

Focus: Current issues in medical ethics

The problem of priorities

Alan Davis and Gordon Horobin *MRC Medical Sociology Unit, Institute of Medical Sociology, Aberdeen*

The current debates about seat belts in motor cars and the evils of smoking may only be straws in the wind if the scenario sketched in this paper were translated into a social, political programme. Then 'illness would increasingly be seen as a failure to keep healthy and thus culpable. The failures [the patients] . . . must either be irresponsible and hence punishable at least by the imposition of financial penalties or insane and thus in need of corrective therapy.' If this sounds like 1984 the reader must read the whole of the argument set out in this paper and make his own judgment. He may not be encouraged by what he reads but he will be forewarned. There is no answer to the question, What shall I do, if this prophecy is true?

The consultative document of the Department of Health and Social Security notes that: ' . . . Some have questioned the morality of devoting large resources to seeking to extend the lives (of the elderly) for what must inevitably be relatively short periods of time, especially when the quality of that extended life may sometimes be open to question not least by those affected'.¹ Meanwhile in Madrid a team of 16 doctors fought to keep one old man alive, whilst half a million old people in Britain were at risk of death from hypothermia², and a New Jersey court said that doctors were not allowed to switch off the machines which kept alive a 'brain-dead' girl³. We heard a neurologist say that a (non-legal) criterion for turning off the machines was 'a lack of purposive response - when there's no personality in there. . .'. Over to the psychologists?

Clinical death is a complicated business; and the allocation of resources even more so. But the issues are not new; they only appear so in a situation of technological change and economic stagnation. The future of the medical enterprise is certainly being questioned now in a number of ways. Most obvious is the seemingly infinite capacity of the health services to soak up money to satisfy the presumed medical needs of the population which refuses to

be well despite all the advances in aetiological knowledge, technology and therapeutics. At the same time the reorganized service seems already ripe for further reorganization. Even before the last reorganization of the National Health Service administrative staff in the hospital increased by over 50 per cent in eight years compared with an increase of about 36 per cent in nursing and medical staff. In the same period waiting lists also increased and the average number of occupied beds declined by 11 per cent⁴. Patients, nurses, doctors and, we suspect, other administrators find it increasingly hard work hacking a path through the administrative jungle. More 'consultative committees' do not necessarily make collaboration between NHS and local authority health and social service workers at the 'coal face' any easier than it ever was before.

Medical effectiveness

Questioning of the medical enterprise has been particularly pointed and radical in the area of 'effectiveness' and this has been to some extent independently of the economic crisis^{5,6}. In this version, scientific medicine has contributed relatively little to the eradication of epidemic disease and to the improved health and longevity of the population. Indeed, medicine can be seen as doing little other than tinkering with the problems that increased longevity has produced. The main thrust of this argument is that attention should be directed towards tackling the 'environment', including the illness-producing industries such as tobacco, alcohol, sugar, white flour and even medicine itself^{7,8,9}.

These challenges to modern medicine are not just technical quibbling but are serious moral challenges, for medicine is itself an essentially moral enterprise*. Whilst this is a commonplace it is, unfortunately, sometimes forgotten when matters of choice become converted into a purely technical task of balancing measurable cost against some crude assessment of effectiveness. Depending on the hierarchical level at which these choice decisions are made, they can be translated into the languages of 'clinical judgment', 'management' or 'politics'.

*The moral nature of medicine is, of course, separate from what are often more conventionally called 'ethical issues' in medicine.¹⁰

Their moral basis is thus obscured but never eliminated. The view from the 'coal face' (or 'shop floor' or 'the trenches' or whatever metaphor is preferred) seems to be, 'I am trying to do my job and could do it better if only *you* didn't strangle me with red tape and *they* would stop playing politics'. Everywhere, it seems, it is someone else's decision (or failure to make a decision) which is causing the problem. As Brown¹¹ remarks, '. . . So long as the NHS is financed mainly from general taxation the problem of priorities cannot be passed back to the consumer.' This is true, but the morality of priorities can be obscured.

The 'engineering model' of the medical enterprise

So who *do* make the decisions and on what issues? Formally it is possible to distinguish a number of levels: Government via its estimates and political judgment of the moment; the health departments through the allocation of the 'health' budget; regional, area and district boards, allocating their budgets; economists, planners, architects, accountants, lay representatives and professional members of boards through their persuasion, bargaining and advocacy; and finally, the health workers at the level of patient contact. Outwith this structure, and fitting into it awkwardly at certain points, are the various social services, statutory and voluntary. Other organizations and groups cannot be ignored either: for example, the Royal Colleges and university medical schools act as 'pressure groups'. Also, of course, hierarchical administrative structures like the NHS do have various formal and informal channels of upward communication as well as downward delegation. It has become something of a sociological truism that organizations in practice bear little or no resemblance to their theoretical charters, and consist rather of a multiplicity of actions, interactions and trade offs. It is our contention that professional versions of the medical enterprise, in particular that version which McKeown⁵ calls 'the engineering model', are key elements in the construction and maintenance of the health services.

