
Smokers' rights to health care

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Abstract

The question whether rights to health care should be altered by smoking behaviour involves wideranging implications for all who indulge in hazardous behaviours, and involves complex economic utilitarian arguments. This paper examines current debate in the UK and suggests the major significance of the controversy has been ignored. That this discussion exists at all implies increasing division over the scope and purpose of a nationalised health service, bestowing health rights on all. When individuals bear the cost of their own health care, they appear to take responsibility for health implications of personal behaviour, but when the state bears the cost, moral obligations of the community and its doctors to care for those who do not value health are called into question. The debate has far-reaching implications as ethical problems of smokers' rights to health care are common to situations where health as a value comes into conflict with other values, such as pleasure or wealth.

Introduction

Underwood and Bailey, two cardiothoracic surgeons, launched the recent controversy with a *British Medical Journal* paper (1) which begins: '... when resources are restricted and some form of rationing of health care is effectively taking place, is it ethical to restrict access of patients to particular treatments if there are alterable factors in their lifestyle which make the treatment less likely to work?'. A fierce debate then began within the profession (2,3), crystallised around the slogan: 'Should smokers be offered coronary bypass surgery?' (the title of Underwood and Bailey's paper).

Subsequently, surgeons at two separate UK medical centres were reported to have withdrawn non-urgent coronary bypass operations from those refusing to give up smoking (4), and later that month *The Times* newspaper found four other hospitals where this practice was widespread (4). When asked

to comment, British government ministers tacitly supported this new method of health-rationing, declaring these decisions should be left to doctors, even if 'they were now playing God' (4).

The wider issue

The issue has implications well beyond the smoker; if individuals wilfully endanger their health, it may be unreasonable for the state to pay for the consequences. Hence the question: Should health service budgets be 'squandered' on those whose drinking, diet and poor compliance with medication damages their health' in contrast to those whose illnesses arise *despite* efforts to remain healthy?

By extension those who take part in dangerous sports could also find themselves without state health care in the event of injury. One estimate of the cost to the British NHS of road traffic accidents is about 90 million pounds per annum (5). Would those who are willing to withdraw treatment from smokers also consider doing so from those who do not wear seat-belts?

Alternatively, the fact that people still smoke could be viewed as a failure of public health campaigns. Preventative health makes good economic sense, but when public education campaigns fail, the state frequently *forces* us to look after our health, for example road safety laws compel us to wear motor vehicle seat-belts. These measures followed the failure of such road safety education campaigns as the 'clunk-click' campaign, which had not significantly influenced public attitudes towards seat belts (5).

Before the 1983 legislation only 40 per cent of drivers wore them. Since then, however, it has been estimated that 95 per cent of motorists obey the new law and that as a result, calculations are that 700 deaths and 6,000 serious injuries have been avoided in a single year (5). At no point did anyone suggest surgery should not be offered to those not wearing belts. Furthermore, well before that stage could ever have been reached, legislation has been used to coerce 'healthful' behaviour. It would follow that if

Key words

Smokers; rights to health care; ethics; medical treatment.

smoking is a serious enough behaviour to affect health rights, then a rational first step to take before this situation arises might be to legislate against the behaviour itself, i.e. to ban smoking.

Doctors concerned with health care implications of smoking may want to consider campaigns to influence state legislation of this behaviour as an alternative or a precursor to withdrawing care from smokers.

Why do smokers continue to smoke?

It could be argued that wearing seat-belts is significantly different from smoking; doctors rarely advise patients on driving safety, but they persistently and forcefully forewarn on the dangers of smoking. If patients knowingly ignore their doctor's advice, does that alter their future claims on their physicians, and hence their health rights?

The argument partly rests on the notion that smokers choose to smoke of their own free will, in full cognizance of the facts, and could give up if they placed the same value on health as they expect their surgeons to. There would appear to be an ethical world of difference between the harms that others inflict upon you, those you inadvertently administer to yourself, and harms that you *knowingly and freely* wreak upon your own body.

