

Human Rights and the Ethics of Care in the Perspective of Health Research

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ABSTRACT

Health Research plays a vital role in addressing injustices and human development, but to attain developmental objectives the research must be based on complete scientific and ethical principles. For now, it is accepted that ethics play a significant role in health research in developing countries and it has focused on debates surrounding internationally sponsored research projects and has taken place largely without adequate participation and understanding socio-cultural scenario of the developing countries. There exists certain research gaps in health status, access to healthcare, and quality of care and provision of health related services are increasing in the context of Globalization. In the face of evident disparities between the health status of the “haves and have not”, health professionals in developed countries must consider the impact of such disparities on the ethical manner of health research. This paper tries to investigate how an ethics based on caring and responsibility can guide clinical research in a manner which is consistent with human rights and justice in the face of global disparities. It examines of two paradigms for moral reasoning- the morality of rights and the morality of care with respect to applying the theory of human rights to health. The morality of rights depends on the concept of justice to guide behavior while the morality of care seeks to guide decision making in a way that takes care of others. The Study, examines real world conflicts and mechanisms to resolve moral dilemmas. For instance, it can enhancement the thoughts of justice, protection and benefit to provide ethical guidance in a wide variety of circumstances. Furthermore, it suggests that the integration of a morality of care into the approach to health care research can depend the ethical discourse, micro strategies for research planning and identify that is more approachable to both health disparities and changing needs.

Keywords: *Clinical research; Ethics; Equity; Human Rights;*

INTRODUCTION

Usually, Human rights inevitable to guide the actions of government, however the ethics in healthcare are concern for the specifications, inspirations and relationships of individual health workers, organizations and researchers. Principles of ethics which is guiding our work are the product of broad based consultation which is conscripted by representatives of professional bodies and organizations and exists in the form of guidelines and proposed codes of conduct. Such as, the world medical associations

implement the Helsinki code in 1964.¹ The Helsinki code, which is at first attentive on research involving human subjects, was the pioneer to the field of bioethics, which incorporate research in life sciences among the ethics of healthcare practices. Likewise United states, bioethics as established in the late 1960 and early 1970, it emphasized the central significance of individual autonomy,

¹World Medical Association Declaration of Helsinki — Ethical Principles for Medical research involving Human subjects. Helsinki, Finland: World Medical Association: 1964

reflecting the individuality of American culture, in contrast to the social harmony characteristic of many other cultures. Human Declaration universal declaration in 1948, though significantly shaped through the diplomatic skills of American Eleanor Roosevelt, reflects the norm of many cultures and traditions and the consent achieved as well as the government of what rights should exist. When the declaration impresses the governments of the countries that sign on to them, after that legal conventions came and in therefore doing affect what is and should be done to safety of health. There is an accountability for observance of and the public origins of, human rights highlights the worth of human rights to public health concerns, [1] for instance, the international covenant of economic, social and cultural rights distinguishes the article 12 “the right of everyone to the enjoyment of the highest of attainable standard of physical and mental health” and starts an associated governmental duties. [2] These responsibilities consist of decreasing infant mortality; developing environmental and industrial health; controlling epidemic and endemic, preventing, treating, and occupational or some other diseases; and confirming the accessibility of medical care in the event of sickness. Most of the countries they have sign up international agreements on human rights, for such instance the world Medical Association’s Helsinki accords, because they have established compatible guiding principle of governing the protection of human research participants. [3]

