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Abstract

1996 marks the fiftieth anniversary of the commencement of the trial of Nazi physicians at Nuremberg, a trial that has been variously designated as the "Doctors' Trial" and the "Medical Case." In addition to documenting atrocities committed by physicians and scientists during WWII, the most significant contribution of the trial has come to be known as the "Nuremberg Code," a judicial codification of 10 prerequisites for the moral and legal use of human beings in experiments. Anniversaries provide us with an opportunity to reflect upon the past, but they also enable us to renew our efforts to plan for the future. This article describes briefly the historical evolution of the Nuremberg Code, discusses its current relevance and applicability by using a case study example, and proposes future steps to be taken by the international community.

L'année 1996 a commémoré le cinquantième anniversaire du procès des médecins nazis à Nuremberg. On évoque ce procès en parlant du "Procès des Médecins" ou encore de "l'Affaire des Médecins." Outre le fait que les atrocités commises par des médecins et des scientifiques au cours de la deuxième guerre mondiale ont ainsi pu être rendues publiques, la contribution la plus importante de ce procès est à présent connue sous le nom du "Code de Nuremberg." Ce code juridique comprend dix conditions préalables à l'utilisation d'êtres humains dans le cadre d'expériences scientifiques. De tels anniversaires nous permettent de réfléchir sur notre passé, mais ils nous aident également à redoubler nos efforts alors que nous établissons des projets pour notre avenir. Cet article décrit brièvement l'évolution historique du Code de Nuremberg, examine son intérêt dans la situation actuelle en présentant une étude de cas, et propose des mesures qui peuvent être adoptées par la communauté internationale.

El año 1996 marca el cincuentavo aniversario del comienzo del juicio de los médicos Nazis en Nuremberg, un juicio que ha sido variadamente designado como el 'Juicio de los Doctores' y el 'Caso Médico.' Además de documentar las atrocidades cometidas por los médicos y científicos durante la segunda guerra mundial, la contribución más significativa de este juicio es hoy conocida como el 'Código de Nuremberg,' una codificación judicial de 10 condiciones previas al uso moral y legal de los seres humanos en experimentos. Los aniversarios nos proveen con la oportunidad de reflexionar acerca del pasado, pero también nos permiten renovar esfuerzos para planear el futuro. Este artículo describe brevemente la evolución histórica del código de Nuremberg, discute su relevancia actual y su aplicabilidad usando un estudio de caso como ejemplo, y propone futuros pasos a seguir por la comunidad internacional.

P e r s p e c t i v e s

MEDICINE AND HUMAN RIGHTS:
Reflections on the
Fiftieth Anniversary of the Doctors' Trial

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Many of our most important human rights documents are the product of the world's horror at the carnage of World War II. There are very broad and powerful announcements of human rights, like the Universal Declaration of Human Rights, adopted by the United Nations in 1948. But there are also more specific statements of aspirations for all the world's inhabitants. 1996 marks the fiftieth anniversary of the commencement of the trial of Nazi physicians at Nuremberg, a trial that has been variously designated as the "Doctors' Trial" and the "Medical Case."¹ In addition to documenting atrocities committed by physicians and scientists during the war, the most significant contribution of the trial has come to be known as the "Nuremberg Code," a judicial codification of 10 prerequisites for the moral and legal use of human beings in experiments. Some of the events planned for 1996 and 1997 include international conferences in Nuremberg (sponsored by International Physicians for the Prevention of Nuclear War), in San Francisco (sponsored by the International Association of Bioethics), and in Washing-

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ton, DC (sponsored by the United States Holocaust Memorial Museum). Anniversaries provide us with an opportunity to reflect upon the past, but they also enable us to renew our efforts to plan for the future. Have we learned the lessons of the Doctors' Trial? What can we do to make those lessons relevant for those practicing medicine 50 years later?

