Closing remarks on ethical problems in surgical practice

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Editor's note

Questions of medical ethics increasingly of concern today are euthanasia in terminal illness, organ transplantation and the relationship between doctors and the State as employer. The UK Royal Colleges' work on a definition of 'brain death' is helpful in decisions about the continuance of artificial life support measures, and some further guidance on organ transplants is in prospect following the report of an official working party to the UK Health Departments. State medicine poses doctors no fundamental ethical problems as long as their employment contracts do not conflict with their basic and personal clinical responsibility for their patient. Nevertheless doctors in state service do become involved in resource allocation decisions with an ethical content. Opposition to the state as employer - by withdrawal of labour in whole or part - may only be justified ethically if the doctor's motive is the long term benefit of his patients.

There is no doubt at all that as the accelerating advance in medical and scientific knowledge opens up more and more new pathways through which doctors, and particularly surgeons, can help patients, the ethical questions attached to many of them press even more heavily upon us and in the practice of surgery today it is necessary to seek a whole new series of moral definitions. An additional factor that probes ever more intrusively, if insidiously, into our consideration of ethics is the alteration in the status of medicine itself in the community and in the relationship not just of doctor to patient - that is relatively simple - but of the medical profession to society. Here various governments, representing their societies with varying degrees of success, but always to their own entire satisfaction, have sought to redefine the status of medicine in the community, often with minimal consultation with doctors.

This discussion is therefore timely and I am greatly honoured by being allowed to take part in it and to refer to the contributions of others. Let me start by adding just a few remarks stimulated by the clear, concise and compassionate contribution of Dr Jonathan Rhoads. There are few aspects of the doctor-patient relationship of more fundamental

importance or of greater interest to the public, and at times the media, than the care of the terminally ill.

Here, though few would dissent in any way from the general statement that it is the doctor's duty to see that his patient dies without pain, without mental distress, and with dignity, in practical terms this may be interpreted in more than one way. There is, of course, a fundamental and absolute difference, not merely one of degree between the positive action which results from a deliberate decision to kill a patient incurably ill and the withdrawal or withholding of treatment which merely prolongs life without helping the patient. There is, of course, no moral obligation upon doctors to prolong the act of dying. In many circumstances it is, in my view, and this is not too strong a word, an immoral act to resuscitate a patient in the terminal stages of, say, cancer when the natural history of his illness is about to allow him to leave this life without pain and suffering. Such an application of science without humanity is not part of the service which a doctor should give to his patient. What a man was Shakespeare: in *King Lear*, when the king lies dying, Kent will not allow a physician to be called but cries 'Oh, let him pass! He hates him much that would upon the rack of this tough world stretch him out longer'. Nevertheless, personally I do not believe that the ethics of the Profession can ever include what some would call 'mercy killing' but which Dunphy, and I agree with him completely, calls 'therapeutic murder'.

The wise and humane physician, in tune with his patient, will know very well when it is time to withdraw treatment. This decision must be made by, and the responsibility borne by, one doctor who has earned and enjoys the confidence and trust of the patient and his family. We must not allow this to become a committee matter. Still less must a decision of this kind become a matter for the courts of law. We have seen, much publicised in the Karen Ann Quinlan case, what happens when an attempt is made to invoke the legal code, and the spectacle was hardly edifying.

The whole question, of course, of when it is or is not right to switch off the respirator is one that is full of pitfalls, both in regard to ethics and in regard to explaining these to the lay public. The position, certainly in Britain, has I believe been

considerably eased by a very clear and unequivocal statement from the Conference of Colleges (UK), following up its earlier document on the diagnosis of 'brain-death'. This statement said that there was unanimity within the Conference that the identification of brain-death, provided that the criteria laid down have been scrupulously observed, means that the patient is dead, whether or not the function of some organs, such as a heart-beat, has not yet ceased. The effect upon the ethical position of accepting this statement is obvious. If a patient with, let us say, a severe head injury becomes 'brain-dead' but with his heart still beating, to switch off the respirator is right and proper in the eyes of most doctors, but nevertheless so long as the moment of death is equated with the cessation of the heart-beat, argument will continue about whether or not it is right for a doctor to withdraw support from a living patient and, in so doing, deliberately cause his death. If, in the circumstances described, the respirator is switched off because the patient is already dead, this ethical difficulty disappears.

