
Controversy: 1**The restoration of medical ethics**Adrian Rogers *General Practitioner, Exeter, Devon*

Author's abstract

The ethical behaviour of doctors has been influenced by recent social and political changes. This paper discusses some of the changes which may have resulted from two far-reaching changes, a major political change, the nationalisation of medicine in the National Health Service (NHS), and a social change, the establishment of the permissive society.

Some of the ethical consequences of these changes which are not considered of benefit to the profession or its patients are discussed. The recognition of these changes and their open debate is now essential so that the restitution of professional standards may take place.

The medical profession in the United Kingdom enjoys a degree of autonomy and self regulation through the existence of the General Medical Council. This council is the final arbiter, save only for the House of Lords, of the behaviour of doctors. It bestows on doctors professional status and in return is responsible to Government and the public at large for the regulation of the profession. Therefore it is the standards of behaviour as recognised by this body alone which should constitute ethical medical practice. I would contend that recent significant changes in the behaviour of doctors have taken place and that these changes have occurred largely unnoticed by the profession and by the General Medical Council.

Two major changes have occurred, these are namely:

- 1: The nationalisation of medicine by the State.
- 2: The effects of the permissive society.

The former was a direct result of political activity and has changed fundamentally the relationship that the majority of patients have with their doctors in that they no longer pay fees. To some extent it has also changed the relationship between doctors.

The latter has changed the personal behaviour of patients so that greater sexual freedom predominates

Key words

Medical ethics; nationalised medicine; National Health Service; the permissive society; patient-doctor relationship.

and the medical profession has had to cope with the ethics of contraception and abortion on a hitherto unknown scale.

As a profession our response to such changes has not been to debate and produce strict rules of ethics such as those which deter a doctor from developing a sexual relationship with a patient or which judges any form of advertising as serious professional misconduct. Instead, we have developed what is most easily described as situational ethics: a system of ethics where there is no clear right or wrong behaviour but where every individual case and all its circumstances are adjudged by the doctor at the time of action, such judgement to be made in the best interests of the patient. Generalisations and 'blanket decisions' may be considered unhelpful as they only apply to an unknown majority and do not take into consideration the precise circumstances of the individual patient. This application of situational ethics suits the cult of individualism well, grey areas abound and the licensing of the personal opinion of the doctor gives each professional a new freedom and a new power.

It is because ethical judgements of doctors began to differ and reveal a lack of uniformity of decision within the profession that the public have been more easily able to take issue with controversial actions. Whereas the public have been accustomed to doctors varying in their medical opinion, they naively expect some uniformity of ethical behaviour. Instead the profession reflects the conflict in society by division within itself. As a simple example of such conflict, some doctors openly claim to provide an abortion for any woman who requests one. Others openly claim this to be wrong.

For examples of the ease with which public controversy can be aroused over the behaviour of the medical profession one needs only to look at the disharmony over such issues as the sterilisation of handicapped children, abortion on demand, confidential contraception for minors, support for euthanasia etc. The public are similarly watchful over issues such as access to their medical records. Also the public are sensitive even to relatively minor changes in the behaviour of doctors such as their use of deputising services.

I contend that some of the recent changes in the

behaviour of the medical profession have neither been in the interests of patients nor in the long-term interests of the profession and that recognition of these changes and public debate about them is the first major step toward their rectification.

Let us look more closely at the two major changes referred to.

The nationalisation of medical enterprise

It has been through the advent of the National Health Service and State-based, socialist medicine that the greatest changes in medical behaviour have been produced. Nationalisation brought job security to doctors and independence for most of the profession from the economics and ethics of the market-place. It turned totally independent professionals into public servants. It diminished the position of the patient in the patient/doctor relationship as the patient was no longer the paymaster.

The stability brought about by State employment diminished the concern doctors had for the behaviour of their colleagues as competitors in the market-place. In general practice, stable list-sizes and the capitation system have meant predictable income and the bulk of payment made irrespective of work performed for patients. Similarly, in hospital medicine full-time NHS contracts and the merit award system have cushioned the system against the vagaries of private practice where reputation, and recommendation by word of mouth, were of paramount importance. These profound changes meant that to some extent for the first time, the medical profession was funded independently of patient demand.

Subtle ethical changes have occurred since the majority of patients ceased to pay doctors' fees. Instead of being the servant the doctor is now the master – not in the sense that doctors ever made medical decisions to suit the whims of their patients, but in the sense that they did attend and consult when called upon and without hesitation. Little wonder that dissatisfaction from patients about general practice largely concerns difficulty in obtaining home-visits, difficulty in obtaining appointments considered urgent by the patient, and the short consultation time, which averages seven minutes a patient. Now the doctor is the master, it is the doctor and not the patient who decides when a home visit is to be proffered or when to grant an urgent appointment, or how long a consultation will last. Furthermore, before security was given to doctors in the NHS, few practitioners would have entrusted their practices so freely to deputising services. Even shared inter-practice, time-off rotas have only appeared since the NHS Act was passed.

