

# MEDICAL PRACTICE

## Contemporary Themes

### Establishing ethical priorities in medicine\*

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Medical ethics might be said to have recently "come of age"—or at least to be passing through the phase of adolescence, in which a new identity is being sought. The origins of the subject are, of course, very ancient, the fundamental source being the code of Hippocrates with its emphasis on the priority of patient benefit above all other considerations. But until recently the term has been understood mainly as a name for an implicit code of good conduct among the members of the medical profession, junior members of the profession learning by precept and example how to behave ethically in clinical practice.

All this is now changing. There is a new mood of self-criticism in the medical profession itself, as there is in many other professions concerned with the health care of individuals. The rapid social changes of our times and the increasing complexity of medical techniques have led the professions to look outside their own ranks for guidance about moral behaviour. A symptom of this change is the emergence of institutes and societies, with their corresponding journals, devoted to inter-professional discussion, such as the Society for the Study of Medical Ethics in London with its *Journal of Medical Ethics* and the Society for Health and Human Values with its newly launched *Journal of Medicine and Philosophy*. These institutes—and other similar bodies—draw their reflections on medical ethics from philosophy, theology, and the social sciences, as well as from medicine itself.

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But when the doors of professionally privileged communication are opened wide in this way the discussion is bound to take on some exciting features. In his celebrated attack on the "medicalisation of life" Ivan Illich has suggested that doctors, like motor cars, probably cause more damage to health than they bring benefit to mankind.<sup>1</sup> Moreover, he is convinced that an overdependence on medical intervention is one of the major diseases of modern Western society.<sup>2</sup> The medical profession, then, would be the very last body to reflect upon the ethical aspects of its activities.

In this short paper I shall not attempt to enter into a proper discussion of Illich's radical critique of modern medicine. No doubt there is a fair proportion of prophetic overstatement in what he says. But whatever the accuracies or inaccuracies of his assertions the focus of his attack seems to me entirely correct. It is now essential that we ask some basic questions about the task and place of medical care within society as a whole. This is not to say of course that the numerous other moral issues connected with particular aspects of clinical practice are unimportant. (In my own writing, for example,<sup>3</sup> I have tried to deal with questions of abortion, prolongation of life, confidentiality, and the ethics of research etc.) But the question of the establishment of priorities in the provision of medical care is now pressing relentlessly on every society. I have therefore chosen this topic as the pivotal point for my paper. It may be encapsulated in the question: given that the resources of a society are of a limited nature, and that the needs for health care are virtually limitless, how are the medical needs of that society to be met in the most equitable manner possible? In philosophers' language, this is an aspect of the problem of "distributive justice."

In order to cope with the problem I intend to look briefly at three issues: (1) the relation between medical care and the ideal of positive health; (2) the tension between the freedom of the individual and state intervention in medical care; and (3) the problem of determining how an equitable distribution of resources may be made in conditions of diverse and competing medical needs.

## Medicine and the ideal of health

Perhaps the most widely quoted of all attempts to define health is the World Health Organisation's definition—"Health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity."

Two points must be immediately made about this definition. Firstly, it is obvious that medical intervention alone can never achieve such a goal. Whether we define medicine as a science or as an art or as some subtle blend of the two, it necessarily concentrates upon the prevention or correction or both of disorder of mind and body. It offers no magic formulae for positive mental and physical wellbeing. The achievement of such wellbeing depends far more upon the nature of society in general, its educational provisions, its social structure, its living conditions, and its life-style. These are factors in which the medical profession holds no particular expertise—although it might well make recommendations about some of them on the basis of its knowledge of the diseases and disorders of modern societies. But, secondly, not only is medical intervention an insufficient way of achieving the WHO goal, we must also recognise that even those aspects of that goal which lend themselves particularly well to medical solutions are of a seemingly limitless extent. This may be seen clearly from current problems within all countries attempting to offer comprehensive medical services to their citizens. Maxwell<sup>4</sup> has described the problem as the "paradox of medical needs"—"The fundamental paradox of health care is that medical advances so often breed further needs and increase future requirements for care. The more infant lives are saved the more serious becomes the threat of handicap. The further life expectancy is extended the greater become the demands on geriatric services and long-term care facilities for the infirm and elderly. Each new advance which gives hope to another category of sufferers (heart transplant and renal dialysis are only the most obvious examples) converts a latent need into an immediate and continuing demand. . . ." and, "every inch of ground gained is won with greater difficulty and at higher cost than the last. It is the familiar phenomenon of diminishing returns with one vital difference: no new gain however costly can ever be dismissed as marginal if it promises some real reduction of human suffering."