Historical Context

The two-year trial (1946-47) of the Nazi doctors documented the most extreme examples of physician participation in human rights abuses, criminal activities, and murder. Hitler called upon physicians not only to help justify his policies of racial hatred with a "scientific" rationale (racial hygiene), but also to direct his euthanasia programs, experimentation programs, and ultimately his death camps.² Almost half of all German physicians joined the Nazi Party.³ In his opening statement at the Doctors' Trial, Chief Prosecutor Telford Taylor spoke of the watershed nature of the trial for the history of medical ethics and law:

It is our deep obligation to all peoples of the world to show why and how these things happened. It is incumbent upon us to set forth with conspicuous clarity the ideas and motives which moved these defendants to treat their fellow men as less than beasts. The perverse thoughts and distorted concepts which brought about these savageries are not dead. They cannot be killed by force of arms. They must not become a spreading cancer in the breast of humanity. They must be cut out and exposed, for the reasons so well stated by Mr. Justice Jackson in the courtroom a year ago [before the International War Crimes Tribunal]: "The wrongs which we seek to condemn and punish have been so calculated, so malignant, and so devastating, that civilization cannot tolerate their being ignored because it cannot survive their being repeated."⁴

Sixteen physician-scientists were found guilty, of which seven were executed. A universal standard of physician responsibility in human rights abuses involving experimentation on humans was articulated. The Nuremberg Code has been widely recognized by the world community, if not always followed.

The Nuremberg Code was a response to the horrors of Nazi experimentation in the death camps: wide-scale experi-

mentation without consent, which often had the death of the prisoner-subject as its planned endpoint. The Code has 10 provisions, two designed to protect the rights of subjects of human experimentation, and eight designed to protect their welfare. The best known is its first, the consent requirement, which states in part:

The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision....⁵

Although the Nuremberg Code has never been formally adopted as a whole by the United Nations (UN), a statement related to torture appears as Article 5 of the Universal Declaration of Human Rights. A second sentence added to the text of Article 5, which further reflects the concerns of the Nuremberg Code, appears as Article 7 of the UN International Covenant on Civil and Political Rights. It states:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his [sic] free consent to medical or scientific experimentation.⁶

Most physicians would, of course, be shocked at having any assistance they give to patients considered “torture or...cruel, inhuman or degrading treatment.” They would thus view the Covenant’s provisions in much the same way most physicians view the Nuremberg Code: as a legal document not applicable to actions taken by physicians. But this is a mistake, and only helps protect aberrant physicians by marginalizing their actions as nonmedical in nature and therefore of no concern to the medical profession. It is when a doctor disregards a person’s bodily integrity that torture and involuntary human experimentation become virtually indistinguishable.⁷

The World Medical Association

In late 1946, 100 delegates representing 32 national medical associations met in London to form the world's first international medical organization. The World Medical Association (WMA) was created to promote ties between national medical organizations and among doctors around the world. Its objectives are:

- To promote closer ties among national medical organizations and among the doctors of the world by personal contact and all other means available;
- To maintain the honor and protect the interests of the medical profession;
- To study and report on the professional problems which confront the medical profession in different countries;
- To organize an exchange of information on matters of interest to the medical profession;
- To establish relations with, and to present the views of the medical profession to the World Health Organization (WHO), the United Nations Education, Science and Culture Organization (UNESCO), and other appropriate bodies;
- To assist all peoples of the world to attain the highest possible level of health; and,
- To promote world peace.⁸

In September 1947, shortly after the final judgment at the Doctors' Trial, the first official meeting of the WMA was held in Paris. The WMA formulated a new physician oath to promote and serve the health of humanity. This was followed by discussion of the "principles of social security." Key principles adopted included:

- Freedom of every physician to choose his [sic] location and type of practice;
- All medical services to be controlled by physicians;
- That it is not in the public's interest that doctors be full-time salaried servants of government or social-security bodies;

- Remuneration of medical services ought not to depend directly on the financial condition of the insurance organization; and,
- Freedom of choice of patient by doctor except in cases of emergency or humanitarian considerations.⁹

Thus, one of the WMA's first acts was to protect the welfare of physicians themselves, which of course is perfectly consistent with the organizations' original objectives. The "principles of social security" were designed to support the personal and financial welfare of physicians rather than the security of their patients. The quest for a fee-for-service, private practice mode is in striking contrast to the social-obligation model that nearly all industrialized countries ultimately adopted: universal health care entitlement based on social welfare.

