A Code Of Health Rights And Responsibilities: The Adequacy Of Existing Recognition And Protection

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Introduction

There is growing concern to date about the adequacy of existing legal mechanisms to protect health care consumers. In this respect there has been an increasing focus in recent years on fundamental ethical principles, individual rights and the extent to which recognition and protection is afforded in law. In Queensland there is now a clear commitment to the development of a formal statement giving recognition to such principles in the form of a Code of Health Rights and Responsibilities.

Given this formal legislative commitment to the development of a Code, two specific questions must be considered:
(i) The content of the Code: what "rights" are to be given formal recognition; and
(ii) Perhaps more importantly, the mode by which such a Code is to be promulgated. The answer to this question directly impacts on the legal effect of such a Code and the status in law ultimately afforded to the rights that the Code recognises.

This paper seeks to explore the concepts of "rights" and "responsibilities" and suggests a better understanding of such terms might assist in formulating a Code of Health Rights and Responsibilities. In this respect the paper explores the role of such a Code and more importantly the effect it may have in providing additional protections for health consumers. The principal concern is that a Code that simply comprises a broad statement of fundamental principles may ultimately fail to provide the additional protection sought. Whilst no doubt the process of formulating a Code serves a positive educational role, providing a basic statement of the rights and responsibilities surrounding the health consumer and health care professional/institutional relationship, the document may not go far enough in establishing legally enforceable rights and remedies.

Use of the term "rights" is something that has become commonplace in recent years; attributed largely to a growth in "consumerism". Driven initially in the context of increased
expectations concerning the provision of goods and services, the 1970's produced a plethora of consumer protection legislation, imposing higher standards to be met by manufacturers, including information disclosure requirements and increased avenues for redress.

One outcome of this process was the inculcation of an increased awareness amongst consumers of their ability to participate in the decision-making processes that affect them. Although originally contained within matters of commerce and trade, it was only a matter of time before this process of consumerism permeated down to the professional level, and more importantly to the health care arena.

Today, with the availability of more information, the public is becoming better educated. In the context of health care there has developed an equivalent awareness on the part of the public of their ability to challenge the accuracy of many long held assumptions regarding the medical and health care community. The consequence for health care professionals is that their position on the "professional pedestal" is no longer secure. This so-called "shattering of the professional pedestal" has today resulted in health care professionals being treated in much the same way as any other provider of goods and/or services.

It is, however, interesting to note, that the initial consumer movement of the 1970s was still largely paternalistic in approach; most legislation aimed at protecting individuals and providing remedies for injuries incurred. Consumerism today has taken on a different perspective, giving more recognition to concepts of individual responsibility and autonomy. That different approach is reflected in many contemporary laws and regulations which tend to emphasise interests of autonomy and seek to ensure a more equal relationship between consumer and supplier. No more so is this evident than in the health care arena, where the law has well and truly moved beyond the stage of simply providing protections and mechanisms of redress. Rather, the law today increasingly seeks to give legal recognition to the somewhat illusory concept of "rights".

This change in focus is especially evident in Queensland, with the passage of the Health Rights Commission Act 1991 (Qld) (the Act). Although essentially setting up the Health Rights Commission as an independent body to provide for the investigation, review and conciliation of health service complaints, the Act goes significantly further. Specifically, it contemplates the development of a formal Code of Health Rights and Responsibilities.

In order to understand the full implications of a formal Code of Health Rights and Responsibilities, it is appropriate to first consider the notion of "rights". What does it mean to
say someone has "a right"? What is meant when one says someone is entitled to something?

Section 3 (1) of the Act defines "health rights" as: "the rights of an individual relating to the provision of a health service"; a definition that does not really take the concept very far other than placing it in the context of health services. The term "rights" becomes all the more difficult because it is a term which can be understood at a number of different levels. Depending upon the way in which the term rights is actually used there may well be a different resultant effect.

In analysing the meaning of "rights" it is useful to refer to a model of "rights" developed by a well known American jurist, W. N. Hohfeld (1919; See also Simmonds 1986). The "Hohfeld model" of rights is a useful scheme in which to consider the implications of a Code of Health Rights and Responsibilities.

What Hohfeld pointed out was that the term "rights" is apt to mislead; largely because it is used in so many different ways, both in common English usage of the term and more importantly, legal usage. The Macquarie Dictionary defines the term "rights", inter alia, as follows:

... in accordance with what is just or good; in conformity with fact, reason, or some standard or principle, correct; correct in judgement, opinion, or action; a just claim or title, whether legal, prescriptive, or moral; that which is due to anyone by just claim; that which is ethically good and proper and in conformity with the moral law; to do justice to."