It is in this context of seemingly limitless demands for medical care that the question of priorities in the allocation of medical personnel and resources must be seen. The choices raise such fundamental questions about justice that they take us well beyond the "management" criteria of cost-benefit analysis or efficiency of services. This is not to deny of course the need for such criteria (see especially Cochrane<sup>5</sup>), but in a situation of continually expanding demands we must face the fact that somebody has got to lose in order that others may gain. The vital moral question is: on what basis should such discrimination between needs or demands from different groups be made?

In tackling this question I shall try to survey briefly two fundamental ethical ideas: (a) the concept of freedom of the individual and its relation to social control; and (b) the concept of equality and its relation to equity.

## Freedom and control

The moral ideal of "freedom" is one to which every society to a greater or lesser extent apparently subscribes, but the problem is to establish the precise meaning of such a high-sounding term. (According to one modern political theorist,<sup>6</sup> it is so "porous" that there are few interpretations it is able to resist.) To speak of freedom in any meaningful way we must know: (1) who are supposed to be free; (2) what they are supposed to be free from; and (3) what they are supposed to be free to do. Thus medicine might be seen as serving the ideal of freedom. It endeavours to set people free from life-threatening disease, from disabilities that limit their capacities for happiness, from the fear of pain and poverty, and from feelings of useless-

ness. But freedom is more than the absence of constraints—more than "freedom from." To this must be added the notion of "freedom to"—for example, freedom to develop one's own life in ways that one chooses, to adhere to beliefs and practices one holds to be right, and to pursue goals of objectives that one believes will bring fulfilment and happiness. These two types of freedom have sometimes been referred to as "negative" and "positive" types of freedom. Both of them contain the same difficulty: how can such freedoms be equally achieved in a society?—are we speaking of the freedom of all, or only of the freedom of some?—a dilemma summed up by the English utilitarian philosopher, Jeremy Bentham, as follows: "No liberty can be given to one man, but in proportion as it is taken from another."

While it may be unnecessary to take so gloomy a view as Bentham, it is nevertheless obvious that there can be no freedom in a society without the correlate of social control. A society that lacks such controls upon individual liberty becomes merely an arena for power battles. The freedom it offers is a freedom shrouded in fear and protected merely by physical and not any longer by moral force. Both freedom from and freedom to require channels through which they can be exercised. (They require what Kant called autonomy—a freedom that acts in accordance with universal laws or principles.)

Within the sphere of health care the necessity for such channels or controls is becoming more and more evident. A historical example would be the realisation in nineteenth century England that if the cholera epidemics were to be controlled then extensive sanitary reform of the living conditions of the poor would be necessary. This led to the introduction of legislation enforcing controls upon those social groups who had aimed at a maximum profit with minimum financial outlay. The same type of lesson is being learnt in many countries that encourage or support extensive private enterprise in health care. For example, Richard Titmuss's celebrated essay on methods of blood donation<sup>7</sup> showed that where blood is commercially obtained the result can only be exploitation of the consumer. In Titmuss's own words: "In commercial blood markets the consumer is not king. He has less freedom to live unharmed; little choice in determining price; is more subject to shortages of supply; is less free from bureaucratisation; has fewer opportunities to express altruism; and exercises fewer checks and controls in relation to consumption, quality, and external cost."

Although the example of commercial blood markets is an extreme one I believe that it provides a paradigm for the case for comprehensive social control of health care provision. In laissez-faire conditions medicine presents an endlessly fruitful field for unscrupulous and inhumane profiteering; or equally for an unintended perpetuation of injustice. This is particularly clear in developing countries. As Abel-Smith<sup>8</sup> has observed—"At first sight it would seem that the more those who can afford to pay for their health services can be made to do so, the more publicly financed services can be made available for those who cannot pay. . . . But this is not the way it tends to work out in practice. Once the better off go to different and better services, they may resent paying both directly for their own services and indirectly through taxes for the services of poorer people. . . . Secondly, if the better off use different services, they cease to press for improvements in the basic free services. . . . Finally, private practice can seriously restrict the number of doctors willing to work in the organised services. Thus by all these routes less may come to be provided for the poorer section of the population than if all had used the same services."

Thus the freedoms that medicine offers are only to be guaranteed in a society when they are channelled by means of social control. On the other hand we must be aware of an equal threat that will be posed by a powerful and all-embracing government bureaucracy—an entity aptly nicknamed "Leviathan" by the political philosopher Thomas Hobbes. (Indeed the conditions of laissez-faire and overcentralisation are not so very different. For usually Leviathan is the outcome of power seized by some group in the absence of democratic

controls, whether by an aristocracy, a plutocracy, or a monolithic political party.)

