

Should the public decide?

Michael Thomas *British Medical Association, Tavistock Square, London*

Editor's note

Dr Thomas, Chairman of the British Medical Association's Central Ethical Committee, agrees with Kennedy that the era of medical paternalism is past and that the public should decide the broad issues of medical ethics. To this end he urges the medical profession 'to rekindle the fires of debate of the 1850s, so that the public can provide a moral framework appropriate to the circumstances of today, within which doctors make the clinical decisions for which they have been trained'. However once these broad guidelines are drawn the public should then 'trust in the medical profession which in turn must not abuse that trust or believe that in some way it sets doctors above the common man'.

In the last of the 1980 Reith Lectures, Mr Ian Kennedy accused the medical profession of paternalism. In the first lecture, he said 'We (the public) must become the masters of medicine, not its servants . . . it is we who must have the power' (1). This implies that doctors have aggregated power to themselves as part of a plan of aggrandisement and somehow the down trodden patients must now rise and cast off the yoke of subjugation.

Why did doctors adopt an attitude of paternalism? Until very recent times, their therapeutic armamentarium was very sparse. The ancient saying, 'The duty of the physician is to encourage his patient, while nature cures him', illustrates the problem. It was only by exuding confidence and taking a dogmatic stance that the physician could bolster the patient's morale, despite the pathetic remedies available. The public did not, however, invest its faith in the medical profession totally blindly. In the 1850s strenuous public debate laid down the moral criteria within which the medical profession were expected to work, and one of the by-products of this debate, was the setting up of a statutory disciplinary body for the medical profession - the General Medical Council.

It was during this time that the public came to distinguish between the professions and trade. A professional man always gave of his best and acted in the best interests of his client, whereas the tradesman was motivated by the profit factor. A doctor must always put the needs of his patient first, whereas a tradesman will only act in the best

interest of his customer, as long as these interests do not conflict with his own. A butcher will sell good meat to a valued customer, but if you are a visitor to the area, and will probably never enter the shop again, you may well find that you are palmed off with an inferior cut, which is not what you wanted, and will be encouraged to buy a slow moving line.

The moral and ethical framework which resulted from these discussions worked well for a century because the practice of medicine and scope of treatment available hardly changed. But it was not equipped to handle the moral dilemmas which have arisen from the recent explosion in technical knowledge. The idea that the resources of the nation would be unable to fund the totality of medical treatment was unthinkable at the time of Beveridge, let alone in the 19th century, and moral dilemmas, such as whether to prescribe contraception to a girl under 16 without the consent of her parents, were not considered because such advice was not available, or even foreseeable, for adults.

Should the public be involved in the debate over these new dilemmas, or should the medical profession be left alone to find its own salvation? The era in which required paternalism is past. Modern treatments can offer miraculous cures, but these are counterbalanced by increased risks and often unpleasant side effects. It is therefore essential that the patient, who ultimately accepts the risks, should make an informed decision, not only on whether to accept treatment, but also in the general areas of moral debate. Even if the cry for public involvement is, at present, only coming from a small vocal middle class group, this is no excuse for resisting or ignoring it. The medical profession must be initiators in the movement to involve the public. It was for this reason that the BMA made its *Handbook of Medical Ethics* (2) available to the general public and, although detractors have described the handbook as inept, it was a genuine effort by a group of concerned doctors to involve the public in general in the debate.

Since it is agreed that the public ought to be involved, how can this aim be achieved? To make a useful contribution, a participant in a discussion must be well informed. To this end, source documents, such as the *Handbook of Medical Ethics* and the *Dictionary of Medical Ethics* (3), must be generally available and the media have a role in informing and highlighting new or unresolved areas

However meaningful discussions can only take place in a forum where doctors and public meet and talk face to face. Institutions such as the London and Edinburgh Medical Groups and the Linacre Centre have vital roles to play in educating, discussing and, through an interchange of views, allowing a consensus to emerge. It is for the public to decide on the broad issues, allocation of resources, fluoridation of drinking water, compulsory seat belts versus personal liberty, smoking versus non-smoking, and, having reached a consensus view, the public must decide whether they wish to enforce their decisions by legislation or to encourage conformity by education.

Unfortunately, the public frequently refuses to make a decision. Doctors have been accused of encouraging high technology medicine, but in fact it is the heart transplant which catches the public imagination, and, as Enoch Powell said in a recent BBC Radio 3 programme, 'There are no votes to be won in reducing the amount of open heart surgery and giving the money saved to mental health'. Are the public willing to impose penalties on their fellows who abuse the health services, by smoking, or becoming overweight? Are they willing to accept that health resources are finite, and that in these circumstances they have a duty to decide how the cake is to be cut up? These are problems that derive from public involvement and from them arises the question of what the medical profession should do when the public will not involve themselves. Are we to be driven back to paternalism?

Other problems will arise from public involvement. What does a doctor do if he honestly believes that he cannot work within the constraints laid down by the public, especially if he campaigned against a certain decision whilst it was being discussed? This problem would be at its most acute if the whole medical profession were to be at odds with the remainder of the population. Another problem is the detail with which public criteria or guidelines should be formulated. Dr Tony Smith (4) discusses, apropos who should make the decisions, the question of which patient should be operated on by the trainee cardiac surgeon. This decision must obviously be made by the consultant, but there is room for public involvement. The public must answer three questions:

- 1) Do they want this particular operation to be performed?
- 2) If they want it, do they want trained surgeons to perform the operation?
- 3) Are they going to allow surgeons to gain their skills by operating on animals, or are they to gain experience on human patients, working under the guidance of an experienced consultant?

Once these questions are answered the public

involvement is complete, and, if the answer is to have surgeons trained on patients, then the public must delegate the responsibility of choosing suitable cases to the consultant, who has the clinical training to make such decisions.

We therefore need to rekindle the fires of debate of the 1850s, so that the public can provide a moral framework, appropriate to the circumstances of today, within which doctors make the clinical decisions, for which they have been trained. As no code can take account of every circumstance, and each individual is unique, any code must be general enough to allow doctors to make individual decisions appropriate to specific circumstances. It is almost certainly beyond the wit of man to devise a code that will solve *The Doctors' Dilemma*.

Mr Kennedy, in different parts of the Reith Lectures, suggests various cures for what he sees as the overwhelming power of the medical profession. These include more elaborate training methods for medical students in the field of ethics, a much greater application of informed consent, greater patient consumerism, better and more sophisticated methods of disciplining the medical profession. Better training in medical ethics is occurring at present, but it will only be necessary to use these extra skills if the public involvement has failed and doctors are thrown back on making moral and ethical decisions on their own. Informed consent has been widely introduced and, especially in the field of research, is now virtually mandatory. More consumerism and stricter discipline only tend to emphasise that the public does not trust the medical profession. Our aim has to be to strive for a situation where all doctors are willing to accept that the public has a right to take part in the decisions on major moral and ethical issues, and that the public discharges its duty by fulfilling its role in this process. Once these broad guidelines are drawn, the public must then place its trust in the medical profession, which in turn must not abuse that trust or believe that in some way it sets doctors above the common man.

References

- (1) Kennedy I. The rhetoric of medicine. *The Listener* 1980 Nov 6: 600-604.
- (2) British Medical Association. *The Handbook of Medical Ethics*. London: British Medical Association, 1981.
- (3) Duncan A S, Dunstan G R, Welbourn R B. *Dictionary of Medical Ethics*. London: Darton, Longman & Todd, 1981; 2nd edn.
- (4) Smith T. Doctor's dilemma: the right balance of paternalism and open medicine. *The Times* 1981 Feb 18: 12.