The engineering model is, of course, largely an implicit one taking on the character of a set of unexamined assumptions, taken for granted by all but a handful of critics. In this model, individuals are seen as bundles of interconnected biophysical properties best understood and acted upon by specialists in organs or systems. The medical frontiers are in the teaching hospital and the laboratories where the scientific advances can be made using a battery of diagnostic aids, high technology and an army of technical assistants. The image of the intensive care unit or operating theatre, where elegant and precise intervention in the chemistry of the body can be performed, is a very

potent image in our society, and it is hardly surprising if many medical students want to get in on the act and the public increasingly expect that kind of service as an inalienable right.

Let it be understood that we do not totally decry this; as patients we too expect the best when we take our bodies along for repair. And even the redoubtable Illich might be a little put out if clutching a ruptured appendix, he is told, 'I'm sorry, we're into environmental medicine now'. Hospital medicine does work and works well for some patients with *some* conditions. But not all conditions do respond to treatment. General practitioners (often responding to pressure from patients and their families) refer known incurable patients, old patients 'block' beds and others have to be discharged disabled or chronically sick. In general, and as we all know, engineering medicine is ill equipped to deal with the rising tide of cardiovascular accidents, schizophrenics, arthritics, alcoholics and the other problems of our overweight, underexercised, smoke-kippered, aging population.

Proffered solutions to the problems outlined

So what solutions to these problems have been proffered?

1) FURTHER REORGANIZATION

In itself this is, of course, not seen as a total solution but rather as a short-, or intermediate-term response to some perceived administrative and financial difficulties. Discussion of further organizational change usually centres on, for example, removing one tier of the administrative structure, local health 'rates' to allow for more autonomous local developments, stimulating 'team work', 'total care', etc.

As we see it, however, if the engineering model still dominates thinking and planning, then the problems we have outlined merely become translated into problems of bed use and turnover to be solved by handing 'unsuitable' patients over to general practitioners or reallocating selected groups of unrewarding patients to patchily developed 'community care'.

2) RE-DEFINITION OF PROBLEMS AS NON-MEDICAL

Before the economic squeeze there was an apparent trend towards what has been called 'the medicalization of everyday life'. This occurred mainly in psychiatry, perhaps as what were previously 'moral' problems became medically colonized. Homosexuality, alcoholism and kleptomania (an apparently unmotivated form of shop lifting, mainly in middle-class women) are examples. A reaction to this began some years ago¹² but newer 'epidemics' of depression, anxiety, drug dependence increasingly preempt the time and attention of general practitioners and psychiatrists. This self-fulfilling

prophecy, once initiated, is hard to handle. The spiralling use of tranquilizers and antidepressants to keep the hordes at bay, encouraged by the industrial interests of the drug companies in the promotion of ill health, leads like a Greek tragedy to iatrogenic effects and ultimately to thalidomide 'accidents'.

3) COMMUNITY CARE

This can mean one or more of several things including community hospitals, the primary care team, local authority services, the family, 'good neighbour schemes'; in fact, anything which is not done in the general hospital. In one sense the idea of community care is the direct embodiment of the engineering model; that for which no engineering technique is readily available and is thereby ineligible for hospital treatment and thus someone else's responsibility.

4) ENVIRONMENTAL MEDICINE AND CONTROL

As we suggested earlier, more radical challenges to medicine have emerged in the past decade. These range in scope from giving higher priority to environmental medicine, epidemiology and health education to legislative control of, or change in, the environment. For example, people can be urged to give up smoking while the tobacco industry remains in full production, or drivers can be urged to wear seat belts but not to be required to do so by law. Legal intervention does have its advocates but for the most part they confine themselves to restrictions on individual behaviour. If environmental causes of illness are to be taken seriously, however, then logically a larger and more powerful 'inspectorate' is required in, for example, food production. A few critics go further in calling for improved roads, stiffer taxes on heavy goods vehicles to force haulage onto the railway system, banning unstable vehicles such as motor cycles and cycles, and so on as the only means of reducing road accidents.

Increased pressure to conform to health rules

Needless to say such far-reaching social change is highly unlikely to occur in the foreseeable future. It would be extremely expensive and politically very unattractive. Given the diffuseness of decision making which we hinted at above, together with a continuing economic freeze, and, as we postulate, the centrality of the engineering model in the medical enterprise, it seems much more likely that we shall see not environmental control but increased pressure on individuals to conform to a set of

health rules. In this scenario illness would increasingly be seen as a failure to keep healthy and thus culpable. The failures, as in Butler's *Erewhon*, must either be irresponsible, and hence punishable at least by the imposition of financial penalties, or insane and thus in need of corrective therapy.

We began by stating that all choices are moral ones. It follows that failure to make choices is also itself a moral choice. It also follows that the current pressure to 'take politics out of medicine' is either naive or disingenuous. Since the allocation of resources by some independent health corporation would still entail making political choices between priorities, we would only exchange one set of politicians for another.

Transferring responsibility for health to individuals can be done by design or by default; either way it is an issue of both medical as well as political morality, going far beyond what is conventionally thought of as the subject matter of medical ethics. If health is now 'everybody's business', as the Department of Health and Social Security would have it, can this be easily reconciled with central direction, professional autonomy and consumer choice?

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