EthxWeb Search Results

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* Book Document 1
Wolff, Jonathan
THE HUMAN RIGHT TO HEALTH
Call number: RA427.9 .W65 2012

Article Document 2
Schneiderman, Lawrence J
Response to open peer commentaries on "Rationing just medical care".
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Article Document 3
Kuczewski, Mark G
Who is my neighbor? A communitarian analysis of access to health care for immigrants.
Theoretical medicine and bioethics 2011 Oct; 32(5): 327-36
Abstract: Immigrants lacking health insurance access the health care system through the emergency departments of non-profit hospitals. Because these persons lack health insurance, continued care can pose challenges to those institutions. I analyze the values of our health care institutions, utilizing a Walzerian approach that describes its appropriate sphere of justice. This particular sphere is dominated by a caring response to need. I suggest that the logic of this sphere would be best preserved by providing increased access to health insurance to this population. This access would marry the rights of these members of our community to access care to our responsibility to contribute to financing of the system. I close with some considerations on what it means to be a member of the community.
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Article Document 4
McCartney, Margaret
Adult and child asylum seekers should be treated with humanity.
BMJ (Clinical research ed.) 2011 September 7; 343: d5571
Georgetown users check Georgetown Journal Finder for access to full text

Article Document 5
Fuchs, Victor R
The doctor's dilemma—what is "appropriate" care?
Georgetown users check Georgetown Journal Finder for access to full text

Document 6
Rhodes, Karin
Taking the mystery out of "mystery shopper" studies.
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Document 7
Upton, Hugh
Rationing: the loss of a concept.
Abstract: In the literature on the subject there is a trend towards understanding the idea of rationing in healthcare very broadly, to include any form of restriction in supply. It is suggested in this paper that there are good reasons to resist this move, since it would both render the concept redundant through being trivially true and displace an earlier, egalitarian one that retains great moral significance for the supply of healthcare. The nature and significance of the narrower, egalitarian conception is set out, drawing particular attention to the fact that it marks a contrast with the idea of prioritising certain people or groups over others and to the fact that it is a form of rationing that is plausibly regarded as a morally desirable response to severe shortages. It is contrasted with the broad conception and arguments in favour of this latter are considered and rejected.
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Document 8
Braun, Brenda
Ethical issues of hospital crowding solutions.
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Document 9
Miracle, Vickie A
The rights and responsibilities of patients and nurses.
Abstract: This is a brief reminder of the rights and responsibilities of patients and nurses. An overview of these topics is presented.
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Document 10
Bean, Sally
Navigating the murky intersection between clinical and organizational ethics: a hybrid case taxonomy.
Abstract: Ethical challenges that arise within healthcare delivery institutions are currently categorized as either clinical or organizational, based on the type of issue. Despite this common binary issue-based methodology, empirical study and increasing academic dialogue indicate that a clear line cannot easily be drawn between organizational and clinical ethics. Disagreement around end-of-life treatments, for example, often spawn value differences amongst parties at both organizational and clinical levels and requires a resolution to address both the case at hand and large-scale underlying system-level confounders. I refer to issues that contain elements of both clinical and organizational issues as hybrids and propose a new taxonomy to characterize hybrid cases. I contend that salient contextual features of an ethical issue, such as where it is identified, who it impacts and where it is ideally resolved in relation to its scope of impact, should inform procedure. Implementation of a Hybrid taxonomy viewing ethical issues as existing on a continuum furthers that end. The primary goals are to 1) systematize thinking about ethical issues that arise within healthcare delivery institutions and 2) allow the content of the ethical challenge to drive the process, rather than continuing to rely on the traditional binary issue-based choice. Failure to capture the complexity of hybrid situations perpetuates incomplete information and ultimately an inchoate resolution that creates more questions than answers.

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Document 11
Dyer, Clare
Poland violated human rights of woman who was refused timely access to prenatal tests.
BMJ (Clinical research ed.) 2011 June 3; 342: d3484
Georgetown users check Georgetown Journal Finder for access to full text

Document 12
Biller-Andorno, Nikola
Who cares?
Georgetown users check Georgetown Journal Finder for access to full text

Document 13
Rasanathan, K; Sivasankara Kurup, A; Jaramillo, E; Lönnroth, K
The social determinants of health: key to global tuberculosis control.
The international journal of tuberculosis and lung disease : the official journal of the International Union against Tuberculosis and Lung Disease 2011 Jun; 15 Suppl 2: S30-6

Abstract: Improved tuberculosis (TB) diagnosis and treatment through the DOTS and Stop TB strategies have saved millions of lives; however, their impact on TB incidence has been disappointing and the scale of the epidemic remains overwhelming. To reduce the incidence of TB, the drivers of the epidemic and social determinants of TB need to be addressed. These include co-morbidities and substance use and, moreover, the social and economic conditions that determine both the course of the TB epidemic and exposure to these risk factors. Doing so builds on the history of TB prevention and treatment during the public health revolution that resulted in a dramatic reduction in incidence in many countries. Addressing the social determinants is also imperative to address pervasive inequities in the incidence, mortality and morbidity of TB between different population groups, including in the performance of health systems in delivering diagnostic and treatment interventions, and in the financial consequences of people seeking care. Action on the social determinants can be categorised in terms of health-sector interventions, intersectoral policies impacting across society, and measurement and research to better understand inequities and links between TB and other factors. TB programmes cannot carry out these actions alone; however, they can make important contributions in the delivery of interventions and in advocating and negotiating for intersectoral efforts. The considerable progress seen in the clinical care of TB needs to be sustained; however, the attainment of TB targets, including elimination by 2050, will require expansion of the lens of TB control efforts beyond 'business as usual' to address the social determinants of the disease.

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McGee, Glenn

Fat chance getting an obstetrician in South Florida? Ethics and discrimination in obstetrics and gynecology.

Rhodes, Karin V; Bisgaier, Joanna

Limitations in access to dental and medical specialty care for publicly insured children.
LDI issue brief 2011 May-Jun; 16(7): 1-4

Abstract: Medicaid and the state-run Children's Health Insurance Program (CHIP) cover about 42 million children, many of whom would not have access to care without public insurance. Federal law requires that this access be equivalent to that of privately insured children for covered services, and many states have implemented policies to improve longstanding disparities in primary and preventive care. Reimbursement rates are up, but significant disparities remain, especially for dental and specialty services. It is important to understand the distinct effect of provider-related barriers, because they are potentially more modifiable through health policy than patient-related ones. This Issue Brief summarizes research that directly measures the willingness of dental and medical providers to see publicly-insured children, using research assistants posing as mothers calling for an urgent appointment for their child.

Wang, Emily A; Wildeman, Christopher

Studying health disparities by including incarcerated and formerly incarcerated individuals.
JAMA : the journal of the American Medical Association 2011 Apr 27; 305(16): 1708-9

dos Santos, Ellen Cristina Barbosa; Teixeira, Carla Regina de Souza; Zanetti, Maria Lucia; dos Santos, Manoel Antonio; Pereira, Marta Cristiane Alves

Health services users with diabetes mellitus: from knowledge to the use of healthcare rights.

Abstract: This descriptive study with qualitative approach analyzes the knowledge of individuals with diabetes mellitus (DM) concerning their health rights. Open interviews were conducted with 12 individuals with DM in a university center in the interior of Sao Paulo, Brazil. Content analysis enabled the identification of two categories: the users' (lack of) knowledge concerning their rights and the unaware exercise of their rights. The results revealed that despite the legal advancements achieved in public policies, most users with DM are unaware of their rights, although
they use the benefits that accrue from law in an unconscious way. Providing complete and sufficient information is essential so that individuals are able to make the best decision in relation to their treatment, preserving their autonomy.

Document 19

McHale, Jean V

**The new EU healthcare rights directive: greater uniformity?**
British journal of nursing (Mark Allen Publishing) 2011 Apr 14-27; 20(7): 442-4

**Abstract:** On 9th March 2011 the new EU Directive on Patients’ Rights in Cross-border Healthcare was adopted. This article explores its implications for the delivery of health care in the UK. It notes that the final version of the Directive provides much greater discretion to member states to control access to resources than was suggested in early drafts of the Directive. It explores the situations in which care can be subject to prior authorization and suggests that perhaps the greatest long-term impact of the Directive will not be in patient mobility as such but rather in relation to its impact on broader standard setting across the EU.