Human Rights and Health Research

The credit which are protecting of human research subjects is an appropriate public concern and the modern human rights movement are both quite young ideas. During the world war there are medical experiments conducted camps and it prompted military judges to disseminate the standard of informed consent. Decisions of Nuremberg have framed medical research as a social-justice issue, such as Robert Levine

has noted. Words of current revision of the Helsinki Declaration on ethical principles for human-subjects research capture social-justice concerns both obviously, with language about “appropriate caution’ in the ways of research which could affect the environment” and tacitly, in a controversial standard concerning controlled trials². Starting with the establishment of the United Nations (U.N) in 1945, the values of human rights have been categorized in a series of international declarations and treaties. Charter of U.N was followed by the international bill of Human Rights (1948), the international Covenant on civil and political Rights (1966), the international covenant on economic, social and cultural Rights (1966), and the convention on the removal of all forms of discrimination against women (1981), and the convention on the Rights of the child (1989)³. Healthcare suppliers and professionals should be involved in fortifying these benefits as rights. UDHR, (Universal Declaration of Human Rights) approved by the U.N General Assembly shortly after the U.N was formed, recognized a common standard to which all peoples and nations could hope. [4] According to Article 25th in section of health, says that everybody has the right to a standard of living suitable to the health and well-being of himself and his family, including food, housing, clothing, medical facilities and necessary social services. The implementation of the United Declaration of Human Rights through 48 member states and it reflects the assurance of the international community to a minimal standard of healthcare for all people.

²“The benefits, risks, burdens and effectiveness of a new method should be tested against those of the best current prophylactic, diagnostic, and therapeutic methods. This does not exclude the use of placebo, or no treatment, in studies where no proven prophylactic, diagnostic or therapeutic method exists.”

³Not all United Nations member nations are signatories to this and the above agreements. As of April 1, 1998, 191 countries had either signed the Convention or become State Parties to it by ratification or accession.

Consequent, related covenants and treaties underline the responsibility of governments to be responsible for the social, political, and economic situations in which people can embellishment. This assurance is echoed in the World Health Organisation's (WHO) constitution, which declared that the pleasure of the maximum achievable standards of health is one of the basics rights of every human being. [5] Both deteriorating to provide ample opportunities for health and directly preventing access to health care inhibits the enjoyment of the highest attainable health standard. While deteriorating to guarantee universal access to clinical care is the most clear, such defect obstacles to the pleasure of health right more often operate delicately at a social level. Subsequently people are susceptible to disease through membership in society such as the common cold acquired from one's neighbour; health couldn't always be attained by transforming individual behaviour. Those who inhabit a lower step of the social ladder face an augmenting problem, being more likely to fail ill and less able to seek out help for it. [6] The strongest interpreter of health over the long run is neither heredity nor it is individual behaviour, but social status. [7] For the detection of disease distribution such as who becomes ill and disease effects such as who most often dies or is disabled, Therefore AIDS or HIV epidemic is revealing. In every country the epidemic firstly affects the particular groups, which is depending on how and where the virus enters that society. Though, over times it focuses amongst those parts of the populations who grip the least power and who live on the edges of society. [8] Before twenty years ago, the maximum incidence rates of AIDS patient were seen in America's large coastal towns. Such as, in the starting thirteen months of the AIDS epidemic which is between June 1981 and July 1982, where 48% of cases came from New York city (217 of 452)., the maximum incidences are in the rural south, as compared to 29% in the Northeast, and even though smaller ratio in other regions. [9] The

system of downward social agility of epidemic disease is not novel, but there is another illness has been followed a similar pattern. Such as tuberculosis, once the crest of an elitist and subtle lifestyle in the west⁴ is now almost entirely a disease of the poor. There is another example such as Asthma, an allergy like condition to which inborn susceptibility is possibly universal, it is now so common amongst with the urban poor and it has become a reason of Cilbre to advocates for develop housing and health care in north eastern region. [10] So far advances in political and economic rights have not essentially been accompanied by developments in health. For such instance, breakdown of an oppressive political gear in the former Soviet Union was followed by economic interruption and social disorder with major health consequences. There are increasing crime and disparities in resources led to serious disease in congested prisons, epidemics in many societies, and worsening in life expectancy. Some of the Asian countries such as China and Vietnam, where economic reforms and the opening of society to western impact has increased drugs misuse and commercial sex, and the diseases that foldaway with them. The Chinese recall us to reflect the potential untoward significances of advantageous innovations, saying that "it is well to open the window and let it in fresh air, but flies could enter as well." The human rights framework focuses the vibrant nature of the relationship between fundamental human rights and health. It delivers language to explain the common practice of oppression as well as people around the world and amenities communication through disciplines, as well as health care workers, politicians, community activists, lawyers and others. The nature of work they do

