MEDICAL PRACTICE

New Horizons in Medical Ethics

Priorities in Medicine

This tape-recorded discussion was devoted to some ethical problems of the selection of patients for different types of treatment. In their working papers circulated before the discussion Professor Philip Rhodes, professor of obstetrics and gynaecology, asked whether there is a limit to which the weak, the distressed, and the diseased shall be supported; Dr. Chisholm Ogg, renal physician and director of a dialysis and transplantation unit, discussed the conflict between ethics and supply; and Dr. Donald Irvine, a general practitioner, draws attention to the conflict between the individual and society. The working papers are printed below followed by the discussion which was chaired by a member of the B.M.J. editorial staff.

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Primary Concern is Comfort

PHILIP RHODES

It is important to define one's terms from the beginning. Morals derives from "that which is customary, or generally accepted," and try to answer what is good and what is right within a given context. Ethics is moral philosophy: it is that area of philosophy which concerns itself with the inquiry into the nature of moral judgement. Thus consideration of priorities in medicine, whether for the individual patient or for society as a whole, is a legitimate subject for a discussion in a series on medical ethics. Nevertheless, morals vary from culture to culture, and since cultures evolve and change, so do morals. Concepts of what is right or good therefore alter with time. There can be no absolutes. Morals help to determine right action when a dilemma is posed. The morality of an action is to be judged by the concepts of the society in which that action takes place. The problem is that these concepts are not codified and vary from group to group, within society.

Western medicine is grounded in the ethics of Christianity, which takes for granted that all individuals are equal in the sight of God. When Christianity was formalized under the authority of the church, all could easily assent to this idea and an arbiter could be found when there was a moral dilemma. With the weakening of formal Christianity the guidelines are less clear, but the injunction "thou shalt love thy neighbour as thyself" still epitomizes the philosophy of medicine. When the number of patients reaching doctors was restricted by their ability to pay, and when treatment was relatively ineffective and cheap, full concentration on the individual was usual. The changes have been the numbers of people able to seek medical care, and the expensive cost of treatment being shouldered by the community at large. These factors create tensions between the individual and society. How much of the resources of society may any individual command? How deeply may he put his hand in your pocket?

Is there or is there not a limit to which the weak, the distressed, and the diseased shall be supported? In theory it is pleasant to believe that there is no limit, but in practice this has never been so—though many doctors have not realized it. Now that the resources which the community will allot to medicine are plain for all to see, the limitations on medical practice and research are tangible. The total constraints are defined; within them priorities have to be determined. This involves value judgements about the worth of individuals and about the worth of various branches of medical practice and research. Inevitably there must be strong emotional reactions aroused when individuals, both patients and doctors, feel threatened by such assessments.

When a disease is common and there is a remedy, the principle must be "the greatest good of the greatest number," and such diseases must form the basis of medical practice. In matters such as spina bifida and hydrocephaly there has probably been too much activism, which may have preserved lives of little worth to anyone. Time might be allowed to elapse before deciding on therapy and surgeons restrained from operating simply because the lesion presents a challenge. The same might be said of many of the tumours of older people. The passage of time too often helps in decisions about brain damage and when it is time to stop efforts to keep the patient alive. The age and social circumstances of the patient are obviously other factors to take into account.

I am very doubtful too about efforts to prolong the life span, until we have solved the social problem of what the old can contribute to society except just to eke out an existence. Research into the biology of ageing may be interesting, but what is to be done about its results? This raises the problem of screening for disease—for instance, by regular medical checks, mass radiography of the chest, well-woman clinics, and cervical smears. The value of all these, even to individuals, is doubtful and perhaps we need the courage to stop them and put the resources expended in them elsewhere. With a population explosion, of which we are assured (though I am doubtful about the validity of this too), the question arises of the sense of extended treatment of infertility, leading to research into the possibility of external fertilization with transfer of the zygote to the uterus subsequently, and tubal and even uterine or ovarian transplantation.

The mortality of life is 100%. Death is inevitable. There is no special virtue in staving it off indefinitely. But living must be made as comfortable as possible. This is the major priority in medicine today—to realize that striving to prevent death should be accorded less emphasis and that more emphasis should be given to helping the best possible adjustment of the individual to his environment. This will change the philosophy of medicine towards manipulation of the environment as well as manipulation of the individual to harmonize it, and therefore towards prevention rather than therapy. In terms of numbers the greatest need is for a better approach to psychological disorder, for this

is the greatest scourge of the present day, causing the most unhappiness and failure to adjust to the environment.

The general message must be that medicine now should be more orientated to the fact that it is more concerned with the comfort of individuals than with the prevention of death, which has been its prime concern for centuries. This change in attitude will limit its objectives within the constraints now being applied by society and will bring medicine more into accord with present morals. There are signs that this is already happening, but doctors and society must try to evaluate just what they are doing and what will be the consequences of such a change.

