Guest editorial

Professions and public alike need to think about their moral values

Rabbi Julia Neuberger

We are in the midst of one of the greatest upheavals in health care in the UK since the creation of the National Health Service. As we move into a system which is governed by a purchaser/provider split, with providers trading as free-standing trusts, and with stringent financial limits being set on expenditure on health and community care, health care professionals have taken refuge in a somewhat sentimental critique of the present system, comparing it with the old one to its detriment. This discussion can be paralleled all over the world, since escalating health costs are not a uniquely British problem. It is perhaps most clearly felt in the US where Hillary Clinton, wife of the president, is charged with examining the US health care system and trying to make some sense of it.

But one advantage of the US health care system over the UK system is that these days, in their training, the health care professionals within it have a considerable component of their course focused on ethics, and indeed they are likely to read journal articles to do with ethical issues in medicine and in health care, to consult an Institutional Review Board (IRB) on a regular basis, and to know and work with the hospital ethicist. Questions of ethics, moral questions, are not foreign to American health care workers, even if the practice, to a UK observer, sometimes seems unethical, and often seems over-enthusiastic.

It is important that health care workers have some training in ethics in the US. It means that they will try to assess treatments by making a judgement as to whether to do it, or not do it, is ethical, rather than necessarily only doing it because it is standard practice. It also means that issues of research, and issues of experimental treatment, tend to get taken more seriously in the US than in the UK. But Americans are likely to face some changes in the system in the near future, with some 35 million people uninsured at present and health care costs spiralling upwards forever and at present standing at roughly 13 per cent of Gross Domestic Product (GDP). Health care professionals’ ability to deal with ethical issues makes it easier for them to face those changes, if not with equanimity – after all, it may mean a loss in income – at least with some courage and engagement in the debate. That is because it is not an unfamiliar exercise to look at standard practice, or prospective research, and ask what the point of it is, what the aims are, and whether this is the best way to do it. Health care professionals in the US are much more used than they are in the UK to examining what they do in the cold light of reason, and often moral reasoning at that.

After all, values education is big business in the United States. It is not the values education of some form of missionary sect, preaching a particular set of values, to which everyone has to give credence or regard themselves, and be regarded, as unworthy. Rather, it is an attempt to make people try to define what their own values are, so that they can set those values against the stated and implied values of their particular professional group and against the stated or implied values of the institutions in which they end up working.

For instance, in Britain we might take the stated values of the NHS, of treatment free at the point of delivery, given to each individual according to his or her need. We might then get the participants to work out whether that is really how they decide to give care. Do they, for instance, carry out major interventions for someone in their seventies or eighties? And is that irrespective of whether the person is an NHS patient or a private patient, paying for himself, or funded by an insurance company? Does it make any difference to the decision about treatment whether the person has a spouse or other carer who could look after her or him, so that she or he does not become a charge upon the state? Does it matter if the patient is a vagrant? If he has Alzheimer’s? If the relatives would prefer no treatment, in order to hasten death? And in that last case, would it matter if the health care professional felt that the relatives wanted a ‘quick death’ for the sake of the patient’s suffering, or because they wanted to inherit the money quickly and not see it all swallowed up by nursing home care?

It is never hard to design the questions. But by getting people to give their answers, usually relatively quickly, without time to reflect, a pattern begins to emerge in the series of views held by the people involved, which is unlikely to produce a set of
objective criteria to do with quality of life. Instead, biases will creep in, reflecting religious beliefs, upbringing, class, cultural background, and the value system or systems which the individual has taken on board.

In Britain, within the NHS, people find it difficult to get to grips with these issues precisely because they have accepted a 'value' about equity of care free at the point of delivery, according to need, even if they do not believe, in their heart of hearts, that it is true. Some of the problems will come about as a result of a profoundly held belief that everything which can be done must be done, for each individual – the 'duty to care' is adduced in support of this view. The extent of resource availability is irrelevant when faced with the individual patient. Yet, irrespective of cost, there was something wrong with a system which held that the patient's views, and sometimes the carer's views, are not as important, or more important, than those of the health care team. So another exercise in values clarification is to ask, using a case-study method, who ought to make the decision about the extent of medical intervention in a variety of cases, ranging from the easiest with, say, an elderly person who is entirely mentally competent with a life-threatening, non-small-cell lung cancer, who could either have chemotherapy or not, to one of the hardest, a physically fit, relatively young person with Alzheimer's disease, with the same condition. Students can argue through the cases, but should first be allowed to react quickly, to see what their underlying attitudes are, before they debate and think through the problems slowly.

Once this has been carried out, using a largely case-study method of eliciting views, people can begin to see how their attitudes are going. They can assess their instant reactions and set them against their considered reactions. They can continue by carrying out similar exercises in pairs and then in small groups. Such exercises are very valuable in pointing out biases in what people perceive as 'common sense', and also in rooting out prejudices which lie within the system, or within the class group, of a particular profession.

These are not comfortable exercises. But when used with medical students they serve as a valuable aid in helping them to get to grips with some of the difficult decisions, pulling them away from always considering issues from the point of view of the four basic principles of autonomy, beneficence, non-malefice and justice, in which other values are implicit. Where it can be even more impressive as an approach is in working with more senior medical staff, and with managers of services, who have tended to get stuck in a particular way of allocating resources, and in the concerns of the specialty or sub-speciality in which they work. For purchasers, it brings home some of the biases which lie in the system, and challenges personal preferences. For managers, it often reveals that their concern to manage efficiently and cost-effectively is tempered by a desire, often expressed but rarely worked through, to do it fairly, respecting the principle of equity.

But the real test comes when it is not only health care professionals, be they doctors, nurses or managers, who think in this way. It is when the public can begin to be engaged in thinking through what they think is right, whether it is about cessation of life-support systems for those in a persistent vegetative state, or about the more mundane issues of whether to resuscitate the failing elderly person with Alzheimer's. Those decisions have tended to be made on an ad hoc basis, with individual cases sometimes coming to the courts in the UK. But if this were more the stuff of public debate, in tandem with health care professionals who would need to give detailed, unbiased information, then there is some chance that the values of the public might enmesh with the values of health care professionals.

There is one major difficulty in this. Neither the public, nor the health care professions taken overall, whether in the UK or the US, have a coherent value system by and large. Nor is it uniform in any one group or any one profession. Such an approach requires listening carefully to a variety of views and, as often as possible, enabling people to live and die, and practise, according to their personal view and value systems. It requires the acceptance of a plural society and therefore assumes the legitimacy of differing views. It also means the acceptance of patients' views and value systems, and those of their carers, taking precedence, in the last resort, over those of their professional health care workers. That is hard for people to accept. Yet, if values clarification can do anything, it can bring home to young health care students that others have value systems, that their own values are infinitely challengeable by others and by themselves, and that ultimately it is a better way to practise – in partnership with patients, trying to understand the values that they hold dear.

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