⁴Renej. Dubos, the white plague: tuberculosis, man, and society (1987); susansontag, illness as metaphor and aids and its metaphors (1990). Dubos emphasizes the inextricability of social organization and the occurrence of disease. Sontag is concerned with the role of metaphor in the framing of disease meanings in modern society.

needs that health specialists practice in relationship with others, whichever individuals or populations. Human rights misuses including constraint of resources hindered professional practice in that they compromise these relationships by limiting the ability to support care. There is difference between health care which is inaccessible or unaffordable, and that care is insufficient or intermittent, which is no such difference at all. Health practitioners which care for those on both sides of the divide the penniless and the privileged are thus held hostage by such misuses or abuses. Although health professionals could be incapable to change political systems or entrenched economic structures in ways that totally reject underlying inequalities and obstructions to health, their sense of professionalism or humanitarian responsibility changes them, and repeatedly leads them to feel grateful to take actions against such misuses or abuses. Actually it is in this mode that the activities professionals which offer health service or conduct research are connected to human rights. There are some specific issues between human rights and health research ethics which are the following – 1) Medical progress, 2) Altruism, 3) Equipoise, 4) Placebo Control, 5) Informed Consent, 6) Medical Care for Research Participants. These six themes stand up often when patients and health care suppliers make decisions about research contribution. Obviously, the particularly interested in the choices presented when research is done in the context of health inequalities or where intricate motivations ambiguous definition of right or wrong. About medical progress, it is the aspiration to gain more information motivates nearly every clinical trial as well as all health research in general. There are researchers and supporters of research that the methods of improving health can be devised if better information is available. Evidently, the health care suppliers want to attain more knowledge that may help of patients aligns with the researcher's motivation to advance medical science and

contribute to progress. But then again progress for whom? "Medical progress" it is for the shared good; there is no meaning at the individual level, and we should not pretend that it does. Undoubtedly research protocol supports one person, but only one, to survive; it has profited that person, even if it flops to more medical knowledge, although if it flops to help large numbers of people. Would a research protocol that is profited to one or a minimum number of individuals be uninhibited just because of it is not success to rise to the "progress" standard? There are researchers, health care providers and potential research participants must be identified the disjunction between contributing to combined progress and lightening an individual's suffering. The researcher tries to find out to the benefit of humankind, an abstract idea of good. The individual contributor practices direct effects of research contributor, and seeks empirically that their decision to participative was good or bad. It is the health care supplier which is the most directly confronted through the disjunction between combined and individual profits. There is deeper problem emerges when there is a material inequalities in resources between where the research is formulated and funded, and where it is carried out. Development is highly appreciated in the technology heavy economies of the western industrialized nations; there is the potential for development accepted rationale for running the threat of research. The statement that improvement arising from the fruits of medical research is more possible to advantage the people of the world that funds the research than those of the world where is carried out amplifies the divergent weighing of improvement. Further issue is an Altruism which is linked to the multiple inequalities that energize medical improvement as an ethical problem. Altruism is mainly created by researchers or research funders who look for justify plans which are at the best paternalistic. Altruism word itself reveals the positivist roots of the concept. It was introduced into English in