To the WMA's credit, however, one of the first issues discussed by its 1947 General Assembly was the "betrayal of the traditions of medicine" that occurred in Germany. The Assembly asked, "...why did these doctors lack moral or professional conscience and forget or ignore the humanitarian motives and ideals of medical service" and "...how can a repetition of such crimes be averted?" Also, it acknowledged the "widespread criminal conduct of the German medical profession since 1933."¹⁰ The WMA endorsed "the judicial action taken to punish those members of the medical profession who shared in the crimes, and it solemnly condemned the crimes and inhumanity committed by doctors in Germany and elsewhere against human beings."¹¹ The Assembly continued, "We undertake to expel from our organization those members who have been personally guilty of the crimes....We will exact from all our members a standard of conduct that recognizes the sanctity, moral liberty and personal dignity of every human being."¹²

Nonetheless, consistent with its physician-protection goals, the WMA focused more on physicians' rights than patients' rights. Through its 1964 Declaration of Helsinki, for example, it endorsed shifting the focus of protection of human subjects in medical research toward the protection of patient welfare through physician responsibility away from the protection of the individual through informed consent.

Further, the 1964 Declaration divided research into two types: research combined with professional care, and nontherapeutic research. Consent was required only for the latter. For the former, the individual serving as the subject of the research was identified as a patient, and consent merely urged:

If at all possible, consistent with patient psychology, the doctor *should* [emphasis added] obtain the patient's freely given consent after the patient has been given a full explanation.¹³

The Declaration of Helsinki thereby undermined the primacy of subject consent as it appeared in the Nuremberg Code and replaced it with the paternalistic values of the traditional doctor-patient relationship.¹⁴

Although the WMA has also issued a number of noble statements condemning physician involvement in torture and capital punishment, it has largely acted like other professional trade associations. Its primary interest is the welfare of its members, with a secondary objective of issuing lofty ethical statements. With the exception of barring membership of Japanese and German medical professionals following World War II, the WMA has never sought to identify, monitor, or punish either physicians or medical societies who violate its ethical principles.¹⁵

British Medical Association Report

The 1992 report of the British Medical Association's (BMA) Working Party on the Participation of Doctors in Human Rights Abuses documents continued physician involvement in crimes against humanity throughout the world.¹⁶ Physicians have been directly involved in the torture of prisoners, as well as in indirect activities that facilitate torture. Physician involvement includes examination and assessment of fitness of prisoners to be tortured; monitoring of victims while being tortured; resuscitation and medical treatment of prisoners during torture; and falsification of medical records and death certificates after torture.

The BMA report documents cases of physician involvement in psychiatric diagnosis and commitment to mental institutions of political dissidents, forced sterilizations, force-feeding of hunger strikers, and supervision of amputation and

other corporal punishments. Countries implicated span the globe, including the former Soviet Union, the United States, the United Kingdom, China, India, South Africa, as well as countries in the Middle East and in Central and South America. The Working Party notes the existence of international law and codes of ethics, but acknowledges the lack of enforcement and inability to monitor compliance. The theme of the report is that neither medical associations nor international law have been effective in preventing physician involvement in human rights abuses.