Document 20

Schroeder, Doris

**Does the pharmaceutical sector have a coresponsibility for the human right to health?**

Document 21

Leisinger, Klaus M; Schmitt, Karin M

**Access to healthcare and the pharmaceutical sector.**

Document 22

Grover, Anand; Citro, Brian

**India: access to affordable drugs and the right to health.**
Lancet 2011 Mar 19; 377(9770): 976-7

Document 23

Fitchett, J R

**The right to health in practice.**
Document 24

Menzel, Paul T

The cultural moral right to a basic minimum of accessible health care.

Kennedy Institute of Ethics journal 2011 Mar; 21(1): 79-119

Abstract: (1) The conception of a cultural moral right is useful in capturing the social-moral realities that underlie debate about universal health care. In asserting such rights, individuals make claims above and beyond their legal rights, but those claims are based on the society’s existing commitments and moral culture. In the United States such a right to accessible basic health care is generated by various empirical social facts, primarily the conjunction of the legal requirement of access to emergency care with widely held principles about unfair free riding and just sharing of costs between well and ill. The right can get expressed in social policy through either single-payer or mandated insurance. (2) The same elements that generate this right provide modest assistance in determining its content, the structure and scope of a basic minimum of care. They justify limits on patient cost sharing, require comparative effectiveness, and make cost considerations relevant. They shed light on the status of expensive, marginally life extending, last-chance therapies, as well as life support for PVS patients. They are of less assistance in settling contentious debates about screening for breast and prostate cancer and treatments for infertility and erectile dysfunction, but even there they establish a useful framework for discussion. Scarcity of resources need not be a leading conceptual consideration in discerning a basic minimum. More important are the societal elements that generate the cultural moral right to a basic minimum.

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Document 25

Dubrey, Simon W; Mehta, Paresh A; Sharma, Ritu; Shah, Sheila

Entitlement to hospital treatment in the UK: qualifiers, challenges and comment.


Abstract: Entitlement to NHS care is in some cases complex. Regulations include inter-country reciprocal agreements and specific categories of individuals who qualify. This article describes the current, albeit fluid, situation with discussion around some of the more contentious areas.

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Document 26

Menzel, Paul T

Dishonesty, ignorance, or what?

The Hastings Center report 2011 Mar-Apr; 41(2): 16-7

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Document 27

Sulmann, D


Abstract: All citizens have the right to dignified and respectful social care and assistance. The state and society as a whole have the responsibility to guarantee the realization of these rights. However, the question arises what is dignified and respectful long-term care and assistance for the individual? One possible answer is given by the German Charter of Rights for people in need of long-term care and assistance. The charter summarizes existing books of law such as the German Federal Constitution or the European Social Charter and translates them into a specific context of long-term care. It is written in a language easily understood by everyone and reflects the central situation of people in need of long-term care and assistance. It sets an explicit benchmark for health and social care
in Germany. The Charter was developed in 2005 at the round table for long-term care, hosted by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth in collaboration with the Federal Ministry of Health and Social Security. The round table consisted of representatives of users, consumer groups and other stakeholders, but also of care providers and health and care insurance funds in Germany. Many institutions, such as residential homes and health care services have now successfully applied the Charter in their daily work and it has found its way into several books of law at national and regional levels. The following article gives an overview of the structure, content and intention of the Charter and also highlights examples of implementation and its effects on the care structure and daily work with people in need of long-term care.

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Document 28

Parker, Joseph Clint

Conscience and collective duties: do medical professionals have a collective duty to ensure that their profession provides non-discriminatory access to all medical services?

Abstract: Recent debates have led some to question the legitimacy of physicians refusing to provide legally permissible services for reasons of conscience. In this paper, I will explore the question of whether medical professionals have a collective duty to ensure that their profession provides nondiscriminatory access to all medical services. I will argue that they do not. I will also argue for an approach to dealing with intractable moral disagreements between patients and physicians that gives both parties veto power with regards to participation. Finally, I will respond to three objections to allowing physicians broad freedom to act on their consciences: such allowances would violate the conscience of the patient, would lead to unfairness, and would thwart important societal goals.

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Document 29

Chatterjee, Patralekha

Seeing health care as a human right in India.
Lancet 2011 Jan 15; 377(9761): 195-6

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Document 30

Kruse, Jerry

Rationing medical resources: panacea or peril for American health care?

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Document 31

Venkatapuram, Sridhar; Bell, Ruth; Marmot, Michael

The right to sutures: social epidemiology, human rights, and social justice.

Abstract: The article examines the convergences and contrasts between social epidemiology, social medicine, and human rights approaches toward advancing global health and health equity. The first section describes the goals and work of the WHO Commission on Social Determinants of Health. The second section discusses the role of human rights in the Commission's work. The third section evaluates, from the perspective of social epidemiology, two rights-based approaches to advancing health and health equity as compared to a view that focuses more broadly on social justice. The concluding section identifies four areas where social epidemiologists, practitioners of social medicine,
and health and human rights advocates can and must work together in order to make progress on health and health equity.

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**Document 32**

Chapman, Audrey R

**The social determinants of health, health equity, and human rights.**

**Abstract:** This article explores the benefits of a rights-based approach to health according greater attention to the social determinants of health, health equity, and the power structure. It uses the report issued by the World Health Organization Commission on Social Determinants of Health (CSDH), "Closing the gap in a generation: Health equity through action on the social determinants of health," as a lens through which to address these issues. After presenting a brief overview of the CSDH report, the article compares the document with a rights-based approach to health on three topics: 1) the social determinants of health and the underlying determinants of health; 2) health inequalities and inequities; and 3) power, money, and resources. The article argues that the right to health requires greater attention to the social determinants of health, health inequalities, and power dynamics than these topics have received to date.

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**Document 33**

Braveman, Paula

**Social conditions, health equity, and human rights.**

**Abstract:** The fields of health equity and human rights have different languages, perspectives, and tools for action, yet they share several foundational concepts. This paper explores connections between human rights and health equity, focusing particularly on the implications of current knowledge of how social conditions may influence health and health inequalities, the metric by which health equity is assessed. The role of social conditions in health is explicitly addressed by both 1) the concept that health equity requires equity in social conditions, as well as in other modifiable determinants, of health; and 2) the right to a standard of living adequate for health. The indivisibility and interdependence of all human rights—civil and political as well as economic and social—together with the right to education, implicitly but unambiguously support the need to address the social (including political) determinants of health, thus contributing to the conceptual basis for health equity. The right to the highest attainable standard of health strengthens the concept and guides the measurement of health equity by implying that the reference group for equity comparisons should be one that has optimal conditions for health. The human rights principles of non-discrimination and equality also strengthen the conceptual foundation for health equity by identifying groups among whom inequalities in health status and health determinants (including social conditions) reflect a lack of health equity; and by construing discrimination to include not only intentional bias, but also actions with unintentionally discriminatory effects. In turn, health equity can make substantial contributions to human rights 1) insofar as research on health inequalities provides increasing understanding and empiric evidence of the importance of social conditions as determinants of health; and, more concretely, 2) by indicating how to operationalize the concept of the right to health for the purposes of measurement and accountability, which have been elusive. Human rights laws and principles and health equity concepts and technical approaches can be powerful tools for mutual strengthening, not only by contributing toward building awareness and consensus around shared values, but also by guiding analysis and strengthening measurement of both human rights and health equity.

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**Document 34**

Rasanathan, Kumanan; Norenhag, Johanna; Valentine, Nicole

**Realizing human rights-based approaches for action on the social determinants of health.**
**Abstract:** Health inequities are clear evidence of violations of the right to health. Yet despite this common ground, action on the social determinants of health aiming to reduce health inequities is sometimes disconnected from implementation of human rights-based approaches. This is explained in part by differing histories, disciplines, and epistemologies. The capacity of human rights instruments to alter policies on social determinants can seem limited. An absolutist focus on individuals and processes can seem at odds with the attention to differences in population health outcomes central to the concern for health equity. However, developments in rights-based approaches have seen the terrain of human rights increasingly address social determinants. Human rights provide a firm legal basis for tackling the inequities in power and resources that the Commission on Social Determinants of Health identifies as fundamental to achieving health equity. Indicators and benchmarks developed for rights-based approaches to health systems can be developed further within health sectors and translated to other sectors and disciplines. The discourse and evidence base of social determinants can also contribute to implementing rights-based approaches, as its resultant policy momentum can provide essential levers to realize the right to health. Therefore, there is no clear-cut delineation between the human rights and health equity movements, and both may constructively work together to realize their goals. Such constructive collaboration will not prove straightforward; it will, instead, require profound engagement and innovations in both theory and practice. Yet this effort represents an important opportunity for those who seek social justice in health.

