
Protection from the sun's rays can be achieved by:

(1) *Clothing*—A hat provides cover for the face only down to the level of the nose and is usually worn by people who have already sustained actinic damage. The amount of protection from clothing depends on the weave of the fabric and will be relatively low for a woman wearing a light, cotton dress.

(2) *Glass and plastic*—Hard glass in particular acts as a poor filter. Perspex absorbs ultraviolet B strongly but does not provide an appreciable barrier to ultraviolet A.

(3) *Ultraviolet absorbent sun screens*—All commercially available sun screens contain substances that selectively absorb ultraviolet radiation. Their efficiency is expressed as the sun protection factor. The higher the factor number the better the protection. Such preparations as Spectraban 15, Coppertone Supershade 15, and ROC Total Sunblock Cream 10 are regarded as drugs and may therefore be prescribed in the normal way for certain skin conditions. Sun screen agents should be applied well before the start of perspiration. Unavoidable inaccuracy in application will lead to some areas being better protected than others. The liberal use of a poor sun screen is better than the conservative use of a powerful one spread thinly.

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# *Philosophical Medical Ethics*

## Medical oaths, declarations, and codes

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A common response to the new fangled concept of philosophical medical ethics is that it is unnecessary. Medicine has had its own scheme of ethics for at least 2500 years, and, although the moral rules of the Hippocratic Oath[1] have undergone considerable development and modification, much of modern medical practice is at least officially ethically inspired by its modern successors, the World Medical Association's declarations, including those of Geneva, London (the international code of medical ethics), Helsinki, Lisbon, Sydney, Oslo, Tokyo, Hawaii, and Venice.[1]

### Declarations of the World Medical Association

*The Declaration of Geneva* (1948, revised 1968 and 1983) is a sort of updated version of the Hippocratic Oath. It requires the doctor to consecrate his life to the service of humanity; to make "the health of my patient" his first consideration; to respect his patient's secrets (even after the patient's death); to prevent "considerations of religion, nationality, race, party politics, or social standing [intervening] between my duty and my patient"; to "maintain utmost respect for human life from its beginning" (until 1983 the wording of this clause required "utmost respect for human life from the time of conception"); and not to use his medical knowledge "contrary to the laws of humanity."[1]

*The World Medical Association's international code of medical ethics*, adopted in London in 1949 and revised in 1968 and 1983, requires, among other things, adherence to the Declaration of Geneva, the highest professional standards, clinical decisions uninfluenced by the profit motive, honesty with patients and colleagues, and exposure of incompetent and immoral colleagues. It states that "a physician shall owe his patients complete loyalty and all the resources of his science"; and it says that "a physician shall preserve absolute confidentiality on all he knows about his patient even after the patient has died."[1]

*The Declaration of Helsinki* (1964, revised 1975 and 1983) governs biomedical research in human subjects, and among its many principles is the stipulation that "the interests of the subject must always prevail over the interests of science and society."[1] It also requires that in any research the doctor should "obtain the subject's freely given informed consent."

*The Declaration of Lisbon* (1981) concerns the rights of the patient. These are declared to include the rights to choose his or her physician freely; to be cared for by a doctor whose clinical and ethical judgments are free from outside interference; to accept or refuse treatment after receiving adequate information; to have his or her confidences respected; to die in dignity; and to receive or decline spiritual and moral comfort including the help of a minister of an appropriate religion.[1]

*The Declaration of Sydney* (1968, revised 1983), on death, states

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among other things that "clinical interest lies not in the state of preservation of isolated cells but in the fate of a person" and it stipulates the much more specific rule that when transplantation of a dead person's organs is envisaged determination of death should be by two doctors unconnected with the transplantation.[1]

*The Declaration of Oslo* (1970, revised 1983), on abortion, remains, even after its recent revision, which changed "human life from conception" to "human life from its beginning," the most equivocal of all these declarations for it requires doctors both to maintain the utmost respect for human life from its beginning and to accept that attitudes towards the life of the unborn child are diverse and "a matter of individual conviction and conscience which must be respected."[1] Subject to a host of qualifications the declaration has always sanctioned therapeutic abortion.

*The Declaration of Tokyo* (1975, revised 1983), on torture, is unequivocal in forbidding doctors to "countenance, condone, or participate in the practice of torture or other forms of cruel, inhuman, or degrading procedures."[1] It also forbids force feeding of mentally competent hunger strikers.

