Ethics and the professions

The law

It is deceptively easy to make a comparison between medical ethics and the ethics of the legal profession. It is easy, because the members of either profession share similar fundamental notions of right and wrong which inspire their relationships both with those who consult them and also with one another. It is deceptive because, although the phrase 'medical ethics' is a commonplace one, so that everyone thinks he knows what it means, the phrase 'legal ethics' is unfamiliar. You could not start up a 'journal of legal ethics'; some unkind people would say there was no such thing. The reason for the contrast is really one of emphasis. In the legal profession, ethical questions largely arise between members, while between the members and their clients the law of contract is the main regulation. It is true that 'forensic ethics' is a meaningful expression, and that it involves the moral obligations of the practitioner *vis-a-vis* his opponent, the judge and the public, being less concerned with the parties to the litigation. Nevertheless the contrast with the medical profession is a clear one. Of course the physician too is bound to his patient in the justiciable relationship of contract, but that is only a part of the story. If a physician, in the course of treatment, introduces his patient to a dangerous procedure not for that patient's personal benefit, but in the general interests of scientific experiment, he may be liable for the consequences in an action on breach of contract. But that is not the reason why such conduct is – or ought to be – repugnant to him.

I am describing a difference in emphasis, not in kind. The lawyer has moral obligations to his clients too, although perhaps his personal contacts with them are not so close or so continuous as to raise the same ethical problems as are seen in the medical profession. Furthermore, the physician and surgeon are in the front line in a great war in defence of health and in relief of ill health. They are scientists as well as consultants and practitioners. The lawyer would be likely modestly to decline the honour of such a classification. His task of keeping his clients on the rails, or getting them back on again, does not involve pushing forward the frontiers of knowledge. Or at least few see it as such. But what the doctor and the lawyer each have in common, namely, the acceptance of a moral standard more exacting than the obligations which legal rights enjoin, is owed to membership of a profession. We need not pause for a definition of 'profession', nor enquire what other associations can or cannot make equivalent claims.

I find it strange that there should be misunderstanding of a fact so obvious as this: that the duties laid upon a man in consequence of his acceptance of professional standards are owed by him to the world at large. They are not evidence of a private or corporate privilege. Bernard Shaw in one of his rare foolish passages describes all professions as a conspiracy against the laity. This is like calling compulsory pilotage in narrow waters a conspiracy against the ship's passengers. Again, I understand that the Monopolies Commission is mounting an enquiry into the Bar. That is good. But it is hard to to see the monopolistic element in one of the topics they are looking at, namely, the prohibition of advertising. When the Church's turn comes for investigation, I shall not expect to find on the agenda an enquiry into the seal of the confessional. It is not as a monopoly that a profession demands the right to lay down rules for the conduct of its members in the interests of those they serve, together with the conjunct right to exclude from membership those who do not conform to the standards their brethren lay down.

There is this further contrast between the legal obligations of the medical man and his ethical duties. I do not suppose that much space will be taken up in the journal with the discussion of conduct which is traditionally described as 'unethical', and leads to the intervention of the General Medical Council. In the same way one will not be concerned with negligence, arising from ignorance or carelessness, giving occasion for decisions of the courts. The most fascinating aspect of medical ethics in the broad sense is that controversies within its boundaries can be most acute just where knowledge, skill, and enthusiasm are at their most advanced. It may be that one will be concerned to assess, from an examination of conduct, not the moral structure of individuals but rather the justification for attitudes to the science of medicine itself. It is the leaders of the profession, not the black sheep, who will be engaged in procedures the very existence of which society itself may at any given moment be inclined to challenge on ethical grounds.

The burden on the medical profession of care for

individual patients, quite apart from the exercising of the more sophisticated and exciting functions which are on the borders of academic science, is one which, although heavy, members of other callings may find themselves inclined to envy. In the course of each case, everyday decisions are called for which truly demand instant ethical judgments. Since these have to be made in the light of the same conscience which illuminates the conduct of all men of goodwill, the general interest of the subject matter of this journal seems plainly established.

KILBRANDON

Nursing

The physician who decides not to administer antibiotics to the elderly patient does not, by his decision to cease active treatment, expect the nurse to cease to care for her patient. She must continue to do for the patient all those things which he can no longer do for himself: she must keep him clean, see that his mouth is moist, that his bed linen is fresh, and that his relatives are relieved of as much distress as possible. Patients have the right to expect that, even if treatment is discontinued, they are cared for until the end. The nurse's caring role extends beyond the doctor's curing task.

The nurse's prime responsibility is to her patient. This gives her a unique function and one that includes and goes beyond the carrying out of the doctor's instruction. A high level of integrity is expected of those to whom the bodies and minds of patients are entrusted. 'Always act so as to increase trust' wrote Sir Harold Himsworth, when secretary of the Medical Research Council, and this is as applicable to nurses as it is to doctors or any professional group.

Professional nursing is little more than a hundred years old with at present no code of professional conduct although this will shortly be remedied by the Royal College of Nursing which has a draft code awaiting ratification. The need for such a code has been emphasized in recent years by medical advances as nurses find themselves involved in ethical dilemmas almost as frequently as do doctors. No longer does the nurse see herself as the blindly obedient physician's handmaiden. It is often the nursing student who, in two or three minutes, must decide whether or not to initiate mouth-to-mouth respiration or cardiac massage, for it is often the nursing student who is left alone at night in charge of a ward full of sick people.