This definition clearly recognises a correlation between "rights" and "morality" or ethical values. If there is such a relationship between "rights" and the ethical or moral concerns of society, then those "rights" that do exist will need to be constantly assessed to ensure that they continue to reflect the values held by society.

The legal usage of the term "rights" is even more variable. Essentially Hohfeld identified four different legal uses of the term; namely
(i) claim rights, (which according to Hohfeld are true rights);
(ii) powers;
(iii) immunities; and
(iv) liberties, (or as Hohfeld calls them, "privileges").

The difference in effect between these different uses of the term "rights" lies in their implication for the legal relationship existing between parties.
Claim Rights

As a true right, a claim right implies a reciprocal duty or obligation on another identifiable person. Such rights may exist voluntarily, for example by way of contract between parties, in which case they will be limited to the specific parties to that contract. Claim rights may also be imposed by legislation or common law, in which case they will have a wider impact.

Claim rights pervade the health care arena. For example, under the Medicare system in Australia, a person who presents at the accident and emergency unit of a public hospital has an enforceable right against an identifiable person or institution to be treated. That person or institution has a positive co-relative obligation to provide that individual with the necessary services. Similarly, under Freedom of Information legislation, an individual citizen has the right to access their medical records in a public institution, and that institution has a positive legal duty to provide them with access.

Likewise, at common law, reference may be made to the recent High Court decision in Rogers v. Whitaker (1993) 67 ALJR 47. By recognising the existence of an enforceable duty on the part of a medical practitioner to provide a patient with information concerning the risks involved in treatment provided by the medical practitioner, (at least those risks that are "material" in the circumstances), the High Court, in effect, gave clear legal assistance to the "right" of a patient to be so informed.

It is, however, in the context of so-called "claim rights" that most misunderstanding and confusion exists. For example, those groups that advocate "active" euthanasia would argue that individuals have a "right to die". Despite the use of "rights" language, this is not a true claim right. If it were so, it would, in the Hohfeld sense, mean that there was a reciprocal duty or obligation on the part of a medical practitioner to accede to a patient's request for a fatal injection. Clearly, this is not the case in Australia, despite the position adopted by medical practitioners in some other countries, for example the Netherlands, where many doctors do openly give their patients the fatal injection upon request, under a belief that it is their duty or obligation to do so.

Liberties

In many respects, the so-called "right to die" fits better at the other end of the spectrum, as a mere liberty right. Liberty rights do not entail any duty owed by another. They are often referred to as "freedoms", indicating that there is some recognition or respect by the law for individual
freedoms, such as the freedom of choice or perhaps even the broader notion of patient autonomy. In this way the law does not impose any duty on the individual, the holder of the liberty right, which would otherwise interfere with that person's freedom to choose. In other words, "liberties" constitute the very minimum form of protection afforded by the law in that it will not interfere with an individual's "right" to choose. The fundamental right to autonomy is thus a liberty right in the sense that the law recognises a freedom to determine what is done to one's own body.

So too, the "right to die", (a specific exercise of the broader autonomy principle), is a liberty right, in that the criminal law today has removed suicide as an offence. It is not a claim right in the strong positive sense described above as there is no requirement, obligation or duty imposed on another person to assist a person to die.

However, the distinction at either end of the spectrum between "claim rights" and mere "liberties" is not always clear. This is because often liberties may actually be surrounded by a perimeter of claim rights. The "right to die" provides a good example. Via the common law on consent and more specifically refusal of consent (see Malette v Shulman (1991) 2 Med. L.R. 162), or indeed even stronger statements by specific legislation, such as the Medical Treatment Act 1988 (Vic), the so-called "right to die" becomes a limited claim right in that the law provides a patient with some protection by imposing an obligation on others not to exercise their liberty rights in a way which interferes with that of the patient. Specifically, under the Victorian legislation, a medical practitioner commits a statutory offence of medical trespass if she treats a patient contrary to directions contained in a duly executed refusal of treatment certificate (Medical Treatment Act 1988 (Vic) s. 5).

In this way, many of the "rights" that people assert often contain a liberty as well as claim right component; and the claim right component can be both positive or negative.