Yet there are many risks which smokers are not explicitly warned of in health education campaigns. While much stress is laid on lung cancer, the risk of circulatory diseases such as Buerger's disease, is seldom emphasised (6). Ironically, this area, of circulatory diseases, is precisely the area within which cardiothoracic surgeons operate, and from which they seek to exclude smokers. In one poll, while most smokers were aware of the links with lung cancer, 63 per cent did not know that smoking causes most cases of bronchitis, and 85 per cent were unaware that it causes most cases of emphysema (6).

Another ethically relevant issue is how free smokers are to give up. If they were suffering from an addiction, this could excuse them from failure to give up. Receptors for the active ingredients of tobacco have been discovered in the brain, while nicotine dependence has been classified as an addiction by the American Psychiatric Association (7) and the World Health Organisation (8). Surveys suggest that 90 per cent of regular smokers have tried to quit on at least one occasion; one study found that only 36 per cent had succeeded in maintaining abstinence for a whole year, while relapse rates after a given period of time are almost the same for nicotine as for heroin (9).

This is not to say giving up is *impossible*, just that it may be *difficult*. But no matter how difficult: do smokers have an ethical obligation to their cardiothoracic surgeons to *try* giving up, or even to *succeed* in giving up?

Are there ethical obligations to give up smoking?

If there is a moral obligation for doctors to promote their patients' health – do patients have a corresponding ethical duty to seek their own health? In other words, are doctors and patients engaged in a common moral enterprise which legitimately claims the allegiance of both parties?

Parsons (10) delineated the existence of a 'sick role' (ill persons are viewed as having social obligations), to positively value health and co-operate with doctors in order to regain it. In coming under the care of doctors, it appears patients enter a relationship defined and oriented by the importance of health values (11). Not to value health while seeking help and advice from doctors might represent an attempt to enter such a relationship under false pretences.

Hence, implicit in the very act of *any* medical consultation could be the agreement that both parties, doctor and patient, value health (11). But smoking would seem to suggest, at the very least, that other values, such as pleasure, have a higher priority than health. Do not doctors have the right, when this implicit contract within which they attempt to work meaningfully with patients has been violated, to withdraw care (11)?

The problem with this argument is that patients rarely value health as much as doctors do (except possibly in the case of hypochondriacs). Doctors, by their personal orientation and professional training, probably value health more than anyone else in society. For most people, other values, such as those to do with money or pleasure, frequently take priority over health. In fact it could be argued that patients often do not see doctors because they value health – they avoid doctors so as to *avoid suffering*. Hence their tendency to make appointments after experiencing pain or discomfort, rather than attending for health check-ups or preventative health advice.

If this is the case, the notion of shared values between doctor and patient becomes questionable, and equally so would any ethical obligations based on such values. While doctors may value health, they could not meaningfully make their medical practice contingent on these values being found in their patients. Among other problems this would automatically exclude many, such as the suicidal and the mentally handicapped, from rights to medical care.

On the other hand, the suicidal and the mentally handicapped are presumed not to value health for reasons other than fully conscious rational choice. If patients in full possession of their faculties and the facts choose a hierarchy of values which represents a relative *depreciation* of health, should doctors' contrasting set of priorities be relied on to come to the rescue?

It seems morally inconsistent to expect to be helped precisely because those who provide the help

hold a set of values you have rejected. The individual can maintain moral consistency only by relinquishing expectations of help in the context of behaviour which does not value health, or by accepting the set of values which provides the context in which help is provided, and hence changing his/her behaviour.

Are smokers' health rights a medical issue?

The gap in health values between doctors and patients means that if doctors had their way, patients might be subject to much more restrictive legislation than at present, for example, the freedom to box, or drink in public houses or bars at any time of the day could be limited (12). Given the tension in values between profession and public, primarily ethical decisions such as those to do with smokers' rights, should perhaps be left to the state and not to doctors. While doctors have ethical obligations to provide good treatment for patients – *who* should actually receive health care is possibly not a *medical* decision – but instead one society and its elected representatives should resolve (13).

