

Will international human rights subsume medical ethics? Intersections in the UNESCO *Universal Bioethics Declaration*

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The International Bioethics Committee (IBC) of the United Nations Educational, Scientific and Cultural Organisation (UNESCO) is currently drafting a *Universal Bioethics Declaration* ("the declaration"). The content and even the name of the declaration has yet to be finalised, but it is expected to range widely over human and non-human bioethics. It appears likely to include many articles directly related to medical ethics. The declaration may well evolve, like the *Universal Declaration of Human Rights*, into a component of international customary law, or be the precursor to an *International Convention on Bioethics*. This article discusses whether this process will facilitate bioethics and, in particular, medical ethics, being subsumed by the normative system of international human rights.

quality and safety of technology, medical services, essential medicines, and other preconditions for health.¹

Bioethics and medical ethics in particular, however, are being challenged now by international human rights in many important aspects of professional regulation and normative theory including development, communication, interpretation, implementation, and credibility. Problems in these areas have been present throughout the history of both bioethics and medical ethics. Their contemporary significance arises not only because of increased community expectations of transparency and quality and safety in doctor/patient relations, but also from the rapid expansion of, and public respect for, the system of international human rights in those very areas. The term regulation here refers to the various mechanisms, either based on application of rules or encouragement of virtue, which attempt to effectively control the flow of events and outcomes in this area of human activity.²

The professional regulatory system known as medical ethics has been one of the most visionary and socially valuable creations of the medical profession. Its beneficial influence has extended beyond physician/patient relations, to the shaping of many key humanistic and egalitarian features of the world's legal and political institutions. The continued existence of medical ethics as a professionally influential normative system, however, is being challenged by international human rights. The UNESCO *Universal Bioethics Declaration*, I will argue, is likely to be an important point of intersection in this process.

An additional challenge arises from the increasing enunciation in the system of international human rights, of norms previously considered within the sole province of bioethics and medical ethics. This process may most clearly manifest with the creation of the United Nations *Universal Bioethics Declaration* and possible subsequent *Bioethics Convention*. The system of international human rights has evolved from a tradition of moral and political discourse between citizens and the powers which govern, and should protect, respect, and fulfil their interests. United Nations declarations and conventions have become the most authoritative sources of international human rights.

Medical ethics has played morally inspirational, educational, disciplinary, and normative roles from its location in traditional professional oaths, codes prepared by medical associations, as well as guidelines applied by clinical and research ethics committees. Contemporary medical ethics is conceptually enriched by influential texts and academic articles summarising and categorising its core professional virtues and principles.

Bioethics, overlapping with medical ethics, is less directly concerned with regulation of the medical profession and the responsibilities of health professionals to patients. Broadly involving the application of moral philosophy to ethical problems in the life sciences, Bioethics is an important non-legal regulatory feature in areas such as reproductive and end of life issues, biodiversity, and environmental protection, as well as genetic testing, manipulation, and data storage. Its norms also attempt to regulate the conduct of scientific research, access to and

INTERSECTIONS BETWEEN THE HIPPOCRATIC OATH AND INTERNATIONAL HUMAN RIGHTS

Evaluations of medical ethics customarily begin with the virtues and principles allegedly originally found in documents such as the *Hippocratic Oath* and the *Epidemics*, both attributed to Hippocrates of Cos, a descendant of Asclepius, in the 4th century BC. These include the virtues of professional self respect, collegiality, and

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Abbreviations: IBC, international bioethics committee; ICCPR, *International Covenant on Civil and Political Rights*; ICESCR, *International Covenant on Economic, Cultural and Social Rights*; SARS, Severe Acute Respiratory Distress Syndrome; UHDR, *Universal Declaration of Human Rights*; UNESCO, United Nations Educational, Scientific and Cultural Organisation

competence, as well as the principles of respect for patient confidentiality, beneficence, non-maleficence, respect for life and, arguably, egalitarian treatment. Indeed, central to a dominant history of the medical profession has been the culture and gender selective narrative that “through the long lapse of many centuries, in every land and age of civilisation” the Hippocratic Oath “has been the tutelary genius of our art, its guide and aegis, its pillar and cloud of fire”.³ Like a sacred scroll, of the type sought by the ancient Chinese pilgrim Hsuan-tsang (Tripitaka), a professionally well accepted narrative suggests that the revered tenets of this oath have been carefully passed from medical luminaries such as Scribonius Largus and the Benedictines at Salerno monastery, to those great codifiers, Gregory, Percival, and Benjamin Rush, and thence to the World Medical Association and its modern restatement of the *Hippocratic Oath* in the *Geneva Declaration*.⁴