Powers

Liberty rights can and often do, become what Hohfeld refers to as powers, largely the result of specific legislation. Hohfeld's definition of a "power" refers to the ability to alter legal rights and duties, or legal relations in general. Powers differ from claim rights in that there is no co-relative duty imposed on another person. A good example is provided by the specific provisions that exist in most jurisdictions in Australia enabling a medical superintendent of a hospital to stand in the shoes of a parent vis-a-vis providing consent to a necessary blood transfusion for a minor (See for example Human Tissue Act 1982 (Vic), s 24; Transplantation and Anatomy Act 1979 (Qld), s 20; Human Tissue
and Transplant Act 1982 (WA), s 21; Human Tissue Act 1985 (Tag), s 21; Transplantation and Anatomy Act 1978 (ACT), s 23; Emergency Medical Operations Act 1973 (NT), s 23; Children (Care and Protection) Act 1987 (NSW), s 20A; Consent to Medical and Dental Procedure Act 1985 (SA), s 6). This power directly alters the legal "rights" and relations between parent and child in relation to the ability of a parent to consent to medical treatment in respect of their child.

**Immunities**

Finally, by his definition of "Immunities", Hohfeld appears to contemplate the specific situation that exists in the United States of America where there is a formal Bill of Rights, setting out a number of constitutionally guaranteed interests, for example, the freedom of speech or the right to privacy which has been utilised in the context of both abortion and euthanasia debates. The effect of such constitutional "rights" is that they cannot be readily abrogated by legislatures. In other words, the state or government of the day cannot intervene in certain circumstances by denying individuals any freedom or liberty rights that are recognised in the Bill of Rights.

In Australia, despite much debate over the years and, indeed, more recently in Queensland (EARC Public Seminar 20–21 July 1992) there is no equivalent Bill of Rights under the Australian Constitution. Thus, in Australia, the so-called "right of freedom of speech" is more likely to be classified as a liberty right rather than an immunity. This is clearly an area where a formal Code of Health Rights and Responsibilities has enormous potential to alter the status of existing "rights".

Immunity rights can also exist outside the traditional state/citizen model. An example is provided by the High Court decision in *Re Marion (Health and Community Services (NT), Department of, Secretary v JWB and SMB*, (1992) 66 ALJR 300.) concerning the ability of a parent to consent to the sterilisation of their intellectually impaired child. As a result of that decision, a child has, in effect, an immunity right as against their parent, in that there is imposed on the parent a disability to consent to the sterilisation of the child. That is, the parent cannot interfere with the child's liberty rights, in this case, the right to autonomy and more specifically, the right to procreate.

Of course, the Hohfeld model of rights, does not, itself, provide a precise mode of classification. As demonstrated above, many so-called "rights" themselves often straddle two or more classifications. For example, anti-discrimination legislation, in one sense, creates a positive duty on the part of a medical practitioner to treat an HIV-positive patient, and in this respect could be regarded as creating a claim
right: that is a right to be treated without discrimination. In another sense, this right to treatment could also be classified as a mere power, in that it imposes a liability on the part of the medical practitioner if she refuses to provide treatment.

Despite problems in precise definition, the Hohfeld model does highlight just how difficult, indeterminate, illusory and indeed often contradictory the concept of "rights" actually is. Nevertheless, in spite of the lack of clear division between the different types of "rights", it is important that some formal consideration be given to these problems of definition.

As stated by one international jurist on human rights:
"...[the] analysis of the nature of rights is not just an academic exercise. It is misleading and perhaps futile to treat all..rights..as of one class. Understanding the nature of the "right" involved helps clarify our consideration of the degree of protection available, the nature of the deocations or exceptions, the priorities to be afforded to various rights, the question of whether a series of rights will be treated in hierarchical relationships, and similar problems" (Shestack 1985 p. 74).

These distinctions and problems of definition, are vital in the context of determining the specific content of a Code of Health Rights and Responsibilities, and, perhaps, even more importantly, deciding how such a Code is to be promulgated and enforced. Depending upon the mode in which the a Code is implemented and depending upon the "rights" that it contained, some "rights", especially those that may currently be mere liberty rights, will take on a different legal status. If for example, a Code is promulgated by way of legislation it may, in effect, create new claim rights.

**Rights and Responsibilities**

When one talks about rights, in whatever sense, it is obvious that it is not all one sided. Some balance is required. This is reflected specifically in the Act by the very title of the Code referring to "rights" as well as "responsibilities".

The Macquarie Dictionary defines "responsible" as, inter alia:
"answerable or accountable, as for something within one's power, control, or management; having the capacity for moral decisions and therefore accountable".

In this way the use of the word "responsibilities", in its ordinary common language meaning, stands as a clear acknowledgment of the need for accountability. It recognises
the existence of a corresponding obligation, both morally and perhaps even legally.

This reference to "responsibilities," and its specific recognition and contemplation in a Code of Health Rights and Responsibilities presents as a double-edged sword. On the one hand, the reference to both "rights" and "responsibilities" contemplates a co-relative obligation, albeit perhaps only morally, on the other party to the relationship to be responsible for ensuring that the respective rights contained in the Code are recognised. So, for example, when one talks of the right of a patient to be informed of material risks inherent in medical treatment, this places an obligation squarely on the health care professional to provide the patient with the relevant information. This view of "responsibilities" is specifically recognised by the Act itself. Section 3(1) of the Act defines "health responsibility" as: "the responsibility of a provider in relation to the provision of a health service".

