

organisations should avoid knee-jerk commitment to instant reporting (best left to newspapers) and should acknowledge a responsibility to release findings that have been double-checked and, in appropriate cases, peer-reviewed. There have been serious cases of false allegations (eg, the notoriously invented claim that Saddam Hussein's forces threw babies out of hospital incubators during the invasion of Kuwait), and some non-governmental organisations have left themselves open to the criticism that they have exaggerated allegations against unpopular governments to raise money or membership.

The new international criminal courts which deal with war crimes have developed laws of evidence to protect certain witnesses—notably war correspondents and human-rights monitors—whose compelled testimony could imperil sources or make perpetrators less willing to cooperate. These rules, which generally allow sources' anonymity and compel testimony only if crucial to the result of the case, need to be adapted to take into account the ethical concerns of doctors, nurses, and aid workers who are also potential witnesses. Patients' confidentiality is an acknowledged value, but might have to be overridden in the interests of bringing home responsibility for a war crime, whereas medical staff can be compelled to testify, certainly if their evidence is vital to cases involving attacks on hospitals or ambulances.

The articles in this series are particularly welcome for their analysis of the South African cases that have forced drug companies to reduce the price of vital medicines, and of the Indian decisions that infer from the constitutional right to life a right to primary health care and to health insurance. These second-generation rights have often been regarded in developed countries as unjusticiable, or at least as unenforceable against the state, but creative

## The printed journal includes an image merely for illustration

Families of the Detained and Disappeared group protest against Pinochet (Santiago, Jan 22, 2000)

lawyers in South Africa and India have found ways to make them meaningful. Another connection between human rights and health can be discerned in the evidence of the resurgence of diseases long thought to have been eradicated, in states which evince no respect for the civil rights of their citizens. This causal link serves to emphasise the indivisibility as well as the universality of fundamental rights: freedom from avoidable illness is as essential as freedom from discrimination or persecution. That means that medical services must now be delivered within an ethical framework infused by human rights considerations: dilemmas will remain, but they will be more acceptably resolved.

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## Right to the highest attainable standard of health

The right to the highest attainable standard of health lies at the heart of the health and human rights movement. Of course, this right does not provide magic solutions to complex health issues, any more than do ethics or economics. Nonetheless, the right to health has a crucial constructive role to play. Health policymakers and practitioners who ignore this fundamental human right are failing to use a powerful resource that could help to realise their professional objectives.<sup>1</sup>

At the international level, the right to health was first articulated in the Constitution of the World Health Organization 1946. Subsequently, it was enshrined in several binding international human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights, as well as many national constitutions.<sup>2</sup> However, it remained little more than a slogan for more than 50 years.<sup>2</sup> Not until 2000 did an authoritative understanding of the right emerge—when

See [Comment](#) page 368

See [Perspectives](#) page 381

See [Series](#) page 449

the UN Committee on Economic, Social and Cultural Rights, in close collaboration with WHO and many others, adopted General Comment 14.<sup>3</sup>

This substantive instrument confirms that the right to health not only encompasses access to health care, but also the underlying determinants of health, such as safe water, adequate sanitation, a healthy environment, health-related information, and freedom from discrimination. The right has a preoccupation with disadvantaged groups, participation, and accountability.<sup>4</sup> Moreover, it places a responsibility on high-income countries to help developing countries deliver the right to health to their people.<sup>5</sup>

Although General Comment 14 leaves many questions unanswered, it remains groundbreaking and marks the moment when the right to health ceased to be a slogan and became an important instrument for all health policymakers and practitioners.

