2 billion people needed additional resources, it would provide only \$20 for each); nonetheless, it focuses on proper global goals and suggests that not much redistribution is required to have a major impact on the lives of most people in the world.

Multinational corporations should be actively involved in promoting human rights as well, because they control much of the wealth of the world. This has become evident in the global environmental movement in the areas of pollution, resource conservation, and global warming, and should be evident in the area of health care as well. Much of the agenda for research on drugs and vaccines, for example, is controlled by large multinational corporations, not by governments.

By broadening our perspective, the language of human rights highlights basic needs, such as equality, education, nutrition, and sanitation. Improvement in each of these areas can have a major role in improving health. Over the past decade, the World Bank has become involved in international health. In 1993, the World Bank issued a report entitled *Investing in Health*.<sup>15</sup> Although not stated in the language of human rights, the report's agenda for action implicitly acknowledged that only the recognition of basic human rights could improve the health status of most

of the world's population. In low-income countries, for example, the World Bank's two primary recommendations for improvement of health were "increased investment in schooling for girls" and the financing and delivery of a basic package of public health programs, including AIDS prevention.<sup>15</sup> The other major recommendations included increasing the income of the poor, promoting the rights and status of women through "political and economic empowerment and legal protection against abuse," and delivering essential clinical services to the poor.<sup>15</sup> These recommendations directly address the human-rights issues of access to education, access to health care, and discrimination against women.

#### HUMAN RIGHTS AND PUBLIC HEALTH

World War II, arguably the first truly global war, led many nations to acknowledge the universality of human rights and the responsibility of governments to promote them. Mann perceptively noted that the AIDS epidemic can be viewed as the first global epidemic, because it is taking place at a time when all countries are linked both electronically and by easy transportation.<sup>16</sup> Like World War II, this tragedy requires us to think in new ways and to develop effective methods to prevent and treat disease on a global level. Globalization is a mercantile and ecologic fact; it is also a reality in health care. The challenge facing medicine and health care is to develop a global language and strategy to improve the health of all the world's citizens.<sup>17</sup>

Clinical medicine is practiced one patient at a time. The language of medical ethics is the language of self-determination and beneficence: doing what is in the best interests of the patient with the patient's informed consent. This language is powerful, but often has little application in countries where physicians are scarce and medical resources very limited.

Public health deals with populations and prevention of disease — the necessary frame of reference in the global context. In the context of clinical practice, the treatment of human immunodeficiency virus infection with a combination of antiviral medicines makes sense. In the context of worldwide public health, however, such treatment may be available to less than 5 percent of people with AIDS.<sup>18</sup> To control AIDS, it has become necessary to deal directly with discrimination, immigration status, and the rights of women, as well as with the rights of privacy, informed consent, education, and access to health care. It is clear that population-based prevention is required to address the AIDS epidemic effectively on a global level (as well as, for example, tuberculosis, malaria, and tobacco-related illness). Nonetheless, it has been much harder to articulate a global public health ethic. The field of public health itself has had an extraordinarily difficult time developing its own ethical language.<sup>19,20</sup> This problem of language has

two basic causes: the incredibly large array of factors that influence health at the population level, and the emphasis by contemporary public health professionals on individualism and market forces rather than on the collective responsibility for social welfare.<sup>19,21</sup> Because of its universality and its emphasis on equality and dignity, the language of human rights is well suited to public health.

On the 50th anniversary of the Universal Declaration of Human Rights, I suggest that the declaration itself sets forth the ethics of public health, since its goal is to provide the conditions under which people can flourish. This is also the goal of public health. The unification of public health and human-rights efforts throughout the world could be a powerful force to improve the lives of every person. In my view, the declaration is a much more powerful public health document in 1998 than it was in 1948, because global interdependence and human equality are better recognized today.