Case Study: Physician Participation in Hunger Strikes

The increasing use of hunger strikes worldwide, especially by refugees and asylum seekers, creates situations urgently requiring physician attention to medical ethics. At the same time, it calls for effective international organizations to uphold and enforce standards relating to physician behavior. Within the past few years, there have been well-publicized hunger strikes for a variety of causes in many countries, including the United States, the former Soviet Union, China, South Africa, Sudan, Poland, the former Yugoslavia, Bangladesh, France, Egypt, Canada, Israel, and the Netherlands.¹⁷

For physicians, some of the most difficult situations involve individuals in the custody of the state, usually in prisons or other detention centers. In this context there have been deaths, most notably of 10 Irish hunger strikers in Maze Prison in Northern Ireland in 1981.¹⁸ Hunger strikes present two primary ethical questions for doctors: when is it ethical to force-feed a competent adult hunger striker, and when is it ethical to artificially provide nutrition to a hunger striker who has become incompetent or unconscious? Medical groups have offered conflicting ethical advice on the first issue, and virtually no guidance on the second. Thus, actual practice is mostly based on the personal beliefs of individual physicians rather than on professionally agreed upon ethical principles.

In the United Kingdom, the most definitive ethical statement remains the BMA's Central Ethical Committee's 1974 pronouncement, that prison physicians must make the final decision with respect to intervention in prison hunger strikes.¹⁹ The BMA's position seems to infer—wrongly in our

view—that force-feeding a competent adult should not always be viewed as torture. The WMA’s point of view states that the doctor should act on behalf of the hunger striker as in any other doctor-patient relationship. However, the WMA avoids taking a position on the more difficult issue of what the physician should do after the hunger striker loses competence or consciousness, leaving to the individual physician to do what “he considers to be in the best interest of the patient.”²⁰ The lack of definitive ethical standards caused consternation in the Netherlands in 1991 when a group of 180 Vietnamese refugees began a long hunger strike. The strike prompted the Johannes Wier Foundation for Health and Human Rights to organize a seminar in 1992 on Assistance for Hunger Strikers, in cooperation with the Royal Dutch Medical Association.²¹

The seminar resulted in two concrete suggestions, both of which unfortunately raise more questions than they answer. The first is that the hunger striker be asked to fill out a document, modeled on the living will, called a Statement of Non-Intervention. In this document, the striker sets forth his or her instructions regarding medical intervention in case there is a loss of competence. But does the living will model apply? Is the degradation of force-feeding eliminated by unconsciousness? Is the physician’s role in accepting the written statement at face-value more political than medical?

Second, the document suggests that an independent “doctor of confidence” be made available to prisoners who engage in hunger strikes. Of course prisoners should have access to physicians who can practice medicine free of state control, just as they must have access to their own lawyers; but what rules should this “doctor of confidence” follow? Moreover, what position should the prison physician take in countries where no such alternative physicians are available, and how can prison physicians who refuse to participate in torture or force-feeding be protected themselves?²²

The lesson from the hunger strike example is that there is no credible international body capable of articulating universal medical-ethical standards, let alone any sort of plan to enforce them.²³ Until one is created, individual physicians will continue to muddle through these situations as best they

can, using general ethical principles in settings in which these principles have little practical meaning.

A “Permanent Nuremberg”

In light of these problems and many other ethical and human rights issues involving physicians, the authors, along with others, have argued that the world needs an international tribunal with authority to judge and punish those physicians who violate international norms of medical conduct, as well as an independent body to conduct ongoing surveillance and to develop a rapid response capacity. Without these, the world is as before Nuremberg—with international norms of medical conduct relegated solely to the domain of poorly defined medical ethics. In addition, the courts of individual countries, including the United States, have consistently proven incapable either of punishing those engaged in unlawful or unethical human experimentation, or of compensating the victims of such experimentation. Primarily, this is because such experimentation is often justified on the basis of national security or military necessity.²⁴

The International War Crimes Tribunal in 1946 declared that there were such things as war crimes and crimes against humanity, and that those who committed these crimes could be punished for them. The remaining trials at Nuremberg, including the Doctors’ Trial, although based on the legal precedent articulated by the International War Crimes Tribunal (the so-called Nuremberg Principles), were held exclusively under the control and jurisdiction of the United States Army. M. Cherif Bassiouni, Robert Drinan, Telford Taylor, and others have argued eloquently and persuasively that a permanent international tribunal is needed to judge and punish those who commit war crimes and crimes against humanity.²⁵ Nonetheless, the international political will to form and support such a tribunal is lacking. There has even been difficulty in setting up ad hoc tribunals regarding Bosnia and Rwanda.

