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A RIGHT TO HEALTH CARE?: A COMPARATIVE PERSPECTIVE

Dieter Giesen†

I. INTRODUCTION

THE EXISTENCE OF A RIGHT TO HEALTH CARE has been one of the most problematic and debated issues in medical ethics and medical law. In a world of scarce resources, budgetary constraints and ever-increasing demand, the value of asserting a right to health care has become apparent to those who seek to shield existing services from cutbacks and to extend access to medical care to disadvantaged groups in society. In the course of this article, some of the practical legal implications of recognizing a right to health care will be examined from a comparative perspective. At the outset it is important to distinguish between 1) claims made by individuals upon society in general to ensure access to health care, and 2) claims made by those in need of treatment upon individual doctors to ensure that vital medical assistance is afforded, especially in times of emergency. In establishing the general structures for the provision of health care and in determining the extent of a doctor's liability for refusal to treat a patient in need, the law plays a pivotal role in enforcing the ethical norms of any given society. A comparison will show that, at first blush, the relevant legal rules vary considerably, reflecting differing political and philo-

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The author wishes to let it be known that he disagrees with the way the footnotes have been edited and citations changed, often beyond recognition, so as to conform to THE BLUEBOOK. A UNIFORM SYSTEM OF CITATION (15th ed. 1991) which is not in all instances acceptable authority in European citation practice as preferred by the individual legal systems referred to in his article, and in any case is a serious infringement upon his rights as author to use citations and quotations in the way they are used in conformity with the jurisdiction the source comes from.
sophical priorities. In many common law countries, especially
the U.S., an austere individualism is favored at the expense of
the elementary obligations of common humanity and solidarity
which are acknowledged by almost all the civil law jurisdic-
tions. Nonetheless, the extreme libertarianism of the Anglo-
Saxon world has been considerably tempered and modified such
that at the societal and individual levels, access to medical ser-
vice has been expanded, albeit in an indirect fashion. In spite
of these advances, a comparative analysis will also highlight
outstanding deficiencies in the legal rules governing access to
health care in a number of jurisdictions, deficiencies which are
at odds with the expressed value-commitments of these
societies.

Once a discussion of the question of access to health care
as a matter of rights and obligations has begun, consistency
demands that the issues arising within the therapeutic context
also be considered from a normative perspective. The individual
who submits himself to medical procedures does not for that
reason forfeit any of the fundamental rights which the law of
all civilized nations recognizes him as holding. This view of the
patient, *qua* an autonomous subject of the law, as central to the
health care system has important implications for contempo-
rary medical practice and for judicial attitudes thereto.

II. THE HEALTH CARE SYSTEM: RIGHTS AND
OBLIGATIONS

Article 25 of the Universal Declaration of Human Rights\(^1\)
states that:

> Everyone has the right to a standard of living adequate for
> the health and well-being of himself and his family, including
> food, clothing, housing and medical care and necessary social
> services, and the right to security in the event of unemploy-
> ment, sickness, disability, widowhood, old age or other lack
> of livelihood in circumstances beyond his control.\(^2\)

\(^1\) (1948), *reprinted in* INTERNATIONAL LAW: THE ESSENTIAL TREATIES AND OTHER

\(^2\) *Id.* (emphasis added). The Universal Declaration of Human Rights was adopted
by the General Assembly of the United Nations on December 10, 1948. *See* LOUIS B
SOHN & THOMAS BUERGENTHAL, BASIC DOCUMENTS ON INTERNATIONAL PROTECTION OF
HUMAN RIGHTS 33 (1973).
Although this provision has been strongly influential in the post-war world, its identification of an affirmative right to health care can at best be seen only as aspirational. The assertion of a right to medical services founders upon difficulties of political philosophy, and such a right is not recognized by the legal system of any democratic society. Unlike the classic rights to "negative" liberty, as first embodied in the U.S. Constitution and the French Declaration of the Rights of Man, which restrain the state from the arbitrary and oppressive use of its powers, a right to health care would allow the individual plaintiff, by means of litigation, to oblige the state to allocate resources to a specific extent and for a specific purpose. Yet the availability of such a remedy would clearly overturn the collective decision-making process as performed by the legislative arm of government. It is for this reason that courts in many jurisdictions have been firm in rejecting claims for an affirmative right to health care services, as beyond the scope of the adjudicative function. As the English Court of Appeal stated, "it is not for this court, or any court, to substitute its own judgment for the judgment of those who are responsible for the allocation of resources. . . . The courts of this country cannot arrange the [waiting] lists in the hospital . . . ."