However, the reference to both "rights" and "responsibilities" also implies that the person claiming the right, may themselves bear some responsibility. No more so is this evident than in the specific context of deciding upon treatment, where the need for joint responsibility is a vital part of the decision-making process. Thus, the patient, once informed, carries the burden of responsibility for that information, as in the case of a heavy smoker, who, having been fully informed of the risks of smoking whilst taking a contraceptive pill, is ultimately accountable for the consequences of choosing to pursue that form of contraception. Similarly, one could argue, a patient bears the burden of responsibility for providing the health care professional with information that may impact upon treatment, especially if asked a specific question by the health care professional; as for example, where a medical practitioner asks a patient about other medication currently being taken.

Interestingly, the Consumer's Health Forum of Australia, when advocating for a formal Charter of Health Rights, recognise the role of patient responsibility in such a Charter, but leave it to another day to consider its full implications (Health Forum, No. 17, March 1991 p. 7). Does this perhaps imply that the burden of responsibility is something that patients may not be all that willing to assume, at least, not in all cases. In this respect perhaps Dostoyevsky's Grand Inquisitor in "The Brothers Karamazov" may have been correct in predicting that patients may not wish to assume the responsibility engendered by, what he referred to as "that terrible gift of freedom" (Dostoyevsky 1958 pp. 298-301).

This leads on to the next issue. Having canvassed briefly what is meant by "rights" and the concept of "rights" and
"responsibilities", is it necessary to consider the intended role or effect of a formal Code of Health Rights and Responsibilities? The problem is perhaps best summed up by a cartoon from the Consumer's Health Forum of Australia depicting the need for an umbrella code to provide health consumers with the necessary protections that are currently lacking (Health Forum, supra note 9).

One could ask: Is there really a need for an umbrella? Are consumers in fact all "out in the rain" so to speak, and if they are, what form should the umbrella, or code take? These are but some of the many difficult questions involved in formulating a Code of Health Rights and Responsibilities. Queensland is about to embark on a consultative process over the next year that will hopefully provide some direction.

The issues raised by the analogy to an "umbrella" are obvious. Many of the so called "rights" to be contained in a Code of Health Rights and Responsibilities are already recognised in one form or another by our legal system; if not through common law actions such as negligence and trespass to the person, then via specific legislative provisions, for example anti-discrimination legislation or freedom of information legislation.

The real question to be asked is whether any of the existing recognitions and protections afforded in law are sufficient? Is there still room for additional protection by way of an "umbrella" code? More importantly, what form should that protection take? Should it, for example, have a separate legislative base?

Organisations like the Consumer's Health Forum of Australia have been advocating for an "umbrella" code for some years now. The reasons given, apart from the obvious, of clarity and comprehensiveness, are that existing recognition or protection of "rights", where they do exist in law, are often unclear, uncertain and inconsistent. On this point, most lawyers would have to concede that at least in the case of those rights having their base in common law, there is some substance to such claims. The common law is, of course, slow to develop and keep abreast of changes, largely because the it is case-driven. For example, it was not until two recent High Court decisions that two important "rights" issues were to some degree resolved.

In Re Marion (supra) the High Court drew together considerable differences of opinion between divisions in the Family Court of Australia on the ability of parents to consent to the sterilisation of their intellectually impaired child. More recently, Rogers v Whitaker (supra) seems to have clarified the position for all states and territories in Australia on the matter of informing patients of material risks inherent in medical treatment.
Another problem with the common law is that cases which concern such important and difficult "rights" issues, also involve complex policy considerations, something many would argue judges are not comfortable with and a task that is better left to Parliament, the duly elected representative of the people. This itself, highlights the concerns that issues of "rights" and the other side of the equation, "responsibilities"; intertwined as they are with difficult questions of morality, are perhaps best dealt with after a process of public participation.

Even where specific legislation does exist, advocates for a formal Code of Rights argue that there is considerable variation in the degree of protection afforded between the various states and territories in Australia. For example, only Victoria, South Australia, Northern Territory and more recently the Australian Capital Territory have specific legislation recognising, in part, the right of a patient to refuse certain medical treatment in circumstances where the patient is no longer capable of expressing that wish (Medical Treatment Act 1988(Vic); Natural Death Act 1983 (S.A); Natural Death Act 1988 (N.T) and Powers of Attorney Act 1956 (ACT)).