Arguments for a permanent international medical tribunal are every bit as compelling as those for a “permanent Nuremberg.” Furthermore, establishment and support of a medical tribunal could also serve as a model for the broader international tribunal. The medical profession is perhaps the

best entity to take a leading role in this regard. That is because it has an apolitical history; has consistently argued for at least some neutrality in wartime to aid the sick and wounded; has a basic humanitarian purpose for its existence; and regards physician acts intended to destroy human health and life as a unique betrayal both of societal trust and of the profession itself. Moreover, it is much harder for governments to adopt inherently evil and destructive policies if they are denied the patina of legitimacy that physician approval provides.

An International Medical Tribunal

Medicine and law are often viewed as opponents, but in the promotion of human rights regarding health they have a common agenda. In 1992, the world's physicians and lawyers were urged to work together to form and support an international medical tribunal.²⁶ Ideally, such a body would be established with the sanction and authority of the United Nations. However, given the competing political agendas of the member States, as evidenced by recent controversies at WHO, initial failure to win UN approval and support should not doom this project. Even if unable to punish with criminal sanctions, a tribunal could hear cases, develop an international code, and publicly condemn actions of individual physicians who violate international standards of medical conduct. Establishment and support of such a tribunal is a worthy project for the world's physicians and lawyers.²⁷

To move forward, establishment of such an international medical tribunal could become part of the advocacy efforts of medical and legal associations around the world. Because the tribunal must be both authoritative and politically neutral, no single country or political philosophy could be permitted to dominate it, either by having a disproportionate representation on the tribunal or by disproportionately funding it. The tribunal itself should be composed of a large panel of distinguished judges, the selective recruitment of which would be necessary for the tribunal's credibility. Governments would have to support the tribunal in a variety of ways, ranging from the funding of its infrastructure to permitting selected judges to take time off from their full-time judicial duties to hear cases.²⁸

Other Steps the International Community Can Take

Steps should be taken at the level of national medical licensure boards (and state boards in countries in which political subdivisions have medical licensing authority) to articulate specific rules denouncing physicians who commit war crimes and crimes against humanity. Those found to have been involved in such crimes would lose their license to practice medicine, or be ineligible to obtain one if they were not yet physicians. Physicians who lost their license to practice medicine for war crimes or crimes against humanity in one jurisdiction would be prohibited from practicing medicine in all jurisdictions. Licensing agencies themselves could enter into a compact or agreement to adopt and enforce these rules and goals.

A central registry of physicians who have been found to have participated in war crimes or crimes against humanity could then be established. The registry could be kept by an independent nongovernmental organization comprised of international physicians, lawyers, and jurists. The registry would also be a repository of evidence, such as affidavits and sworn testimony, that could be used by licensing agencies. Prior to licensing physicians, licensing agencies would query the central registry. The creation and use of such a registry is especially important in instances where countries authorize and use physicians to violate human rights, and where such violations would otherwise go unnoticed and unpunished. We, of course, realize that without an external investigating body and a functioning tribunal it will be difficult to identify these physicians, in that they are carrying out these violations in the name of the State. While this licensing sanction is not as strong as one might wish, it puts physicians on notice that should an investigation or adjudication reveal their involvement in human rights violations they would be unable to practice their profession outside of their own country.²⁹

Conclusion

What lessons have we learned from the Doctors' Trial? Three stand out:

- 1) Statements, even authoritative statements, of medi-

cal ethics are not self-enforcing and require active promulgation, dissemination, and enforcement;

2) Human experimentation and torture are important areas in which violations of human rights and medical practice occur, but they merely represent some of the broad range of physician involvement in human rights abuses around the world; and,

3) The world has no effective mechanism for promulgating and enforcing basic medical ethics and human rights principles.