Society Should be Better Informed

CHISHOLM OGG

Improvement in public health measures and the advent of antibiotics have greatly diminished the medical importance of acute infective illnesses and the principal problems of medicine today concern the prevention and treatment of chronic degenerative diseases and the long-term care of people with stable disabilities. The treatment of chronic disease is, by definition, prolonged and—with the development of techniques for replacement of organs—is becoming increasingly expensive. Such treatment can very seldom be justified on economic grounds and arguably could be regarded as having no priority at all. The interests of the individual patient who receives the treatment clash with those of society, which pays the bill, and the justification for continuing treatment can only be a humanitarian one. In biological terms it is a very shaky policy indeed.

At present the problem is most acutely developed where it concerns the management of patients with chronic renal failure. Something like 7,000 patients die from chronic renal failure each year in England and Wales and, of these, between 2,000 and 3,000 are suitable for treatment by regular haemodialysis or by renal transplantation. At present, less than half are actually offered these treatments, partly because of the limited availability of dialysis facilities and partly because of the inadequate supply of kidneys for transplantation. Inevitably, therefore, some sort of selection policy has to be used with the implication that some patients who could derive benefit will be refused treatment. Such a policy is clearly unethical, and is in direct opposition to the traditional medical code. However, it is dictated by the law of supply and demand. In the South-east Metropolitan region we are fortunate in having a relatively large number of renal units and at Guy's Hospital a patient

is taken on if there is a place available and he is not obviously unsuitable for treatment.

The cost of home dialysis treatment is high: the initial outlay for equipment for each patient is about £3,000, and each year something in the region of another £2,000 has to be found to cover the costs of disposable items, the depreciation of equipment, and the supporting hospital unit. The problem is a cumulative one and it is possible to foresee a situation ten years hence when the annual budget for dialysis treatment could be £30 to £40 m. In contrast, transplantation is a much cheaper alternative; if all goes well the patient does not pose a continuing financial burden to the community. Furthermore, his health may be incomparably better than that of even the best adapted dialysis patient. Unfortunately, the mortality of transplantation is still much higher than that of dialysis and expansion of the programme is severely limited by the supply of donor kidneys, so that it will be many years before renal transplantation can be offered to all who need it. Organ replacement by transplantation must ultimately be the definitive treatment of chronic degenerative disease and should, I think, be accorded the highest possible priority.

Decisions concerning the allocation of a proportion of the nation's facilities to medicine in general and to renal replacement programmes in particular must be made centrally by an informed administration, and clearly medicine must take its place among other priorities. Nevertheless, the implications of such decisions must be clearly understood and stated publicly and we must all be aware that a decision to increase the defence budget, or to spend more money on roads or on prisons must divert funds from another area. One thing seems certain: once a life-saving treatment such as dialysis exists, it must be made available to all who need it. To withhold it creates a sort of medical black market in which only the wealthy or influential can be treated and leads to pathetic campaigns to raise funds to support the less fortunate.

Doctors and Society

DONALD IRVINE

In the past half century social and economic improvements, together with remarkable progress in the basic sciences and medical technology, have substantially altered the pattern of disease. With the removal of the life-threatening infections as the major cause of mortality, we now have a situation in which chronic conditions predominate. I am thinking, for example, of the degenerative diseases of the middle-aged and elderly, the sequelae of trauma in all age groups, and children with congenital handicaps who would not have survived earlier. And then, aside from the major problem of organic psychiatric illness, there are apparently increasing numbers of people who have a variety of psychosocial handicaps, often impinging on areas which doctors have not always thought of as traditionally medical.

In recent years medical technology has advanced to a point

where the "unnatural" survival of an increasing number of individuals with a number of conditions is possible—usually at high cost. This poses a special problem for doctors whose medical training, reflecting the importance our culture places on the individual, have emphasized that their prime duty is to do everything possible for their individual patients, without undue regard to the collective needs of groups—even of those individual people in the care of other specialties. Society has a similar dilemma. Given finite resources, how much should be channelled to the expensive support of a few, when more people might have better health and comfort at less cost in other ways. What price the heart transplant for one, as compared with prolapses repaired, marriages saved through the resolution of sexual handicap, for many more?

A task definition for medical services which places greater emphasis on the quality of living, rather than the prolongation of survival at any cost, whether social or financial, might form a basis for discussion (should you live it up till 70, or drag it out till 90?). Such a definition set against the prevailing pattern of illness, raises a number of questions.

(1) *Control of known Adverse Aetiological Factors.*—Should more emphasis be placed on preventive medicine? For example, a serious effort to curtail smoking, and to control diet and weight, could transform both morbidity and mortality from carcinoma of the lung, coronary heart disease, and hypertension, and so hold the possibility of releasing even greater resources presently used in the therapeutic field for other purposes.

(2) *Earlier Diagnosis.*—Is there value, for example, in recognizing conditions at an earlier stage than is normally possible in clinical practice today, as in screening, unless there is hard evidence that such knowledge might modify the outcome of the disease process beneficially as a consequence? I remain sceptical of uncritical screening. On the other hand, should we spend more on trying to improve on the early diagnosis of congenital disease in utero, so as to reduce the number of children born with handicap?