The arguments against the formulation of a Code of Health Rights and Responsibilities are equally numerous. Many would argue that it is the very nature of common law and its flexibility that best enables it to adapt and mould the law to meet changes in society. In this way, a formal Code of Health Rights and Responsibilities has its own inherent limitations. At best, a Code can only attempt to identify the basic principles and rights and as such, will only ever result in a "normative" statement of principles. A formal Code of Health Rights and Responsibilities would itself, necessarily, be lacking in specifics.

The principles, rights and responsibilities contained in a Code, are often written in vague terms, leaving it to others such as the courts, to imply the necessary qualifications. On the other hand, if a Code is expressed in specific terms, spelling out with some precision the exact parameters of the rights protected, there may be problems in rigidity. In particular, the Code and the protections it contains may be inadequate in dealing with future unforeseen or new social situations, especially if one accepts the correlation between "rights" and general notions of morality. The more specific and detailed the approach in formulating a Code of Health Rights and Responsibilities, the more likely that the document itself will serve to inhibit the development and recognition afforded to future rights and freedoms; something the common law has always prided itself in doing well. This particular concern may well add further weight to the view that a Code of Health Rights and Responsibilities can and indeed, should only contain a statement of fundamental, universal and enduring
rights, rather than those of particular relevance to contemporary society.

Once attention is focused on the content of the Code, problems exist both in identifying those rights to be contained in the Code, but equally, and conversely, those rights which might be omitted. A fundamental defect often identified with a written Code of Rights, is that many "rights" may ultimately be excluded from the formal document. In this event, those "rights" omitted may, over time, gradually become of decreasing value to society (see for example EARC Public Seminar, "A Bill of Rights for Queensland?" supra).

There are, of course, some solutions to the problem. Greater flexibility in interpretation can be achieved by adopting a general objects clause or preamble. This itself would assist in further development of rights at common law. Equally, promulgation of the Code as an ordinary Act of Parliament, rather than one having a formal Constitutional base, would allow for a greater flexibility and ability to amend.

There are many other important issues that should be addressed in the process of formulating of a Code of Health Rights and Responsibilities. For example, in determining the content of the Code, should the rights specifically identified be recognised as "absolute" rights, or should there be provision for restrictions in those circumstances where individual rights may need to be balanced against the broader interests of society see for example the Canadian Charter of Rights and Freedoms which expressly contemplates this result. This can be contrasted with the United States Bill of Rights where rights are recognised as absolute and only restricted, if at all, as a result of the courts reading down the provisions.

Related to issues concerning the content of a Code, one may well ask a more fundamental question; what is the desired purpose of formulating a Code of Health Rights and Responsibilities? Is the function of such a Code simply to provide a universal statement of fundamental principles to guide government in their future formulation of policy and ultimately, legislation? Alternatively, should the Code be enforceable, and if so, against whom (for example, government and other individuals) and by what means (for example, by legal action through the courts, or some other independent tribunal). If a Code of Health Rights and Responsibilities fails to provide any specific remedy for a violation of the rights it recognises, then one must seriously question whether there is indeed a need for such an "umbrella". It has been said that "a right without a sanction to enforce it is but the expression of a pious hope." The rationale for having a Code of Health Rights and Responsibilities that is ultimately unenforceable, may solely be related to its role as a moral educator and potential standard setter.
On the other hand, some would argue, especially in the event of a statutory basis for the Code, that there will be a concomitant increase in litigation. This would result in more so-called "defensive" medicine. More people, it is argued, would resort to the legal system for the purpose of asserting their "rights" than has previously been the case. The desirability or not of this prospect is largely a matter for individual determination. It is, nevertheless, an important issue that must be addressed, and public input is required.

Regardless of the various arguments for and against the development of a formal Code, at least in Queensland there is a specific legislative commitment to the formulation of a Code of Health Rights and Responsibilities.

The Development Of A Code Of Health Rights And Responsibilities For Queensland

Section 37 (1) of the Act states:

"Within 3 years after the commencement of the Act, the Commissioner is to develop a Code of Health Rights and Responsibilities for the consideration of the Minister".

The process of developing the Code is also spelt out in the Act. Section 38 states:

"In developing the Code of Health Rights and Responsibilities, the Commissioner is to;
(a) consult with the council; [that is, the Health Rights Advisory Council of Queensland] and
(b) invite submissions from and consult with interested persons and bodies to the extent necessary to ensure that a wide range of views is available in the development of the code."

That process is well and truly under way with a preliminary discussion paper shortly to be released by the Health Rights Commission inviting submissions and/or comments by the public. Initially, focus is on the principles which are to be taken into account in formulating the Code and its scope and content. These submissions will result in a first draft Code later this year. At that stage further public discussion and debate is to take place. The aim is to meet the deadline set out in the Act, and have a draft Code of Health Rights and Responsibilities presented to the Minister by 1995.

