

# The right to treatment for self-inflicted conditions

Ofra Golan

The Unit for Genetic Policy and Bioethics, Gertner Institute for Epidemiology and Health Policy Research, Tel Hashomer 52621, Israel

## Correspondence to

Dr Ofra Golan, The Unit for Genetic Policy and Bioethics, Gertner Institute for Epidemiology and Health Policy Research, Tel Hashomer 52621, Israel; [ofrag@gertner.health.gov.il](mailto:ofrag@gertner.health.gov.il)

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## ABSTRACT

The increasing awareness of personal health responsibility had led to the claim that patients with 'self-inflicted' conditions have less of a right to treatment at the public's expense than patients whose conditions arose from 'uncontrollable' causes. This paper suggests that regardless of any social decision as to the limits and scope of individual responsibility for health, the moral framework for discussing this issue is equality. In order to reach a consensus, discourse should be according to the common basis of all theories of justice, Aristotle's formal principle of justice: 'equals must be treated equally and unequals must be treated unequally, in proportion to the relevant inequality'. This paper deals with the question of whether and under what circumstances risk-taking behaviour could be regarded as a 'relevant inequality' with respect to the right to health care. Following a discussion of the relevant inequalities in health care, the conclusion is reached that the fact that the condition was avoidably caused by the patient and is therefore his or her fault can not be regarded necessarily as a relevant inequality. Therefore, the issue is one of societal support for health care; after defining relevant inequalities in this respect, the paper attempts to apply them to self-inflicted conditions. This analysis reveals that, in theory, it may be just to restrict societal support in such cases. However, the application of this conclusion requires proof of many factual claims—for which there is often very limited evidence.

Avoidably self-inflicted (hereinafter self-inflicted) conditions constitute a large portion of the causes of death. For the USA in 2000, they amounted to approximately 40% of all deaths.<sup>1</sup> The cost of caring for patients with such conditions is also extremely high.

The prevention of such conditions is the main goal of health promotion, which raises individuals' awareness of their responsibility for and ability to affect their own health. Furthermore, it creates 'ripple' effects on society's attitudes towards health issues. One of these issues is the right to health care. In particular, if certain health aspects are under the individual's control, and one neglects these aspects, should the ensuing self-inflicted damages be included in the 'right' to health care as a societal obligation? This question is amplified in light of the data as to the scope of the phenomenon and its collective implications.

Some argue that patients with self-inflicted conditions have less of a right to treatment at the public's expense than others whose conditions arose from 'uncontrollable' causes. For example, an international survey of healthcare professionals concerning their values regarding healthcare spending priorities<sup>2</sup> found that across all countries cancer treatment for smokers was ranked as the

least important priority for healthcare spending. Participants seemed to invoke the principle of individual responsibility, with smokers in effect being 'blamed' for their cancer.

Other studies show similar findings both among health professionals and the general public.<sup>3–6</sup> There are also official policy statements whereby patients who fail to take care of their own health have a lesser right to treatment for resultant diseases.<sup>7–8</sup> The issue can be framed as a social decision as to the limits and scope of societal versus individual responsibility for one's health. However, when it comes to the practical applications of this sociophilosophical debate, inevitably the reality of healthcare resource allocation must be confronted. For example—at the level of macro allocation—what priority should be given to smoking-related cancer treatment compared with treatments for diseases affecting 'naive' patients? At the micro allocation level—is a heavy drinker of alcohol less deserving of receiving a donor liver graft than a non-drinker?

## THE MORAL QUESTION

The moral question has been framed as: 'Whether the extent to which a disease is a result of individual choices should be allowed to affect the degree to which it is given priority?'<sup>9</sup>

The framework for discussing this issue is that of fairness and equality. As such, decisions are based on moral assessment of how competing claims can be fairly adjudicated, and thus are all explicitly or implicitly based on some theory of justice. The theories of justice vary, in essence, with respect to their substantive criteria for allocating scarce medical resources. They do, however, share a common basis, which is Aristotle's formal principle of justice: 'Equals must be treated equally and unequals must be treated unequally, in proportion to the relevant inequality.'<sup>10</sup> It follows that in order to reach a consensus on the issue at stake, discourse should relate to this common basis for all theories of justice.