For an influential minority, the *Hippocratic Oath* appears to have been a source of professional inspiration, encouraging conscience to overcome rules of etiquette, or even law if necessary, to assist in relieving the suffering of patients. Ignaz Semmelweis—for example, drew strength from the *Hippocratic Oath* in his campaign to reduce fatal perinatal infection, by making obstetricians wash their hands after leaving the morgue.⁵ Dr Bourne similarly, if more contentiously, relied on its hallowed injunctions to do good and no harm when he openly performed an abortion, then deemed illegal, at the request of a 14 year old girl who had become pregnant after being violently raped.⁶

Academia and professional regulators are accustomed to viewing medical ethics and international human rights law as distinct normative systems. The prospect that the *Hippocratic Oath* might metamorphose into a UNESCO *Universal Bioethics Declaration* is quite alien to the current professional regulatory paradigm. Yet, there are many normative elements common to both systems and numerous common interests and difficulties that suggest the likelihood of increasing convergence.

Historically, the development of medical ethics and human rights has many intriguing parallels. John Locke, a founding father of human rights jurisprudence, was a physician who studied alongside Sydenham, a great clinical empiricist inheritor of the Hippocratic tradition of medical ethics.⁷ It is interesting to speculate that a major factor promoting both the corpus of human rights norms, as well as those of the *Hippocratic Oath*, was direct proximity of physicians to the relief of individual human suffering.⁸

International humanitarian law is an aggregation of customary and treaty based norms concerned with the treatment of wounded, civilians, and prisoners in war. It has many areas of overlap with medical ethics. Its origins may similarly be traced to the unrelieved suffering of wounded soldiers directly witnessed by Henry Durant on the battlefield after the battle of Solferino in 1859.^{9–13}

Proving a breach of the *Hippocratic Oath*'s ethical obligation to “do no harm” was central to the conviction of the Nazi doctors at the Nuremberg Trials after the second world war for non-consensual, brutal experimentation, sterilisation, and active non-voluntary euthanasia. Those proceedings spurred creation of a tripartite collection of documents that remain central to medical ethics: the *Declaration of Geneva*, (or the modernised *Hippocratic Oath*), the *Nuremberg Declaration on Human Experimentation*, and the *International Code of Medical Ethics*.¹⁴

Mirroring these international medical ethics documents was the tripartite international Bill of Human Rights. This included the *Universal Declaration of Human Rights* (UDHR),¹⁵ the *International Covenant on Civil and Political Rights* (ICCPR),¹⁶ and the *International Covenant on Economic, Cultural and Social*

Rights (ICESCR).¹⁷ These instruments were unambiguously directed at relationships between individuals (albeit within the sphere of governmental responsibility), as well as relations between states.¹⁸ They contained many principles and obligations that resembled norms of medical ethics.

Particularly overlapping with medical ethics in the UDHR were provisions requiring respect for human dignity and equality (articles 1 and 2), as well as the human right to life (article 3). Others resembled components of medical ethics in prohibiting torture or cruel, inhuman or degrading treatment or punishment (article 5), requiring non-discrimination (article 7), freedom from arbitrary interference with privacy (article 12), and progressive realisation of the human right to a standard of living adequate for health and medical care (article 25). In the same category was the human right to share in scientific advancement and its benefits (article 27).