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**Document 35**

Friedman, Eric A; Adashi, Eli Y

**The right to health as the unheralded narrative of health care reform.**

*JAMA : the journal of the American Medical Association* 2010 Dec 15; 304(23): 2639-40

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**Document 36**

Kirby, N

**Access to healthcare services as a human right.**

*Medicine and law* 2010 Dec; 29(4): 487-96

**Abstract:** The existence of a right to healthcare or, at least, access to healthcare services, is a right that exists in terms of the Bill of Rights in the Constitution of the Republic of South Africa, 1996. This article explores the scope and ambit of the right and its meaning within the context of both of constitutional directives, the duties imposed upon the State to progressively realise the right for its citizens and the practical implications of the right with reference to existing healthcare infrastructure in the Republic of South Africa.

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**Document 37**

da Silva, Sílvio Eder Dias; Ramos, Flávia Regina Souza; Martins, Cleusa Rios; Padilha, Maria Itayra; Vasconcelos, Esleane Vilela

**[Citizen constitution and social representations: reflecting about health care models]. = Constituição cidadã e representações sociais: uma reflexão sobre modelos de assistência à saúde.**


**Abstract:** This article presents a reflection on the meaning of the terms citizenship and health, addressing the Theory of Social Representations as a strategy for implementing and evaluating health care models in Brazil. First, a brief history about the concept of citizenship is presented; then the article addresses the principles of freedom and equality according to Kant; the third section of the article shows that health is as a right of the citizen and a duty of the state. Finally, the Theory of Social Representations is emphasized as a strategy to evaluate and implement the health services provided to citizens by the current health care models in Brazil.

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Bradley, Andrew

Positive rights, negative rights and health care.
Journal of medical ethics 2010 Dec; 36(12): 838-41

Abstract: In the current debate about healthcare reform in the USA, advocates for government-ensured universal coverage assume that health care is a right. Although this position is politically popular, it is sometimes challenged by a restricted view of rights popular with libertarians and individualists. The restricted view of rights only accepts 'negative' rights as legitimate rights. Negative rights, the argument goes, place no obligations on you to provide goods to other people and thus respect your right to keep the fruits of your labour. A classic enumeration of negative rights includes life, liberty, and the pursuit of happiness. Positive rights, by contrast, obligate you either to provide goods to others, or pay taxes that are used for redistributive purposes. Health care falls into the category of positive rights since its provision by the government requires taxation and therefore redistribution. Therefore, the libertarian or individualist might argue that health care cannot be a true right. This paper rejects the distinction between positive and negative rights. In fact, the protection of both positive and negative rights can place obligations on others. Furthermore, because of its role in helping protect equality of opportunity, health care can be tied to the rights to life, liberty, and the pursuit of happiness. There is, therefore, good reason to believe that health care is a human right and that universal access should be guaranteed. The practical application, by governments and non-governmental organisations, of several of the arguments presented in this paper is also discussed.

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Perehudoff, S K; Laing, R O; Hogerzeil, H V

Access to essential medicines in national constitutions.
Bulletin of the World Health Organization 2010 Nov 1; 88(11): 800

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Castledine, George

The changing patient.
British journal of nursing (Mark Allen Publishing) 2010 Nov 25-Dec 8; 19(21): 1381

Georgetown users check Georgetown Journal Finder for access to full text

Aggarwal, Neil Krishan; Rowe, Michael; Semyak, Michael A

Is health care a right or a commodity? Implementing mental health reform in a recession.

Abstract: The Patient Protection and Affordable Care Act, signed into law by President Obama in March 2010, contains elements of two seemingly contradictory positions: health care as a commodity and as a right. The commodity argument posits that the marketplace should govern demand, supply, and costs of care. The law's establishment of state insurance exchanges reflects this position. The argument that health care is a right posits that it is a need, not a choice, and that government should regulate care standards that may be compromised as insurers attempt to minimize costs. The law's requirement for coverage of mental and substance use disorders reflects this position. This Open Forum examines these arguments in light of current state fiscal crises and impending reforms. Despite the federal government's interest in expanding prevention and treatment of mental illness, states may demonstrate varying levels of commitment, based in part on their perception of health care as a right or a commodity. The federal government should outline clear performance standards, with minimum services specified to maximize state commitments to services.
Document 42

Golan, Ofra

The right to treatment for self-inflicted conditions.

Abstract: The increasing awareness of personal health responsibility had led to the claim that patients with 'self-inflicted' conditions have less of a right to treatment at the public's expense than patients whose conditions arose from 'uncontrollable' causes. This paper suggests that regardless of any social decision as to the limits and scope of individual responsibility for health, the moral framework for discussing this issue is equality. In order to reach a consensus, discourse should be according to the common basis of all theories of justice, Aristotle's formal principle of justice: 'equals must be treated equally and unequals must be treated unequally, in proportion to the relevant inequality'. This paper deals with the question of whether and under what circumstances risk-taking behaviour could be regarded as a 'relevant inequality' with respect to the right to health care. Following a discussion of the relevant inequalities in health care, the conclusion is reached that the fact that the condition was avoidably caused by the patient and is therefore his or her fault can not be regarded necessarily as a relevant inequality. Therefore, the issue is one of societal support for health care; after defining relevant inequalities in this respect, the paper attempts to apply them to self-inflicted conditions. This analysis reveals that, in theory, it may be just to restrict societal support in such cases. However, the application of this conclusion requires proof of many factual claims—for which there is often very limited evidence.

Document 43

Rabinowitz, Aaron

Media framing and political advertising in the Patients' Bill of Rights debate.

Abstract: The purpose of this article is to assess the influence of interest groups over news content. In particular, I explore the possibility that political advertising campaigns affect the tenor and framing of newspaper coverage in health policy debates. To do so, I compare newspaper coverage of the Patients' Bill of Rights debate in 1999 in five states that were subject to extensive advertising campaigns with coverage in five comparison states that were not directly exposed to the advocacy campaigns. I find significant differences in coverage depending on the presence or absence of paid advertising campaigns, and conclude that readers were exposed to different perspectives and arguments about managed care regulation if the newspapers they read were published in states targeted by political advertisements. Specifically, newspaper coverage was 17 percent less likely to be supportive of managed care reform in states subject to advertising campaigns designed to foment opposition to the Patients' Bill of Rights. Understanding the ability of organized interests and political actors to successfully promote their preferred issue frames in a dynamic political environment is particularly important in light of the proliferation of interest groups, the prevalence of multimillion-dollar political advertising campaigns, and the health care reform debate under President Barack Obama.

Document 44

Ridde, Valéry

Universal access to health care systems: defending rights and overturning the pyramids.
Global health promotion 2010 Sep; 17(3): 3-4, 60-2, 95-8

Document 45
Kirschner, Kristi L
One city, two worlds.
The Hastings Center report 2010 Sep-Oct; 40(5): 6-7

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Saraçoğlu, G.V.; Tokuç, B.; Güler, F.; Gül, H.
Evaluation of patient rights practices in a developing country: the Edirne model for the implementation of patient rights in Turkey
Journal of Medical Ethics 2010 August; 36(8): 488-493

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http://jme.bmj.com/content/36/8/488.full.pdf (link may be outdated)

Shaw-Ridley, Mary; Ridley, Charles R
The health disparities industry: is it an ethical conundrum?
Health promotion practice 2010 Jul; 11(4): 454-64
Abstract: Reducing health disparities is the purported mission of a huge network of professionals representing many specialties and organizations offering a variety of products and services. Given its elaborate infrastructure and specialized set of activities, we identity the network as the health disparities industry. In this article, we question the ethics of this industry. Specifically, we ask whether the public mission is trumped by questionable industry leadership, ethics, and quality assurances. Drawing on general principles of ethics and differentiating ethical concerns from ethical problems, we conclude that the collective behaviors within the industry may represent an ethical conundrum. The article concludes with a call for the cross-examination of the industry practices.