As for the principles to be contained in the Code, the Act itself provides direction. Whilst giving some scope to the Health Rights Commissioner to make independent recommendations as to the content of the Code,17 s. 39 (2) and specifically s. 39 (3), identify the relevant principles that must be considered in determining the content of the Code.

Section 39 (2) (a) states:
"In developing the content of the Code, the Commissioner - (a) may have regard to all matters relevant to the provision and use of health services (s. 39(I))".

There are a number of principles that have been identified by the Commissioner as relevant under this section (i) Every person is entitled to treatment and health services of high quality given as promptly a circumstances permit.

This principle encompasses three different ideas; the right to treatment, the right to high quality care and the right to access timely and appropriate care.

**The right to treatment, including the right to obtain a second opinion.**

No doubt, under the Medicare system in Australia, this general human right of access to health care facilities is already recognised. The entitlement is, however, limited to public health services. It does not encompass any right to private health services. Indeed, this limitation has been recognised by many professional associations which make it clear that, except in cases of emergency, there is no obligation on the part of private health care providers to treat.

Examples of existing statutory recognition of this right to treatment are numerous. The *Health Services Act 1991* (Qld), s. 1.6 (a) has as its stated objective the following:

"to ensure that the health and well-being of all Queenslanders is promoted, maintained and improved according to principles of social justice and equity"

At the federal level, the *Human Rights and Equal Opportunity Act 1986* (Cth) (Schedule 5), provides Australian residents with the means of implementing rights recognised under various United Nations treaties to which Australia is a signatory. For example, the *Declaration of the Rights of Disabled Persons* (1971), guarantees disabled citizens such things as the right to medical, psychological and/or functional treatment, including medical and social rehabilitation, AIDS counselling, training and education (Clause 6(C)).

Further recognition of this right to treatment is reflected in many professional codes of conduct. The Australian Medical Association's Code of Ethics, 1992, states that a medical practitioner has a:

"responsibility not to deny treatment to any patient on basis of colour, race, religion, political beliefs or nature of illness (AMA Code of Ethics 1992, pp. 2-3).

A medical practitioner could only refuse to treat in non-emergency situations and then only after giving the
patient adequate notice. Equally, this could only be done where alternative care is reasonably available.

The real problem in formally recognising the right to treatment in a Code of Health Rights and Responsibilities is a question of balance. Is the right to treatment absolute? To what extent is/should the consumer's right to treatment be balanced against a health provider's legitimate right to refuse to treat? Should the Code go so far as to specify situations in which a provider is obliged to treat? More particularly, should there be provision for the "good-Samaritan" situation; that is, should a Code recognise a positive duty on the part of a health professional to treat in an emergency. Such an absolute right to treatment or, more importantly, responsibility on the part of a health care professional to treat would be inconsistent with existing legal provisions. At common law, there is no general positive duty to go to the assistance of another person, there being no general liability for omissions (see Balkin and Davis 1991 pp. 217-218).

The right to high quality care

No doubt providers, consumers and governments expect high quality health services and this is reflected in various mechanisms already in place to ensure that certain standards are maintained. Most professional codes reflect this need to maintain high standards. Further recognition at the government level is demonstrated by the National Mental Health Policy 1991, Australian Health Minister's Conference, which states, inter alia, that a health consumer has a "right to timely and high quality mental health care..". This concern with the quality of health care services is also seen in many statutes. For example, under the Health Services Act 1991 (Qld), s. 3.18 (2) (a) affirms, as part of the function of a Regional Health Authority: ...... that health services in the region are of a high quality, delivered equitably and under regular evaluation and review" (see also Area Health Services Act 1986 (NSW)).

Of more interest, the Pharmacy Board of Queensland has recently promulgated a statutory Code of Professional Conduct of Pharmacists under s. 27 of the Pharmacy Act 1976 (Qld). Part of this Code of Professional Conduct requires a pharmacist to "keep abreast of the progress of pharmaceutical knowledge to maintain the highest standards of professional competence".

Perhaps one of the biggest challenges in drafting a Code of Health Rights and Responsibilities, is determining whether and if so, how one can actually guarantee the delivery of a certain quality of care. There are a number of alternatives that may be considered, for example, provision for re-accreditation of all health care providers and/or, required
participation in quality development activities and ongoing continuing education.

**Access to timely and appropriate care**

This principle raises an important and somewhat political contemporary question, that is, the equity of access to health care services according to need. With increased demand of the wide range of treatments and services now available, there is increasing pressure on the health system. This has resulted in obvious shortages and the current problem of "waiting lists". Such issues force a consideration of a more difficult task, that is, evolving some ethical basis for allocating scarce health resources.