In considering the intersections between medical ethics and human rights it is important to take into account article 38 (1) of the *Statute of the International Court of Justice*. This provides the following definitions of international law:

- a. international conventions, whether general or particular, establishing rules expressly recognised by the contesting states;
- b. international custom, as evidence of a general practice accepted as law;
- c. the general principles of law recognised by civilised nations, and
- d. judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law.

Thus, as a declaration, rather than an international convention, the UDHR did not directly create binding human rights norms under international law upon signatory states. Neither did UNESCO's *Universal Declaration on the Human Genome and Human Rights*, which overlaps with many areas of bioethics and medical ethics and pronounces that the human genome represents part of the common heritage of humanity, whilst forbidding practices contrary to human dignity, such as human reproductive cloning.¹⁹ Nevertheless, under article 38 (1) 6 such declarations can come to be accepted as representing international customary law if sufficient states implement them with the sense of being obliged to do so.

The final wording of article 38(1)(c) of the *Statute of the International Court of Justice* on “general principles of law” was a compromise between those who viewed them as derived from natural law and others who focused descriptively on domestic legal systems. The significance of this here is that many viewed the principles of medical ethics enunciated in the tripartite texts after the Nuremberg Trials as arising from a natural law position.¹⁴

Contemporary bioethics and medical ethics also clearly overlap with international human rights norms in the regional *European Convention on Human Rights and Biomedicine*. Though in force since 1997, the regulatory impact of this convention has been restricted by limited ratification.²⁰ It covers matters such as equitable access to health care (article 3); consent (chapter II); private life and right to information (chapter III); the human genome (chapter IV); scientific research (chapter V); and organ and tissue removal from living donors for transplantation (chapter VI).

Similarly, many other international conventions contain protections of the “right to life” and prohibitions on “torture or cruel and unusual treatment or punishment”, as well as obligations upon states to progressively realise the “human right to health”.²¹ Numerous jurisdictions have constitutional provisions on similar subjects and interpretation of them

contributes to the global development of international human rights, as well as bioethics and medical ethics.

One area of explicit overlap between bioethics/medical ethics and international human rights concerns consent to medical treatment and experimentation. Article 7 of the ICCPR provides that “no one shall be subjected without his free consent to medical or scientific experimentation”. Under general comment 20, the United Nations human rights committee has interpreted this to require “special protections”—for example, no institutionally nominated surrogate decision making—for persons “under any form of detention or imprisonment”, or those hospitalised on grounds of necessity or involuntarily due to mental illness.²⁰ International law obligations to protect individuals from third party violations could create state responsibility to protect patients from doctors who failed to provide such “free consent”, even where doctors are not considered state agents.

Even apart from article 7 of the ICCPR, ethical requirements for informed consent before medical or scientific treatment probably constitute international law as involving “general principles of law” under article 38 (1) (c) of the *Statute of the International Court of Justice*.²² The reference to “civilised nations” in this context could well introduce an ethical requirement to such evaluations that many contemporary developed nations may fail.²³

Having highlighted the many contemporary intersections between medical ethics and international human rights, the issue of possible assimilation will now be considered by evaluating their roles in resolving difficulties in the following central regulatory areas: development, communication, interpretation, implementation, and credibility.

PROBLEMS WITH DEVELOPMENT

The globalisation of medical ethics has arguably been hampered by too great a reliance on the narrow cultural origins and associations of the *Hippocratic Oath*. Though similar professionally significant documents, espousing like virtues and principles, have been ascribed to Buddhist, Hindu, Confucian, and Islamic medical traditions, they have not received equivalent attention in the relevant academic and professional literature.²⁴ Similarly underemphasised has been the strong tradition of mutual influence between the authors of Islamic and Jewish medical ethics texts and the keepers of the Hippocratic corpus.²⁵ International human rights law, in so far as it intersects with regulatory areas such as the doctor/patient relationship, on some views, has the problem of limited cultural specificity to a lesser degree.

Contemporary medical ethics is largely known through the principles and rules appearing in codes prepared by national and regional medical associations, as well as through guidelines and reports. The fragmented, institutionalised process of development exhibits significant problems with transparency, consistency and, arguably, depth of analysis.