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Güvercin, Cemal Hüseyin; Arda, Berna
The perception of the concept of patient rights in Turkey. Examples from the press

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http://eng.bioetica.ro/atdoc/RRBv8n3_2010_Guvercin_EN.pdf (link may be outdated)

Meier, Benjamin Mason; Fox, Ashley M
International obligations through collective rights: Moving from foreign health assistance to global health governance.
Abstract: This article analyzes the growing chasm between international power and state responsibility in health rights, proposing an international legal framework for collective rights - rights that can reform international institutions and empower developing states to realize the determinants of health structured by global forces. With longstanding recognition that many developing state governments cannot realize the health of their peoples without international cooperation, scholars have increasingly sought to codify international obligations under the purview of an evolving human right to health, applying this rights-based approach as a foundational framework for reducing global health
inequalities through foreign assistance. Yet the inherent limitations of the individual human rights framework stymie the right to health in impacting the global institutions that are most crucial for realizing underlying determinants of health through the strengthening of primary health care systems. Whereas the right to health has been advanced as an individual right to be realized by a state duty-bearer, the authors find that this limited, atomized right has proven insufficient to create accountability for international obligations in global health policy, enabling the deterioration of primary health care systems that lack the ability to address an expanding set of public health claims. For rights scholars to advance disease protection and health promotion through national primary health care systems - creating the international legal obligations necessary to spur development supportive of the public's health - the authors conclude that scholars must look beyond the individual right to health to create collective international legal obligations commensurate with a public health-centered approach to primary health care. Through the development and implementation of these collective health rights, states can address interconnected determinants of health within and across countries, obligating the international community to scale-up primary health care systems in the developing world and thereby reduce public health inequities through global health governance.

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**Document 50**

Maru, Vivek

**Allies unknown: Social accountability and legal empowerment.**


**Abstract:** This essay suggests that two strands of social action which have hitherto developed separately - legal empowerment and social accountability - ought to learn from one another. Legal empowerment efforts grow out of the tradition of legal aid for the poor; they assist citizens in seeking remedies to breaches of rights. Social accountability interventions employ information and participation to demand fairer, more effective public services. The two approaches share a focus on the interface between communities and local institutions. The legal empowerment approach includes, in addition, the pursuit of redress from the wider network of state authority. The essay suggests that social accountability interventions should couple local community pressure with legal empowerment strategies for seeking remedies from the broader institutional landscape. Legal empowerment programs, for their part, often under-emphasize injustices related to essential public services such as health and education, perhaps in part because they tend to wait for communities and individuals to raise problems. Instead, legal empowerment programs should learn from social accountability practitioners' use of aggregate data as a catalyst for community action. Legal empowerment organizations would also benefit from adopting the attention to empirical impact evaluation that has characterized experimentation in social accountability.

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**Document 51**

Furler, John S; Palmer, Victoria J

**The ethics of everyday practice in primary medical care: responding to social health inequities.**

Philosophy, ethics, and humanities in medicine : PEHM 2010 May 3; 5: 6

**Abstract:** Social and structural inequities shape health and illness; they are an everyday presence within the doctor-patient encounter yet, there is limited ethical guidance on what individual physicians should do. This paper draws on a study that explored how doctors and their professional associations ought to respond to the issue of social health inequities.

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**Document 52**

Mira, José Joaquín; Lorenzo, Susana; Vitaller, Julián; Guilabert, Mercedes

**[Patients' rights. More than a question of attitude]. = Derechos de los pacientes. Algo más que una cuestión de actitud.**

Gaceta sanitaria / S.E.S.P.A.S 2010 May-Jun; 24(3): 247-50

**Abstract:** To analyze hospital and primary care physicians' knowledge of certain patients' rights recently modified by
Spanish Law 41/2002 (law of patient autonomy).

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Document 53
Clingerman, Evelyn; Fowles, Eileen
**Foundations for social justice-based actions in maternal/infant nursing.**
**Abstract:** The purpose of this article is to discuss health disparities and inequities and their most significant effects on maternal/infant health. A literature background on the social context of justice and distinct ethical theories is provided. Different ethical approaches to guide interventions that can improve the health of mothers and infants are presented. By adopting an ethical framework of social justice, nurses can better understand and thus influence outcomes and ameliorate health disparities and inequalities.

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**From conception to realization: a human right to health.**
The Hastings Center report 2010 May-Jun; 40(3): 4; author reply 5-6

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Meier, Benjamin Mason; Forman, Lisa
**From conception to realization: a human right to health.**
The Hastings Center report 2010 May-Jun; 40(3): 4-5; author reply 5-6

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Manriquez, Luis
**Service learning is no substitute for social justice.**
Family medicine 2010 Apr; 42(4): 235; author reply 236

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Flores, Glenn
Committee on Pediatric Research
**Technical report on racial and ethnic disparities in the health and health care of children**
Pediatrics 2010 April; 125(4): e979-e1020

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American Academy of Pediatrics. Council on Community Pediatrics and Committee on Native American Child Health

**Policy statement – health equity and children’s rights**

Pediatrics 2010 April; 125(4): 838-849

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Abbing, Henriette D C Roscam

**Health law: facing the European challenges.**

European journal of health law 2010 Mar; 17(1): 1-10

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**Document 60**

Abbing, Henriette D C Roscam

**Patients’ rights in a technology and market driven-Europe.**

European journal of health law 2010 Mar; 17(1): 11-22

**Abstract:** This article deals with the impact on patients' rights of medical and technological advances in a market oriented (European) society: what are the advantages and risks, what are the challenges that lay ahead of us? After introducing the subject matter, the first part deals with risks for patients' rights in the European cross border context (health care, direct to the public screening offers and biomedical research). The second part sketches some of the implications of innovation in health care and medical technology for patients' rights to autonomy and private life, particularly when third party interests are involved. The article ends with some suggestions on how best to protect patients' rights in the perspective of innovation in health care and medical research.

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Casamassimo, Paul S

**Don't confuse an agenda with a solution: why dental therapists won't do much to improve access.**

Pediatric dentistry 2010 Mar-Apr; 32(2): 96-8

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Matsuda, Masami

**From health care reform to health care with dignity: reflections on my mother's care [editorial comment]**

Nursing Ethics 2010 March; 17(2): 157-158

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Nairn, Thomas

**Catholics understand health care as a right.**

Health Progress 2010 March-April; 91(2): 58-60

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Pitman, Alexandra
Medicolegal reports in asylum applications: a framework for addressing the practical and ethical challenges.
Journal of the Royal Society of Medicine 2010 March; 103(3): 93-97
Abstract: The clinical care of asylum-seekers may bring clinicians in contact with the immigration authorities. A request for a medicolegal report usually requires the responsible clinician to state their opinion on the risks involved in returning an applicant to their country of origin, taking into account their current condition, the treatments available in that country, and the risks involved in travel. This review draws on clinical experience and a review of the literature to describe the work involved in preparing a medical report requested by immigration authorities. Although the starting point chosen is the psychiatric report, the principles described apply to the preparation of immigration reports in any medical discipline.

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Nairn, Thomas
Catholics understand health care as a right
Health Progress 2010 March-April; 91(2): 58-60

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Clark, Peter A.; Sillup, George P.; Capo, Joseph A.
Afghanistan, poppies, and the global pain crisis.
Medical Science Monitor 2010 February 26; 16(3): RA49-RA57
Abstract: The World Health Organization has reported that somewhere between 30-86 million people suffer from moderate to severe pain due to cancer, HIV/AIDS, burns, wounds and other illnesses annually and do not have access to proper opiate anesthetics to control the pain [1]. The vast majority of these people live in poor nations where medicinal opiates are either too expensive or not readily available. In this paper, it is argued that access to adequate healthcare is a human right and that adequate healthcare includes management of pain. The solution to this problem may be in Afghanistan, a country now overwhelmed with poverty and war. Afghanistan is the world's leading producer of heroin. The increase in heroin production in Afghanistan has caused the United States and the international community to begin to eradicate Afghanistan's poppy fields leading to increased poverty among poppy farmers. This paper proposed a paradigm that can be implemented in Afghanistan which would allow for Afghan farmers to continue growing their poppy crop for medicinal opiates like morphine for poor nations. The paradigm covers all parameters of medicinal opiates production including licensing, security, cultivation, harvest, and factory production of medicinal opiates. The paradigm proposed is less expensive than eradication, brings honest income to Afghan farmers and the new Afghan nation, and can eventually lead to Afghanistan acquiring a respectable role in the world community. In closing, a full ethical analysis of the paradigm is included to justify the arguments made in the paper.