the mid-1800 through the translators of Comte, who has given its present meaning⁵. To faiths in Altruism that social good this is measurable and desirable to good for the individual. However, researches recommend that an individual would enrol in their study for what they term "altruism cause", they are telling that whereas participating in research can be harmful to the individual, the study may be beneficial to people in common. Choice of ethics has been created by researchers. For them it is the choice between intellections. There are individuals who have to decide to participate or not, the choice is not similar. The potential participants have to choose between choices. First, they must to choose at the level of their own comfort and safety whether to enter the individually non ideal state of research involvement. Furthermore, they have to decide on the basis of their own faiths whether to consider the potential advantage of the research to the community at huge. The details that the research has been permitted through some recognized authority and it is going forward that is, which is the decision has been created through the researchers modifies the valence of the potential participant's decision-making. Being told about the research could be benefit everybody, but the potential participant's decision to enter a study or not becomes a question of selfishness or unselfishness. The individual's moral equipoise is vanished. Therefore, that the situation is likely to become even further determined if the health care deliver, mostly a trusted health care supplier, endorses the research. So there is term "altruism" is such a tip-off to an ethical squash play. Third one is Equipoise that is the fact of not knowing which of two claims is true. In the perspective of health research, equipoise states that the investigator's truthful ignorance as to which of two intrusions is more advantageous. Most of the writers

have highlighted the main importance of this state of not knowing in the ethics of health research. If one treatment regimen is clearly most effective than others, subjecting patients to the fewer effective approach violets the consensus standard expressed in the Helsinki declaration which everybody is entitled to the maximum current standard of care. If there are only researcher genuinely undecided about that tactic is better is it reasonable to conduct a clinical trial. Benjamin Freedman not accepted individual equipoise on the part of the investigator, the true absenteeism which he called "treatment preference," it is as an obstruction to carrying out clinical trials. Many others and Charles Weijer have joined Freedman in advocating community equipoise likewise prevaricate against insincere contentions on the part of researchers that they were truly unclear of weather there was a difference between treatments A and B. It is not just the investigator, but the medical community, those writers have claimed, it must be genuinely unclear as to whether treatment A is choice to treatment B, or the converse. ^[11] Equipoise, through those claims it has to be made permissible to expose some individuals to a new treatment that is few effective than the best treatment.

Levine has discussed that equipoise motivates research in two ways. ^[12] Even though, not knowing which tactics is more generates a need to look out. The research is such as reasonable if it serves to release equipoise in a way that assists to decide which approach is much better. Even there are results propose that one treatment is better than another, equipoise is lost, and the researcher is grateful to break the study even though full protocol has not been finished. Presently, standards for stopping are normally assimilated into clinical trial protocols, an acknowledgment of the essential equipoise principle. If equipoise is the idea on which ethical acceptance in clinical trials is based, then the point where equipoise disappears is an ethical pivot. Obviously, the exact point at which

⁵Oxford English Dictionary 259 (1971).
Socioeconomics 479, 479-81 (1998) (offering an economic analysis of the ethic of care and the ethic of justice).

indication makes a new treatment look better than placebo cannot be similar for one health care provider than for another. Clinical trials attempt to regulate that point, so that all health practitioners will agree that it is not so far proven that treatment is better to placebo. The clinical trial accordingly averts decision-making on the part of the individual health care supplier and researcher validates its own continuation or the commencement of another trial. Moreover, demands to the medical community to decide while treatment A is better than B invite the inevitability of consensus, but do not essentially produce truth. There has been codifying how to induce an inference from clinical trials does not totally work. Part of the distress health care providers and suppliers experience when listed patients into some clinical trials come from their own sense which the placebo and treatment options are not exactly comparable, doesn't matter what the medical community says, while the health care provider is again hostage. For instance, medical improvement, equipoise would have to be relegated from its main role in ethical decision-making if the ethics of health care research which were based on the difficulties of caring for individuals acting individually. Another one come to placebo control which is the outcome of a randomized placebo controlled trials are the *sine qua non* of proof in an increasingly indication bound, health science formation. Investigators who look out to find a good treatment regimen are basically required to mount a placebo-controlled trial. Even though researchers are concerned that patients given placebo are not receiving satisfactory care, they could find no substitute to the placebo controlled trial. If the treatment's usefulness is to be believed and the treatment used therefore people can be helped, some people-the contributors who are randomized to the placebo arm-will have to accept no treatment at all. Obviously, occasionally a treatment is destructive, and placebo receivers are the lucky ones. Till now, the randomized