For example, in many countries, if they cannot afford it, people do not receive medical care. This is not a decision taken by doctors, but by those who constructed that health care system. The public, via their governments, have decided that medical care should largely be rationed through the free market. Even in the British National Health Service (NHS) there are many treatments which are no longer offered – much dental care, for example. Again these are not rationing decisions taken by health professionals, but by those who administer the health service, and therefore it could be argued that it is they who ought to wrestle with the ethics of whether doctors should treat smokers, and not doctors (13).

While this is the line taken by some of the correspondents involved in the debate over smokers' health care rights in the *British Medical Journal* (13), it seems an inadequate response for, among others, British fundholding general practitioners. These have a budget allocated by the state, with the precise undertaking that they will be responsible for rationing decisions within the constraints of that budget (14).

Part of the power of fundholding was always intended to be the product of bringing together medical expertise with wider management and administration skills under the same roof (14). While this has undoubted efficiency advantages, it does also push fundholders into the front line of ethical rationing dilemmas precisely of the kind: 'Should smokers be referred for expensive treatments?'

Even doctors who are not fundholders are morally implicated in these questions – frequent attempts are made to disguise the ethical dilemma as a clinical one. In Underwood and Bailey's original *British*

Medical Journal paper, the emphasis was on the poorer prognosis of smokers receiving coronary bypass surgery (1). The problem with this perspective is that while a *terminal* prognosis is often the basis of a decision to withhold treatment on the grounds of mercy, a poor prognosis is not necessarily a good clinical reason for withholding treatment – in fact often the contrary applies, very ill people often attract more care from doctors not less.

Smokers' rights to health

Another way of looking at the dilemma is: Do some people lose their right to equal access to health care as a result of their behaviour? After all we readily accept that while everyone has a right to liberty, that right is lost in committing a serious crime.

Just as we all have obligations to obey the law, ill people can also be viewed as having certain social obligations, for example, to positively value health, and to co-operate with doctors in order to regain it. Those who do not fulfil these obligations should surely lose their claims on others. For example, patients who are violent to general practitioners have long been considered as relinquishing the obligation of being kept on the practice list.

However, these examples also illustrate the principle that while we are used to giving people many social and economic rights, and also taking them away in certain circumstances, there is a distinction between these and even more fundamental rights – *human* rights – rights to life, for example, often considered as worth preserving under almost any circumstances (15). For example, however heinous the crime, criminals have a right to trial, and to certain basic conditions in prison. Might not health be considered such a *basic human right*?

Another ethical principle which comes to bear on the dilemma over smokers and their rights to health care, is the general acknowledgement that our individual actions should not endanger others, and that where necessary this principle should be enforced by law. The smoker who uses up the health service budget on expensive operations could be seen as endangering the life of others, since their health resources get squeezed as a result (16).

This leads to a utilitarian question: does the doctor have less of an ethical responsibility for the *individual* patient sitting in front of his desk, and a more primary obligation to the *group* of patients on his list? Should he not make decisions which maximise the well-being of the *group*, even if that is at the expense of the smoking minority?

A characteristic feature of an individual 'right' is its regulation of how individuals may be treated, however desirable the collective goal. For example, individual rights to freedom take precedence over the well-being of the population at large. Utilitarianism conflicts with rights theory precisely at this point. Utilitarianism allows significant individual

interests to be sacrificed in order to attain collective benefits.

Any nationalised health system is likely to exhibit a compromise between principles of individual responsibility and community solidarity, as it assumes that the financial risks of ill-health should be borne by society at large. The risk in doing this is that individuals are no longer penalised for overeating, drinking and smoking. Yet any lifestyle involves an implicit valuation of one's own health. Average health under such a system becomes rather like a public good, such as clean air or uncongested roads, from which everyone benefits, but towards which none have an incentive to contribute.

The problem is that this very discouragement of personal responsibility for health may eventually become detrimental to the individual herself in the long term. Hence, another aspect of the dilemma over smokers' right to health: if smokers are denied rights to health care this may in itself act as a forceful incentive to give up smoking. This becomes an empirical question for which there is currently inadequate data. However, if one long-term consequence of denying smokers' rights is to reduce the number of smokers, enabling those who have given up to have access to health care, a utilitarian argument may then supervene, namely, do more smokers benefit in the long run from depriving a minority of rights to health care? This argument resonates with several key elements of the legislation-over-seat-belt-wearing debate.