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Li, Meng; Vietri, Jeffrey; Galvani, Alison P; Chapman, Gretchen B
How do people value life?
Psychological science : a journal of the American Psychological Society / APS 2010 Feb 1; 21(2): 163-7
Abstract: Who should be saved when health resources are limited? Although bioethicists and policymakers continue to debate which metric should be used to evaluate health interventions, public policy is also subject to public
We investigated how the public values life when evaluating vaccine-allocation policies during a flu epidemic. We found that people's ratings of the acceptability of policies were dramatically influenced by question framing. When policies were described in terms of lives saved, people judged them on the basis of the number of life years gained. In contrast, when the policies were described in terms of lives lost, people considered the age of the policy's beneficiaries, taking into account the number of years lived to prioritize young targets for the health intervention. In addition, young targets were judged as more valuable in general, but young participants valued young targets even more than older participants did.

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Cumberland, Sarah

Human rights and health go hand-in-hand.

Document 69

Fortes, Paulo Antônio de Carvalho

[Equity in the health system according to Brazilian bioethicists]. = A equidade no sistema de saúde na visão de bioeticistas brasileiros.
Abstract: To understand the meaning assigned to ethical thought that should guide Brazilian bioethicists regarding the equity of a Health System.

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Shah, Seema; Zettler, Patricia

From a constitutional right to a policy of exceptions: Abigail Alliance and the future of access to experimental therapy.
Yale Journal of Health Policy, Law, and Ethics 2010 Winter; 10(1): 135-96

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DER (SELBST-)GESCHÜTZTE PATIENT: EINE GESUNDHEITSWISSENSCHAFTLICHE STUDIE

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Gray, Ron; McCormick, Marie C.
Socioeconomic inequalities in survival in neonates [editorial]
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Avafia, Tenu; Morrison, Cailin; Clark, Bruce; Kohler, Jillian Clare
Panel: Canada's law on global access to affordable medicines.

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Vieira, Fabiola Sulpino; Zucchi, Paola
[Judicial demands and therapeutic assistance in the Brazilian Public Health System]. = Demandas judiciais e assistência terapêutica no Sistema Unico de Saúde.
Abstract: To analyze the qualitative coverage of therapeutic policies at federal level in the Brazilian Public Health System (SUS) for diseases that were the subject of lawsuits.

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Kurtz, Paul
Health care is a human right [editorial]
Free Inquiry 2009 October-November; 29(5): 7

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Journal of Medical Ethics 2009 September; 35(9): 587-588

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Radiotherapy provision "inadequate" as study reveals 30,000 patients fail to get access [news]
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UK offers to help world's poorest countries provide free health care
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Persistent disparities in access to care across health care systems [commentary]
Journal of Health Politics, Policy and Law 2009 August; 34(4): 635-647

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Ageism in mental health care.
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Placing mercy at our portals: ethical response in tough times.
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**State responsibility and right to health in Brazil: a balance of the Branches' actions.**
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**Ethics, law, and pain management as a patient right.**

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**Excessive wealth is damaging the nation's health: health equality cannot be achieved without policies to address disparities in individual wealth**
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**National survey of patients' bill of rights statutes.**
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Keener, Steven R.; Vasquez, Javier
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Rogers, Hugh; Maher, Lynne; Plsek, Paul
Better by design: using simple rules to improve access to secondary care
BMJ: British Medical Journal 2009 February 14; 338(7691): 384-387

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Universal health insurance coverage or economic relief -- a false choice [commentary]
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Murray, Aishling; O'Neill, Desmond
Health-care equity -- for all generations? [letter]
Lancet 2009 January 24-30; 373(9660): 299
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Adshead, Fiona; Thorpe, Allison
Health inequalities in England: advocacy, articulation and action.
Perspectives in Public Health 2009 January; 129(1): 37-41
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Schroeder, Doris
Editorial. Health and human rights
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Migration and the human right to health
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Rid, Annette; Biller-Andorno, Nikola

Justice in action? Introduction to the mini symposium on Norman Daniels' Just health: meeting health needs fairly.

* Article  Document 108
Wilson, J.

Not so special after all? Daniels and the social determinants of health.
Journal of Medical Ethics 2009 January; 35(1): 3-6

Abstract: Just health: meeting health needs fairly is an ambitious book, in which Norman Daniels attempts to bring together in a single framework all his work on health and justice from the past 25 years. One major aim is to reconcile his earlier work on the special moral importance of healthcare with his later work on the social determinants of health. In his earlier work, Daniels argued that healthcare is of special moral importance because it protects opportunity. In this later work, Daniels argues that the social determinants of health (which in fact tend to have a larger effect on health outcomes than healthcare does) should also be considered special. This paper argues that it is a mistake to base a theory of justice for health on the claim that health (or the social determinants of health) are "special", for three reasons. First, once we realise that health is to a large part socially determined by features such as distribution of income, which are also of independent importance for justice, we cannot talk about a theory of justice for health in isolation from an overall theory of justice. Second, when we are trying to work out the place of health in a general theory of justice, being told that health (or the social determinants of health) is special is unhelpful. The relevant starting point should rather be whether health matters in a fundamental way for justice, or whether it matters merely for the effects it has on those goods which are of fundamental importance for justice. Third, treating the social determinants of health as special would in fact be counterproductive in terms of the broad approach to justice Daniels favours.

* Article  Document 109
Hurst, S.A.

Just care: should doctors give priority to patients of low socioeconomic status?
Journal of Medical Ethics 2009 January; 35(1): 7-11

Abstract: Growing data on the socioeconomic determinants of health pose a challenge to analysis and application of fairness in health. In Just health: meeting health needs fairly, Norman Daniels argues for a change in the population end of our thinking about just health. What about clinical care? Given our knowledge of the importance of wealth, education or social status to health, is fairness in medicine served better by continuing to avoid considering our patients' social status in setting clinical priorities, or by attempting to equalise existing health inequalities by giving priority to the socioeconomically disadvantaged at the point of care? In this article, I argue that doctors should not attempt the latter. Granted, giving priority to low status would go some way towards compensating unjust health inequalities and the impression of being left aside in other social spaces. It would represent reverse discrimination, but could still be justified inasmuch as disadvantaged groups could be identifiable, and as long as the intent was compensation rather than retribution. However, under current circumstances such priority would risk being attributed arbitrarily, would represent a form of medical proselytising, risk leaving the worst-off with less by alienating the powerful, and require teaching doctors to act in strongly counter-cultural ways--possibly at great cost. Crucially,
however, we protect both equal health and equal regard by treating all alike: priority to low status would promote the first somewhat, but at the expense of sacrificing the second.

http://www.jmedethics.com (link may be outdated)
Abstract: This paper responds to discussion and criticism contained in a mini-symposium on Just health: meeting health needs fairly. The replies clarify existing positions and modify or develop others, specifically in response to the following: Thomas Schramme criticises the claim that health is of special importance because of its impact on opportunity, and James Wilson argues that healthcare is not of special importance if social determinants of health have a major causal impact on population health. Annette Ried is concerned that the relevance condition in accountability for reasonableness is unclear and does little work. Harald Schmidt aims to flesh out where an account of responsibility for health should go since one is under-developed in Just health. Michael Schefczyk and Susanne Brauer challenge aspects of the prudential lifespan account. Samia Hurst asks what impact a population view should have on clinician obligations.