In many jurisdictions, the medical associations enunciating such ethical principles and rules represent less than half the eligible, practising doctors. In others, legislation against collective bargaining, or international trade agreements preventing non-tariff barriers to trade in services, increasingly inhibit effective normative development by such organisations. International human rights, on the other hand, has the obvious advantage of operating amidst the very international forums where many of the most significant decisions affecting the medical profession are being made.

PROBLEMS WITH COMMUNICATION

In its contemporary quest for continued regulatory relevance, medical ethics is often cast as the allegedly doctrinally rigorous, and relatively easy to communicate, four principles of Beauchamp and Childress. Those authors claimed the

principles of autonomy, beneficence, non-maleficence, and justice were not derived from any ideal or utopian doctor/patient relationship, but arose instead from “considered judgments in the common morality and medical tradition”.²⁶

The cluster of medical ethics principles known as “autonomy” was linked—for example, philosophically, to the deliberated self rule of Kant’s categorical imperative (beings capable of reason should not be treated instrumentally, but as ends complete in themselves). From this basic ethical principle were deduced specific medical ethical rules related to keeping promises, maintaining confidentiality, truth telling, and providing a patient with adequate prior information about the nature of a planned procedure or treatment and its material risks.²⁷ Beauchamp pronounced that “principles gave an anchor to a youthful bioethics in the 1970s and early 1980s and contributed a sense that the field rests on something firmer than disciplinary bias or subjective judgment”.²⁷

One of the alleged advantages of basing medical ethics education on the “four principles” approach was said to be the ease with which its components could act as simple mental triggers for professional duties to patients. Asking students to recall the basic ethical principles in this mantric way was also said to readily emphasise their equivalence—that is, that none was primary. The importance of what came to be called “principlism” in medical ethics instruction was profound, but carried some disturbing features.

Principlism was designed to be communicated through lectures or group discussions about relevant ethical theories—for example, deontology or utilitarianism—and related principles and rules. It was also expected to assist in the development of the cognitive skills necessary to effectively apply such principles to complex clinical dilemmas.²⁷ Principlism’s use of deductive logic appealed to the apparent legalistic paranoia of the many doctors concerned about rising indemnity costs. It greatly influenced the construction of codes and guidelines of medical ethics. Yet an over-emphasis on principlism has been a major reason why many professional educators feel that contemporary medical ethics has been inadequately communicated.

Beauchamp and Childress came to accept that basic ethical principles had an important association with virtue.²⁷ Yet, those authors did not explicitly answer Pellegrino’s call “to derive the four principles from a single, coherent, virtue based theory of the doctor/patient relationship”.²⁸ Beauchamp and Childress asserted, for instance, that their four principles could be “balanced” through a process of “coherence” reasoning that they explicitly modelled upon Rawls’s process of “reflective equilibrium”.²⁷ They failed to emphasise that the latter notion is explicitly based upon intuitive convictions about a foundational social virtue: justice.²⁹

Principlism, thus, despite its importance to the communication of contemporary medical ethics, has no manifest theoretical derivation from any foundational professional or social virtue. Principlism’s lack of a virtue base remains the major conceptual flaw at the conceptual heart of medical ethics.³⁰ Its presence renders more difficult the task of communicating medical ethics in a way that consistently motivates conduct in accordance with informed conscience.

Attempts have been made to renovate the theoretical framework of medical ethics by means of custom built virtue theory.³¹ Pellegrino, as mentioned, has argued forcefully that virtue must reclaim its normative role in the medical profession.³² Doctors with an active professional conscience (notably those in non-governmental organisations (NGOs) such as *Medecins Sans Frontiers*, *Medact* or *International Physicians for the Prevention of Nuclear War*) increasingly look for their inspiration, not to medical ethics, but rather to

the radical international idealism of conscience, intrinsic dignity, and inalienable rights expressed in the UDHR.