An agenda for action flows naturally from these lessons: the world's physicians and lawyers should work together to develop and support worldwide mechanisms to articulate and enforce standards of medical ethics and human rights, including the establishment of an international organization dedicated to this cause, such as a permanent tribunal with the authority to punish relevant human rights abuses.

References

1. G.J. Annas and M.A. Grodin, eds., *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation* (New York: Oxford University Press 1992); and *Trials of War Criminals Before the Nuremberg Military Tribunal*, Under Control Council 10, Vol. 1 and 2. (Washington, DC: Superintendent of Documents, U.S. Government Printing Office, 1950); Military Tribunal, Case 1, *United States v. Karl Brandt, et al.*, October 1946-April 1949.

2. R. Proctor, *Racial Hygiene: Medicine Under the Nazis* (Cambridge: Harvard University Press, 1987); and J.R. Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, 1986).

3. R. Proctor, see note 2, pp. 65-70.

4. Telford Taylor's Opening Statement to Trial, see note 1, pp. 27-74.

5. The Nuremberg Code: (from Trial, see note 1, in Vol. 2 at pp. 181-185.)

1) The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to reach an understanding and make an enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or

person which may possibly come from his participation the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2) The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3) The experiment should be so designed and based on the results of animal experimentation and a knowledge of natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

4) The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5) No experiment should be conducted where there is an *a priori* reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimenting physicians also serve as subjects.

6) The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7) Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

8) The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9) During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

10) During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill, and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

6. The International Covenant on Civil and Political Rights, G.A. Res. 2200 (XXI), 21 U.N. GAOR, Supp. (No. 16) 52, U.N. Doc. A/6316 (1966), art. 7.

7. J. Katz, "Human experimentation and human rights," *Saint Louis University Law Journal* 38(1) (Fall 1993):7-54.

8. T.C. Routley, "Aims and objects of the World Medical Association," *World Medical Association Bulletin* 1(1)(1949):18-19.

9. *Ibid.*

10. Editorial, *World Medical Association Bulletin* 1(1949):3-14.

11. WMA, see note 10.

12. WMA, see note 10.

13. World Medical Association, 1964 Declaration of Helsinki.

14. G.J. Annas, "The changing landscape of human experimentation: Nuremberg, Helsinki, and beyond," *Health Matrix: Journal of Law-Medicine* 2(1992):119-140.
15. On the WMA election of a former member of the Nazi party as president-elect, see M.A. Grodin, G.J. Annas and L.H. Glantz, "Medicine and Human Rights: A Proposal for International Action," *Hastings Center Report* 23(4)(1993):8-12.
16. Working Party, British Medical Association, *Medicine Betrayed: The Participation of Doctors in Human Rights Abuses* (London: Zed Books, 1992). (EDITOR'S NOTE: See J. Leaning, this issue, for review of this book).
17. G.J. Annas, "Hunger Strikes," *British Medical Journal* 311(October 1995):1114-15.
18. Some hospitalized patients, for example, may be as vulnerable to authoritarian measures as prisoners. In the most famous case in the U.S., a competent young woman, Elizabeth Bouvia, was continually force-fed in a California hospital after she threatened to starve herself to death. Although she was almost totally paralyzed from the neck down, four or more attendants were required to daily wrestle with her and restrain her while a nasogastric tube was forced through her nose and into her stomach. Her right to refuse such "treatment" was ultimately vindicated by the California courts, which have recently also ruled that prisoners retain this right of refusal as well. Legal authority is not the same thing as ethical conduct, but U.S. courts have held that a prisoner who is on a hunger strike to obtain a transfer or for better living conditions may legally be force-fed if necessary to preserve "order" in the prison setting. G.J. Annas, "When suicide prevention becomes brutality: The case of Elizabeth Bouvia," *Hastings Center Report* 14(2) (1984):20-21; *Thor v. Superior Court*, 5 Cal. 4th 725, 855 P.2d 375 (1993); G.J. Annas, "Prison Hunger Strikes: Why motive matters," *Hastings Center Report* 12(6) (1982):21-22.
19. Ethical statement: "Artificial feeding of prisoners," *British Medical Journal* (1974):52-53.
20. World Medical Association, Declaration of Malta on Hunger Strikers (adopted by the 43rd World Medical Assembly in Malta in 1991 and revised at the 44th Assembly in Marbella in 1992).
21. This seminar was the basis for a pamphlet that has just been made available in English. The pamphlet itself relies heavily on the British Medical Association's 1992 Working Group report, *Medicine Betrayed: The Participation of Doctors in Human Rights Abuses* and reprints the report's chapter on hunger strikes as its introduction. Johannes Wier Foundation for Health and Human Rights, *Assistance in Hunger Strikes: A Manual for Physicians and Other Health Personnel Dealing with Hunger Strikers* (Amersfoort: Johannes Wier Foundation for Health and Human Rights, 1995), pp. 5-12; British Medical Association, see note 16.
22. Perhaps the most arresting aspect of the Dutch document, representing as it does the philosophy of members of the only society to approve of physician killing, is what it leaves out. While the document was being prepared in early 1993, a 65-year old Dutch cancer patient went on a hunger strike after her physician refused to end her life through mercy killing. After 12 days of a highly-publicized hunger strike, her request for