As UN Special Rapporteur on the right to the highest attainable standard of health, I try to make the right to health—and General Comment 14—more specific, accessible, practical, and operational. Informed by consultations with a wide range of health workers, my 30 or so reports focus on poverty and discrimination. Some reports look at the right to health in specific countries, such as Sweden, Romania, Mozambique, Peru,

and Uganda.<sup>6-8</sup> Some focus on special situations, such as Guantánamo Bay and the war in Lebanon and Israel during mid-2006.<sup>9,10</sup> Several address broad right-to-health issues, such as maternal mortality, mental disability, access to medicines, sexual and reproductive health rights, and the skills drain of health professionals—a perverse subsidy from the poor to the rich that undermines the right to health of those who live in sending countries. Because the right to health is subject to progressive realisation, one report sets out a human rights-based approach to health indicators, to enable progressive realisation of the right to health to be monitored and measured.<sup>11</sup>

All these reports and interventions look at issues through the right-to-health lens. In this way, they develop an analytical framework for unpacking the right to health. This framework deepens understanding of complex health issues and helps to identify practical policy and programmatic responses, including measures that are meaningful to disadvantaged communities and individuals.

One of the most pressing challenges is the integration of the right to health in all national and international health-related policies. To achieve this end, the traditional human rights methods and techniques (such as naming and shaming, letter-writing campaigns, taking test cases, and slogans) are not enough. These traditional methods must be supplemented with new techniques and skills, such as indicators, benchmarks, impact assessments, and budgetary analysis. These new methods are now taking shape, reflecting the growing maturity of the health and human rights movement.<sup>12</sup>

Unfortunately, some commentators seem to be oblivious to these new developments. They still seem to treat the right to health as if it were little more than a bumper sticker or an instrument for tackling torture and, at a pinch, discrimination within health care.

Obviously, the realisation of the right to health depends on enhancement of public health and delivery of medical care by health workers. Equally, the classic traditional objectives of the health professions can benefit from the new dynamic discipline of human rights. Health workers can use the right to health to help them devise equitable policies and programmes that: benefit the most disadvantaged; strengthen health systems; place important health issues higher up national and international agendas; secure better coordination across health-related sectors; raise more funds from treasuries;



UN Photos

Flags outside the UN building in New York, USA

leverage more funds from developed to developing countries; and in some countries, improve the terms and conditions of those who work in the health sector.

In short, the right to the highest attainable standard of health is an asset and ally, which is at the disposal of all health workers. Why not grasp and use a resource that not only helps to achieve professional objectives, but also helps to fulfil professional responsibilities?<sup>13</sup>

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I declare that I have no conflict of interest.

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## Epilepsy onscreen: getting it wrong

Cinematic and television portrayal of people with epilepsy has been blamed for the poor understanding of the condition found in a recent survey by Sallie Baxendale and Annette O'Toole at University College London, London, UK.<sup>1</sup> The internet-based survey of over 4600 staff and students and their email contacts suggested that a high proportion of individuals do not know what happens during seizures, and would do potentially dangerous or unnecessary first-aid interventions.

Many respondents thought that foaming at the mouth and violence were characteristics which happened “often” or “always” during a seizure. More worrying was the proportion that could not identify the correct first-aid procedures for during or after seizures. Two-thirds of respondents would immediately call an ambulance on encountering a seizing person, and one-third would even place an object in their mouth in the belief that such an intervention would prevent the patient swallowing their tongue, with the risk that the object might cause choking or damage teeth. Typical first-aid guidelines state that an ambulance is required only if the seizure lasts longer than 5 min, if the person is unconscious for more than 10 min or if there are multiple seizures, and that the seizure should be allowed

to occur while ensuring that the person is in no danger from sharp, hard, or otherwise dangerous objects.<sup>2</sup>

A key factor in the survey determining understanding of seizures was familiarity with epilepsy. Seeing an epileptic seizure being managed in public was also shown to improve knowledge of the correct first-aid interventions. Surprisingly, however, witnessing an epileptic seizure did not improve an individual's knowledge about the physical presentation of seizures.

Are these results specific to epilepsy? Probably not; asking people about other first-aid situations, such as cardiac arrest, might show similar misinformation. Perhaps what Baxendale and O'Toole's study suggests is that broader and wider-reaching first-aid teaching is required in the UK, especially if first-aid procedures are misrepresented by screenwriters and the mass media.

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I declare that I have no conflict of interest.

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