There are additional practical reasons for this communicative shift, related to changing global influences on medical regulation. Many of the most significant problems confronting medical ethics now occur as a result of debates and strategies in international forums such as the World Trade Organisation, the World Bank, or the board rooms of multinational pharmaceutical cartels. The *Doha Declaration on the TRIPS Convention and Public Health*, allowing access to cheap generic drugs, was promoted—for example, by physician activists in *Medecins Sans Frontiers*, as a victory for human rights, as expressed in the UDHR, over pharmaceutical companies aggressively enforcing drug patents to the detriment of HIV/AIDS sufferers.³³ Medical ethics did not appear to provide a significant normative reference system in this debate.

Confirming this alteration in the focus of communication, growing numbers of published articles on areas that would once have concerned medical ethics are now being written by primary reference to international human rights.³⁴ Also increasing is the teaching of international human rights in areas of the medical curriculum previously regarded as the sole domain of medical ethics.³⁵ Relevant techniques have included student visits to police cells and prisons, and interviews with torture victims and doctors who have campaigned against such human rights violations.³⁶

PROBLEMS WITH INTERPRETATION

The norms of contemporary medical ethics are often interpreted by courts in order to determine the professional standard of care, or to assist in resolving difficult cases, where no settled and definitive legal rule exists. One example of the latter was the decision of the US Supreme Court in *Roe v Wade*, in which considerable space was devoted to an analysis of the *Hippocratic Oath's* alleged prohibition on abortion.³⁷

Particular controversy, in this regard, has arisen over reinterpretations of the World Medical Association's *Declaration of Helsinki*. Some contentious issues concerned the distinction between “therapeutic” and “non-therapeutic” research and the use of “best proven treatment” or placebo in control arms. Yet the value of such revisions is questionable where “governments have demonstrated grossly repressive or corrupt behaviour, or where ethical review systems cannot be regarded as independent”.³⁸ The lack of formal links between the decisions of professional disciplinary bodies make it difficult to build up a globally consistent body of interpretations of medical ethics.

There are now, however, innumerable tribunals both within the United Nations and at regional level, authoritatively interpreting norms of international human rights concerning doctor/patient relations. These include the English Court of Appeal and House of Lords, as well as the European Court of Human Rights. Cases concerning new reproductive technologies, end of life decisions, privacy, and informed consent, are now heavily influenced by international human rights norms, either because of parliamentary or judicial incorporation into domestic law, or to remedy a common law lacuna, ambiguity, or obscurity.

PROBLEMS WITH IMPLEMENTATION

It has been alleged that ready access to an enhanced means of enforcing or implementing rules has been a major reason behind the increasing use of law rather than medical ethics in professional regulation.³⁹ The exponential growth of health legislation controlling the interstices of doctor/patient relations may provide some proof of this. The *Patient Self-Determination Act* (US) (1991), one representative example of

such legislation, covers much of the traditional territory of medical ethics in requiring hospital staff, at the time of admission, to inform patients of a right to participate in their own health care decisions, to accept or refuse treatment, and to make an advance directive.

The obvious disadvantage of medical ethics being subsumed for enforcement purposes by domestic law, is that protection of patients would thence be more open to manipulation by the state. This argument cannot with equal force be raised against the regime of international human rights. Development of the capacity for individual patients, with the assistance of doctors, to petition human rights committees and courts concerning violations of patient human rights under optional protocols, provides an increasingly effective and transparent enforcement mechanism (Jonsen,²⁵ pp 24–5).

PROBLEMS WITH CREDIBILITY

Many, but not all, medical schools continue to use the *Hippocratic Oath* as a graduation pledge.⁴⁰ High profile public inquiries, such as that into paediatric cardiac surgery at the Royal Bristol Infirmary, confirm that most whistleblowers, and few of the physicians and surgeons they confront, are now so motivated by what they perceive as this antiquated document, to see—for example, its reference to “purity” of life and art, as a powerful encouragement to professional character development.⁴¹

Shortly after the medieval period, Western medical ethics is said to have resembled merely a set of guild rules protecting the selfish interests of members from internal and external competition (Jonsen,²⁵ pp 24–5). Its codification was arguably only an income protective measure, which aimed to ward off the damage to the profession's social esteem from quacks and non-allopaths.⁴²

Admittedly, the principles of medical ethics, like those of religious systems, cannot be effectively impugned merely by cataloguing those innumerable instances when they have been breached, ignored, or flaunted; unless perhaps such faults arise from manifest textual obscurity, or indicate a catastrophic loss of general faith and respect.

