HEALTH INEQUALITIES **Gerry McCartney, Chik Collins, Danny Dorling**

Would action on inequality have saved Labour?

Had Labour narrowed the mortality gap, the current parliament might have looked different

Inequality in health is among the factors that could have made a crucial difference in this year's UK general election. How? We know that the gap in life expectancy between the worst and best local authorities grew in the 10 years after New Labour was elected in 1997. The effects of this inequality have not been politically neutral. In the areas that tend to elect Labour party representatives people are likely to die relatively young, and in the areas that tend to elect Conservative party representatives people tend to live longer.

Taking older voters at previous elections from 1997, 2001, and 2005, we can confidently say that a higher proportion of those who voted Conservative than of Labour voters were still around to do so again in 2010. The great irony is, of course, that this growth in health inequality is now part of the legacy of the longest ever period of Labour government

The quotation "Vote early—and vote often" has been attributed to Chicago politics. However, an interpretation of the saying can perhaps help cast some light on the recent UK general election result and the subsequent emergence of the Conservative-Liberal Democrat coalition.

New Labour was elected in 1997 on a manifesto that included tackling the underlying causes of bad health and reducing health inequalities. Frank Dobson, as the government's first health secretary, wanted to establish the basis for the future use of the slogan "vote Labour, live longer."

After 13 years in government Labour has lost power. The election produced a "hung parliament." Theoretically 326 seats are required for a parliamentary majority, though in practice fewer would have been workable. With 258 seats Labour could not quite, even with the support of the 57 Liberal Democrats, come close enough to the required figure. The Tories failed to win an outright majority because their vote rose by most in seats that they already held. But with 306 seats a coalition with the Liberal Democrats became possible.

With such a finely balanced result, anything that could meaningfully have influenced where and how votes were cast in the election could be advocated as tipping the balance of power. One such thing is a continuing inequality in terms of the opportunity that certain people, in certain places, with certain political dispositions get to "vote often"—not in the literal sense of frequency of voting but in terms of the number of opportunities to vote across their lifetimes.

National statistics show that the gap in life expectancy between the worst and best local authorities in the United Kingdom grew from under nine years in 1997 to almost 13 years by 2007. This suggests that during the period of the New Labour government the "political participation expectancy gap" between these local authority areas grew—because of differences in mortality—from roughly two to three general elections.

The effects of this inequality, as indicated above, have not been politically neutral. Those politically disposed to the Tories have tended to benefit from it. In relation to Dobson's slogan, we might say that those who voted Labour before 2010 did tend to live a bit longer but that those who voted Conservative tended to live rather longer still—and vote more often.

Mass electoral participation is, in historical terms, a relatively recent phenomenon in the United Kingdom. It was not until 1928 that the suffrage, or "right to vote," was secured for virtually all adults over 21. Without this progress it would have been hard to have imagined the 1945 Labour landslide that helped usher in the NHS. Even given that, the post-1945 intake of members of parliament showed inequalities in mortality reflecting the communities from which they were drawn.

The hope invested in voting among many of today's "socially excluded" communities is rather lower than that of their "politically excluded" forebears. In such areas the proportion of people using their vote has fallen precipitously, representing a further loss in terms of the number of Labour votes. When asked, people who abstain say they would be much more likely to vote Labour than Conservative.

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See **FEATURES**, p 1386, and **ANALYSIS**, p 1392

Abstention reflects a feeling that voting matters less and doesn't change anything very much. This is a feeling that is backed by some fairly compelling arguments and evidence about the operation of our democracy in recent decades. Democratic institutions in Britain have seemed, in recent years, increasingly to separate people from, rather than connect them to, the operation of power.

However, as this most recent election has shown in its own very particular way, the securing of a parliamentary majority remains crucial to the operation of this "democracy." Voting does matter. The parties were aware of the demographics. In the marginal constituencies in particular, their backers' resources were expended to maximise their vote. And the legacy of New Labour was such that the Tories had many more of their older voters still around to mobilise.

Had it narrowed rather than widened the mortality gap in the UK during its term of government, the balance of the current parliament might have been a bit different—perhaps different enough to have facilitated a coalition that would have seen Labour retain its Downing Street presence.