A nationalised health service and smokers' health rights

Perhaps one thing this debate about smokers' health rights has made clear is that the ethical principles on which the British National Health Service were founded, have been forgotten. The possible referral strategies for smokers which are being contemplated, contravene these principles.

The welfare state is based on the assumption of 'each according to his ability, to each according to his need'. This is sympathetic both to the *right* to be unhealthy and to a duty to care for the unhealth of others, paid for through heavy taxation (17). In other words those who cannot look after themselves should be looked after by those who are more able. It is important to remember this in the current smoking debate, as wealthy smokers will always be able to afford bypass surgery: the issue is really one of the rights of *poor* smokers to health care.

The nationalised health service was founded to ensure wealth should not make a difference (whether it succeeds or not the intention still stands) and refusing to refer the smoker for health care returns to the days when affluence did matter. The rich smoker will always be able to obtain his operation, while the poor smoker will not.

Yet if the wealthy smoker is forced to pay for his own treatment because he smokes, this will save the

health service money, which can be used to treat many others – a solid utilitarian argument. The potential savings to the health service seem unlimited if the same principle is applied to other medical problems – drinkers in need of liver transplantation, HIV patients who acquired the infection through drug addiction or promiscuous sex, heart patients who are overweight, accident victims who had been driving carelessly or under the influence of drink, and those with sports injuries.

In fact the very best economics might be to *encourage* people to smoke. This is because no matter how much a patient does exactly what his doctor advises, everyone dies of something sooner or later. Doctors tend to forget that the medical costs of smoking-related diseases can only be calculated after the costs that *would have been incurred* had the people killed by smoking died of something else later, are subtracted (18). In fact, in terms of overall medical expenditure over the course of their lives as a whole, there is some evidence that there may be *no significant difference* between smokers and non-smokers in medical costs to society (19). Smokers even save the state money by dying early.

Smoking tends to cause few problems during a person's productive years, and then kills them before social security and pensions payments are made (18). In fact, it is the non-smoking pensioner who benefits financially from the contributions his smoker counterpart never lives to claim. And then, let us not forget the billions in tax revenue cigarettes contribute to the exchequer: eight per cent of total British government revenue (20).

Denying the smoker treatment on the utilitarian/economic grounds of costs to society ignores hazardous behaviours smokers might replace smoking with if it did not exist, and the health problems they would live to develop if they did not die of smoking. Utilitarianism taken to this extreme always extinguishes individual rights. If a health service were founded on principles of maximum economic utility, then it might even make sense to encourage smoking!

When can rights to health care be changed?

Part of the force behind many of the arguments over smokers' rights to health care is the unfairness of 'changing the rules after the game has begun'. For doctors to practise medicine within a health service which embodies certain implicit values, only then to attempt to change their personal practice in a way which becomes inconsistent with that health service, demonstrates an inconsistency which requires these doctors either to leave that form of employment, or reform their personal practice.

There is another sense in which 'changing the rules after the game has begun', applies to smokers' rights to health care. If smokers were informed

before their decision to start smoking that such behaviour would jeopardise their rights to health care, then there is a sense in which such decisions to smoke, taken on that understanding, appear to reduce these smokers' entitlement to demand health care as a right.

An important distinction

If this argument is accepted it should also be apparent that starting smoking with no awareness that such behaviour would reduce rights to health care, does not permit the smoker the chance to change his behaviour in the light of this information. Therefore subsequently to enforce such a restriction on rights to health care appears unfair. This contention suggests that rights to health embodied in a society or a health care system, whatever they might be, cannot be made up or changed 'on the hoof', and that patients have the right to know how their behaviour will affect entitlements to health care *before* they make decisions about such behaviour. Hence, attempts to reduce smokers' rights to health care should only be made with generations who have yet to take up smoking. This should logically apply to all hazardous-to-health behaviours.