It was the open-ended and inchoate nature of the putative right to health care that led the U.S. President's Commission to agree that, as long as the ethical and jurisprudential debate on access to health care was focused upon attempts to assert and refute a right to medical services, it could provide no useful guidance to those involved in formulating law and policy in the health care sector. This admission does not, however, exhaust

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4. Central Birmingham Health Authority, ex parte Collier, at *3.

ethical and legal consideration of access to health care, for the concept of a moral right clearly must be distinguished from that of a moral obligation. While all moral rights necessarily entail moral obligations (i.e., to ensure that the appropriate entitlements are met), the existence of moral obligations does not in every instance imply the existence of correlative moral rights. Thus, as the President's Commission said, most appositely, "a person may have a moral obligation to help those in need, even though the needy cannot, strictly speaking, demand that person's aid as something they are due."6

The autonomy of the individual citizen has been recognized as the core value of the legal and constitutional order, both in civil law and common law countries.7 In addition, it must be acknowledged that individuals require a minimum level of health and physical well-being in order to develop autonomously their life-styles and to fulfill their goals in accordance with their value commitments. As such, health may be viewed as a basic good, an essential prerequisite to the exercise of personal autonomy and an irreducible condition of human flourishing.8 To the extent that any society denies access to basic health care services, it disvalues individual autonomy and thereby exposes itself to serious moral criticism.9

Among the democratic states of the developed world, the moral force of this obligation is borne out by the prevalence of state-funded health-care systems. Thus, the British National Health Service Acts require the Secretary of State to provide such accommodation, facilities and staff as are necessary to meet the reasonable requirements of the health service.10 In

6. Id. at 34; see also R. v. Instan, [1893] 1 Q.B. 450, 543-44 (Coleridge, L., Eng.).
8. Although a detailed philosophical discussion is beyond the scope of this article, the following may be profitably referred to: JOHN FINNIS, NATURAL LAW AND NATURAL RIGHTS 100-160 (1980); JOSEPH RAZ, THE MORALITY OF FREEDOM 400-429 (1986); John A. Hayes, Health Care as a Natural Right, 11 MED. LAW 405, 406-407 (1992).
9. SECURING ACCESS, supra note 5, at 34.
10. National Health Service Act 1977, ch. 49, § 3 (Eng.) obliges the Secretary of State to provide accommodation, medical, dental, nursing and ambulance facilities, facilities for expectant and nursing mothers, facilities for ill persons (i.e. preventive care, active care and after care) and services for the diagnosis and treatment of illness. Similar provi-
Sweden, a directly funded national health-care system is also in place. A differently funded, but no less comprehensive coverage is achieved in Canada through government financing of privately run health-care structures. A duty upon the state to provide for medical assistance also may be inferred from Article 20(1) of the German Federal Constitution which states that: "The Federal Republic of Germany is a democratic and social federal state." This concept of a "Sozialstaat" is implemented by the provision of a state-run health insurance scheme, in addition to a range of private health insurance programs, which ensures that all German citizens have access to medical attention and hospital care when it is necessary.

Of course, it must be acknowledged that aspects of these various systems have been rightly criticized as often wasteful and inefficient. A combination of rising public expectations, the expansionist dynamic of medical science and increasing demands upon finite public resources have necessitated careful scrutiny of health care expenditures. Furthermore, it has been shown that a concentration upon highly expensive medical technology of limited use has reinforced pre-existing inequalities of access. Thus, in Britain, the Black Report, which regrettably did not receive adequate attention from health policymakers, noted marked discrepancies between the health of different income groups and regions and found that mortality levels rose inversely with falling occupation rank or status.
The development of efficient and more equitable strategies for the prevention of ill-health has been hindered by many doctors' view of themselves as "scientist problem solvers and curers" and their correspondingly insatiable desire for costly new techniques and equipment. Notwithstanding these forceful criticisms, it is clear that the moral obligation to provide access to adequate medical facilities is honored to a significant extent in each of the countries mentioned. This is made especially clear when the existing health care structures in the U.S. are examined.

