Debate

Medical ethics needs a third dimension

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It is difficult for most people and particularly doctors (I suspect) to see the distribution of resources as being in any sense an ethical problem. A doctor's ethical code is essentially related to a face-to-face relationship with his patients. It is what Paul Sieghart, in his Lucas Lecture-ship, called the unequal model of ethics, shared by the Church, the Law and Medicine. (1) 'The classic model of medicine is that it takes place in a single relationship between two people, the doctor and the patient. The patient, being by definition the weaker party, owes the doctors hardly any obligation apart from paying the fee if there is one. . . . ' By contrast, the doctor's obligation to the patient is heavy. He (or she) takes full responsibility for the patient's health so far as it is in his power, and for the consequences of the treatment he gives or prescribes; he must use a high degree of skill and care; he must preserve total confidence about the patient's affairs, and he must be ready to turn out at all hours if the patient needs him. In his discussion of 'excellence' it is clear that Mr English believes that the pursuit of excellence is desirable, among other reasons, because it further helps to fulfil the doctor's ethical commitment to his patient to give him the best treatment that he can. I hope I do not build too much on this if I take the implication to be that, having discharged that obligation to his patient, the doctor is then free to pursue excellence for what may be described as entirely 'self-regarding' motives.

Indeed, the evidence I have for this is that Mr English says that 'a desire to excel in one's chosen work . . . is a fundamental human quality', and, therefore, presumably to be admired in itself, irrespective of the consequences. And it is not that Mr English does not see the consequences of taking this attitude. He goes on to say that such a pursuit of excellence has led to 'super specialisation' remarking that 'there is no doubt that this has created problems . . . with the provision of a properly balanced health service'. But he concludes that the result of all this is that 'we have to accept . . . that excellence in a particular field of medicine demands concentration on that subject to the exclusion of other areas of medicine of equal importance. Here there is an obvious potential conflict of interest. . . .

Most of us are enthusiastic about our chosen specialty and it may be difficult to be objective about the value of another clinician's work, when all are competing for a limited share of the available funds. However, rather than trying to examine how that thorny problem might be solved, let us simply accept that a high degree of specialisation in medicine is inevitable.' (My italics).

Many doctors would accept these propositions without dissent, and will most probably wonder what one could find objectionable about them. And, indeed, if one could accept that simple 'two dimensional' model of medical ethics, which I outlined at the beginning of this article, there could be nothing to which one could object. But two dimensional models are not real. And the third dimension which needs to be added to make the model approach the reality of medicine in the National Health Service (NHS), is the social context in which these ethical considerations need to be placed. It is the introduction of this third dimension which gives rise to an ethical conflict, both for the doctor himself, and between the doctor and society.

Mr English recognises that such a conflict does exist; one must congratulate him for this. However, having recognised it, he retreats from it hastily, with such statements as 'rather than trying to examine how that thorny problem might be solved' and 'it would be . . . naive to anticipate that a correct and just balance between the limitless demands made on delivery of health care will always be achieved'. Unfortunately, those who are responsible for the allocation and distribution of available resources, cannot afford the luxury of retreat from the solution; this is at the heart of the conflict.

There is, of course, another conflict. Mr English defines excellence very carefully, and as we have seen uses it to justify the pursuit of personal development. However, the definition, applied to administrators, lay and professional, in the NHS, must mean that they seek the best and most equitable distribution and use of resources throughout the district for which they are responsible. This must inevitably conflict with the individual clinician's pursuit of excellence.

However, Mr English thinks he sees a solution to these conflicts. He is of the 'firm conviction' that a 'basic structure exists for a fair and reasonable distribution of health resources now and in the future'. This is

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said to be a 'tripartite structure comprising firstly, the
general public in the form of its elected political
representatives; secondly a branch of the Civil Service
... and thirdly the medical and associated health pro-
fessions'. Unfortunately, those who have watched and
taken part in this tripartite system are only too well
aware that whatever its merits, it has not succeeded in
producing a 'fair and reasonable distribution of health
resources' so far. It seems less than likely to be able to
do so in future. Of course, the degree to which this
statement is accepted, depends on what one regards as
a 'fair and reasonable distribution of health resources'.
Again, when Mr English discusses this, it becomes
clear he sees the competition for resources, and the
need for equity in distribution, to be solely in the area
of high-technology, hospital-based medicine. All the
examples which he gives, (renal transplantation,
oncology, and cardiac surgery) are in this field.

But this is not how society views the conflict about
our resources. (And here, I accept Mr English's defini-
tion of the voice of society being expressed through its
elected political representatives.) Successive secre-
taries of state of both political parties have always made
their priorities in the NHS the care of the elderly and
the mentally handicapped with, in third place, care in
the community, which overlaps the other priorities.
Never, so far as I am aware, has any minister of health
ever declared as a priority any branch of high-
technology medicine. The present secretary of state, in
an attempt to produce some re-allocation of resources
has gone further than his predecessors, and has
announced annual monitoring of the performance of
his agents - ie the regional and district health
authorities, to see (among other things) how far his
priorities in health care are being observed. Yet this
clear expression of society's demands plays no part in
any of Mr English's discussion of excellence. So, if he
does not recognise the demands of society, do these
demands present him with an ethical problem?