What then are the alternatives to laissez-faire or Leviathan in health care provision? Here I must speak in a shorthand fashion in order to make my point briefly: *there can be no justice in the allocation of medical resources so long as they are under the sole control of one sector in a society*. It is of no consequence whether this sector is a social or professional group, a financial empire or a political party. In all of these cases resources are bound to be allocated according to the prejudices of the profession or the purchasing power of the wealthy consumers or according to the dogmas of the party in power. Worse than any one of these sectors being in control is when there is an alliance between all three. The result (as studies of the misallocation of health care resources in some developing countries have shown<sup>9</sup>) is medical care for the benefit of a privileged minority and an escalating health problem for the vast proportion of the population.

Instead of such concentration of power within a society what is required is a genuinely national health service. (I do not mean by this a health service necessarily in precisely the form we have it in Britain.) Such a service must be national in two senses: firstly, the provision of medical services must become a function of government for all groups in society; but secondly, in order to control the power of such a centralisation, there must be structures at community level that can guide the decisions of priorities that are to be made—in a phrase: decentralised democracy in health care provision.

### Equality and equity

One cannot suppose, however, that such a move towards greater public participation in health policy decisions is all that is needed to bring greater justice. It was the great advocate of liberty, J S Mill, who spoke most eloquently of the "despotism of the majority."<sup>10</sup> Although an advocate of the greatest happiness of the greatest number, Mill was also constantly concerned to defend the rights of minorities within the society. This is the second crucial issue within the general problem of priorities in health care. What we are aiming towards is an equitable treatment of all groups so far as the resources available will permit it. How is such a goal to be achieved? Are all individuals to be treated equally? Often Aristotle's famous dictum is quoted as a guide-line here: "Injustice consists as much in treating unequals equally as treating equals unequally."

By this Aristotle meant that we must take into account the differences between people in order to determine what kind of treatment each ought to receive within a society. But which differences are the morally relevant ones to take into account? In Aristotle's time this principle could justify the ignoring of the rights of slaves or of women or anyone not of pure Athenian stock. In our own time it can be used to justify discrimination in terms of race, social class, or "usefulness to society."

In my view there can be only one moral ground for discrimination, and that is the degree of need presented by different groups and individuals. It is obvious, for example, that a young child needs more care and attention than a mature and reasonably healthy adult; and that an elderly and infirm person will not survive in a society that gives him no more support than he got when his facilities were at full strength. These are discriminations at a very obvious level of difference. But in order to ensure equity in health care we need to develop to a much finer degree relative assessments of medical needs. The decisions are hard ones. Is it more important to prolong some lives by transplantation (or by the other facilities of high-technology acute medicine) or to lower infant mortality rates in the community at large? Is it more tolerable to have outmoded and inhumane institutions for the mentally retarded and the senile than to have less than adequate facilities in community health centres?

It is unlikely that any final answer can be given to such

highly emotionally charged issues of political and social policy. Abel-Smith<sup>11</sup> has described the problem as one in which we are "... deep in the uncharted sea of interpersonal comparisons where there are methods of drawing maps but no agreement on what is sea, land, and frontier." This sea of uncertainty is not, of course, to be confused with more easily defined (though not necessarily more easily solved) problems of the maldistribution of health services to people with the same needs. Tudor Hart<sup>12</sup> has suggested that an "inverse care law" operates within the NHS, whereby discrimination operates according to income level and place of residence of patients—"In areas with the most sickness and death, general practitioners have more work, larger lists, less hospital support, and inherit more clinically ineffective traditions of consultation than in the healthiest areas; and hospital doctors shoulder heavier case loads with less staff and equipment, more obsolete buildings, and suffer recurrent crises in the availability of beds and replacement staff. These trends can be summed up in an inverse care law: that the availability of good medical care tends to vary inversely with the need of the population served."