In most hospitals with ethical committees nurses are represented, and rightly so, for it is the nursing staff who, in their round-the-clock duties, become intimately involved with patients and their relatives. They are the people who must remain with patients 24 hours a day and they are the people who so often have to explain to the relatives the purpose and implications of medical research.

The nurse has a duty to respect the dignity of her patient. She has a duty to acquire the appropriate technical skills and knowledge and to keep up to date. She has a duty, when acting in her professional capacity, to refuse to take any action which would endanger her patient or the public at large. A particular dilemma was posed for some nurses recently when a few trades unions sought strike action by their members. The professional ethic does not allow any nurse, in any circumstance, to abandon the patient in her care. How far nurses who remain with their patients should carry out the tasks of others – ancillary workers, domestics, and porters – is a problem that probably can only be settled locally but it does create dilemmas for nurse managers and for individual nurses.

It has been firmly established that any nurse can take advantage of the conscience clause in the Abortion Act but maintaining her right under the Act has sometimes been difficult for those who are not Roman Catholics. Nurses with such conscientious objections should inform their employing authorities before the occasion arises. (The General Nursing Council has had to remind some hospital authorities of the nurse's rights under the Abortion Act.)

A very real problem arises when the nurse believes that a doctor's instructions are not in the best interest of the patient. With the concept of team work in the care of the sick and the nurse taking her proper place in that team, such dilemmas are likely to be fewer but probably not wholly avoidable.

The unique role of the nurse is only slowly being understood; but it will be further strengthened by the establishment of two chairs of nursing in British universities. The unique role of the nurse will only remain if it is firmly buttressed by the twin pillars of sound professional practice and the professional ethic.

P D NUTTALL

Social work

An important reason for social workers to be closely involved in health matters, and inevitably therefore in ethical issues deriving from them, is the prominent part played by health in the whole of human life. Of all personal problems, those of disease and infirmity carry the greatest dread because their ultimate outcome is death. The main feature of social work, differentiating it from other professional

care, is concern with the quality of human living. The more specific preoccupations of social workers with particular problems of social functioning – such as delinquency, family relationships, poverty, homelessness – are tangible expressions of this wider concern and not a substitute for it. Many of the clients of social workers come from severely underprivileged groups in society, and defects in health are a frequent byproduct of various other deprivations which in their turn create additional problems as the experience of family service unit social workers has shown (Philp, 1963).

Social workers are constantly called upon in their professional capacity to deal with the effects of these deficiencies as they manifest themselves in the lives of their clients by means ranging from advocacy to psychological support. Thus their involvement in matters of health within the context of their overall concern to promote individual wellbeing brings them face to face with the fundamental moral question regarding the right to health and the increasingly acute moral dilemmas which derive from that right.

Experience of the British National Health Service since its inception has exploded the myth in the minds of some that the provision of universal health care would gradually lead to a decline in ill health and would thus result in a fall in the demand for health services. On the contrary, there has been a steady increase in the demand and in recent years the gap between demand and the availability of services has been widening. Of the many factors which have contributed to this state of affairs, two are of particular ethical significance: the rise in expectations resulting from an enhanced awareness of the right to health, and the rate at which society has been producing health problems of an increasingly intractable or chronic nature in the place of those which have been overcome.

If the right to health is limited by a number of constraints – some derived from biological and psychological endowment and others from social and economic factors – the problem of managing the limited resources for health care and of using them on the basis of some system of priorities becomes of considerable ethical importance. Who should make these crucial decisions and on what basis should they be made? Does youth and its requirements take preference over old age because such a priority would reflect some of the prevalent current social values? How far is it possible to avoid in any system of selection and rationing in an area of basic human rights a fundamental compromise of the chief value inherent in human nature? These are by no means rhetorical questions: they are issues of direct and current relevance to many people.

There are also those groups in society with whom social workers are particularly involved and so responsible with others for the provision of that care which will ensure them respect, security, comfort, and dignity. It is a sad but true reflection of the qualified responsibility accepted by society for people in these and other underprivileged groups that so much of the discussion revolving around them and their needs tends to focus on their right to live and ignores the equal responsibility for ensuring that life is worth living.

It is my firm conviction that social workers have an important part to play in helping individuals and communities to live more healthily. The many ethical issues inherent in such a function as 'promoter of health' and 'educator in social living' are part and parcel of all forms of intervention in the lives and in the affairs of others. All of these activities call for a genuine respect for others and for their personal autonomy and require safeguards against the abuse of the subtle power inherent in all 'helping' relationships.

These general ethical considerations assume particular importance in the context of 'social engineering'. Without entering into the controversy regarding particular forms of this type of engineering, its general characteristic is the degree of social control thought to be justifiable over individual behaviour and choices. Given this fact, it is essential for social control not to be unduly centralized, a point argued most cogently by Zola (1972).

Finally, the ethics of collaboration – a subject not unique to health care but undisputedly of particular importance in this field. Ready lip service is given to the value of team work in the prevention, treatment, and alleviation of illness but practice lags a long way behind precept in many if not most instances. Many of the problems of coordinating different contributions and of collaboration between different services and individuals stem from deficiencies in knowledge, structure, and policy rather than from a lack of goodwill but there are also significant ethical components involved, such as professional rivalry, vested interests, or excessive self importance with its accompanying tendency to denigrate the contribution of others. Social workers carry a full share of responsibility for these failings. The recognition of the close and intricate connexions between health and general wellbeing should surely result in the acceptance by both doctors and social workers of their interdependence.

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References

Philp, F (1963) Family Failure, London: Faber.

Zola, I K (1972) Medicine as an institution of social control, *The Sociological Review*, **20**, 487–504.