Nevertheless, in the eyes of significant portions of the public and the profession itself, the inadequacies of medical ethics are at least partially responsible for physicians continuing worldwide to be involved in torture, the death penalty, institutional abuse of the vulnerable, armaments manufacture, and warfare, as well as many other inhumane activities.⁴³

In 1976, the United Nations invited not the World Medical Association (the body responsible for drafting many core documents of medical ethics such as the *Geneva Declaration*) but the World Health Organization (WHO) to prepare a draft code of medical ethics against physician involvement in torture or cruel or unusual treatment or punishment.⁴⁴ In 1982 the United Nations General Assembly passed a resolution on principles of medical ethics, which endorsed WHO instigated recommendations of the International Organisation of Medical Sciences on this issue.⁴⁵

The multinational pharmaceutical companies, managed care organisations, and other private corporations that increasingly control or influence much of the contemporary medical profession on a global basis, manifestly have little understanding of, or genuine respect for, medical ethics. Globalisation of financial and social services, as well as the rapid international spread of infectious diseases, such as HIV/AIDS and Severe Acute Respiratory Distress Syndrome (SARS), have bypassed state sovereignty and necessitated international cooperation on doctor/patient matters in a wide range of international institutions.⁴⁶ Global corporate colonisation and international “microbialpolitik” has created a

need for terminology and norms, which extend medical ethics into the realm of international obligations.⁴⁷

THE UNESCO BIOETHICS DECLARATION: A POINT OF INTERSECTION

On June 13 2003 the international bioethics committee of UNESCO issued its report on the possibility of elaborating a universal declaration or convention on bioethics.⁴⁸ This was the outcome of work, which began with a resolution of the general conference of UNESCO at its 31st session, calling on its director general to submit “the technical and legal studies undertaken regarding the possibility of elaborating universal norms on bioethics”.⁴⁹

The content of norms to be included in such a declaration or convention remains a matter for speculation. The first step was to draft a *Universal Bioethics Declaration* and a team of eminent scholars was appointed to coordinate this task under the chairmanship of Justice Michael Kirby of the High Court of Australia. Criticisms may be made concerning the transparency of UNESCO’s procedures in this regard: public access to deliberations is apparently restricted and few meetings take place in developing countries.⁵⁰ There may have been an initial reluctance on the part of some members to expeditiously tackle difficult issues, such as restricting patents over the human genome, supporting health care or scientific whistleblowing, and alleviating the deleterious effect of expansive international intellectual property laws on access to medicines.

Creation of such a UNESCO *Universal Bioethics Declaration* may represent a pivotal stage in the process whereby the moral, political, and international law aspects of human rights begin to subsume medical ethics. It could create norms categorised as both medical ethics (to the extent that they regulated the medical profession of ratifying states and affected doctor/patient relations therein) and international human rights law. The scope of bioethics, both human and non-human, which could be included is vast.

Some important contemporary issues of vital importance to the medical profession globally should be included in the declaration. The following are some suggestions. It would be advantageous, for instance, for the *UNESCO Universal Bioethics Declaration* to follow on from the UDHR in its emphasis on the importance of professional conscience. In particular, it should include an article that supports healthcare whistleblowers—that is, those people who make a reasonable and non-vexatious disclosure in good faith about significant events seriously and immediately impacting on the public good. The declaration should include an article requiring that international intellectual property rights be interpreted and applied so that, as far as possible, they do not inhibit universal access to affordable, essential medicines. The declaration should likewise also enunciate a principle requiring that the human rights provisions afforded subjects in medical research be scrutinised by journal editors as a crucial published part of any refereed publication of that data.