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Daniels, Norman

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King, Nicholas

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Call number: R724.M66 2009

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Access to health care
In her: Biomedical Ethics: A Canadian Focus. Don Mills, Ont.: Oxford University Press, 2009: 363-396
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Sen, Amartya

Why and how is health a human right? [comment]
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Belhadj, Hedia; Touré, Aminata

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Right to health and the Universal Declaration of Human Rights [comment]
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The right to health: from rhetoric to reality [editorial]
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Negro Calduch, E.; Diaz, A.; Diez, M.;
Ethical and legal issues related to health access for migrant populations in the Euro-Mediterranean area.
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Kiefer, Bertrand
Is health a right? = La santé est-elle un droit?
Revue Médicale Suisse 2008 December 17; 4(184): 2768
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Health care for children in UK detention centres [editorial]
Lancet 2008 November 22-28; 372(9652): 1783
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**Saying no isn't NICE -- the travails of Britain's National Institute for Health and Clinical Excellence**
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Shevell, Michael I.
**The neurological advocate?**
Canadian Journal of Neurological Sciences = Le journal canadien des sciences neurologiques 2008 November; 35(5): 542-543

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Bell, Sue Ellen; Hulbert, James R.
**Translating social justice into clinical nurse specialist practice.**
Clinical Nurse Specialist 2008 November-December; 22(6): 293-299; quiz 300-301

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Tang, Shenglan; Meng, Qingyue; Chen, Lincoln; Bekedam, Henk; Evans, Tim; Whitehead, Margaret
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Obama, Barack
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McCain, John S.
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Kraemer, John D.; Bhattacharya, Dhrubajyoti; Gostin, Lawrence O.
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Garattini, Silvio
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Jecker, Nancy S.
Response to open peer commentaries on "A broader view of justice".
American Journal of Bioethics 2008 October; 8(10): W1-W2
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Jecker, Nancy S.
A broader view of justice.
American Journal of Bioethics 2008 October; 8(10): 2-10
Abstract: In this paper I argue that a narrow view of justice dominates the bioethics literature. I urge a broader view. As bioethicists, we often conceive of justice using a medical model. This model focuses attention at a particular point in time, namely, when someone who is already sick seeks access to scarce or expensive services. A medical model asks us how we can fairly distribute those services. The broader view I endorse requires looking upstream, and asking how disease and suffering came about. In contrast to a medical model, a social model of justice considers how social determinants affect the health of a population. For example, social factors such as access to clean drinking water, education, safe workplaces, and police protection, profoundly affect risk for disease and early death. I examine one important social determinant of health, health care coverage, to show the limits of a medical model and the merits of a broader view.
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Harhay, Michael Oscar
Health, democracy and the 2008 presidential election.
American Journal of Bioethics 2008 October; 8(10): 14-15
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http://bioethics.net (link may be outdated)
Health disparities and autonomy

Abstract: Disparities in socioeconomic status correlate closely with health, so that the lower a person's social position, the worse his health, an effect that the epidemiologist Michael Marmot has labeled the status syndrome. Marmot has argued that differences in autonomy, understood in terms of control, underlie the status syndrome. He has, therefore, recommended that the American medical profession champion policies that improve patient autonomy. In this paper, I clarify the kind of control Marmot sees as connecting differences in socioeconomic status to health disparities. I then discuss his use of Amartya Sen's capabilities approach to justice, arguing that he is unsuccessful in relating autonomy as a descriptive property with a normative framework that can adequately explain why and to what extent we should reduce health disparities.

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The right to health and accountability [letter]

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A renaissance in primary health care [editorial]
Lancet 2008 September 13-19; 372(9642): 863

Document 151

Smith, George Davey; Krieger, Nancy
Tackling health inequities: WHO calls for global action to ensure health equity within and between countries [editorial]
BMJ: British Medical Journal 2008 September 6; 337(7669): 529-530

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McGibbon, Elizabeth; Etowa, Josephine; McPherson, Charmaine
Health-care access as a social determinant of health.
Canadian Nurse 2008 September; 104(7): 22-27

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Castillo Pineda, J.C. de la Cruz; Figueredo Grijalva, R.; Dugloszewski, C.; Díaz Reynoso, J.A.S. Ruy; Spolidoro Noroña, J.V.; Matos, A.; Carrasco, F.; Chirife, G.; Vergara, A.; Moya Rodríguez, J.; Loyola, G.; Alvarez, A.; Barozzi, C.; Vargas, M.; García de Lorenzo, A.
Declaración de Cancún: declaración internacional de Cancún sobre el derecho a la nutrición en los hospitales = The Cancun Declaration: the Cancun International Declaration on the Right at the hospital Nutrición Hospitalaria 2008 September-October; 23(5): 413-417

Document 154

Dodds, Susan
Inclusion and exclusion in women's access to health and medicine
Document 155

Forman, Lisa

*Justice and justiciability: advancing solidarity and justice through South Africans' right to health jurisprudence*


**Abstract:** The South African Constitutional Court's jurisprudence provides a path-breaking illustration of the social justice potential of an enforceable right to health. It challenges traditional objections to social rights by showing that their enforcement need not be democratically unsound or make zero-sum claims on limited resources. Indeed the South African experience suggests that enforcing health rights may in fact contribute to greater degrees of collective solidarity and justice as the Court has sought to ensure that the basic needs of the poor are not unreasonably restricted by competing public and private interests. This approach has seen the Court adopt a novel fights paradigm which locates individual civil and social rights within a communitarian framework drawing from the traditional African notion of 'ubuntu', denoting collective solidarity, humaneness and mutual responsibilities to recognize the respect, dignity and value of all members of society. Yet this jurisprudence also illustrates the limits of litigation as a tool of social transformation, and of social rights that remain embedded in ideological baggage even where they have been constitutionally entrenched and enforced. This paper explores the Constitutional Court's unfolding jurisprudence on the right to health, providing background to the constitutional entrenchment of a justiciable right to health; exploring early Constitutional Court jurisprudence on this right; turning to the forceful application of this right in relation to government policy on AIDS treatment; and concluding with thoughts about the strengths and limits of this jurisprudence in light of subsequent case-law.

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Document 156

den Exter, André

*Claiming access to health care in the Netherlands under international treaty law*


**Abstract:** In the Netherlands, access to healthcare has been guaranteed by social health insurance legislation. But since the introduction of the health insurance system in the 1960s, it has been under frequent review, the latest reform was the introduction of regulated competition. At the same time, claiming health insurance entitlements under international (European) law has been changing, notably due to judicial activism.

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Document 157

Prudil, Lukas

*Access to health care: solidarity and justice or egoism and injustice?*


**Abstract:** The aim of this paper is to answer the question whether there is a real demand for equal access to health care or--better--to medical care and which interest groups (patients, health care professionals, policy makers and others) are interested in equal access. The focus is on EU countries including recent case law from the European Court of Justice and the European Court of Human Rights. We discuss whether there is a need to have legislative safeguards to protect equal access to medical care and whether such norms really work. The paper concludes that some of the key players in medical care are not primarily governed by a real willingness to have equal and just access to medical care, but by rather egoistic approaches. It seems that policy makers and politicians are the only ones who, surprisingly, must at least formally call for and enforce equal access to medical care. Interests of other groups seem to be different.

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The right to access health care: health care according to European social security law instruments


Abstract: In this contribution we will look at how the traditional European social security conventions shape the fundamental right to health care. As to the instruments under investigation we focus upon the regional agreements that have been enacted within the framework of the Council of Europe. More specifically we will discuss how the (Revised) Social Charter and the minimum standard setting instrument (Code) give expression to the right to access to health care. This overview is then complemented by an analysis of recent case law of the European Court of Human Rights. The latter Court is indeed increasingly screening the national social security rules on their compatibility with the fundamental rights, as they are enshrined in the European Convention on Human Rights. Hence we will dwell upon the potential impact of this case law on the right to access health care. In the conclusions we will compare the three instruments regarding their legal interpretation of the right to health care.

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Human rights and bioethics
Journal of Medical Ethics 2008 May; 34(5): 379-383
Abstract: In the first part of this article we survey the concept of human rights from a philosophical perspective and especially in relation to the "right to healthcare". It is argued that regardless of meta-ethical debates on the nature of rights, the ethos and language of moral deliberation associated with human rights is indispensable to any ethics that places the victim and the sufferer in its centre. In the second part we discuss the rise of the "right to privacy", particularly in the USA, as an attempt to make the element of personal free will dominate over the element of basic human interest within the structure of rights and when different rights seem to conflict. We conclude by discussing the relationship of human rights with moral values beyond the realm of rights, mainly human dignity, free will, human
rationality and response to basic human needs.

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Woodstock Theological Center

Abstract: "The Project was launched in April 2008 with the forum, "Values Inside the Issues: Religious Voices Discuss Health Care Reform." Panelists include Rabbi David, Saperstein, Director of the Religious Action Center of Reform Judaism; Edmund Pellegrino, M.D., Georgetown Emeritus Professor of Medicine and Medical Ethics, and Chair of The President’s Council on Bioethics; and Dr. Zubair Saeed, Director of Health Education and Programs for the All Dulles Area Muslim Society. The three panelists addressed pre-selected questions designed for an educated audience to compare the Jewish, Christian, and Islamic faiths’ approach to the topic of healthcare reform. A DVD of the event has already been produced and is being circulated." [description from the Woodstock website] John P. Langan, S.J., Member, Board of Directors of Woodstock Theological Center and Kennedy Institute of Ethics, Georgetown University The forum was co-sponsored by the Woodstock Theological Center; the O'Neill Institute for National and Global Health Law; the Program on Church and Interreligious Dialogue; and the Berkeley Center for Religion, Peace and World Affairs.