placebo controlled trial frequently, even though not always, stakes sufficient care for some patients today against the hope of better care for many patients tomorrow. The World Medical Association has chosen to address the placebo dilemma directly in the current review of its statement on ethical principles for research concerning human subjects. It identified unambiguously that new treatments must be tested against better current treatment, not a placebo⁶. Placebo trials are to be undertaken only when there is no confirmed treatment. Meanwhile this appears straightforward, in many actual world situations; the ethics of a placebo arm are not closely obvious. For instance the case of HIV/AIDS drugs shows, there are conducting placebo-controlled trials of reasonable regimens in poor countries while the efficiency of more expensive regimens has been verified is a Solomon's dilemma. But even if a trial goes forward, some people don't do among others, because some will obtain placebo. Even there is no trial is carried out, no one will be treated. Therefore, doesn't matter which choice is made, research disseminate disparity in access to health care. The morality of care and human rights would have to recognize that social inequality lies at the root of the dilemma, and then specify that action to correct to bigger social inequalities be connected to furthering research agendas. Another specific issue is that which is Informed Consent which we derived the right to informed recognized a new standard of justice in health care research when it was agreed on as a part of the Nuremberg code. Even though, informed consent could not be modify offering a treatment regimen which is fewer than optimally advantageous into good care. Getting people to come to an understanding to obtain a fewer standard of care doesn't make an offering insufficient care acceptable. Now we talk as experienced about United States, there are

⁶World Medical Association, World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects, 284 JAMA 3043, 3045, pt. C 29 (2000).

research participants has the right not only to be informed about methods and procedures linked with research and their potential threat and advantage, but also it is the right to understand. Presently clarification of informed consent such closes the gap between researchers settling their responsibility to inform, and the patients required to know and getting what is going to happen a divide that arises willingly while research process are defined in technical jargon. Through observing of informed-consent standard, where the justice is done in that all potential subjects are similarly aware, and therefore equally capable to choose. But there is not concern of only gap; the proclamation is that consciousness creates choices which appear difficult. Definitely, lack of consciousness of possible harm and advantage reduces the range of choices accessible to the subject. But dedicated consciousness, such as the modern informed consent standard seeks to achieve, it might be still leave many choices is not available precluded through the patient's economic resources for instance, sex, gender, class or race through a wish to gratify their family or health care provider. If there are an ethical care providers argued the choice about participation because of their concern for the patients personal condition, must be the providers acknowledge their own attention in the research assignment success although that acknowledgement discloses that they are not that much interested solely in the patients welfare. Informed-consent prompts an ethical challenge about care, even though as it tenacities one about justice. And the last one is Medical care for Research participants according to Marcia Angel states that when investigators join subjects in clinical trials, they predict an obligation analogous to that of clinicians. ^[13] Therefore, investigators are responsible for enriching the health care status of participants in their studies, or are they permitted to leave unaltered the poor health standing of population so far as the inquiry meets the standard test of "doing no loss?"

Repeating Helsinki Declaration addresses a ratio of these issues, proposing only the best evidence therapy such as the standard against which new treatments must be verified. Nevertheless, the dimensions of prosperous countries to avoid moral accounts that highlight their own responsibility to relieve suffering help to produce and maintain that gap. Whereas, wealth might be formed in developed country without impoverishing the fewer developed world, the burden of confirming that the poor are well cared for is a costly one. Still, a full understanding of the morality of care would command action to improve the substantial perspective, so that consent will not be intimidated by social circumstance.

Ethics and public Health Research - Morality, ethics and ethical practice

There are two paradigms often lead to equal or similar ethical decisions, and the restrictions between them which are always been controversial. These paradigms are Morality of rights and Morality of cares⁷. The Morality of Rights stated that the several codes governing biomedical ethics today are stranded in liberal theories of justice, contrary theory and human rights. According to Levin's argument of the basis of medical ethical codes in deontological and utilitarian theories which are pleasure and utility based. These theories carry out the dialectical relation between them. Those ethical codes are illuminating also a melding of Kantian rationalism with the democratic liberalism which has defined by John Rawls. ^[14] Kant's categorical commanding presented the foundation for intellectual

