1.5.7 – L'exercise, en effet, d'un contrôle des conditions de conservation et d'utilisation des embryons surnuméraires par une autorité compétente.

1.5.8 – L'adaptation des règles légales de filiation et de succession aux problèmes posès par le statut de ces embryons.

Article "suspendu" dont l'examen est soumis à la décision de l'assemblée plénière:

1.4 bis – Les techniques de procréation artificielle sont appliquées, en principe, aux couples mariés, en vue d'assurer à l'enfant à naître le maximum de sécurité. Dans les autres cas, il est recommandé au médecin de consulter, avant d'intervenir, l'organisation professionnelle compétente en matière d'éthique médicale.

2.11 Trade in organ transplantation

Adopted in Madrid, 1991;
revised in Cascais, 1993
(CP 91/182 Rev.)

Motion on trade in organ transplant

The Standing Committee of Doctors of the EC (CP), meeting in Madrid on 2-5 October 1991, considered the topic of trade in organ transplantation and its ethical implications.

The CP notes with satisfaction the technical progress made in the field of organ transplant and its benefits for the patients.

However, The CP wishes to express its great concern about the tendency seen for commercial exploitation of this benefit via a trade in human organs.

The CP unanimously agrees that such commerce in human organs is ethically indefensible and that the donation of organs may only be done anonymously (with certain exceptions) and without any commercial aspects for donor, recipient or their relatives.

Furthermore, the CP unanimously agrees that no prisoner or detainee shall be subjected to organ removal under duress or promise of reduction of sentence or other advantages. Nor should the organs of persons who have been executed be used for the purpose of transplant due, namely, to the extreme difficulty of verifyring the presence of informed consent in such cases.

2.12 Living wills/advance directives

(CP 93/83 Final)

Statement of the standing committee of doctors of the EC on living wills/advance directives adopted during the Plenary Meeting held in Cascais on 12-13 November 1993

Introduction

The Standing Committee is opposed to any legislation giving living wills/advance directives the force of law, because if that were the case, it would constrain the ability of the doctor to treat the patient to the highest professional and ethical standards.

Such a document can only be a written expression of the wish and intention of the patient, made at the time when the patient was fully "compos mentis", which can later be of use as a basic framework of care.

The Standing Committee recognises that approaches to this issue are determinated by a range of social, cultural and religious factors, which mean that there are wide variations in legal provision and professional attitudes from one country to another. While respecting these national differences, the Standing Committee has identified basic principles.

Recommendations

1. This form of expression of wish and intention is not intended to promote active euthanasia.
2. Doctors should not be obliged to act contrary to their consciences. The doctor should inform the patient at the outset of any objections which she/he may have to the content of an individual expression of wish and intention and, if necessary, assist the patient in transferring to the care of another colleague.
3. Doctors should at all times seek to act in the best interests of their patients and to recommend the treatments which they consider most appropriate.
4. The doctor/patient relationship is based on mutual respect, trust and good communication. Doctors should explain treatment options to patients and ensure that they have sufficient information on which to base decisions.

   In the absence of contrary evidence, a valid statement of wish and intention is of value in representing a patient's settled wish when the patient may no longer be competent to express a view. The patient is responsible for ensuring that the existence of his/her advance directive is known to those who may be asked to comply with its provisions.

   Those who interpret it must take account of the possibility that the patient's views about treatment may change as his or her clinical condition changes.
5. Patients may wish that every possible treatment should be provided to the point of death. They also have the right to refuse treatment at all times.

6. Patients who become incompetent should retrain the same rights in respect of health care as those who remain competent.
7. It should be possible for a statement of wish/intention to be overridden where the clinical circumstances are not precisely covered by their provisions. Such circumstances are a matter of clinical judgement and would merit further discussion.
8. If there are discussions about developing policy on the use of statements of wish/intention, representatives of medical and other health professions should be involved while the complexity and sensitivity of the various factors which must be taken into account should be drawn to the attention of the public and appropriate authorities.

2.13 Ethical and economic consequences of the limitation of resources for health care (CP 94/49)

Recognising that the problems raised by an increase in health expenditure at a rate which exceeds that of the GNP are a challenge not only for governments and the citizen, but also for the medical profession.

Recognising that it is difficult to reconcile the need to guarantee the citizen the enjoyment of the best health care available with the most recent developments in the world of medicine and the desire by the various governments to control increases in expenditure.

The Standing Committee hereby expresses the following opinion:

I. *The Problem*

Although it appears to be a legitimate desire on the part of governments to contain expenditure, it must nevertheless be emphasised that:

1. that part of the nation's wealth which is devoted to health care is a function of choices made by society.
2. public health also constitutes an investment, and the potential benefits for the health of the citizen of an increase in the share of GNP allocated to health care have not been given suffcient consideration.
3. the health care sector constitutes a source of employment for a not inconsiderable proportion of the active population at a time when the problems of unemployment and employment are among the principal concerns of the majority of Governments and trade unions;
4. an important proportion of the expenditure in this area returns to the state in the form of taxation;
5. the health care sector also has productive aspects to it if account is taken of the pharmaceutical industry, biomedical equipment, computer technology, construction, etc.

It is therefore clear that the health care sector is not only a source of expenditure but also a source of benefit for public health and the state.

It is therefore appropriate to consider it in terms of its positive economic aspects, and not only in terms of expenditure.

II. *The causes*

The increase in expenditure results from a number of medical and social and economic factors which need to be identified in order to establish which proportion of it is unchangeable and, of that which is changeable, which it is acceptable to change and which it is not.

Certain causes have their origin in natural developments and are difficult to avoid.

1. medical progress which make available to patients increasingly effective diagnostic and therapeutic techniques;
2. more effective but also more expensive medicinal products;
3. the increased use of organ transplants as a routine procedure;
4. an increase in the number of physically and mentally handicapped people, due to an increase in their life expectancy;
5. an increase in the longevity of the chronically sick;
6. an increase in the average age of the population, while the incidence of chronic afflictions and of cancer is higher for aged persons.
7. the emergence of new illnesses such as AIDS;
8. the need experienced by medical teams to have at their disposal for the benefit of patients increased numbers of better qualified staff, who are by that very fact more costly;
9. an increase in the insurance premiums for professional negligence, caused by medical techniques which are more effective but which at the same time carry greater risks.
   This increase in medical liability also affects the attitude adopted by medical practitioners, who feel obliged cover themselves by means of increased levels of professional guarantees, particularly by multiplying their procedures;
10. increasing public pressure for progress in preventive medicine which, even though it gives rise to certain savings, is nevertheless very costly.

Certain causes have their origin in society itself, and could become the subject-matter of preventative action on the part of the governments:

1. increasing levels of severity in road traffic accidents;
2. an increase in illnesses caused by pollution and the working environment;
3. an increase in the number of alcoholics and drug users who all require increased levels of health care.
   Certain factors are worthy of increased consideration: additional demands made by citizens on