Ethics briefings

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A right to treatment?

There is growing international debate about the so-called “right to health” and the likely content of such a right as it is gradually defined by international bodies such as the UN committee on economic, social, and cultural rights. Although some countries, such as Mexico, have incorporated the right of access to basic treatment into their national constitution, practical implications generally remain to be fully articulated. Lawyers have been trying to do this by developing internationally accepted indicators which can be used to measure a nation’s progress towards compliance with social, economic and cultural rights. Clearly, compliance can only be judged against the yardstick of resources.

Restructuring of health services and the need to contain spiralling health costs have led many countries to focus on developing a basic health care package as a “right”. The USA, in the Clinton era, had inconclusive discussions about this and basic packages have been implemented by governments as diverse as Brazil, Germany, Israel, and the Netherlands. As the BMA has discussed, the prime responsibility for ensuring that rights are fulfilled rests with governments who are signatory to international human rights declarations. Nevertheless, hospitals and other health facilities may logically be deemed to have some obligations, by delegation from government, to respect the rights of people needing urgent treatment.

The question of what this right means to health professionals needs exploring. Access to health care, particularly in a life-threatening emergency, appears to be a fundamental component of any such postulated right. Also, individual health professionals are generally perceived as having an ethical duty to respond to “need” when they are able to help. In July 2001, the potential legal consequences of failing to do so were highlighted by a case in India where the medical administrator of a Delhi hospital refused emergency treatment to an accident victim whose family were unable to pay. The Indian Medical Association pointed out that such cases are not unknown but the fact that the doctor was charged with “culpable homicide” made this an exceptional case which raises many questions.

Euthanasia, assisted suicide and human rights

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where this does not compromise effectiveness. Current guidelines stress these points.  

Circumcision for purposes other than therapy poses different questions. The BMA’s advice is about how doctors should behave, although many circumcisions for religious purposes are done by non-doctors. The standard measures of “evidence based medicine” cannot be used where the benefits and harms are not measured. Medical bodies began to address the balance of benefits and harms, and to comment as far as a medical association can, and should, on these issues. Any further guidelines that are done by non-doctors. The standards of “evidence based medicine” cannot be used where the benefits and harms are not measured. The BMA, which has already begun to steer a middle path through the inevitable debate. The aim is to address the balance of benefits and harms, and to comment as far as a medical association can, and should, on these issues. Any further guidelines that result will be on the BMA’s website.

**Bristol report**

The report of the Bristol Royal Infirmary (BRI) Inquiry into the management of the care of children receiving complex cardiac surgical services at the BRI was published in July 2001. The inquiry was charged with making recommendations to help to secure high-quality care across the National Health Service (NHS). The report concluded that the events at Bristol were not caused by “bad” people who did not care, or who deliberately harmed patients. Rather those involved were dedicated and well motivated although some lacked insight and their behaviour was flawed. The report states that the health professionals were victims of a combination of circumstances which owed as much to general failings in the NHS at the time as to individual failings. The report’s recommendations are numerous and far reaching, covering issues such as communication, consent, organisation, competence, training, revalidation, management, monitoring standards and performance, and public involvement in providing health services. The report made clear that improvements would require additional investment, pointing out that “nothing can be achieved ‘on the cheap’.

The report has provided considerable food for thought for bodies such as the BMA, which has already begun the long process of analysing and encouraging and facilitating the practical changes necessary to make a real difference. The BMA, for example, sent a Consent Tool Kit to over 70,000 doctors and a report on the teaching and practice of seeking consent to NHS medical and clinical directors. Other work has been ongoing and will continue to build on such initiatives.

Reports into practices in the NHS have been issued before, but there is a real sense in which this one will not, and cannot be allowed to, be forgotten. There is certainly the will to make things happen and the BMA hopes resources to make changes happen are forthcoming.

### Regulating assisted reproduction in Canada

The Canadian Standing Committee on Health is due to report, in January 2002, on draft legislation on human assisted reproduction. The proposals set out activities that should be regulated and proposes prohibitions on the following activities:

- Cloning humans (including “therapeutic cloning”);
- Germline genetic alteration;
- Keeping an embryo outside a woman’s body for more than 14 days;
- Creating embryos either from another embryo or fetus, or solely for research purposes;
- Transplanting reproductive material from animal to human;
- Using human reproductive material previously transplanted into an animal;
- Sex selection (including by the sperm-sorting technique) except where there are medical indications;
- The sale and purchase of human embryos or gametes;
- Commercial surrogacy.

The committee proposes establishing a regulatory body to license people and organisations carrying out regulated activities, including research involving human embryos. This body will provide information about success rates, maintain a register of donors, recipients and people born from assisted reproduction, provide public information and advise ministers on policy developments. The objective is to protect the health and safety of those seeking assisted reproduction by, for example, limiting the number of embryos to be transferred or specifying the conditions under which human gametes or embryos can be stored. The draft legislation seeks to balance the privacy of donors and the wishes of children born following treatment by giving donors the option of whether to allow identifying information to be passed to their genetic offspring.

### References

6. Motion for resolution presented by Mr Mundis and others to the Parliamen tary Assembly of the Council of Europe. 4 Jul 2001. Doc 9170.

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