⁷Joan C. Tronto, *Moral Boundaries: A Political argument for an ethics of care*, 6-11 (1993). Tronto recognizes that political context problematizes morality. She discerns at least three apparent "boundaries" to morality that is induced by the framing of moral judgment within social or political contexts: a false consciousness of a distinction between political acts and individual acts; a false distance that arises from the presupposition that moral accounts must be disinterested; and a false dichotomy between public and private.

morality. ^[15] It predicts that all human being have access to cause even though we do not always use it. "True" moral theories thus arise such as universal and it could be derived not from acuity, which might be shifting or faulty. Kantian moralism is certainly intellect, but since it is not accept practice as the grounds for moral decision-making. It also predicts that right moral theories are impartial, because only impartial tenets can apply universally. Finally, it needed that moral narrative be "read" by reason, Assumption is that what is moral, is it right or correct. Kantian moralism in healthcare research in the injunction to "do no harm". It is in the controversial argument that what the maximum standard of care is for the wealthy have to be the standard of care for the poor. Right-based morality stated also on the utilitarian underpinnings of western liberalism. Utilitarian values proposed a little different valance to moral decision making. Presently, health care ethics, we understand utilitarian moralism play in the discussion about managed care, whether by socialized or private insurance. Health care management costs permits for more efficient cost sharing and thus fewer payments in general. Through the making care provision few subjects to patients' characteristics such as prosperity or knowledge which is provides the "happiness" or rise in community well-being, of expanding the accessibility of suitable care. The next main impact on right established morality comes from democratized or common realism⁸. Meditative equilibrium⁹ of Rawls and agreed upon principles of justice, and unambiguous contract approach that arises from it, this guide is the important¹⁰ aspects

of ethics that are evident in codes such as Helsinki Declaration. It's a great honour a subjective conclusion by the participant, counterfeit in agreement with a researcher, to look for mutually what everyone wants individually. Therefore, the morality of rights methods is based on theories that at any one time can be comprise some the following: Equality, impartiality, beneficence and individual autonomy. These ideologies lead to rules that we found in this article of the various codes of conduct, such as Helsinki. They look out for to advocate specific aspects of care for people. There are some of the aspects or attributes of right based ethics are privacy, ^[16] the right to disclosure¹¹, right to information, ^[17] risk communication and avoidance of harm, privacy, connected with deontological morals, it is also a notion of contract theory. The right to information directly comes from Rawlsian theory of justice: people must know what is wrong with them and what might occur to them if they are capable to look for just solutions to the problems of ill health and inequitably distributed resources. The information of right connected with the confidentiality right to create an apprehensive equality, or at least a levelling of the playing field and it indicates that holders of information must be share. It is the mainly component of the philosophies underlying rights and an unambiguous attributes of care based ethics. Escaping of harm states that an important line between the intellects ethics of rights and the realistic ethics of care. Certainly, the theories improved by philosophies of moral constraints are plentifully evident to caregivers, while it is as perceived truths and received wisdom or by training and practices. Totally privacy and information

⁸The oxford companion to philosophy, 712 (Ted Honderich ed.,1995)

⁹RAWLS, supra note 29. His introduction of the concept of reflective equilibrium offers a profound departure from categorical approaches, without requiring that the moral guidance afforded by the equilibrium depart from that of duty.

¹⁰David Gauthier, *Morals by agreement* (1986), especially Chapter 5, Gauthier seeks to produce a

form for finding justice when there is no self-evident or mutually acceptable reason to be just.