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Vision and Voice: Faithful Citizens and Health Care
Abstract: This DVD is part of a larger adult education resource "Vision & Voice: Faithful Citizens and Health Care."
The print resources, including facilitators' manuals and participants' manuals are available free online without a charge at http://www.visionandvoice.org. The DVD is to be used with Sessions 2 and 3 of the four session packet. Session 1 is a reflection on personal experience with US health care and hearing the experiences of others; Session 2 is the moral case for change in the US health care system; Session 3 helps participants develop a message they can use as a faith voice advocating for health care reform; and Session 4 helps participants think about the role of faith communities in social change and what their role will be as communities and as individuals. The DVD shows faith leaders from different traditions "reflecting on what the moral teachings of their tradition bring to work on health care." The DVD is expected to be released in late March 2008.
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Abstract: This paper argues for the necessity of universal health care (as well as universal free education) using a different argument than most that have been made heretofore. It is not meant to conflict with but to strengthen the arguments previously made by others. Using the second paragraph of the Declaration of Independence and the Preamble to the Constitution we argue that universal health care in this day and age has become a necessary condition if the ideals of life, liberty and the pursuit of happiness are to be more than an empty promise and if the discussion of "promoting of general welfare" in the preamble is to have any meaning.
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Relevance and limits of the principle of “equivalence of care” in prison medicine
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Abstract: The principle of "equivalence of care" in prison medicine is a principle by which prison health services are obliged to provide prisoners with care of a quality equivalent to that provided for the general public in the same country. It is cited in numerous national and international directives and recommendations. The principle of equivalence is extremely relevant from the point of view of normative ethics but requires adaptation from the point of view of applied ethics. From a clinical point of view, the principle of equivalence is often insufficient to take account of the adaptations necessary for the organization of care in a correctional setting. The principle of equivalence is cost-effective in general, but has to be overstepped to ensure the humane management of certain special cases.
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Abstract: Neglected diseases remain one of the largest causes of disease and mortality. In addition to the difficulties in provision of appropriate drugs for specific diseases, many other factors contribute to the prevalence of such diseases and the difficulties in reducing their burden. We address the role that poor governance and politically motivated oppression have on the epidemiology of neglected diseases. We give case examples including filariasis in eastern Burma and vector-borne diseases (Chagas' disease, leishmaniasis, and yellow fever) in Colombia, we show the links between systematic human rights violations and the effects of infectious disease on health. We also discuss the role of researchers in advocating for and researching within oppressed populations.
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Abstract: Individuals and populations suffer violations of their rights that affect health and wellbeing. Health professionals have a part to play in reduction and prevention of these violations and ensuring that health-related policies and practices promote rights. This needs efforts in terms of advocacy, application of legal standards, and
public-health programming. We discuss the changing views of human rights in the context of the HIV/AIDS epidemic and propose further development of the right to health by increased practice, evidence, and action.

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**A fair range of choice: justifying maximum patient choice in the British National Health Service**
**Abstract:** In this paper I put forward an ethical argument for the provision of extensive patient choice by the British National Health Service. I base this argument on traditional liberal rights to freedom of choice, on a welfare right to health care, and on a view of health as values-based. I argue that choice, to be ethically sustainable on this basis, must be values-based and rational. I also consider whether the British taxpayer may be persuadable with regard to the moral acceptability of patient choice, making use of Rawls’ theory of political liberalism in this context. I identify issues that present problems in terms of public acceptance of choice, and also identify a boundary issue with regard to public health choices as against individual choices.

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**Is there a right to health?**


**Abstract:** This article challenges the widespread contention-promoted by the World Health Organization, the U.N. Human Rights Commission, and certain non-governmental organizations-that health care should be regarded as an individual human right. Like other "post-modem" rights, the asserted individual right to health care is a positive claim on the resources of others; it is unlimited by corresponding responsibilities; and it pertains exclusively to the individual. In fact, an individual human right to health, enforceable against either governments or corporations, does not currently exist in law. If established, such a right would portend a dramatic expansion of government control over health care, with negative consequences for efficiency and patient welfare. Voluntary efforts based on partnership, rather than the imposition of legal requirements, are the most productive means of expanding access to health care while preserving incentives for continued development of innovative health technologies.

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Abstract: The focus of this paper will be on how health care systems in three countries, Malaysia, South Africa and the United States, are responding to the health needs of immigrants with a strong focus on the legal aspects of the respective national responses. The Malaysia portion emphasizes legal immigration and analyses as to how the country's Ministry of Health and the delivery system itself is responding to the demands of immigrant's health. In the context of South Africa, the paper explores implications of the South African Constitution, which establishes a right to access health care, and explores whether such a right can be extended to non-citizens, or can be tempered by economic constraints. In the American discussion the focus is on whether publicly supported health care programs can be accessed to provide coverage for undocumented residents, and highlights recent constraints in using government monies in this area.

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*Does access to cardiac investigation and treatment contribute to social and ethnic differences in coronary heart disease? Whitehall II prospective cohort study*


**Abstract:** OBJECTIVE: To determine whether access to cardiac procedures and drugs contributes to social and ethnic differences in coronary heart disease in a population setting. DESIGN: Prospective study with follow up over 15 years. Civil service employment grade was used as a measure of individual socioeconomic position. Need for cardiac care was determined by the presence of angina, myocardial infarction, and coronary risk factors. SETTING: 20 civil service departments originally located in London. PARTICIPANTS: 10,308 civil servants (3414 women; 560 South Asian) aged 35-55 years at baseline in 1985-8. MAIN OUTCOME MEASURES: Use of exercise electrocardiography, coronary angiography, and coronary revascularisation procedures and secondary prevention drugs. RESULTS: Inverse social gradients existed in incident coronary morbidity and mortality. South Asian participants also had higher rates than white participants. After adjustment for clinical need, social position showed no association with the use of cardiac procedures or secondary prevention drugs. For example, men in the low versus high employment grade had an age adjusted odds ratio for angiography of 1.87 (95% confidence interval 1.32 to 2.64), which decreased to 1.27 (0.83 to 1.94) on adjustment for clinical need. South Asians tended to be more likely to have cardiac procedures and to be taking more secondary prevention drugs than white participants, even after adjustment for clinical need. CONCLUSION: This population based study, which shows the widely observed social and ethnic patterning of coronary heart disease, found no evidence that low social position or South Asian ethnicity was associated with lower use of cardiac procedures or drugs, independently of clinical need. Differences in medical care are unlikely to contribute to social or ethnic differences in coronary heart disease in this cohort.

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**Promotion and enforcement of patients' rights**


**Abstract:** European health systems have experienced a "right-revolution" in the last 10 years'. The existence of a large number of policy trends and normative initiatives in European countries demonstrates a strong interest in patients' rights. The increasing interest and involvement of the general public is also decisive and can favour further development and involvement by policy-makers and the legislators. Numerous measures exist to promote and enforce patients' rights. It is now time for the anti-cancer associations to play an active role in this important event and to try to define a new mission for the benefit of the patients.

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**A reassessment of the right to health care**


**Abstract:** This paper examines the right to health care in the Netherlands as provided for under the Constitution. The author discusses the relationships between human rights, economic forces and political choices in this connection and offers a view that these are due for reassessment.

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Constitutional limits to the financing of health care in the Czech Republic and in selected European countries
Abstract: The aim of this paper is to describe the constitutional limits to the financing of health care and especially of public health insurance in the Czech Republic. It describes the current situation in the financing of health care on
the basis of the Czech constitutional order as it has been interpreted by the Constitutional Court. Finally it presents an overview of the incorporation of the right to health into the constitutional documents of several European countries with the stress on the right to receive health care “free of charge”. It is not typical within the European region to specify in constitutional acts to what extent it is giving the right to health care free-of-charge or more precisely to what extent and for what groups health care is paid for by persons other than by the citizens (patients). The Czech Republic is one of the exceptional cases in which the basic right to health care free-of-charge on the basis of public insurance is given directly by the Constitution.