Here then we have an important distinction: while it may be possible to hold a smoker at least partly culpable for subsequent ill-health (as it is common knowledge that smoking is injurious to health) it appears less fair to withhold *treatment* unless the smoker was also aware that such treatment would be withheld before she began smoking, or aware in sufficient time after she had begun smoking to give her the chance to change her behaviour in the light of such information.

This point also has a bearing on doctors' and patients' responsibilities for health. If a doctor withholds a treatment and consequently a patient dies from an illness that the patient could not have reasonably prevented, then that doctor would be seen as responsible for the patient's death. If, however, the illness was partly produced by the patient's behaviour, which the patient knew would be self-injurious, then although the doctor still has some responsibility for the patient's death if treatment is withheld, it now appears that as the patient could also have prevented death by a prior change in personal behaviour, the patient now also shares some responsibility for her own demise.

The patient appears to have even more responsibility for her death if she further knew also that her behaviour would lead to the doctor deciding to withhold treatment. If by withholding treatment from one patient the doctor instead saves another, then the doctor is no longer responsible for a death, but merely for *who* dies. Supposing that someone had to be treated and therefore someone else had to go without treatment, the fact that in this situation a smoker dies could be seen as being even more that

smoker's responsibility, if she had prior knowledge such a choice would be made, and she could have prevented that death by not smoking.

Looked at from the perspective of varying patient and doctor responsibilities for death, and therefore conversely health, although there is always some medical responsibility for the outcome of withholding treatment, as patient responsibility waxes and wanes depending on the patient's ability to avoid death by choice of behaviour, it is possible that the responsibility for the death of the smoker by the withholding of treatment, should be placed less at the door of a surgeon, than if similar treatment is withheld from the non-smoker. What I am suggesting is that there is some diminution of the responsibility of the surgeon for the smoker's death if treatment is withheld.

On the other hand, just because a particular set of circumstances makes a doctor less responsible for the death of a patient, does that mean these circumstances produce any less of a moral obligation on the doctor to *attempt to save* the patient's life?

In fact it is acknowledged that while doctors do have moral obligations to save their patients' lives this does not appear to be significantly different from the obligation we all have to save life if we find ourselves able to do so (21). Doctors may possess special skills which enable them to rescue others more frequently than the rest of us, but the reasons *why* they should do so are the same as the reasons *why* we should all do so. If doctors' moral obligation to save life is no different from anyone else's, it follows that doctors should not be expected to value life any more than the community within which they function values life.

However, if doctors find themselves working in a community which does not appear to value health or life as highly as the profession may feel it ought to, then doctors may wish to attempt to alter the community's views by health campaigns or individual patient counselling. However, if doctors should not impose their own values of health on a community, similarly a community must abide by the decisions of its doctors, if these merely reflect the values of that society.

Difficulties

While doctors may be expected to value life more than particular individuals they care for may choose to do, such as the suicidal or drug abusers, they cannot be expected by the community in which they work, to value life more or less than the culture in which they function. Hence, it also follows they cannot be expected by their patients to value life in a way not required by the values of the system of medicine constructed by the society (and hence their patients) within which they function.

Difficulties for doctors occur when they appear to be expected by patients to value life or health more or less than the health service constructed by the society

in which the doctors live and work. For example, in a democratically approved, strict fee-for-service system for non-emergency health care, it would appear odd for the general public to expect doctors still to have a moral obligation to provide non-emergency medical care for those who could not afford it.

The system that society evolves for distributing health care embodies within it values which apportion moral obligations to doctors. However, individuals within that society, even large groups, may disagree with the majority view of the moral obligations of doctors to provide non-emergency health care, and may campaign to change that system. Yet this does not mean they can expect doctors to practise medicine in ways which radically depart from the views shared by the rest of society. Their disagreement is not, then, with doctors, but with the rest of society.

It is important to remember that there are other circumstances which convey society's estimations of the moral obligation to save lives. For instance, once someone engages in a hazardous behaviour, an implicit value is placed on the life put in danger by the amount society is willing to invest in a rescue attempt. It appears inconsistent to expect doctors to place a higher or lower value on a life than that conveyed by society's general attempts at rescue.