More subtle has been the metamorphosis of medical practice from straight detection, cure and prevention of illness into areas of social medicine. Ever since the World Health Organisation defined health as including the social well-being of the individual, the way has been paved for socialist medicine to promote social

medicine. Whereas the social well-being of a person is the legitimate concern of his or her doctor, doctors have no special professional knowledge of how to improve their patients' social well-being: This remains the concern of all men.

For instance, whereas it is certainly the case that doctors in Britain may give medical recommendations for re-housing, the criterion for judgement is that of the medical condition of the patient, and that alone. Only judgements which require a medical education are the strict province of the doctor. Other judgements can be made by lay people and are often delegated to social workers.

Increasingly, the doctor finds his role as physician diminishing and his role as counsellor and social worker extending. Difficult patients no longer mean those whose diagnosis is perplexing but those who, in the new general practice jargon, trouble their doctors because of social problems and emotional inadequacy.

The ethics of computerisation of medical records may have been the focus for patient concern regarding confidentiality but diminished confidentiality has been overlooked where it is most obvious. In family medicine the patient-doctor relationship now extends to members of the primary-health-care team. Several people in each practice have easy access to medical records. This contrasts vividly with the situation of any doctor working alone and without staff. Whereas that in itself may have disadvantages for patient care, at least extension of confidentiality is not inherent in the system. Few would disagree that this aspect of health care warrants further debate: on the other hand the threat to confidentiality by the computer has to some extent been overcome.

In hospital patients' notes can be handled by even more individuals and the unofficial word-of-mouth network which exists in every hospital can spread confidential information within hours about a particular patient.

It may not be easy to avoid such changes in the seepage of confidential information. Doctors may have to make far more conscious efforts to conceal information from various other health professionals who work with them. Hospital employees may need a simple classification of the type of information which may or may not be available to them. A stricter code of personal conduct may now be vital to curtail open discussions about patients in public places during coffee breaks or meals.

Another disturbing change in medical practice has been the tendency of doctors, or hospital administrators acting on their behalf, to make public statements about the victims of crime or disaster. In many instances detailed medical information with personal social implications is broadcast through the national media without patient consent or the consent of relatives. Privately run establishments often cater for highly newsworthy personalities yet rarely issue such statements.

To a fee-collecting profession the greatest

professional wrong was that of advertising, but in recent years this has been diminished by the frequency with which marginal cases have escaped chastisement. Those proclaiming great advances in medicine or treating famous people or dealing with international situations often allow themselves to be seen, and named, commenting in the media. The public must, perhaps rightly, assume they are experts in their field. Their activity, thus portrayed, could be construed as a subtle form of advertising. Doctors should not forget that advertising of any sort is outlawed because it encourages doctors into open public competition. It diminishes the trust between patient and doctor and between doctor and doctor. In a profession which serves people as vulnerable as the sick and disabled, open competition, which would be inevitable with free-for-all advertising, would not be seemly for the profession and could cause much misery for patients.

Before NHS medicine even the slightest hint of public announcement of enhanced professional esteem would have been deemed professional misconduct. Today, since no one complains and few care, charges are rarely brought. Only a total proscription of all advertising can be equitable within the medical profession. Doctors announcing new treatments, or treatments construed as new, to the press would fall into this category. The position of medical writers should be more carefully examined. In the past it has been assumed that the collecting of patients as a result of any publicity is unethical. It remains important that such doctors should not build up practices as a result of their media work.

When general practitioners charged a fee for all consultations they jealously guarded their patients from consultants. The consultant only offered advice to the doctor and rarely to the patient. All treatment and any further referral was carried out by the general practitioner. Now this ethic is occasionally abandoned because it is more convenient for GP and hospital doctor if changes are made at the source of advice. Whatever the motive of the traditional practitioner, at least there was the advantage that all changes in treatment were modified by a doctor who had continuing care of the patient. The GP and patient together might assess the advice of the specialist and many a patient has changed his or her mind about a treatment or asked for a further opinion as a result of this sort of deliberation.

Domiciliary consultations used to be the object of strict ethical procedure; today the consultant will often call alone and unattended. The consultant is deprived of the GP's fuller knowledge of the patient's history at the bedside and the patient is deprived of the familiar presence of his GP. Certainly in general practice the number of other doctors who deem it ethical to treat and advise one's patients without referral has increased. Now it is not uncommon for patients to receive advice from occupational health doctors, family planning doctors and well-women clinics, as well as from venereal disease clinics, casualty

departments and even radio doctors.