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Blum, John D.; Talib, Norchaya; Carstens, Pieter; Nasser, Muhammad; Tomkin, David; McAuley, Adam

**Rights of patients: comparative perspectives from five countries**

Medicine and Law 2003; 22(3): 451-471

**Abstract:** Recognition and articulation of patient rights are core issues in the medical jurisprudence of most nations. While the nature of rights in medical care may vary from country to country, reflecting the idiosyncrasies of domestic law and health delivery, there are commonalities in this area of law that cut across borders. This paper presents five case studies in the patient rights area from Malaysia, Ireland, South Africa, Indonesia and the United States, respectively. The case discussions range from ongoing and fundamental concerns over broad patient rights issues, such as access to health care and informed consent, to rights concerns of those suffering from HIV/AIDS, to a novel consideration over ethical and legal issues concerning ownership of infant organs. It is the hope of the authors that individually, and collectively, the cases will provide helpful insights into this core area of medical law.

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Zaremski, Miles J.

**Patients rights and accountability: can there exist rights without remedies in an American legal and legislative framework?**

Medicine and Law 2003; 22(3): 429-450

**Abstract:** Considerable attention has been given patient rights within the borders of the United States over the last five to 10 years. This has been driven by the creation of the managed health care organization. But as this form of health care delivery within the United States has a strong foothold, perils in its administration have arisen, notably how America's legislative and civil justice systems need to respond to the issue of accountability for such entities when they make decisions as to what care and treatment should be provided to enrollees of their plans. This has come to be known as decisions involving what is medically necessary care and treatment. The American Congress has tackled, legislatively, the issue of patient rights (and remedies within these rights) to be accorded patients affected by decisions made by managed care organizations. Unfortunately, these efforts have stalled, principally over the remedies to be so afforded patients whose care has been unacceptable, i.e., fallen below a standard of care.
that results in injury or death. Experience from other nations has not been helpful due, in large measure, to the system of health care delivery within those countries. America's civil court decisions, however, are not only illuminating a proper path to follow nonetheless, but also are a beacon to follow for justice systems in other countries faced with the same or similar issues.

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Global battle cry: health is a right, not a commodity


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**A personal reflection: whose rights are they, anyway?**

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Smokers' rights to coronary artery bypass graft surgery
Abstract: Imagine a health maintenance organization creating a policy to deny all smokers access to nonemergent coronary artery bypass graft surgery. The cost savings to the organization and society would be potentially significant. Now envision the smoker, a hardworking father with daily angina, and the provider, writing costly prescriptions to manage the angina. What ethical and legal questions do you suppose would present in that setting? Now imagine how you would respond if given this scenario of denying smokers access to nonemergent coronary artery bypass graft. This article discusses the implications of resource allocation with self-inflicted health behaviors such as smoking. Tough questions are raised that explore both the pros and the cons of smokers' rights to coronary artery bypass graft.
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Treatment providers' knowledge of the Health and Disability Commissioner's Code of Consumer Rights
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Abstract: The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumer's Rights (the Code) defines in law the rights of consumers of health and disability services in New Zealand. In the first few years after publication health educators, service providers and the HDC extensively promoted the Code. Providers of health and disability services would be expected to be knowledgeable about the areas covered by the Code if it is routinely used in the development and monitoring of treatment plans. In this study knowledge of the Code was tested in a random sample of 217 clinical staff that included medical staff, psychologists and counsellors working in Alcohol and Drug Treatment (A&D) centres in New Zealand. Any response showing awareness of a right, regardless of wording, was taken as a positive response as it was the areas covered by rights rather than their actual wording that was considered to be the important knowledge for providers. The main finding of this research was that 23% of staff surveyed were aware of none of the ten rights in the Code and only 6% were aware of more than five of the ten rights. Relating these data to results from a wider sample of treatment providers raised the possibility that A&D treatment providers are slightly more aware of the content of the Code than a general sample of health and disability providers however overall awareness of the content of the Code by health providers is very low. These results imply that consumer rights issues are not prominent in the minds of providers perhaps indicating an ethical blind spot on their part. Ignorance of the content of the Code may indicate that the treatment community do not find
it a useful working document or alternatively that clinicians are content to rely on their own good intentions to preserve the rights of their patients. Further research will be required to explain this lack of knowledge, however the current situation is that consumers cannot rely on clinicians being aware of the consumer's rights in health and disability services.

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Abstract: OBJECTIVES: To compare rates of revascularisation in south Asian and white patients undergoing coronary angiography in relation to the appropriateness of revascularisation and clinical outcome. DESIGN: Prospective cohort study of patients with two and a half years' follow up; appropriateness of revascularisation rated by nine experts with no knowledge of ethnicity of patient. SETTING: Tertiary cardiac centre in London with referral from five contiguous health authorities. PARTICIPANTS: Consecutive patients (502 south Asian, 2974 white) undergoing coronary angiography in the appropriateness of coronary revascularisation study (ACRE). MAIN OUTCOME MEASURES: Coronary revascularisation, non-fatal myocardial infarction, mortality. RESULTS: There was no difference between south Asian and white patients in the proportions deemed appropriate for revascularisation (72% (361) v 68% (2022)) or in the proportions for whom the physician's intended management was revascularisation (39% (196) v 41% (1218)). Among patients appropriate for revascularisation, age adjusted rates of coronary angioplasty (hazard ratio 0.69, 95% confidence interval 0.47 to 1.00, P=0.058) and coronary artery bypass grafting (0.74, 0.58 to 0.91, P=0.007) were lower in south Asian than in white patients. These differences were smaller but still present after adjustment for socioeconomic status and after restriction of analysis to those patients for whom the intended management was revascularisation. There were no differences in mortality and non-fatal myocardial infarction between south Asian and white patients (1.07, 0.78 to 1.47). CONCLUSION: Among patients deemed appropriate for coronary artery bypass grafting, south Asian patients are less likely than white patients to receive it. This difference is not explained by physician bias.
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**Developments in patients' rights in Turkey**


**Abstract:** Today, the social, economic, cultural, ethical, and political climate has given rise to an international movement, that is re-evaluating the importance of patients' rights. In Turkey, as competition continues to increase between public and private hospitals, the emphasis on presenting health care services in the most advantageous way has become a focal point of debate. As a result, patients' rights issues are being actively discussed in both the private and public health care sectors in the country. In this study, the development of patients' rights issues in Turkey is reviewed and the results of some selected descriptive studies are summarized. Suggestions are made toward policies for effective and efficient health care provision in terms of both broad and specific issues that have arisen in the field of patients' rights.

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**Monitoring patient rights -- a clinical seminar [Israel]**

Medicine and Law 2002; 21(3): 521-539

**Abstract:** Israel enacted the Patient Rights Law in 1996. The Law embodies a movement from paternalism to autonomy in doctor-patient relations. The following year, law students at the Israeli Centre for Academic Studies participated in a clinical seminar designed to measure internalisation of the Law, through personal interviews with hospitalized patients. The seminar can be adapted for medical students. The methodology is taken from human rights field work. The objective is to use patient rights as indicators of quality of care in medical settings. Students studied the text and principles of the Law in light of personal testimonies taken from relatives and friends. They developed an open-structured questionnaire, and were trained in interviewing with due respect for the patients' dignity and privacy, and the need to obtain their free and informed consent to the interview. The interviews were conducted in Hadassah Hospital, Jerusalem, after receiving approval of the Helsinki Committee. The findings, though in no way statistically valid, are nonetheless interesting. Students received training in listening and advocacy skills. The approach is conciliatory rather than adversarial. The thesis is that respect for patient rights is an efficient tool for quality control, risk management, conflict resolution and prevention of litigation.

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**Moral person and the right to health care.**


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**Health inequalities and why they matter**


**Abstract:** Health inequalities are of concern both because studying them may help one learn how to improve health and because health inequalities may be unjust. This paper argues that attending to these reasons why health inequalities may be important undercuts the claims of researchers at the World Health Organization in favor of focusing on individual health variation rather than on social group health differences. Inequalities in individual health are of little interest unless one goes on to study how they are related to other factors.

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Abstract: During the last fifteen years, an increasing number of European countries have adopted laws or other legal instruments respecting and protecting the rights of patients. This reflects the progressive recognition of the inherent dignity and equal and inalienable rights of all (potential) users of the health care system. At the same time, however, a growing number of persons seem to encounter difficulties in accessing health care. This raises the question to what extent patients' rights should also include entitlements to health care services.

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