This paper therefore deals with the question: Whether, and in what circumstances, could risk-taking behaviour be regarded as a 'relevant inequality' as far as the right to health care is concerned?

## RELEVANT INEQUALITIES WITH RESPECT TO HEALTH CARE

Identification of relevant inequities ought to begin with an attempt to apply the formal principle of justice to the realm of health care. Health care is a social good that is meant to satisfy needs that all human beings have (or might have). Therefore, basically all human beings should have equal access to all available health care in proportion to their need for it.

Given that health care is usually provided by each country to its residents, our discussion will be restricted to the equality of access for all residents of a given country to all available health care within that country in proportion to their need for it. However, due to the limited amount of medical resources available, this principle can not be optimally met. Therefore, either certain healthcare technologies will not be provided at all, in order to make other healthcare technologies available for all, or certain differences between competing claimants should be recognised as relevant inequalities with respect to the treatment in question.

I suggest that the only definitely relevant inequalities between patients are those that would be relevant in the context of access to health care even in a situation of infinite resources (in which prioritisation was not necessary). The relevance of any other kind of inequality can, at best, be controversial.

### Medical need

Healthy people do not need and can not benefit from—and can even be harmed by—the use of a medical technology peculiar for the treatment of a certain disease. Conversely, sick people with the disease who may benefit from the technology do need it. Clearly, therefore, even with unlimited resources, technology would be provided only to those who need it and can benefit from it (and not to those who do not). Differences in medical need are thus indisputably relevant inequalities for the just distribution of health care.

Furthermore, as the primary purpose of providing healthcare interventions is to benefit the recipients' health, and the criterion of effectiveness correlates with a patient's capacity to benefit from the proposed intervention—the effectiveness of a proposed healthcare intervention should be added to the criterion of need.<sup>11</sup> Moreover, in circumstances of limited resources it would be widely accepted that these should be used to provide the greatest good, so that differences in anticipated benefit may also be generally accepted as relevant inequalities for healthcare priority setting. Accordingly, health technologies should be distributed such that greater and more urgent needs have priority over other lesser and less urgent needs, in proportion to the level of benefit that the technologies provide. Indeed, the severity of the disease if untreated and the benefit from the intervention are the most accepted criteria for priority setting of healthcare resources.<sup>9</sup>

### The patient's autonomous will

In addition, in an ethical system that assigns high value to the autonomous wishes of the patient, such wishes should also be regarded as relevant inequalities between patients, even when resources are unlimited. Competent patients who autonomously refuse to receive medical treatment should thus not be given it. While people normally want to live and recover from poor health, some people may knowingly and deliberately refuse treatment that might help them. This inequality should be regarded as relevant in a way that competent patients who autonomously refuse medical treatment should not be given it.

### The prospects of success

Another criterion that is widely agreed to be relevant at the micro level, mainly for the allocation of extremely scarce healthcare resources (such as organs for transplantation) is the likelihood of the intervention to succeed (prognosis).

There are several difficulties with the use of medical prognosis for determining which patient(s) should have priority for treatment. First, medical prognosis is not an accurate science.

Furthermore, even the smallest probability of successful treatment would be worth pursuing from the viewpoint of an individual patient, so that in the Utopian situation of infinite resources, the probability of success is not a relevant inequality between patients, as every patient who has any chance of benefiting from the intervention should have received it.

However, in non-Utopian reality, with its scarce resources, the prospects of success may be regarded as a relevant inequality because 'Treatment can be necessary only if it is efficacious',<sup>12</sup> and the efficacy of the treatment differs from one patient to the other. So, in circumstances in which not everyone who needs and wants the treatment can have it, there are grounds to argue that the prospect of benefit from that treatment is a relevant inequality for priority setting between otherwise equal claimants.