The authors of a leading American health law textbook have correctly asserted that "virtually every developed national in the world except the United States assures universal access to health care." The strong tradition of individualism in American political culture emphasizes that health care is largely a matter of private interest, the allocation of which is best left to the market. This tradition has, however, been modified by the acknowledgement of certain community obligations to provide minimal facilities and, indeed, a statutory or constitutional duty to provide at least some services for the indigent is recognized in all but three states. Consequently, the coverage available to individuals in the event of ill-health is made up of an uneven patchwork of individual insurance schemes, employment-related schemes and a number of federally sanctioned initiatives to assist the needy. The latter are chiefly comprised of the Medicare scheme, which provides for the health needs of the elderly and the "medically needy", and the Medicaid scheme, which makes treatment available to the "deserving" poor.

- Giesen, supra note 14, at ¶ 1446.
- Id. at ¶¶ 1442-1513; see also Kennedy, supra note 15, at 70-75.
- Id. at 601.
- Securing Access, supra note 5, at 115-182 (detailing various health insurance and medical assistance schemes). See also Furrow et al., supra note 18, at 529-599.
- A rare and useful philosophical exploration of the concept of the "deserving" poor is provided by George Sher, Health Care and the "Deserving Poor", in Appendices Sociocultural and Philosophical Studies, supra note 12, at 293 app. L.
While Medicare generally has been successful, this has not been true of Medicaid. The exacting criteria for Medicaid assistance, whereby most single persons and couples without children are excluded as "undeserving" poor, have meant that only about fifty percent of persons below the federal poverty standard are covered. This in turn has led to the alarming statistics that approximately fourteen percent of the U.S. population were completely uninsured in 1992 and approximately six percent were underinsured. Indeed, one commentator has noted the emergence of a new category of "medically excluded" persons, whose incomes are insufficient to meet the costs of private insurance, but sufficiently high to put them just beyond the reach of the Medicaid program. In addition, escalating price inflation in the medical sector as a whole has meant that levels of reimbursement to doctors attending to Medicaid patients are generally viewed as inadequate, with the result that large numbers of badly needed physicians have forsaken the inner cities and poorer rural areas for more lucrative practices in the suburbs. These difficulties have been exacerbated by economic measures which have crudely reduced the number of services available to Medicaid recipients, rather than tackling the

23. SECURING ACCESS, supra note 5, at 95 (noting that "[t]he income eligibility limits for Medicaid . . . are generally more restrictive than the national poverty guidelines").
24. Bush, Clinton Health Care Plans Analyzed in Families USA/Lewin-ICF Analysis Performed Under Auspices of Bipartisan Committee, HEALTH NEWS DAILY, Oct. 2, 1992, available in Westlaw, HND Database (citing U.S. Dept' of Labor estimates); see also, SECURING ACCESS, supra note 5, at 92-100. As it was put recently, "[i]nstead of rationing medical services themselves, as the United Kingdom does in order to provide everyone basic care, United States health insurance mechanisms simply 'ration' uninsured individuals away from medical treatment altogether." Frances H. Miller, Denial of Health Care and Informed Consent in English and American Law, 18 AM. J.L. & MED. 37, 42 (1992).
25. See Paul Starr, Medical Care and the Pursuit of Equality in America, in APPENDICES: SOCIOCULTURAL AND PHILOSOPHICAL STUDIES, supra note 12, at 3 app. A (discussing the development of marginal inequality in medical care and the rise in employee health benefit plans). See also HAVIGHURST, supra note 12, at 40-46; see generally id. especially at 65, 111, 140.
26. See SECURING ACCESS, supra note 5, at 183-197 (recognizing a growing concern by the American public that rising costs do not result in increased benefits).
27. For an examination of the wide variations in the ratio of physicians to population in the U.S. and the corresponding differences in levels of health, see John L.S. Holloman Jr., Access to Health Care, in APPENDICES: SOCIOCULTURAL AND PHILOSOPHICAL STUDIES, supra note 12, at 79 app. E at 84-85.
root causes of medical expansionism in general. It is, therefore, no surprise that the U.S. President’s Commission found that levels of ill-health were considerably higher among low-income groups and traditionally disadvantaged minorities in American society. Bearing this in mind, it is hoped that President Bill Clinton will remain true to his undertaking to effect a far-reaching reform of the U.S. health care system.