Again, there is already clear and numerous acknowledgments of this principle in many professional codes and administrative policy statements of governments (for example, Mental Health Statement of Australian Health Ministers, 1991). Further recognition exists in many legislative provisions, such as the Disability Services Act 1992 (Qld), which recognises the need to plan, develop and coordinate disability programs and services. So too, the recent Medicare Agreements Act 1992 (Cth), which contains the following:

"Principle 2: Access to public hospital services is to be on the basis of clinical need."

"Principle 3: To the maximum practicable extent, a state will ensure the provision of public hospital services equitably to all eligible persons, regardless of their geographical location".

This question of resource allocation is exceedingly difficult. In the context of a Code of Health Rights and Responsibilities, there are additional matters to consider. For example, should the Code promote the right of consumers to directly participate in these allocation questions, as was the case in Oregon, USA, where a list of priority services was ultimately created with direct public participation, even though the schema was ultimately never actually implemented (Hastings Centre Report, 1990 p. 16).

The Act itself identifies other specific principles that are to be reflected in the Code.

Section 39 (3) (a) and (b) require the Health Rights Commissioner to have regard to the following:

"(a) that an individual should be entitled to participate effectively in decisions about the individual's health; and (b) that an individual should be entitled to take an active role in the individual's health care."
Essentially these provisions recognise the basic principle of autonomy, the "right" of a patient to participate in the decision making process and notions of freedom and choice in the provision of health care. These essentially constitute the "liberty rights" defined by Hohfeld contemplated. Most of these "rights" are again already recognised, in one form or another, by way of professional codes of conduct; institutional handbooks, guidelines, protocols. In some cases the common law may elevate these liberty rights into claim rights, as in the context of consent, by way of an action in negligence and the imposition of a duty to inform of risks, as well as an action in trespass, protecting against non-consensual treatment. Further protection is afforded by state and territories Fair Trading Acts and the Trade Practices Act 1974 (Cth), providing for an action for misleading and deceptive conduct. Specific legislation, such as the Medicare Agreements Act 1993 (Cth) which enables people to choose between being a private or public patient in a public hospital, as well as calling on state and territory governments to provide information to users about available hospital services (Principle 1, Commitment 1). Other legislative provisions address more specialised cases such as those situations where patients have a disability and/or are unable to consent due to some other impairment. The Intellectually Disabled Citizens Act 1985 (Qld) enables the Legal Friend to give valid consent on behalf of such persons, but, only after ensuring that the patient participates to the extent that is possible in light of her impairment. Similarly, the recent Disability Services Act 1992 (Qld), recognises these same rights in the context of the provision of services for people with disabilities.

The problem in formulating a Code of Health Rights and Responsibilities is, that whilst there is multiple recognition already for these principles, there is nevertheless, considerable doubt as to the extent to which they are being followed and adopted in practice. This specific concern again impacts upon issues concerning the mode by which the Code is to be promulgated. Here again, the Code has enormous potential to affect the availability and adequacy of existing remedies.

Section 39 (3) (c) states: "That an individual should be entitled to be provided with health services in a considerate way that takes into account the individual's background, needs and wishes"

This is a clear statement recognising basic liberty rights, or freedoms, as opposed to true claim rights. What is contemplated by this provision are such things as the right of a patient to be treated with consideration, dignity, understanding and courtesy. Reference to these principles further highlights concerns regarding the mode in which the Code of Health Rights and Responsibilities is to be promulgated. If by way of legislation, these "freedoms" might
ultimately be elevated into powers or even true claim rights, thereby altering their legal status.

Another principle identified by the Health Rights Commissioner under this section of the Act is the concern that a person receiving a health service should not be abused or exploited sexually, physically or emotionally by the provider of the service. Again, this is something that is already widely recognised in many professional codes of conduct and institutional handbooks and policies. It is also an area where there are numerous existing legal protections, for example an action for assault and/or, unlawful detention, both of which are criminal offences under the Queensland Criminal Code (see ss 245 and 246 and Chapter XXX dealing with assault, and s355 in the case of unlawful detention. Similarly, there are many civil actions available at common law including an action for false imprisonment and a complaint of sexual harassment under both Commonwealth and state and territory legislation (see for example Sex Discrimination Act 1984 (Cth); Anti-Discrimination Act 1991 (Qld); and Disabilities Discrimination Act 1992 (Cth)). There is a further offence of ill-treatment, wilful neglect or molesting a patient under most Mental Health Acts. And, of course, there is the ultimate sanction of professional disciplinary proceedings.