In addition, Raanan Gillon suggests that the extent of the opportunity cost to others caused by provision of treatment is another 'relevant inequality' for healthcare distribution in the real world—even though it would by definition not be relevant in a Utopian world of unlimited resources.

### THE CRITERION OF PERSONAL RESPONSIBILITY

In a Utopian context of unlimited healthcare resources, personal responsibility for one's own ill health would be unlikely to gain widespread acceptance as a 'relevant inequality' that justifies withholding of health care. Even in non-Utopian resource-stretched reality, personal responsibility for (choice of lifestyle resulting in) ill health is one of a set of contested desert-based criteria for distributive health policies,<sup>9</sup> like age, dependants, irreplaceability and social worth.

Nevertheless, the patient's lifestyle that caused his or her illness may still be relevant to the prospects of the intervention's success. For example, if the prognosis of an alcohol-dependent patient who is about to have a liver transplant is worse than the prognosis of other, non-alcohol-dependent candidates for the same organ, this fact could be taken into account. However, it should be done cautiously and after thorough consideration of the reasons for depriving patients of treatment as a result of their chosen lifestyle.<sup>13–15</sup>

It is worth mentioning that principle 10 of the principles for the development of National Institute for Health and Clinical Excellence (NICE) guidance from 2005<sup>16</sup> apparently reflected this line of thought. It stated that NICE should avoid denying care to patients with conditions that may be self-inflicted, but 'If self inflicted cause(s) or the condition influence the clinical or cost effectiveness of the use of an intervention, it may be appropriate to take this into account'. This principle had been strongly criticised<sup>17</sup> and was revised on the second edition of the principles from 2008,<sup>18</sup> stating that 'if the behaviour is likely to continue and can make a treatment less clinically effective or cost effective, then it may be appropriate to take this into account.' Yet, the principle in both editions not only relates to the clinical effectiveness but also to the cost effectiveness of the intervention, which reveals that this guidance is based on different considerations.

Even so, it might be that the intuitive claim that people who could have avoided their illness should be treated differently does not refer to their right to medical treatment but rather to

<sup>i</sup> The 1993 debate in the *British Medical Journal* on whether or not coronary bypass surgery should be offered to smokers, as well as that from 2007 on whether or not smokers should be refused other kinds of surgery, illustrate how thin the line is between objective medical reasons and judgemental value-laden reasons for such a decision. See also Schneiderman and Jecker's<sup>21</sup> claim that 'On those occasions when physicians did attempt to restrict treatments based on societal factors, it was in the belief that such factors had prognostic medical significance'.

their right to have the costs of such treatment paid by public sources. As, after all, we can not ignore the truthfulness of the statements that 'one man's freedom in health is another man's shackle in taxes and insurance premiums'<sup>19</sup> and that '[T]he person who takes risks with his own health gambles with resources which belong to others'.<sup>20</sup> Is it possible that this characteristic constitutes a relevant inequality in this sense?

This question is not one of 'medical justice' but, rather, one of 'societal justice'.<sup>21</sup>

### RELEVANT INEQUALITIES REGARDING SOCIETAL SUPPORT FOR HEALTH CARE

Ideally, the right to free health care should be granted to any person who needs it, but given the fact that resources are finite, and therefore should at least be used in a way that responds to the needs of society in both the present and the future—entitlement to a particular society's wealth may and usually is justifiably restricted only to its members. Nevertheless, it may be plausible to argue that this right should be further restricted to either:

1. Any member of that society who contributes to it; or
2. Any member of that society who adheres to its rules; or
3. Any member of that society who does not intentionally waste its resources or overuse them.

If so, these specifications may represent relevant inequalities for the right to free or subsidised health care, distinguishing between people who share them and those who do not.