euthanasia was agreed to by another physician. Who was this woman's physician and what role should her physician have played? Could (should) the second physician be considered a "doctor of confidence?" What is the relationship between the right to refuse treatment (including force-feeding) and "the right" to demand "treatment" (including medical killing)? "Hunger Striker Succeeds: Euthanasia for Dutch Woman," *Chicago Tribune* 4 (March 23, 1993).

23. We will not find the "solution" to hunger strikes either by medicalizing them or inventing new forms. Indeed, the Dutch suggestion simply highlights the physician's ethical dilemma, since a hunger striker could reasonably sign the Dutch form declining nutrition after incompetence, but privately instruct his doctor to ignore the signed form if treatment becomes necessary to save his life. This then makes the hunger striker look serious, while counting on the doctor not only to advertise his plight while conscious, but to save his life should the hunger strike be unsuccessful. See G. J. Annas, "Hunger Strikes," note 17.

24. Grodin, Annas, and Glantz, see note 15.

25. E.g., T. Taylor, *The Anatomy of the Nuremberg Trials* (New York: Knopf, 1992); M.C. Bassiouni, *Crimes Against Humanity in International Criminal Law* (Dordrecht: Martinus Nijhoff, 1992).

26. Grodin, Annas, and Glantz, see note 15.

27. Such international nongovernmental organizations as Amnesty International and Physicians for Human Rights may have special roles to play in monitoring, reporting and advocacy. The WMA has proven itself incapable of playing any meaningful role.

28. Ideally this tribunal should be under the jurisdiction of the United Nations and have criminal jurisdiction. But lack of criminal jurisdiction alone should not hamper the creation of this tribunal. Even without criminal jurisdiction, the tribunal could hear individual cases brought to it, adjudicate these cases based on international law, publicize the proceedings and results widely, and refer decisions for further action to relevant professional organizations and the board or agency responsible for licensing the physician or physicians involved. Accused physicians would be notified and given every opportunity to appear and present a defense. Without an international extradition agreement, however, physicians would not be compelled to attend. The trial should nonetheless proceed with appointed defense counsel, if the defendant chooses not to appear, because a major goal is to deter war crimes and crimes against humanity through publication of their brutality and through international condemnation of them: punishment is not the only goal.

29. The advent of online computer networks such as the Internet would facilitate universal access to search a Physicians Central Registry. Issues of privacy, confidentiality and the like would obviously have to be resolved. The World Wide Web is also a powerful tool for disseminating information about human rights. For example, see Human Rights Web Resource page (<http://www.traveller.com/~hrweb/resource.html>).