III. MEDICAL EMERGENCY AND THE DUTY TO RESCUE

The absence of a comprehensive health care system in the U.S., with access predicated upon need, is felt most acutely in cases of medical emergency. In this context, this article is most appropriately focused upon the existence and extent of the moral and legal duty upon medical professionals and hospital authorities to effectively rescue an individual whose health and life is in grave danger by affording urgently required treatment. In dealing with the question of whether the moral duty to render emergency medical assistance as embodied in the parable of the Good Samaritan is to be converted into a legal duty, the approaches of the common law and civil law jurisdictions have diverged considerably.

The individualist bias already noted in this article in connection with the U.S. health care system is also manifested in the refusal of courts in common law countries to impose liability for failure to act to prevent harm or nonfeasance as distinguished from affirmative misconduct or misfeasance. In the medical context, this has meant that a doctor “may flout his Hippocratic oath and deny aid to a stranger, even in an emergency like a road accident.” Indeed, in a leading decision of

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28. Thus, while the recent reforms of the Oregon Medicaid program have expanded the number of persons covered, it has been shown that the state’s novel system of “fluid prioritization” of available health care benefits will disadvantage children and pregnant women considerably. See Sarah Rosenbaum, Mothers and Children Last: The Oregon Medicaid Experiment, 18 AM. J.L. & MED. 97 (1992).


the High Court of Australia, it was stated that in the parable of the Good Samaritan "both priest and Levite ensured performance of any common law duty of care to the stricken traveller when, by crossing to the other side of the road, they avoided any risk of throwing up dust in his wounds." By contrast, the civil law jurisdictions have not been so timorous about obliging rescue in emergency situations, and failure to do so in certain clearly defined circumstances will incur criminal and civil sanctions.

Supporters of the common law position have argued that to impose such a duty upon doctors would deprive them of their right to contract freely for the provision of medical services and, thereby, would amount to a morally unacceptable appropriation of their labor. This analysis, however, ignores significant aspects of the relationship 1) between doctors and society and 2) between doctors and their individual patients. Fundamentally, the practice of medicine is subject to the licensing powers of state authorities and is confined to a select and well-remunerated body of professionals. Furthermore, the newly graduated doctor owes a considerable debt to society — his training having been funded by enormous state investment and his clinical experience having been gained through practice upon willing patients, a disproportionate number of whom will themselves have been indigent. Clearly, a doctor required to provide vital treatment in an emergency situation is not "giving something for nothing." In addition, the characterization of the doctor-patient relationship as a series of arms-length transactions solely rooted in the law of contract is wholly at odds with existing law and with the ancient ethical traditions of the medical profession. Fiduciary duties of disclosure, confidentiality and respect for the patient's fundamental human interests, im-

37. Holloman, supra note 27, at 92-93.
38. It is submitted that a covenant based analysis of the duties of the individual doctor and of the medical profession as a whole more faithfully represents the realities of social practice and ethical understanding. See William F. May, Code, Covenant, Contract, or Philanthropy, 516 Hastings Ctr. Rep. Dec. 1975, at 29.
posed upon doctors by law, recognize the heightened vulnerability and dependency of patients.\textsuperscript{39} This position of patient weakness is at its most extreme in emergency cases, where it is impossible, as a matter of fact, for individuals to negotiate contractual terms or to seek alternative sources of care.