Another similarly interesting change in ethical behaviour has been the increased association with non-medical practitioners. Gradually, doctors are accepting and are often keen to have the benefits of the opinions of chiropractors and osteopaths. In most cases these practitioners are not medically qualified, or else there is no clear distinction between those who are and those who are not, and there is no ethically agreed procedure by which a second medical opinion is obtained before any such referral is made. It may well be that back pain due to carcinoma is relatively rare but there seems little point in having acquired such hard-earned knowledge if it is not to be applied in the patient's fullest interest. Certainly such a basic change in ethics should be debated more fully and be the subject of a full assessment.

One explanation for this change occurring can be seen as the 'no detriment' situation whereby NHS doctors lose nothing and gain relief from patient pressure when the patient consults elsewhere.

A disturbing trend is the way in which the ethical axiom of never criticising another practitioner has changed. Today there are more practitioners than ever more isolated from each other than ever and more readily critical of each other.

At the very least there needs to be a prominent reminder to the profession to maintain respect among colleagues.

Finally, a propensity is developing for doctors to extend their opinions beyond medicine and to 'come out publicly' usually in a political fashion. This may again be part of the 'no detriment' phenomenon of guaranteed State employment and secure jobs. In fact ethical codes have always made it clear that doctors have a duty to take part in public life where necessary but the danger is that by using the caring image of their profession or by use of their medical qualification they give added importance to what are really personal statements. Such medical opining may be seen, for instance, on both sides of the Campaign for Nuclear Disarmament (CND) debate, and on both sides of the abortion debate. Where issues are so obviously personal doctors have a duty to point out that their views have no added weight through medical qualification. As one who has long campaigned on several social issues I am always keen to point out that my views are personal and carry no extra weight because of my medical qualification.

The permissive society

The changes in the life-styles and in particular the sexual behaviour of our patients are now reflecting themselves in changes in medical ethics. Medical advances in contraception and abortion have made sexual relationships easier and their harmful consequences somewhat less harmful. Doctors are more inclined to enter into public controversy about issues such as abortion, contraception for the under

sixteens and euthanasia than about any other areas of medical practice. In fact what these three areas all have in common is that they primarily involve doctors in judgemental decisions which are far more social than medical. In each case the medical component is almost irrelevant and it is the personal ethics of the individual doctor which decides that doctor's behaviour.

To give some simple examples:

1: The selection of a method for euthanasia is a medical decision, to implement the method is a social one.

2: The selection of a method of abortion is a medical decision, the decision to implement the method is 99 per cent a social one. Only in a tiny minority of cases is the medical evidence relating to the health of the mother or baby a factor.

3: The selection of a method of contraception for a girl of fourteen is a medical one. The decision to issue the contraception is a purely social one.

These are areas where doctors have assumed god-like roles and where their ethical behaviour has brought them into greatest conflict with society. Even where Government guidelines have attempted to suggest ethics the advice nearly always consists of rules followed by exceptions. This is really situational ethics in practice. The exceptional cases can be different for each doctor and in general, exceptions have a habit of becoming the rule, although the principle by which one gives each individual patient an individual response has immediate appeal. There are, however, disadvantages, for example a patient might be told that in her case abortion would not be considered but another practitioner, given exactly the same circumstances, would think otherwise. Unless doctors make public their agreed ethical principles patients will effectively be left to shop around to try to have their wishes fulfilled.

The system of ethical guidelines based on exceptions has several disadvantages. First, it delegates responsibility totally to the one particular doctor, a role that might be better delegated to a panel. Secondly, it means patients do not receive uniform care. Thirdly, it blurs more strongly-held ethical principles; if

exceptions exist then any behaviour might become possible; euthanasia might be considered ethical in certain exceptional circumstances; so might advertising, patient canvassing or even sexual relations with patients.

In the end most societies have opted to define clearly the limits of professional behaviour if professional status is to be maintained and patients protected.

Some solutions

Those who accept that such ethical changes have occurred and that they constitute dilemmas for the profession might expect some solutions. Fault-finding is considerably easier than putting matters to rights. There is now a need to restore professional behaviour between doctors: to recognise the weakness in situational ethics: to insist that wherever exceptional circumstances are allowed to qualify guidelines of behaviour then at least one example of an exceptional circumstance is provided. There is a need to distinguish between clinical and social decisions made by doctors and to admit that social decisions are better made by more than one person, and preferably by people from different professions.

It is equally important to recognise the changes which have come about through the nationalisation of medicine. Certainly more healthy debate within the General Medical Council is essential. This important body should look again at the advantages of the stricter guidance of traditional ethics. It should remind doctors of the need constantly to observe and be aware of ethics and it should debate in full some of the changes in ethical behaviour which have recently occurred.

The concept of 'ethical' behaviour is coming to be seen, like the concept of 'morality', as old-fashioned, unnecessary and even uncaring or harmful. In contrast, as a profession we have never faced more dilemmas than we now face and we should seek more uniform guidelines to protect patients from our own weaknesses and those bestowed upon us by the system of medicine within which we practise.