I believe that they do. Mr English says himself that
high-technology medicine consumes a high proportion
of current available resources, particularly in relation
to its cost-effectiveness and numbers of people treated.
But by advocating a continuing search for personal
excellence in these fields, he is openly ignoring the
wishes of society in favour of a self-regarding goal. Are
professions like medicine entitled to ignore society in
this fashion?

But Mr English might very well reply that he is not a
specialist in the care of the elderly or mentally handi-
capped and therefore their share of available resources
is not his concern. Falling back on his model of medical
ethics, he might well say that his duty to the group of
patients in which he specialises means that he must
fight for resources for them to exclusion of every other
group. (Indeed, I have heard some clinicians, although
not Mr English, say that since there is very little medi-
cally that can be done for the long-term elderly patient
and mentally handicapped groups in society, they
should not be counted as part of the health service and
should not be competing for health resources at all.) I
would have a great deal of sympathy with Mr English if
he answered in the first way; and some sympathy for
him if he were to agree with the second proposition.
However, neither his answers, nor my sympathy,
would do anything to resolve the conflict. In fact, they
would make it worse.

They would make it worse, because they would make
the question of how resources should be allo-
cated, and who will decide on the proportion, more
difficult to solve.

Let us look at what I regard as the lesser problem
first. Acknowledging the fact that demand for
resources will always outstrip supply in medicine, and
that there will always have to be some sort of rationing;
and given that society has not placed any high priority
on high-technology medicine - particularly 'frontier' -
medicine; and given that each specialist will advance
the cause of his own branch of medicine, at the expense
of every other branch, who then is to decide how
resources should be allocated between specialties? Mr
English says that his tripartite structure could make a
fair and reasonable distribution of health resources.
But on whose advice? He says on the advice of the
medical profession. But what earthly good is that
advice, if it is admittedly biased? In fact, Mr English
admits 'that there have been occasions when medical
decisions have been imposed on the profession as a
result of predominantly political considerations, and
... other instances when powerful pressure groups
within the medical profession have effected expansion
in a particular direction which has been at the expense
of other developments'. I wonder whether these occa-
sions have occurred because somebody has had to
make a decision in the absence of any reasonable
guidance at all.

And this, as I have said, is the lesser of the two major
problems. By far the greater is the problem of how to
meet society's expectations about the care of the dis-
advantaged groups in the NHS when those whose
activities swallow up so much of the available money
do not even acknowledge the right of these groups to
compete. There is, of course, nothing new about either
of these problems. They have been present since the
start of the National Health Service. The preferred
attempted solution has always been to try to involve
doctors in the management of the service, presumably
in the belief that if some of them were exposed to the
problem they would first become objective themselves
and then, with their newly-acquired objectivity, go out
and convince their colleagues.

If this is the belief, then the sooner it is recognised
for the pious hope that it has always been, the better.
No management structure that has been devised for the
health service has ever succeeded in producing more
than a few doctors who, despite perhaps high personal
contributions to management, have been able to per-
suade or to command their peers. As resources have
become tighter so the minuscule influence they may
have had, has diminished. And doctors are at best
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reluctant managers. They are, as Mr English has said, interested in their specialty and the good which they can do for their own group of patients. That is what they have been trained to do; they want to get on and do it. I accept this argument entirely. But of course, if doctors are not prepared seriously to face the problems of allocating resources and are not prepared to give up their sectional interests, they ought to be prepared to allow others to make decisions which they have traditionally regarded as infringing their rights of clinical freedom and self-advancement and which they claim are rooted in their model of medical ethics.

So we are faced with three potential solutions to what has been described as 'a genuine and difficult problem in seeing how public policies about priorities can best be knitted into the individual clinician's autonomous relationships with his patients', and 'a barren and frustrating clash of ideologies of excellence versus equity' (2). The first solution, that doctors should be brought in to help manage the service, has been tried, and as I have said, in my opinion has failed. However, the second solution, that clinicians should be prepared to allow others to make decisions for them about the amount of available resources which they are permitted to spend, and should accept these decisions, has been rejected out of hand. I believe that a further pursuit of either of these solutions would be time-wasting and frustrating. Any such pursuit is bound to fail because the ethical code which doctors observe makes it impossible for either solution to succeed. Any consent to restraint on the use of resources for their particular specialty, either voluntarily imposed by themselves, or imposed upon them, must in logic break their obligations to their patients as they at present see them.

It seems to me the only hope of breaking out of 'barren and frustrating' conflict, lies in an attempt to persuade doctors that their ethical model is wrong because it is two-dimensional and therefore incomplete. If we can persuade them that the third dimension, the wider social ethic, must be built into this model, then we can return to a serious discussion of how best to involve clinicians in resource distribution decisions, both locally and nationally.

References