There have, however, been a number of attempts to modify the common law position to the advantage of patients in need through a range of legislative strategies and a significant body of case law designed to "force rescue" in emergency situations. Thus, in the U.S. the Hill-Burton Act of 1946,\textsuperscript{40} which provided federal funding for the construction and expansion of hospitals, authorized the federal agency responsible to require assurances from applicants for funding that a measure of hospital care would be provided free of charge to indigent patients.\textsuperscript{41} Furthermore, over half of the U.S. state governments have enacted legislation requiring all general and surgical hospitals to provide emergency care as a condition of their being licensed to operate.\textsuperscript{42} Regrettably, however, it must be admitted that these measures have \textit{not} had a very substantial impact due to widespread non-compliance and under-enforcement.\textsuperscript{43} The Consolidated Omnibus Budget Reconciliation Act of 1985\textsuperscript{44} requires all hospitals participating in the Medicare scheme, which have appropriate facilities, to provide treatment to stabilize an emergency condition, to provide assistance to a woman in active labor or to provide for an appropriate transfer of either type of patient to another medical facility (i.e. where

39. For a comparative analysis with copious references, see Giesen, \textit{supra} note 14, §§ 482-729 (1988) (duty of disclosure); \textit{id.} at §§ 833-90 (duty of confidentiality and patient-physician communication). This analysis is illustrated by recent North American case law from the U.S. and Canada. See, \textit{e.g.}, Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (Cal. 1990) (doctor required by law to disclose any financial or scientific interest he may have in a patient's course of treatment); Norberg v. Weinrib, 92 D.L.R. 4th 449 (Can. 1992) (doctor required by law not only to protect a patient's narrow legal and economic interests, but also fundamental human interests).


41. Furr\textit{ow} \textit{et al.}, \textit{supra} note 18, at 628-629 (synopsis of legislative history and of litigation concerning subsequent regulations for the Act). Note also that discrimination on grounds of race, color or national origin under any program or activity receiving federal funding is subject to review under 42 U.S.C. §§ 2000d to 2000d-6 (1982).

42. \textit{E.g.}, \textit{ILL. REV. STAT.} ch. 111.5, para. 86 (1969); \textit{CAL. HEALTH & SAFETY CODE} §§ 1317.2-.2a, §§ 1798.170-.172 (West 1990).


the benefits of transferring the patient outweigh the burdens of doing so). The effectiveness of this statute is increased by the inclusion of a "civil enforcement" provision allowing a patient who has been injured by a hospital's violation of the provisions of the statute to obtain damages and equitable relief.\textsuperscript{46}

Although in the absence of a contractual agreement a doctor is under no common-law duty to render emergency treatment as was found in the Arizona case of Hiser \textit{v.} Randolph,\textsuperscript{46} courts have shown a notable desire to circumvent the harsher implications of this rule.\textsuperscript{47} Thus, it has been held in both England and the U.S. that, when a patient presents himself at a health care facility in reliance upon the established custom of that facility to afford emergency treatment, a doctor who refuses to attend to him will be liable for medical malpractice,\textsuperscript{48} as will the hospital itself by way of vicarious or direct liability.\textsuperscript{49} Similarly, a doctor who discontinues a necessary course of treatment without making adequate provision for his replacement by another physician will be liable under the law of negligence for abandonment.\textsuperscript{50} In an expansive interpretation of \textit{when} such a course of treatment can be said to have commenced, the Supreme Court of Mississippi has held that where the plaintiff "was recorded as an emergency room patient, and remained there two hours . . . the Hospital and its employees had a duty to use reasonable care in protecting his life and well being."\textsuperscript{51} It has also been held that, where state regulations and licensing conditions require hospitals to maintain emergency


\textsuperscript{46} Hiser \textit{v.} Randolph, 617 P.2d 774 (Ariz. 1980) (holding defendant-doctor was bound by his contract of employment which obliged him to render emergency treatment).

\textsuperscript{47} \textit{See} ROTHENBERG, \textit{supra} note 43 (providing a thorough discussion of American developments in this regard).

\textsuperscript{48} Barnett \textit{v.} Chelsea \& Kensington Hosp. Mgmt. Comm., [1969] 1 Q.B. 428 (Eng.) (denying claim, however, because plaintiff was unable to establish an adequate causal link between omission to treat and death of decedent); \textit{see also} Wilmington Gen. Hosp. \textit{v.} Manlove, 174 A.2d 135, 140 (Del. 1961).

\textsuperscript{49} For a comparative discussion of the vicarious and direct liability of hospital authorities, \textit{see} GIESEN. \textit{supra} note 14, at ¶ 50-106.

\textsuperscript{50} \textit{See id.} at ¶ 724.