The requirement in the Act that the Code of Health Rights and Responsibilities specifically reflect this principle again forces a further consideration of the adequacy of existing laws and mechanisms to discipline health care providers. One particular issue for consideration in formulating the Code is whether it should not only contain statements about freedom from such abuse, but go further and provide additional protection for some of those more vulnerable health service consumers, such as women or the elderly.

Section 39(3) (d) states:
"That an individual Who:
(i) provides a health service; or
(ii) provides care for another individual receiving a health service; should be given consideration and recognition for the contribution the individual makes to health care".

This statement recognises the other side of the "rights" equation; namely the notion of "responsibilities". It confirms that health consumers have rights but so too do they have co-relative responsibilities.

Recognition of these co-relative responsibilities on the part of health consumers currently exists in many professional codes and institutional handbooks. Particular emphasis is placed on notions of consideration (as per s. 39(c) above), participation and forthrightness, especially in the context of information disclosure. Specifically, such provisions impose responsibility on the patient for following instructions of
the provider. More importantly, patients are seen as being accountable for their own decisions. From a legal perspective, of some concern in the development of the Code, is an assessment of the sufficiency of existing protection given to providers. Indeed, this may well have been the impetus for including this principle specifically in the Act.

Section 39 (3) (e) states: "That the confidentiality of information about an individual's health should be prescribed".

The "right" to confidentiality and privacy, is again a "right" currently recognised by the law in various forms. For example; by professional codes of conduct; institution/health department guidelines/ protocol policies; accreditation guidelines, largely focusing on the systems in place in institutions to ensure for the confidential storage and access to files; common law actions of contract, equity or tort; and specific legislation.

Of particular concern in this context is the need to strike an appropriate balance between the individual right to confidentiality and privacy versus a third party's right to know, a problem of special significance in the context of HIV/AIDS.

Section 39 (3) (f) states: "That an individual should be entitled to reasonable access to records concerning the individual's health".

Again, there is some specific recognition already afforded by legislation. Most states and territories now have Freedom of Information legislation in place, guaranteeing a patient the right to access their records in most circumstances. One limitation however, to existing "rights" is that they exist only in the public sector. In the private sector there is still a gap, although most private institutions appear to have their own internal policy encouraging ready access, as is the policy for example of the Queensland Health Department (see Editor's Note, (1993) 1 (8) Australian Health Law Bulletin, 87).

In developing a Code of Health Rights and Responsibilities, specific consideration may well be given to this gap, and whether a similar right of access should be recognised in the private sector. Indeed, recent reports indicate a similar approach being advocated by the Federal Privacy Commissioner ("Let patients see records: Watchdog", The Australian, 19.6.93).

Section 39 (3) (g) states: "That an individual should be entitled to reasonable access to procedures for the redress of grievances with respect to the provision of health services"
This right is well recognised in most jurisdictions throughout Australia by the establishment of alternative complaint handling bodies (See Queensland, Victoria and Western Australia). The gap in other states or territories will soon be filled. The recent Medicare Agreements necessitates the implementation of a complaints unit, at least in those states and territories that are signatories to the Agreement.

It should, however, be noted that recognition of this principle is not necessarily limited to the provision of legal mechanisms for redress. One important question for future consideration concerns the use of patient advocates. Should a Code of Health Rights and Responsibilities contain specific recognition of a right to access advocacy services? This is already recognised under the Disability Services Act 1992 (Qld), which acknowledges the need for access to advocacy services to enable those with a disability to adequately participate in decision making. One issue that needs to be considered in the development of a Code of Health Rights and Responsibilities is whether this principle should be recognised as a right of its own accord.

Conclusion

These are but some of the interesting challenges ahead in Queensland. No doubt, at the very least, regardless of the precise form in which the Code is ultimately modelled, the actual task of formulating a Code of Health Rights and Responsibilities, by its very process, will have a positive effect of generating discussion, enlightened debate and awareness on this important aspect of the health care relationship; that is, the rights, duties and needs of both parties to the relationship; the patient/user and health care professional/institution. Formal recognition of "rights" and 'responsibilities" in whatever form, no doubt can and will legitimise claims.

From another perspective however, there is no doubt that the effect of a Code, enshrining certain fundamental principles, can only ever constitute half of the ultimate task. A Code of Health Rights and Responsibilities can never be expected to work like a magic wand. The mere formulation of a Code will not provide a panacea. At the end of the process little will ultimately be achieved unless both parties to the health care relationship are provided with the necessary means and opportunities to facilitate the two-way process of interaction, and, communication that is at the very heart of most of the fundamental principles required to be to be reflected in the Code.

References