#### HUMAN RIGHTS AND PHYSICIANS

Both medical ethics and human rights represent aspirations that are difficult to enforce.<sup>21</sup> Over the past two decades, medical ethics has been transformed into medical law, with more litigation and regulation. In the United States, for example, medical organizations, hospitals, and health plans often emphasize avoiding legal liability rather than doing the best or right thing.<sup>22</sup> The domain of medical ethics is shrinking.

The domain of human rights, on the other hand, is growing. Not only are human rights being taken more seriously by governments, but they are also becoming a major driving force in private, nongovernmental organizations. Of course, there are different kinds of rights and different ways to enforce them, some of which are more effective than others. Earlier this year, for example, at a meeting in Rome held under the auspices of the United Nations, the countries in attendance voted overwhelmingly (120 to 7) to propose the establishment of a permanent International Criminal Court with jurisdiction over war crimes, crimes against humanity, genocide, and aggression.<sup>23,24</sup> The United States refused to support the establishment of the court unless it could, among other things, veto trials of Americans, especially American troops acting abroad.<sup>23</sup> But this condition, of course, is incompatible with the entire purpose of the court: to punish violations of basic human rights regardless of the perpetrator. The court will be established without U.S. involvement if it is ratified by 60 nations by the end of the year 2000.<sup>23</sup>

Individuals and nongovernmental organizations can use the language and concepts of human rights to energize their own activities. Many groups of physicians have taken the lead in promoting human rights, including International Physicians for the Preven-

tion of Nuclear War and its U.S. affiliate, Physicians for Social Responsibility, Physicians for Human Rights, Médecins sans Frontières (Doctors without Borders), and Médecins du Monde (Physicians of the World). Global Lawyers and Physicians (of which I am a cofounder) broadens the base by providing an opportunity for physicians and lawyers to work together to promote human rights in health care.<sup>2,16,17</sup> The Consortium for Health and Human Rights (<http://www.healthandhumanrights.org>) has provided a new forum for cooperative action among health-related nongovernmental organizations. Other groups, such as Amnesty International and the National Academy of Sciences Committee on Human Rights, have developed very effective letter-writing campaigns on behalf of persons who have been arbitrarily detained and imprisoned. Physicians interested in promoting human rights thus have many organizations they can support. Most of these organizations have concentrated on the medical consequences of wars, torture, abuses of prisoners, and arbitrary detention, as well as the threats to health posed by nuclear, chemical, and biologic weapons, land mines, and other means of killing and maiming.<sup>2</sup>

The fact that the Universal Declaration of Human Rights is a declaration, not a treaty, need not limit its reach to human-rights violations involving crimes against humanity any more than the reach of the Declaration of Independence has been limited by this fact. Although the Declaration of Independence started a war and the Universal Declaration of Human Rights was drafted to prevent war, it is the power of the concepts and language that matters most. As Maier has noted, the Declaration of Independence “rests less in law than in the minds and hearts of the people, and its meaning changes as new groups and new causes claim its mantle.”<sup>25</sup> Lincoln, for example, claimed to be upholding the “all men are created equal” pronouncement of the declaration both when he spoke at Gettysburg and when he issued the Emancipation Proclamation.<sup>25,26</sup> And a century later, Martin Luther King, Jr., stood at the site of the Lincoln Memorial and invoked the words of the Declaration of Independence in calling for a new birth of the freedom Lincoln had promised, by which he meant “an end to the poverty, discrimination, and segregation that left black citizens ‘languishing in the corners of American society,’ exiles in their own land.”<sup>26</sup> The meaning of the Universal Declaration of Human Rights will also be invoked and reinterpreted to meet the changing challenges of the times. The agenda for human rights should be broad; it should include efforts to make basic

health care available to everyone and to prevent disease and injury and promote health worldwide. Fifty years after the signing of the Universal Declaration of Human Rights, the language of human rights pervades international politics, law, and morality. The challenge now is to make the promise of the Universal Declaration of Human Rights a reality.

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