\textsuperscript{51} New Biloxi Hosp., Inc. \textit{v.} Frazier, 146 So. 2d 882, 887 (Miss. 1962).
rooms, access to these facilities cannot be denied solely on the basis of an inability to pay.\textsuperscript{52}

The enactment in many American jurisdictions of so-called Good Samaritan statutes is a further development intended to ameliorate the situation of patients in urgent need of treatment.\textsuperscript{53} These statutes, which only apply outside the hospital context, are intended to provide an incentive to doctors to fulfill their ethical obligations in this regard by generally imposing liability upon them only where they have been \textit{grossly negligent} in the provision of emergency treatment.\textsuperscript{54} As Professor and now Justice Linden stated, this affirmative action rule "does not inhibit would-be rescuers while at the same time is not too inviting to bunglers."\textsuperscript{55} It is submitted, however, that these statutes, which are the result of "active lobbying by medical associations,"\textsuperscript{56} represent a wholly anomalous and unacceptable exception to the general law of negligence. While it has been widely affirmed that in determining whether a defendant is liable in negligence courts must take into account the objective circumstances in which he found himself,\textsuperscript{57} this does not mean that at common law a different, lower standard of care is applied to conduct in emergency situations. Rather, it has been held in England for example that, once a rescue attempt has been commenced, the rescuer must comply with the standard of care of the reasonable man in the particular circumstances.\textsuperscript{58} There would appear to be no principled reason for extending favorable treatment to the medical profession in this regard. Furthermore, doctors' fears of a flood of litigation are wholly misplaced, since no single case has been found in the U.S. or Canada where a physician was actually sued for

\textsuperscript{52} E.g., Guerrero v. Copper Queen Hosp., 537 P.2d 1329, 1331 (Ariz. 1974); see also Thompson v. Sun City Community Hosp. Inc., 688 P.2d 605, 609 (Ariz. 1984) (endorsing the decision in Guerrero).

\textsuperscript{53} For a state-by-state survey of 'Good Samaritan' statutes, see Giesen, \textit{supra} note 14, at \textsection 720.

\textsuperscript{54} But cf. Colby v. Schwartz, 78 Cal. App. 3d 885 (1978) (holding that physicians are not protected by such statutes when working on an emergency case as part of normal hospital routine).


\textsuperscript{56} Keeton \textit{et al.}, \textit{supra} note 32, at \textsection 56.

\textsuperscript{57} Giesen, \textit{supra} note 14, at \textsection 133.

malpractice arising out of treatment rendered at the scene of an emergency.  

It thus emerges that in common law countries, in the absence of an affirmative duty to provide emergency medical assistance, a mosaic of statutory and common law obligations and incentives has been put in place to give effect to the basic humanitarian duty to assist another in peril. Unfortunately, we have also seen that each of these incremental measures has met with but partial success and, indeed, John Fleming's criticism that the "remnants of excessive individualism [in the common law] are apt to evoke invidious comparison with affirmative duties of good neighbourliness in most countries outside the common law orbit" remains valid. It is submitted that a clear, though sharply delimited and defined duty to rescue individuals in grave need of attention should be imposed upon doctors and hospital authorities who are in a position to do so. The cautious judicial development of the defence of necessity, which raises similar fears of undue intrusion upon individual liberty, would provide a useful model for the shaping of a common law duty to rescue. Furthermore, judicial interpretation of Section 323c of the German Penal Code demonstrates that the problems of identifying the appropriate defendant and of establishing causation, which are often cited by Anglo-Saxon commentators as reasons for not imposing liability for omissions, are not insurmountable. Indeed, a number of German decisions indicate that, so far from there being a reduction in the standard expected of doctors in rescue situations, as is the case under the aforementioned Good Samaritan statutes, the extent and quality of the assistance which they are required to provide

59. Giesen, supra note 14, at ¶ 721.
61. Fleming, supra note 33, at 147.
62. Southwark London Borough Council v. Williams, [1971] 1 Ch. 734 (Eng. C.A.) (rejecting claim of a deference of "economic" necessity to an action in trespass, confined the defence to urgent situations of imminent peril). See also Fleming, supra note 33, at 94-98.
63. For a masterful exposition of the analogical basis for a common law duty to rescue and a demonstration of the compatibility of such a duty with the two main philosophical traditions of the common law, see Ernest J. Weinrib, The Case for a Duty to Rescue, 90 Yale L.J. 247 (1980).
64. See Adolf Schönke et al., Strafgesetzbuch: Kommentar notes 1-36 to § 323c StGB (Penal Code) (24th ed. 1991).
may be increased in the light of their special training and skills.\textsuperscript{65}