(3) *Reparative Procedures.*—These fall under several heads. For example, (a) are we spending too much money and manpower on transplants of dubious value, such as the heart, or enough on kidney replacement? (b) should supporting intensive care services be evaluated more thoroughly and used for a more definitely limited period of time? (c) how efficiently should we strive to keep patients alive? Should the child born with congenital handicap have the intercurrent infection it later develops treated intensively, or should it be merely comforted? What is our attitude to caring for the elderly with terminal illness? Death through natural causes would seem to have much to commend it where the outlook is hopeless.

The general allocation of resources between research and service should be the primary responsibility of society, of which doctors are merely a part. Doctors are in a special position to provide facts, however limited, on which decisions might be based; it is questionable whether they should have overriding influence in the decisions themselves, if only because of their

closeness to the problems. More difficult is the evolution of methods by which society can actually make its choices. Existing political frameworks, through government, do not seem to provide an ideal mechanism, but are probably as near as we can get.

There are several other questions which doctors in particular might consider.

(1) Are we as a profession prepared to have our clinical performance evaluated—either formally or informally—by ourselves or an outside agency? This question is vital, because the quality of living for many could be improved by ensuring that existing knowledge is available to more people. For example, the continuing control of hypertension clearly affects prognosis—yet our methods of surveillance of whole populations at risk are rudimentary. And could not surgical and medical waiting lists be reduced by more critical evaluation of in-patient procedures? One suspects that here considerable advances could be made without the need for new money.

(2) How do we prepare ourselves, and our successors, to take a wider view of where the real priorities in medicine lie, even though arriving at these may conflict uncomfortably with our own interests and pursuits?

(3) Consideration of ethical matters which involve value judgements in the management of individual patients barely intrude into medical curricula today. Can we repair this shortcoming?

Appointments of Speakers

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DR. OGG: We can make a judgement on the circumstances; an active fellow of 64, doing a full day's work, taking regular exercise, enjoying family life and contributing to the community would be accepted without question. A man of 55 who's only doing a 10 to 4 job, whose family is grown up, who's not playing a full part in society, would be regarded as a much more doubtful proposition.

PROFESSOR RHODES: We all understand the process because as clinicians we're doing it every day; you're making a decision every day about the ordinary abdominal carcinoma—are you going to do a laparotomy, a radical or a palliative procedure? What we're trying to understand in this discussion are the value judgements this is based on. To some extent I get the impression that these are based on the results of treating certain types of patients.

DR. OGG: This is inevitable when resources are limited; you use the facilities where you see the best return.

DR. IRVINE: So what about the quality of life on dialysis?

DR. OGG: Inevitably it's restricted, and this is why support of the patient by the family is so important. Most patients can go back to work and outwardly seem to enjoy life, though obviously we don't expect them to be entirely happy about their state.

PROFESSOR RHODES: I was fascinated by your phrase "the best return." Isn't it difficult to define this—and how do you measure the quality of life.

DR. OGG: I was speaking purely in terms of survival.

Help in Patient Selection

DR. IRVINE: We have heard that a patient's psychological and social background is important in selection. Should the nephrologist alone be considering those questions? There would seem to be a strong argument in favour of other health professionals more intimately aware of the patient in his home environment having a helping hand in selection decisions.

PROFESSOR RHODES: You don't want lay people in on the decisions on individual patients; they can't understand the actual medical issues involved.

Discussion

CHAIRMAN: Dr. Ogg, would you like to start by discussing your criteria for selecting patients for long-term haemodialysis.

DR. OGG: To begin with, I should say that in the South-east region we are fortunate in having a relatively large number of dialysis units, each having a home dialysis programme. In addition, we have an active transplant unit so that we have a continuous throughput of patients, and we're not confronted with the selection problems as are seen elsewhere in the country. We can take people on to dialysis unless they're obviously unsuitable. We have three main criteria for exclusion: age (patients are seldom accepted under 5 or over 60); other illnesses, particularly vascular disease secondary to severe hypertension; and psychological instability—dialysis is a very tough life and people who aren't self-disciplined don't do as well.

PROFESSOR RHODES: So there aren't value judgements about the kind of person the patient is: they're merely related to whether he can cope.

DR. OGG: Yes. One more factor which must be considered is that I think there's no longer any place for long-term hospital dialysis; this means the patient must have home dialysis—and home dialysis means a home, which weighs against the man without one. But the number of people we've turned down for psychiatric or social reasons has been very small, although in some units the proportion must be fairly large. The selection is done very informally by the doctors on the spot. We may discuss it among ourselves, perhaps with the ward sister if we have doubts.

PROFESSOR RHODES: You're making a value judgement straight away, though, in virtually excluding the over-60s.

DR. OGG: I'm very unhappy about this, but older people don't do so well on dialysis.

PROFESSOR RHODES: But the ability to cope must be related to education and social class, which must therefore be a determining factor in selection.

DR. IRVINE: We all age at different rates; can you really determine the age of the vascular system in a particular individual, for example, to arrive at a cutoff at around age 70?