A notable aspect of the recent health policy statements of the British Government<sup>13-15</sup> has been an acknowledgment that such geographical disparities exist and a declaration of intention to even them out. But the same policy statements have also sought to readjust the priorities given to different patient groups, with a shift away from acute hospital medicine, and an increased emphasis on community care for the disabled and the elderly. In conditions of financial stringency, however, such a shift towards the benefit of one group is bound to jeopardise the life expectancy of another.<sup>16</sup> Implicit within these decisions—but never properly articulated—is some concept of what is a tolerable minimum of health care that each citizen may expect from a society that claims to be providing a national health service. No progress will be made towards clarifying this implicit assumption so long as decisions are taken on an ad hoc basis (as the result, say, of increased pressure from the disablement groups or of public outcry against the maltreatment of psychiatric patients). Rather, the attempt should be made to construct some kind of health status index<sup>17</sup> according to which relative degrees of need could be assessed. Such an index would have to take account of at least two factors: degree of avoidable disablement and degree of possible increase in life expectancy. Co-ordinated research into the relative effectiveness of the medical and social work preventive and curative services currently being provided should give some answers to the vexed questions of the degree of change that such services can achieve and the number of patients affected by such changes. Of course such information—however efficiently compiled and co-ordinated—cannot of itself give an answer to the moral decisions that must be made. Since it is inevitable that some needs must be left unmet, the crux of the moral dilemma is to decide which needs to ignore. But if efforts are made to marshal all the available facts and to make explicit the grounds for discrimination, then at least the determination of priorities would be seen to be based on the criterion of need, rather than on the following of some insufficiently researched fashion in medical or social work practice or on a vote-conscious response to those groups in society that can shout the loudest in the ears of government departments.

### Conclusion

I have done little to answer the question of how specific priority decisions in medicine are to be determined. At the centre of this question there lies an area of deep uncertainty since the objective assessment of priorities demands weighing of one set of needs against another, without any agreed measures for comparison. Two points, however, have emerged with some definiteness. Firstly, discrimination between people with the same needs cannot be morally justifiable. Secondly, decisions of such difficulty and such importance must be discussed



publicly and should not be the sole prerogative of any one professional group or any single agency of government.

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# Bone and Joint Diseases

## Surgery in the treatment of cervical and thoracic disc protrusions

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### Cervical disc disorders

Disorders of the cervical intervertebral discs are a common cause of pain and disability, especially in the fourth and fifth decades of life. Symptoms rarely develop from a cervical disc prolapse but more commonly they arise in association with cervical spondylosis. Two groups of symptoms may arise from the latter—unilateral nerve root pain and paraesthesiae in association with pain in the neck and shoulder or cervical myelopathy produced by interference with the vascular supply of the spinal cord.

#### NERVE ROOT PAIN FROM CERVICAL DISC PROTRUSION AND CERVICAL SPONDYLOSIS

Cervical disc protrusion is rare compared with that found in the lumbar region. It affects young people. The protrusion, which is small, arises in the posterolateral part of the disc and is accompanied by characteristic pain in the neck and arm in the distribution of one cervical nerve root. The horizontal course of cervical nerve roots from the spinal cord to the intervertebral foramina precludes more than one nerve root being affected by the prolapse of a particular disc. Although motor and reflex signs may be present, they are not always observed. Pain is severe proximally, unilateral, and accompanied by paraesthesiae in the fingers of the affected arm.

It is questionable whether prolapse occurs in older people. The same signs and symptoms more commonly arise with cervical spondylosis, when the nerve root may be placed at risk by a thickened hard annulus fibrosus, associated with osteophyte formation in the intervertebral foramen and adjacent vertebral body margins. The nerve root sheath is thickened and adherent. Pain may be in the neck, radiating bilaterally to the proximal parts of the arms or into the occiput, or this may occur with or without unilateral nerve root pain distributed into the more peripheral parts of the arm.

Surgery for cervical disc prolapse is rarely needed as spontaneous resolution tends to occur. Immobilisation of the cervical spine with a collar or the help of intermittent or continuous traction produces resolution within two to three months, with no residual ill effects. Recurrence, however, is possible, but the intervals of freedom from symptoms vary from a few months to many years, and it is impossible to predict the frequency and timing of any recurrence.

Surgery is indicated only for those patients with persistent severe nerve root pain despite adequate closed treatment including head traction with bed rest and suitable analgesia. Surgery for its relief is needed far less often than for lumbar disc prolapse. It aims at reducing movement of the vertebral joints at the affected level, together with decompression of the affected nerve root. Excision of most of the intervertebral disc by an anterior approach through the neck, removing as much disc as is visible, without interfering with the posterior part of the annulus, is accompanied by the insertion of a bone graft removed from the iliac crest to fuse two vertebral bodies on either side of the affected site, so reducing interference with the blood flow in the vessels to the spinal cord. Satisfactory fusion is likely to result in subsequent absorption of osteophyte formation, and this alone will minimise the risk of any future recurrence.

Some surgeons prefer to employ a more radical excision where the intervertebral disc is completely removed by the same approach—excision of the posterior part of the annulus accompanied by fusion of the adjacent intervertebral bodies.

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