For example, Schneiderman and Jecker<sup>21</sup> discuss a specific situation of an imprisoned criminal in need of a heart transplant. They invoke Rawls' conception of an original position from behind a 'veil of ignorance' as a starting point for deliberating about the requirements of societal justice. 'If a person has already taken (or attempted to take) more than his or her just share of society's benefits, or unfairly caused undue burdens to others, should that person forfeit membership in society?' The authors relate to the very specific case and suggest that it is hard to imagine that people in an original position would answer affirmatively to the question: 'If I were to enter a society in which certain life-saving, medical treatments were limited, would I want persons who have already taken benefits away from those who have attempted to live justly to be eligible for further benefits, such as these limited treatments?' In other words, they argue that being an exception to categories (2) and (3) above is a relevant inequality for the right to scarce organ transplants.

### Applying the inequalities to publicly funded treatments for self-inflicted conditions

The intuitive claim that it is not fair that individuals be entitled to society's resources for treating self-inflicted conditions actually suggests that such individuals are unequal in this sense. So what are the characteristics of this inequality?

If the only relevant criterion for entitlement to society's healthcare resources is membership of that society, then any citizen should be entitled to a fair share of the resources to treat his or her ailments, regardless of their cause.

The criterion of the citizen's contribution to society (category (1)) is not a relevant condition to the right to free medical treatment because ill health itself can violate the patient's ability to contribute. Furthermore, as far as self-inflicted conditions are concerned, people can have an enormous contribution to society and yet refrain from preserving their health.

The rationale for such a differentiation must, therefore, be grounded in non-qualification with respect to one of the other categories (ie, failure to adhere to society's rules, or intentional waste or overuse of its resources). Both of these involve fault of

the patient, which is an essential concept for holding individuals' unhealthy choices as being unfair to others.<sup>22</sup>

If, as category (2) suggests, the right to societal support applies only to those who adhere to the rules of that society, this could be relevant to the right to publicly funded treatment of self-inflicted conditions if two public conditions applied:

1. People were obliged to take steps to preserve their health; and
2. The given society removes the right to free medical treatment from any citizen who breaks its (health-related) laws.

To the best of my knowledge, neither of these conditions—let alone both of them—has been adopted by any modern society.

The third criterion of intentional waste or overuse of the communal resources by bringing illness upon one's self (category (3)) is quite appealing. It seems to recognise both the considerations of personal responsibility and the principle of solidarity. It holds the individual responsible for the consequences of his or her choices both on the level of their own health as well as of the burden to others through the demand to use resources for the treatment of otherwise preventable conditions rather than using it to attend other, 'involuntary' needs. In a sense, it may be regarded as the other side of the coin of the state's right to limit the freedom of its citizens in the name of the social good.<sup>23</sup>

Restriction of the right to societal support for health care only to its members who do not intentionally waste its resources or overuse them seems to conform to the ideal of equal opportunity ethics, as analysed by Cappelen *et al.*<sup>24</sup> It seems to suit both parts of the ideal: (1) the principle of equalisation—because it does not deprive patients of their right to treatment for conditions inflicted upon them due to factors beyond their control; and (2) the principle of responsibility—because it holds people accountable for differences in their health status due to responsibility factors (ie, the actual consequences of their choices of irresponsible health behaviour). Are these presumptions sufficiently established to make such a distinction between patients?

### Good facts are essential for good ethics

The notion that patients with self-inflicted conditions should be treated unequally due to their intentional waste or overuse of the common healthcare resources has these three components:

1. The condition is a result of the patient's avoidable and risky behaviour.
2. The risky behaviour is freely chosen by the patient.
3. While choosing to pursue the risky behaviour, the patient is aware of the risks and the likely burden to society from treating the consequences.

Furthermore, the condition of the overuse of healthcare resources implies an assumption that the cost of care for such patients is more burdensome to society than the care for its other, health-preserving members.

