In the light of this it is extremely irresponsible on the part of those proposing hysterectomy for the women with a mental handicap, to say that this is a common surgery and has no side effects. For some women taking these risks without adequate information, and without trying out other methods of dealing with the so-called problems is even more questionable. Such callous indifference on the part of the doctors has to be challenged. At the same time it is important that we investigate what is the implication of hysterectomy for any woman living in this socio-cultural milieu. We also need to find out the extent of its prevalence and the reasons for which it is performed. Only through this process can we evolve our own mechanisms and processes to be able to extend support and strength to each other while facing a situation in which this choice has to be made.

Victims or Perpetrators?

Sandhya Srinivasan

Medicine Betrayed: The Participation of Doctors in Human Rights Abuse, Report of a working party of the British Medical Association; Zed Books in association with BMA, London; 1992.

MEDICAL training does not include a study of the political and social circumstances in which doctors practice. And rarely does it dwell on ethics, on educating doctors of their special responsibilities to their patients, the dangers of misusing their special skills.And the potential for abuse is carried to the extreme when the doctor becomes the accomplice of the state.

Medicine Betrayed is the British Medical Association's second publication on doctors' participation in human rights abuses. The first, published in 1986, established that such involvement was not all that rare. Doctors were known to participate in planning and assisting torture; mistreating prisoners; committing healthy people to psychiatric care, etc. This second report takes a closer look at the circumstances in which torture, and medical involvement in it occurs and at the different ways in which doctors can get involved in torture, both judicial and extra-judicial.

The working group received written and oral testimony and interacted with individuals as well as medical and human rights organisations. After discussing the different aspects of such abuses, it makes recommendations to doctors and medical associations on how to prevent them. The appendices list the stands of various international organisations. The essence of these recommendations is the principle that the doctor's paramount interest is in the patient's welfare, and not the objectives of the state.

The book discusses a number of reasons why doctors get involved in torture — from fear of punishment to the belief that the victim deserves it.

Besides these explanations, which could apply to anyone, the bureaucratisation of the doctor's role often allows him/her to avoid taking a stand.

There are many degrees and types of medical involvement in torture, but the most obvious — and easiest to condemn — is the direct form, when s/he uses skills to inflict pain, mental or physical. But the more insidious role a doctor plays is as the torturer's accomplice — ensuring that torture is carried out without killing the victim. This could be confirming that a victim is fit to undergo further torture, or monitoring the torture to make sure it is not overdone, or treating the victim in between sessions, to enable him to undergo further pain. There is also the doctor who turns a blind eye to evidence of torture, whether by ignoring substandard care to prisoners or giving false or deliberately inconclusive post-mortem reports.

While much torture is done with the tacit, but not open, approval of the government, it is equally important to look at the role doctors play in state-sponsored and socially legitimised violations of human rights. The report looks at three examples in particular — corporal punishment, capital punishment and force-feeding of hunger strikers — where alleviating the distress of a legal act could involve a compromise of medical ethics.

In the first case, doctors are kept on hand, to certify the prisoner fit for punishment, to determine when the prisoner can no longer tolerate the pain, and to treat the injured prisoner. The committee points out that doctors cannot ethically be part of this or any other punitive machinery. Everyone is ready to call amputations and public whippings barbaric, feudal practices. But capital punishment is practised by 'civilised' societies. The examples cited here are primarily from the US, where doctors have participated in executions despite the American Medical Association's opposition.

It might be argued that doctors should be involved to make the death as painless and swift as possible. But even when a doctor does not administer capital punishment, s/he can be made to aid the procedure — by certifying a prisoner fit to undergo capital punishment; treating the prisoner to make him fit for execution; witnessing the execution to confirm that it has succeeded. The BMA condemns all medical participation in all aspects of capital punishment, save the final certification of death, insisting that this take place some time after the execution, and away from the execution site.

On the question of medical treatment of hunger strikers, it is seen as a doctor's duty to revive a critically ill person. When that person chooses to die, should a doctor stand by and watch, revive the hunger striker, even against his/her wishes ? The BMA asserts the patient's right to refuse food to the point of death, as a method of protest. Doctors should keep in mind the best interests of the patient, not of the state. And a doctor who feels unable to follow the prisoner's wishes should hand over charge to another doctor.

While noting doctors' extensive involvement in human rights violations, the BMA acknowledges that they are often unwilling accomplices

to torturers, and are even victims themselves. For this reason, international medical associations must extend support to their colleagues who cannot speak up against the government.

The report dwells extensively on documented violations outside western Europe and the US, but records the growing erosion of civil rights in the UK — repressive legislation, maltreatment of IRA prisoners, conditions in prisons and mental health facilities, etc. And in an early chapter it explains the relatively slack follow-up of medical atrocities in the name of research after the second world war. A senate sub-committee explained that "...the value to the US of Japanese biological warfare data is of such importance to national security as to far outweigh the value accruing from war crime prosecution..."

The wealth of information here would have gained focus if other human rights violations referred to here had also been discussed.

Health and Welfare: Comparative Indices

THIS set of tables compares data on key components of socio-economic development for India and selected developing countries. Among the developing countries India is assigned a low HDI rank of 135 in an array of 173 countries in descending order of the human development index, as defined and computed by the United Nations Development Programme.

Adult literacy rates in India and Sri Lanka and China show the poor progress made in India on this count. As we see in Table 1, in 1992, the adult literacy in India was 49.8 per cent, while that for Sri Lanka was 89.1 per cent and China 80 per cent. For Kerala it was 89.79 per cent. Literacy rates, particularly amongst the women appear to play vital role in reducing the birth rates. Kerala's high female literacy rates occurs with low crude birth rates (18 per cent) as compared with rest of the selected developing countries.

MMR or maternal mortality rate which measures the numbers of deaths among women due to pregnancy-related causes per 100,000 births, was as high as 550 as compared with China and Sri Lanka where it was 130 and 180 respectively. The lower maternal mortality rates in China and Sri Lanka is perhaps linked to large proportion of births attended by health staff which were 94 and 87 respectively; vis a vis India which was only 33 per cent.

India has achieved a life expectancy 59.7 which is much lower than that of other comparable countries. Human development index which is a composite of life expectancy at birth, literacy rate and income ($ PPP/ capita- purchasing power parity per capita) Kerala 0.775 retains its top position on these composite indices followed by Sri Lanka and China.

The remarkable improvement on health status in China, Sri Lanka are attributable in part to government policies that emphasised the financing of cost-effective clinical services. An important factor in India lagging behind other countries in social development has been the level of governmental expenditures for health and education sectors as compared with that in other countries.

There is a significant relationship between the HDI and GNP per capita. For countries such as China, Sri Lanka the HDI Rank is far better than their income rank (i e GNP rank). The highest positive difference between HDI and GNP ranks is for China (+49), and Sri Lanka (38) shows that these countries have made more judicious use of their income to improve the capabilities of their people, as compare to India (R) which is fairly significant.