Some have asked the question – Does this not merely exchange one ethical dilemma for another, for having identified 'brain-death' is it right to continue artificial support if the object cannot any longer be to help the patient and can only be to preserve organs for possible transplantation? The answer must surely be that a doctor does not have the same responsibility towards a dead body as he does towards a live patient and that to preserve artificially the organs of a recently dead patient for the possible advantage of other live patients is entirely right and cannot be criticised so long as a proper regard is paid to the sensitivities and feelings of relatives. A much more difficult question to answer arises when a patient terminally ill with a grossly inoperable cerebral tumour stops breathing. Now – knowing that it cannot help the patient who is beyond help, though still alive, is it ethical to put the patient on a respirator solely in order to preserve organs for transplantation? If the views of the patient and relatives are known, there is no real difficulty, but supposing the views are not known, what then? As always, this ethical decision can only be made according to the individual conscience and one doctor will decide one way and a second another.

Doctors working in the field of organ transplantation are, in fact, surrounded on all sides by difficulties of an ethical nature and although it is never right to dictate to others how they should act in regard to decisions of a moral character, many would agree that the provision of some general guidance on the more thorny problems could be of value to all. It was, no doubt, with this in mind that in Britain the Department of Health set up, towards the end of last year, a Working Party, of which I was Chairman, to produce, if possible, a

set of guidelines that might prove useful to those engaged in this work, not just doctors but also nurses, administrators and others. The Working Party, has, in fact, reported, though its recommendations have yet to be published.

State medicine

A few remarks now in regard to a fundamental change in the practice of Medicine that has taken place in a number of countries since World War II. I refer, of course, to the introduction in one form or another of state medicine. There is an ethical point of importance here, for some have expressed doubts about whether the ethic that is basic to the practice of medicine, that in the one-to-one relationship of doctor to patient the doctor must always put the interest of the patient above all other considerations – is compatible with a doctor accepting employment as a salaried servant of the state, which it is claimed, must introduce at least some element of division of loyalties.

The answer, I believe, must be that there is nothing inherently incompatible with the medical ethic in accepting employment within a National Health Service but that the type of service is crucial and could lead to a situation incompatible with this ethic. For instance, most doctors would believe that if a state should legislate to bring into being a service within which a doctor was compelled to accept state control of his clinical decisions, this would rob him of his ability to put the interests of his patient first and that therefore it would be unethical to accept employment in such a system. This is why it is so important for any country to retain a vigorous independent sector of medicine, whatever variety of National Health Service it may decide to devise. If a state were to introduce more and more controls within a national system and then legislate to proscribe independent medicine, telling patients 'You no longer have the right to seek the help of a doctor other than through the Health Service', their last line of defence would have disappeared. Doctors who, through the ethic of their profession must put the interests of patients first, should not betray their patients by acquiescing in such a system.

It is not, therefore, unethical for doctors to treat patients within a National Health Service, provided that the state, for its part, has been careful not to require doctors to accept a contract of employment which itself conflicts with professional ethics. Quite apart from this all-important basic requirement, the mere existence of a National Health Service introduces a series of new difficulties, some of which spill over into the field of ethics. For instance, there are some who have sought to counter the doubts of the profession by claiming that if the ethical duty of a doctor is to put the interests of his patient first and if the state should

legislate to assume responsibility for the provision of health care, it is reasonable to summate all the individual ethical responsibilities of doctors within a state service and say that the medical profession has the same ethical responsibility to the state as a doctor has to his patient. At the other end of the scale, some doctors appear to argue that if the state chooses to assume responsibility for providing health care, then for every patient, whatever he needs must be provided, however costly and that it is solely for the profession to set the standards, the responsibility of the state being to pay the bills.