¹¹J. Higginson & F. Chu, *Ethical Considerations and Responsibilities in Communicating Health Risk Information*, 44 *J. Clinical Epidemiology* 51S-56S (1991); Paul A. Schulte & Mitchell Singal, *Ethical Issues in the Interaction with Subjects and Disclosure of Results*, in *Ethics & Epidemiology*, supra note 36, at 178-96.

rights are beliefs of caring. Often enough, practitioners derive these principles unconsciously, through the conscious practice of care. The beliefs remain ideas for assessment only, or move the professionals or researcher to act. Cautious health care practitioners are conscious of their need to balance patients' needs for confidentiality and confidentiality with a right to know about fears or risks. They also look out to avoid harm to the patient as it available itself in a given clinical situation. After that they strengthen the positioning of the patient in an eccentric social support system, as well as in the bigger society. These difference after go through the basics of a Morality of Care. The choices proposed by, and decisions made from, justice-based rights paradigm is also frequently fail to reply the real-world concerns of individuals and populations who are the susceptible subjects of health care research. In compare to the time of 1982, Carol Gilligan primarily defined an ethics of duty and care expressed through young women, which looks nearly at context, comprising networks of relationships and power as a guide to the moral path. The significances of decisions are deliberated, along with whether the decisions are correct and just. Such as a woman discussion an abortion might consider not only her personal faiths about when life started, but also the impact of her decision on others to whom she feels responsibilities. Amongst the health practitioners, nursing have proven a specific interest in the progress of an ethics of care.^[18] Because the practice of nursing in its cleanest form is necessary the act of caring for another human being, it is not astonishing that nurse-philosophers catch an ethics of care attractive. Nursing is mainly a profession of women; and the fact is that debate of caring have always been strongly influenced through the feminist view of its first theorists, Carol Gilligan and Nell Noddings^[19] is almost definitely answerable for the some of its demand to the profession. There has been very little formal argument of the ideas underlying an

ethics of care in medicine. Though, at least one philosopher-physician, Edmund Pellegrino, wrote persuasively about the physician's responsibility to care for the patient through feeling kindness, doing for them what they could not do for themselves, accepting duties, and acting competently." most of the writers have advocated that there is no actual difference between an ethics of justice and an ethics of care. They stated that justice is based on caring, although implicitly, and discuss that discriminating morality as based on rights and caring because it is a response to a political calculus which has to do with class, sex, and somehow race. But, It emphasize dissimilarity between ethics based on intellects ideas of right an ethics rising from a caring willingness to regulate practice to the demands placed by real conditions and social structures on persons. And this difference is important in identifying where existing codes of medical ethics are also inflexible or insensitive, and pointing the way in the direction of a more responsive and sustaining approach.

CONCLUSION

The question of what establishes care and harm must be central to the process of health (care & services) research. There are caring, and attention of the multitier difficulties of upholding the human right of each individual to receive care, it can help as the basis for clinical-research ethics that evade harm. Technical and administrative determine to ethical issues, such as newer studied have designs or better oversight through international agencies which are focused at deciding the distribution of justice issues, but mainly they unsuccessful to address the basics questions about conserving personal rights and proposing good personal care. Solutions dispensing reward and risks amongst groups, the moral path of utilitarian, unsuccessful to alleviate harm and fall short of assuring the better care, rather distributive justice, research ethics should guide by personal care and duties. There is an ethical view based on

duties, responsibility and caring which are the practicable for clinicians and researchers. In compare to the difficulty most personal experience in trying to explicate intellectual justice, where both clinicians and researchers often could distinguish a scale of destruction to individuals whichever arising from a given action or pre-existing. On the basis for ethics in research that means assorted health care inequalities may have to be rectified before research could be done. Search for an individual, just standard of clinical or research practice would inevitably be compromised through the economic and social truth of global inequalities in health status, access and resources. Identifying that justice would be compromised through any clarification in the present context, the morality of care and human rights induce social actions through health care providers. Beliefs about the goal of health care and public health is helped through organizing the debate of international justice in research around the standard of caring and the avoidance of loss. Most hurting moral issues are not simple choice between competing rights, difficult conditions of disagreeing duties. Morality of care angers the rules of rights and justice as well as of human rights. It changes the researchers into associations with the health care provider and places both in the shoes of perceptive caregivers; charging them with obligation for the welfare of real persons, asking them to perform professionally within noticeable interpersonal relationship and in the perspective of actual social forces, and seeking to decrease loss.

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