This involves some factual assumptions that must be scrutinised very thoroughly before one can jump to the conclusion that the statement that self-inflicted conditions should be treated unequally is ethical. The following are some crucial questions to be answered before reaching such an extreme inference:

1. Do we really know what people should or shouldn't do to stay healthy? Publications regarding health promotion may be quite confusing and subject to change over time.<sup>20 23</sup> Even behaviours that are generally accepted to be harmful in certain health aspects, such as smoking or alcohol, may, according to some scientific studies, have some benefit to the individual's health in other respects. For example: alcohol is claimed to be good for the heart and it has been shown that

smokers are less likely to get Parkinson's disease. Moreover, self-inflicted conditions can be an outcome of both extremes of the behavioural scale; for example, such conditions can result from indulging in sports and from not indulging in sports, as well as from eating too much or from eating too little, etc.<sup>17 25</sup>

2. Can it be determined that the patient's unhealthy behaviour is the cause, or the only cause, of his or her condition? According to medical science, the development of diseases is caused by interactions among genetic and environmental risk factors, including those of lifestyle. The patient's behaviour in the relevant cases may thus be only part of the cause of his or her condition.<sup>26</sup> Furthermore, in order to determine that the behaviour is the cause of the condition, it is necessary to gather comprehensive information, which makes it impossible and unethical to draw any conclusions concerning the patient's right to treatment.<sup>25</sup>
3. Is the discussed lifestyle a result of free choice or of uncontrollable and inevitable factors such as culture, education, social pressure or addiction? In most cases it would be very hard to be sure that the patient's conduct is a product of free choice. Socioeconomic factors are powerful determinants of unhealthy lifestyles. It is also not uncommon to find individuals who cannot make sound health-related choices because of ignorance, mental incompetence, addictive behaviours or cultural pressures, etc. This has led to a debate among commentators as to whether or not such health risks as are involved in unhealthy lifestyles are freely chosen.<sup>22</sup> Yet, there may be cases in which it would be clear that the patient's condition is a result of voluntary behaviour.<sup>27</sup>
4. To what extent are patients aware of the adverse consequences of their unhealthy lifestyle before adopting it? The answer to this question depends on each case's circumstances. It can be difficult to obtain reliable information about this.
5. To what extent are patients aware of the probable financial impact of their habits over societal resources? As far as equality of entitlement to society's support for health care depends on the patient not having intentionally wasted society's resources or overused them, the issue of awareness should refer to both the health risks of the discussed conduct and to the corresponding burdens to society.<sup>ii</sup>
6. Is the cost of care for these patients more burdensome to society than the social investment in prudent health-preserving citizens? This question is not rhetorical. After all, as Daniel Wikler ironically indicated, it may turn out that 'the truly burdensome individual may be the unreasonably fit senior citizen who lives on for 30 years after retirement'....<sup>22</sup> Recent study indicates that it may indeed be so from an economic perspective.<sup>28</sup>

## CONCLUSION

All the above questions ought to be very thoroughly studied before any society can conclude that risk-taking behaviour should be regarded as a 'relevant inequality' with respect to the right to health care.

Moreover, as John Harris pointed out, 'it is clear that any serious list of people who have or share responsibility for their

own adverse health state would have to include a high proportion of the entire population'.<sup>25</sup> It follows that it may turn out that most members of society 'should be treated unequally' with respect to the financing of health care for their self-inflicted conditions. This may call for either a system of healthcare insurance that is not based on solidarity in this respect, or for a system that grants equal rights to all patients, due to the recognition that everyone is responsible to some extent for their health conditions.

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<sup>ii</sup> A similar argument has been suggested by Brudney<sup>27</sup> as to the conditions for which alcoholic-dependent individuals may have less of a right to liver transplants. One of the conditions satisfied if an agent is to be legitimately given a weaker claim on scarce, lifesaving resource is that the agent must have known or be culpable for not knowing that what she does might create a state of affairs in which she will live only if someone else does not.



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