IV. ETHICS, LAW AND THE PATIENT’S RIGHTS

We have seen that the failure of certain states to provide at least a minimum of health care to their indigent members, and the reluctance of the common law to impose a duty upon doctors to render aid in emergency situations, are both open to harsh criticism in the light of ethical principles generally accepted in society. However, these principles, which generate rights to receive and obligations to provide certain forms of medical treatment, are applicable with equal normative force to the therapeutic relationship itself, once access to the health care system has been obtained.

The overwhelming propensity of medical professionals to view their task as the scientific application of all available technology to the patient has already been identified as a significant cause of increasing costs in the health care sector. Correspondingly, on this model “[d]isease manifests itself as a malfunction in a specific area; it can be corrected or ameliorated with proper diagnosis and reparative techniques. These techniques usually consist of a chemical or biological agent specifically suited to attack and render harmless the germ or biological malfunction that caused the disease.”\textsuperscript{66} Under this conception the individual, although gaining access to medical services, loses all rights on becoming a patient and becomes merely the passive object of those procedures which the attending physicians deem to be in his best interests.\textsuperscript{67} But if the law is to faithfully embody the value of individual autonomy, which is at the core of any civilized society\textsuperscript{68} and which, as we have seen,


\textsuperscript{67} This is also the focus of the scathing criticism to be found in Kennedy, \textit{supra} note 15, at 70-75.

\textsuperscript{68} The central importance of individual autonomy in the legal and political order has been widely acknowledged. See, e.g., Sidaway v. Bethlehem Royal Hosp. Governors,
generates the moral obligation upon society to provide for access to necessary medical care, it cannot allow the medical profession to play God in this manner.  

As Lord Scarman stated, in his formidable dissent in *Sidaway v Bethlem Royal Hospital Governors*:

The doctor’s concern is with health and relief of pain. These are the medical objectives. But a patient may well have in mind circumstances, objectives and values which he may reasonably not make known to the doctor but which may lead him to a decision different from that suggested by a purely medical opinion. The doctor’s duty can be seen, therefore, to be one which requires him not only to advise as to matters of medical treatment but also to provide his patient with the information needed to enable the patient to consider and balance the medical advantages and risks alongside other relevant matters, such as, for example, his family, business or social responsibilities of which the doctor may be only partially, if at all informed.

The patient’s full and valid consent is an unavoidable prerequisite of the legality of any diagnostic or therapeutic procedure to which he is submitted. In this regard, in so far as courts in England (or Scotland) have allowed the medical profession itself to set the standard of disclosure in consent cases, they have abdicated their constitutional function to develop objective standards of care and thereby have failed to vindicate and protect the patient’s right to self-determination. In so doing, the English and Scottish courts are out of step not only with their counterparts in the civil law world, but also with all the other major common law jurisdictions.

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In adopting a patient-centered approach to the question of standards of disclosure in medical malpractice actions, the Supreme Court of South Australia has stated that the law must respect "the right of every human being to make decisions which affect his own life and to determine the risks which he is willing to undertake." While the patient-centered perspective of Australian and Canadian jurisprudence regarding consent to medical treatment avoids the most lamentable shortcomings of the deferential doctor-centered approach in Britain vis-à-vis the medical profession, it is submitted that the qualification of this approach by the adoption of a "reasonable patient" test fails to extend due protection to the patient's fundamental right to self-determination. The application of a test based upon reasonableness means that the patient's "supposedly inviolable right to decide for himself what is done with his body is made subject to a standard set by others. The right to base one's consent on proper information is effectively vitiated for those with fears, apprehensions, religious beliefs or superstitions outside the mainstream of society." These words have been echoed by the German Federal Supreme Court, which has imposed the optimal requirement that the extent of disclosure required of the attending doctor be determined by the subjective informational needs of the particular patient. As it stated, to "respect the patient's own will is to respect his freedom and dignity as a human being."