Neither of these extreme views should command any support. The basic medical ethic of putting the interests of the patient first is an entirely individual one, to be seen in the context of the one-to-one relationship of doctor to patient. In no sense can the state claim that there is any joint ethical responsibility owed to it by the medical profession as a whole.

What, however, the state can quite reasonably claim is that the profession should exhibit some degree of corporate social conscience in the allocation of limited resources within any Health Service and this, of course, has a bearing upon the second of the two views I suggested that we might discard. If resources were unlimited, doctors could very reasonably say that the aim must be to provide every patient with the best treatment known to medical science. As it is, medical science, sharing in the enormous explosion of scientific and technological discovery, during the last few decades, has advanced so rapidly that it has already opened up an enormous gap between what doctors can do for patients and what any state can afford to provide through taxation of its citizens. Any state deciding to take control of health care delivery today automatically finds that it is involved in health care rationing and if the medical profession accepts partnership with the state it must also accept that it has a role to play in the fair allocation of resources inadequate to provide all things for all patients.

A word on the ethical position of those responsible for the care of the patients who go on strike. That a doctor should ever deliberately limit what he does for patients is never less than deplorable, but is it unethical? In certain circumstances it undoubtedly is. Any doctor who walks out on a patient who is under his care, without making sure that a colleague assumes his responsibility is without doubt guilty of unethical conduct, whatever his reasons.

What, though, of the doctor who seeks to put pressure upon his employers, such as the state in a National Health Service, not by withdrawing or limiting his services to patients under his care but by reducing his availability to potential patients? Is he behaving unethically? Of recent years we have seen various examples of this kind of action within

the National Health Service in Britain, including the much publicised work-to-contract by many consultants, upon the advice of the BMA, when threatened with a type of contract that they regarded as unacceptable. This is, in fact, one of the grey areas in medical ethics and no clear and unequivocal answer can be given to the question 'Is it ethical?'. The answer must be that first one needs to know precisely the nature of the action contemplated and precisely the nature of the action being opposed. Even when these are known, the decision whether or not the action proposed is within the profession's ethical code must remain a matter of personal individual opinion. To those who would claim that no action of this kind can ever be ethical, one would have to point out that there can on occasion be an ethical dilemma of near-insoluble proportions, for just supposing that something is proposed which could be so harmful to the practice of medicine that patients would inevitably suffer, and which therefore doctors feel that they must oppose, how can they ethically proceed if the only means of opposition must itself necessarily involve some element of damage to the interests of patients? Probably the most acceptable answer to this very difficult problem is that what matters is the motive behind the action contemplated. If this is purely self-interest; if a surgeon, for instance, says to the government of his country 'unless you agree to increasing my pay by 20 per cent, I am going to operate upon emergencies only', then this, to me at any rate, is behaviour which is unacceptable to the point of being unethical. If, however, the motive is the protection of patients from harm; if, for instance, in contradistinction to the previous example, a surgeon says to his government or its representative, its health department, 'The changes you are proposing to introduce would be so harmful to the interests of patients that I cannot agree to treat other than emergencies in the circumstances that would prevail, the short-term disadvantage to patients being much less than the long-term dangers if you had your way', then not only would this be an entirely ethical stance but, in fact, to do the opposite, to acquiesce in operating a system that was known to be harmful to patients would be at least improper and possibly unethical.

Let me leave this thorny subject of ethics and state-medicine with this one final sentence: I do not believe it to be ethical for a doctor to accept employment in any system within which he cannot put the interests of his patients first.

Surgery, during the last two decades in particular, has advanced at such a pace and with such acceleration that it has brought new hope to many patients whom previously medical science was unable to help, but at a price. Not only have the costs of modern surgery escalated at a rate that makes containment all but impossible, but also each new complexity has brought in its train new problems.

in ethics and morality. The changes in the status of the profession in society have done the same. It is right that we should not ignore these but debate them and seek acceptable answers to these

new problems – and what better forum could there ever be than this most broadly based representation of surgical bodies, the International Federation of Surgical Colleges.

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