Other important areas that might be covered include specifying professional virtues such as truth in medical research or, clinically, loyalty to the relief of patient suffering, from which first order principles and rights may be derived. Enunciation of the precautionary principle in relation to new developments in biotechnology and of the duty of humans to protect the environment for its own sake would also be significant.

It is to be hoped that the *UNESCO Universal Bioethics Declaration* will be written with due recognition of the various areas of intersection between medical ethics and international human rights outlined earlier. It is also to be desired that medical researchers, physician related NGOs, human rights and patient advocacy organisations, as well as a

medical profession increasingly aware of its global identity, will discover in such a document an inspiring and authoritative source of ideals and standards.

CONCLUSION

I have attempted to show that international human rights is now intersecting with numerous important areas of medical ethics and is capable of dealing appropriately with many of the most significant normative problems in professional regulation. The incipient UNESCO *Universal Bioethics Declaration* has been presented as an important focal point in this process.

One of the most important objections to such a view is the claim that the normative credential of international human rights itself undoubtedly remain highly suspect, particularly in Islamic societies, for its lack of connection with religious law as expressed in the *Quaran* or *Sunna*.⁵¹ In such societies, norms of international human rights are consistently qualified by shari’a based Islamic criteria and by suspicions that the primary norm creating bodies in international human rights are dominated by the representatives of developed, northern countries, or large corporations with alien, materialistic social values. In this context, medical ethics may actually gain regulatory strength from its normative separation from such contentiously controlled international institutions. Another objection may be that human rights treaties are generally negotiated and entered by executive fiat, typically without legitimising parliamentary debate, thus undermining the claim that they have greater social legitimacy than the normative system of medical ethics.

One alternative, of course, is for medical ethics itself to seek global coherence with the language and norms of international human rights. Medical boards and clinical and research ethics committees—for example, might even begin to publish their interpretations, gradually building up a global “common law of medical ethics”. Glimmers of this approach appear in the increasing use of concepts such as “human dignity”, “inalienable rights”, “progressive development”, “proportionality”, and the “margin of appreciation” in medical codes and education.⁵²

Medical students could be taught that human rights enforcement mechanisms are actually an important means of implementing medical ethics.⁵³ At the Australian National University Medical School we have begun teaching students that international human rights will probably become more important in professional regulation than medical ethics in the course of their own careers.

The UNESCO *Universal Bioethics Declaration*, like the UDHR, eventually may be accepted as a part of customary international law. In time, work may begin on an international bioethics convention, which will directly create binding obligations on states under international law. States who ratify such a convention may thereby acquire obligations to ensure that their domestic legislation on bioethics, public health, or the doctor/patient relationship conforms to international norms. The convention may have its own monitoring committee receiving states’ reports, issuing general comments, and receiving communications from individuals.

I have not argued here that medical ethics is at risk of being abolished by international human rights. Perhaps, however, by embracing its normative intersections with international human rights, medical ethics may have its credibility enhanced and may meet contemporary global challenges more effectively. If a detailed jurisprudence of informed consent as an international human right is developed—for example, such norms could easily recirculate to sustain a more uniform professional regulatory regime throughout the world.⁵⁴ This process would be facilitated,

particularly in jurisdictions such as the United Kingdom, New Zealand, and the Australian Capital Territory where courts are required by legislation to attempt to achieve interpretive coherence between the domestic legislation and international human rights.

Earlier I compared the *Hippocratic Oath* to the sacred scrolls being sought by the virtue seeking pilgrim, Tripitaka. When Tripitaka and his fellow pilgrims finally reach their journey's end, they are met by a bureaucrat, no doubt appropriately titled "The Golden Crested Great Immortal of the Jade Truth Temple at the Foot of the Holy Mountain".

After the customary prevarications, this official is finally ordered by the Buddha himself to immediately deliver the holy texts. The pilgrims, however, then discover that the documents are blank.³⁴ The point, it seems, is that wisdom resides in the heart or soul of man and not in words or laws. Reinvigoration of this practical message of virtue ethics, perhaps lost in the emphasis on principlism, may be facilitated for medical ethics by its metamorphosis into a universal bioethics declaration within the normative system of international human rights.

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