75. McPherson v. Ellis, 287 S.E.2d 892, 897 (N.C. 1982) (emphasis added) (holding that jury should consider what patient's decision would have been had she had been properly informed of risk of paralysis).


Ethical and legal issues of the most profound significance are also integral to treatment decisions at the "edges of life." A proliferation of new techniques in the field of artificial reproduction presents the serious threat that the pursuit of the novel and the fashionable by medical researchers will leave the law lagging behind and unable to fully implement society's fundamental ethical values. The price of medical prowess in this area has been the destruction of countless human embryos through cryopreservation and experimentation. In the face of this, the law must insist that artificially conceived human life is nurtured in the child's own interests and emphasize that that which is medically possible is not always morally or legally acceptable. As Professor Krause has explained it, "a child is not 'medication' to be prescribed lightly to frustrated, would-be parents . . . the greatest responsibility is owed directly to the child." Put bluntly, the law cannot allow doctors, under the guise of fulfilling societal obligations to provide health care, to take up the glittering stones of human genes and embryonic life and piece together mosaics at random, in accordance with their scientific whims or curiosity.

Similarly, at the other "end of life," technological developments have enabled doctors to prolong the lives of many terminally and hopelessly ill patients (i.e. those in a persistent vegetative state). In these circumstances it is again essential that the medical profession is not allowed to play God with human life. The law must reflect its strong commitment both to individual autonomy and the sanctity of human life in regulating this area of medical practice.

78. See Paul Ramsey, Ethics at the Edge of Life: Medical and Legal Intersections (1978). The importance of the ethical issues at the end of life are discussed in Giesen, supra note 14, at ¶¶ 938-983, 1324, 1328, 1360-1375, 1391, 1405-1416, 1424-1441, 1460-1493.

79. The legal and ethical aspects of artificial reproduction are discussed in Giesen, supra note 14, at ¶ 1343-1416.


82. These were the central concerns of the U.S. Supreme Court in its recent decision in Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990).
V. CONCLUSION

It has been seen that an ethically consistent approach must inform both provisions for initial access to health care and the legal regulation of treatment once this access has been achieved. Discussion of patients' rights is of little significance if individuals are excluded in limine from necessary medical services due to poverty or geographical happenstance. But correspondingly, individuals must be ensured the full enjoyment of their basic human rights once they have entered the system. Common to our consideration of issues of access, consent to treatment and procedures undertaken at the edges of life was the tendency noted among medical professionals to conceive of themselves as the agents of an ever-advancing science, free from ethical and legal constraints. This self-image is fostered by the process of "socialization" and "role modelling" which doctors-in-training undergo. A firm esprit de corps is generated and indeed a doctor's primary duty, as embodied in the Hippocratic Oath, is not to his patient or to society but to his fellow practitioners. In the words of Ian Kennedy of King's College at London, a result of this veneer of scientific invincibility: "we [the public] have come almost to believe in magic cures and the waving of wands. The reality has been a constant disappointment. The promised or expected cures are not there." Doctors are, therefore, better advised to view their relationship with their individual patients and with society as a whole as one of fiduciary partnership in the furtherance of the basic human values of life and personal autonomy through the promotion and preservation of health. As was said by three of the eight judges on Germany's highest court, the German Federal Constitutional Court, in a landmark medical malpractice decision:

Trust cannot be demanded one-sidedly by the physician alone. Endeavors are right to place the burden of a physician-patient relationship not only on the shoulders of the physician but to distribute them more evenly by making the patient cooperate and assume his own part of responsibility for his

84. For a discussion of the tendency of professionals to follow one another, see GIESEN, supra note 14, at ¶¶ 1471-1527.
85. KENNEDY, supra note 15, at 46.
health . . . Co-operation, a real physician-patient dialogue and a general strengthening of the patient's sensitivity of their own responsibility will only be possible where the patient first of all is made an active participant and thus has received the information relevant to his medical care. . . What is required then is that the physician shares with the patient all the inherent uncertainties and risks, unless the patient has made it clear that he does not want more information. In this way the patient will be made privy to the knowledge about his situation and the inherent risks, a consequence which he will not escape anyway if he consents to treatment. This makes him a responsible partner of the physician.86

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