However, there are several different ways of interpreting the value society puts on life and these may not be entirely consistent. For example, the amount spent on making roads safer may not place the same value on human life as that invested in rescue services.

Hence, if as a society we choose not to invest a great deal in warning smokers of the dangers to their health of that behaviour, it appears we have made a collective and implicit decision as to the value of smokers' lives. On the other hand, if much more is spent in providing health care for the same smokers once they become ill, this might lead to a different calculation as to the value of smokers' lives. Hence it appears possible to ascertain the value society places on life by certain policy decisions, and by the way it organises and funds its health service.

Not just societies, but also individuals, may appear inconsistent in the degree to which they value health. Patients who make, but then fail to attend, appointments represent a significant cost in doctors' time and resources (22), and doctors may wonder how obligated they are to push health care onto those who fail to attend by vigorously pursuing them. Given that some patients may not want to be pestered by doctors, it appears patients may also have a *right* not to value health care as much as their doctors. This right is enshrined in the Mental Health Act of 1983 which allows medical treatment against a conscious patient's wishes in only very narrowly defined circumstances; usually only when there is a significant risk to the safety of self or society as a result of a severe mental illness (23).

Therefore, even if doctors do value health more than their patients this does not mean they can

usually force these values on their patients. Patients appear to have the right to place their own value on health in circumstances when this conflicts with doctors'. Given the various circumstances in which doctors' and patients' values on health may conflict, we are left to ask what should guide behaviour in these situations. If patients are not to be dictated to by doctors or vice versa, it appears the only remaining resort is to an inspection of the generally held values of health in the society within which doctors and patients live and work.

Complex interplay

It therefore follows that the outcome of a procedure to save a life is the product not merely of an interaction between an individual doctor and an individual patient, but the result of a complex interplay between the values placed on life by an individual, a society, a health care system and a doctor. It thus follows that it is in fact discrepancies which arise between these different values which account for the moral difficulties created by the rights to health care of those who indulge in hazardous behaviour.

Such difficulties could not arise if hazardous behaviour did not lead to controversy over what constitutes an unreasonable risk to personal health, implying contrasting health values in different sections of society. At an individual level a confusion over values also frequently exists. For example, the very fact smokers demand health care means that two behaviours, smoking and seeking health care, which place a very different value on health, can originate within the same person.

Highlighting the contradictory nature, in terms of health values, of such requests for health care might lead society at large to begin resolving these contradictions, one way or the other. As doctors tend to be more knowledgeable about the health implications of various behaviours it might fall to them to draw attention to conflicts between healthful behaviours and other values; conflicts which would not otherwise occur to those choosing how to behave.

While it seems fairly uncontentious that doctors should play a role in fostering this discussion, it is less obvious that they should determine the outcome. Withholding treatment seems to be taking a firm position before the dispute has had a chance to get off the ground. On the other hand, in taking a controversial stand, those doctors who attempted to withhold treatment from smokers put the debate on the front pages of national newspapers, which probably catalysed the controversy and engaged the public far more than the back pages of academic journals ever could.

Conclusion

This paper has attempted to marshal the main arguments involved in the debate over whether

hazardous behaviours, especially smoking, should affect rights to health care. The particular context of the health care system in which this debate occurs is crucial, as this determines implicit 'rights-to-health' assumptions which underpin doctors' behaviour. In an extreme free-market health care system whether smokers receive treatment will depend solely on whether they can afford it; smoking itself will be an irrelevancy.

If an alternative health care system is constructed which attempts to assign certain basic human rights to health care, and hence to ensure that personal financial considerations are irrelevant to treatment, decision-making within that system should attempt to be consistent with the principles underpinning such a service.

Hence, it would follow that denying smokers health care because they smoke would be inconsistent with the principles on which that health service was founded.

An interesting implication of this argument is that one test of whether a nationalised health care system, based on universal and equal rights to health, has become terminally underfunded, is when debates of this kind begin to occur.

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