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ETHICS MAN **Daniel K Sokol**

How to think like an ethicist

A search for method in the madness of medical ethics

Structure. That is the key. Structure. Did John steal the stethoscope? Go through each of the five components of theft: appropriation, of property, belonging to another, dishonestly, with the intention to permanently deprive. If a single element is missing, there is no theft. Was Tracy negligent when she failed to intubate the young child? Go through the elements of negligence: loss, duty of care, standard of care, breach, causation, and remoteness. Throughout the last year at law school we were told to "think like lawyers." We had to lose the deep rooted instinct to judge the morality of a person's act and replace it with a dispassionate legal dissection of the facts at hand.

When training in medical ethics I was never told to "think like an ethicist." There is no universally accepted way to do ethics, and at times the words from a Dilbert comic strip posted on the notice board of a bioethics department ring worryingly true. Having received the advice he wanted to hear, Dilbert muses that "90% of happiness is finding the right ethicist."

If I were asked to train *BMJ* readers to be medical ethicists (the kind that I would like my doctor to consult if morally perplexed), structure would feature early in the syllabus. The method would be the "four quadrants" approach, developed by the Americans Albert Jonsen, Mark Siegler, and William Winslade in the early 1980s.[1] It is lesser known than the "four principles" approach,[2] and less versatile, but it is more straightforward to use and more attuned to the clinical context. A brief demonstration (which is based on an example given in Jonsen and colleagues' book) follows.

Lucy is an 8 year old girl with a diagnosis of acute myeloid leukaemia. Three months after a course of chemotherapy she relapsed. A transplantation of bone marrow from her older sister was performed. Again, she soon relapsed. Although the oncologist told Lucy's parents that further chemotherapy would provide scant benefit, they insisted on more. The medical team attempted a course of experimental chemotherapy, which unfortunately did not slow the progress of the disease. Lucy, a once cheerful patient, is now despondent. She asks, "Why must I keep doing this?"

The temptation to "jump in" with gut reactions must be resisted. Good ethics starts with good facts. The first quadrant of our analysis, therefore, is clinical indications. What is Lucy's likely prognosis? What is the treatment goal, and how likely are we to attain it? If the proposed treatment does not work, what is plan B? This quadrant clarifies the medical situation and seeks to highlight the harms and benefits of any proposed intervention. Doctors should feel on familiar territory here. The ideal scenario is that the medical team, after reviewing the situation, agrees on the clinical "ought." Of course, in reality, the medical situation may be messy, with various unknowns and disagreements.

Once the medical indications are clear—or as clear as they can be—the next quadrant looks at the patient's preferences. Is Lucy competent to take part in decisions about her care? If so, has she been informed of the situation, and what are her thoughts on the matter? Lucy's remark suggests that someone needs to talk to her about her future care. Keeping her in the dark runs counter to the principle of respect for autonomy and may lead Lucy to feel isolated or abandoned. If dealing with an incompetent adult we would consider prior preferences, including any advance statements.

Next, we consider the third quadrant: quality of life. What will be the effect of any proposed intervention on Lucy's quality of life? How will further aggressive treatment, for example, affect her mental, physical, and social wellbeing? Again, there is no certainty in this assessment, but it is an important factor in deciding what is in Lucy's best interest. An intervention may be medically indicated because it will prolong life. This quadrant will question the value of such an extension. For Lucy, palliative care may be more appropriate.

"The four quadrants of ethics should be as familiar to doctors as the four quadrants of the abdomen"

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Then we turn to the final quadrant: contextual features. This is a hotch-potch category, containing all other relevant factors. In Lucy's case, we would explore the views and feelings of her parents and sister and any underlying religious or cultural issues. Clinicians, too, have prejudices and biases that can affect their decision making, whether they are based on religion, past experience, self interest, or hospital politics. This is also the place to consider the delicate issue of resource allocation and any pertinent legal rules or professional guidelines.

That, in a nutshell, is the four quadrants approach: start with clinical indications and move on to examine patient preferences, then quality of life, and finally contextual features. It is no panacea, however. Sound judgment and an open mind are needed to balance the various considerations raised in the analysis. A solution will not always emerge from the foggy moral landscape; but more often than not it will clear some of the haze and expose the mines strewn along the way. Like any skill, it gets easier with practice.

In the 13th century the surgeon Lanfranc wrote that "no one can be a good physician who has no idea of surgical operations, and a surgeon is nothing if ignorant of medicine." In 2010 physicians and surgeons operate in a morally laden clinical environment, and neither group can be truly at ease without a method to examine the ethical issues in their practice. The four quadrants of ethics should be as familiar to doctors as the four quadrants of the abdomen.

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