



Human rights, ethics and the Krever inquiry

The Commission of Inquiry on the Blood System in Canada — the Krever inquiry — has cleared the final hurdle and is staggering toward the finish line. On Sept. 26 the Supreme Court of Canada threw out appeals by the Canadian Red Cross Society, Bayer Inc., Baxter Corporation and 11 individuals to quash notices that findings of misconduct could be made against them. The success of these appeals would have severely limited the power of Justice Krever's commission to assign blame for the contamination of the Canadian blood supply with HIV and the hepatitis C virus. Among the allegations contained in the notices were that the Canadian Red Cross Society

failed to implement in a timely manner, during January 13 – March 10, 1993, any national donor-screening measures to reduce the risk of transfusion-associated AIDS, this failure causing unnecessary cases [an estimated 1000] of transfusion-associated HIV infection and AIDS to occur¹

and that Baxter Corporation,

[a]fter becoming aware in 1982 and thereafter of the possibility or likelihood that its factor concentrates transmitted the causative agent of AIDS, . . . failed to take adequate steps to notify consumers and physicians of the risks associated with the use of its products and to advise that they consider alternative therapies.”¹

The Krever commission is now free to tell us in its final report not only what went wrong but who was responsible. No doubt much of the fault lay in the inherent administrative and bureaucratic confusion that existed in the blood system in 1982–83 (and still exists today), the confusion surrounding the indistinct lines of responsibility for public health between the federal and provincial governments, and just plain ineptitude. The message of the Supreme Court is clear. Scruples about damaging the reputations of individual players cannot supersede our concern with the truth: only an unflinching statement of the facts can enable “useful, reliable recommendations” to be made in the public interest.

However, a more pervasive problem contributed to the failure of the blood system: the lack of an explicit code of ethics for public health. Physicians in clinical practice can rely on a code of ethics to guide them in their dealings with individual patients. Their essential duty is clear: to act in the patient's best interest. The difficulty faced by public health physicians is that their “patients” are not individuals, but populations. In choosing a course of action, public health officials must manoeuvre in a tight space: measures that are good for a population often compromise and indeed violate the rights of individuals. Existing codes of ethics do not help them.

Jonathan M. Mann² argues that public health ethics must be anchored in the principles of human rights. Are our pub-

lic health activities consistent with such values as the right to information, the right to freedom of association, and nondiscrimination? Baxter Corporation's alleged failure to “notify consumers and physicians of the risks” is inconsistent with the public's fundamental right to accurate and timely information. This right is closely linked with the right to association. In repressive regimes, aggressive and active attempts are made to deter individuals from forming groups to better protect themselves. In democracies, however, it is often a lack of information that prevents people from becoming aware of a problem and reacting. Public health officials often have such information. For example, there is evidence that variant Creutzfeld-Jakob disease (vCJD) can be spread through the blood supply. People who have received blood contaminated with vCJD would have difficulty forming an association: they live in disparate parts of the country and have no knowledge of one another. A code of ethics based on the principles of human rights might require public health physicians to encourage individuals to group together and participate in finding solutions to complex problems.

A code of ethics for public health would help us, moreover, to reconcile the sometimes conflicting claims of individual rights and the public good. For example, in 1982–83 we knew that AIDS was almost exclusively a disease of gay men and that it could be spread through the blood supply. The Krever inquiry has blamed the Red Cross for failing to implement donor-screening measures. Why did the Red Cross fail to act? Clearly, the Red Cross had a responsibility to protect the public from harmful transfusions; at the same time, Red Cross physicians and administrators were trying not to discriminate against gay men. Implementing screening procedures to discourage gay men from giving blood would have violated the rights of these donors. The physicians named by the Krever inquiry may have acted, in part, to protect the right to equal consideration of all members of society.

The lack of a code ethics to steer us through such dilemmas is mirrored by the inattention to public health ethics in medical education.³ There is no doubt that public health officials at the Red Cross and Health Canada and in industry were sailing between Scylla and Charybdis without a guide. We need to develop a code of ethics for physicians whose patients are the public at large and to ensure that its principles are taught in our medical schools.

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References

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