*The Declaration of Hawaii* (1977, revised 1983), on psychiatric ethics, requires inter alia: that patients be offered the best treatment available and be given a choice when there is more than one appropriate treatment; that compulsory treatment be given only if the patient lacks the capacity to express his wishes, or, owing to psychiatric illness, cannot see what is in his best interests or is a severe threat to others; that there must be an independent and neutral appeal body for those treated compulsorily; that "the psychiatrist must not participate in compulsory psychiatric treatment in the absence of psychiatric illness"; that information about patients must be confidential unless the patient consents to its release "or else vital common values or the patient's best interest make disclosure imperative"; that informed consent for the patient's participation in teaching must be obtained; and that "in clinical research as in therapy every subject must be offered the best available treatment . . . be subject to informed consent," and have the right to withdraw at any time.[2]

*The Declaration of Venice* (1983), the most recent declaration of the World Medical Association,[1] reiterates the duty of the doctor to heal and, when possible, relieve suffering and sanctions the withholding of treatment in terminal illness with the consent of the patient or, if the patient is unable to express his will, that of the patient's immediate family. It allows the doctor to "refrain from employing any extraordinary means which would prove of no benefit for the patient" and permits the maintenance of organs for transplantation after death has been certified, given certain conditions.

In addition to these declarations, the World Medical Association has issued other statements about medical ethics: on discrimination in medicine, reiterating its abhorrence of such discrimination on the basis of religion, nationality, race, colour, politics, or social standing[1]; on medical secrecy, affirming the individual's "fundamental right" to privacy[1]; and on the use of computers in medicine, again affirming the patient's right to privacy but stating that the transfer of information rendered anonymous for the purpose of research is not a breach of confidentiality.[1] Other statements concern medical regulations in time of armed conflict, family planning, 12 principles of provision of health care, pollution, the principles of health care for sports medicine, recommendations concerning boxing, physician participation in capital punishment, medical manpower, and medical care in rural areas.

## The moral standing of the rules

Clearly the declarations of the World Medical Association contain a considerable body of moral rules that purport to govern medical practice. Why, however, should doctors take any notice of them? What is the moral standing of the declarations themselves? The question is given particular point as Britain has now left the World Medical Association having unsuccessfully tried to change its voting system to eliminate or reduce the ability of member states to buy voting power. Even if British doctors were morally bound by the Association's declarations when the British Medical Association belonged to the world body, now that the British Medical Association has left are they still thus bound? If so, why? If not, how can a change in medical ethics be justified on the basis of doctors ceasing to belong to a particular organisation?

One answer might be that the ethics of neither the World nor the British medical associations (as specified in the British Medical Association's handbook of medical ethics[1]) are the important ones. Instead, it is the General Medical Council's code of ethics, as specified in its little blue book,[3] that governs medical ethics in Britain because all doctors must by law submit to the General Medical Council's jurisdiction.

Is it then the law that provides a stable and coherent grounding for medical ethics? Surely not a stable grounding, for just as the World Medical Association changed its ethical principle from a requirement of "utmost respect for human life from the time of conception" to "utmost respect for human life from its beginning" so, considerably more dramatically, did British law change in 1967 from forbidding abortion except in the most dire circumstances threatening the mother to a law so permissive that many doctors understand it to permit abortion on request during the first trimester.

Sir Douglas Black, a past president of the Royal College of Physicians and currently president of the BMA, wrote that the change in the abortion law, occurring while he was a member of the General Medical Council, whereby abortion "changed over night from being a crime to being something entirely legal, under appropriate safeguards" was influential in promoting his belief that "medical ethics are relative and not absolute."[4]

(More recently Mrs Gillick's success in the appeal court caused medical ethics as represented in the General Medical Council's guidelines on prescribing the pill to change. They may well change again if the House of Lords reverses the appeal court's decision.)

## Laws are not the basis of medical ethics

I shall return to Sir Douglas's question of relative and absolute ethics; certainly the ease with which laws can be changed, the wide range of conflicting laws that exists in different societies, and, above all, the powerful intuition that almost everyone has that it is possible for laws to be immoral all indicate that it is not law that grounds our ethics, medical or otherwise. Indeed, the *Declaration of Geneva* itself indicates that medical ethics is neither self sufficient nor entirely reliant on national laws when its pledges the doctor not to use his medical knowledge "contrary to the laws of humanity, even under threat."

The underlying assumption is that medical ethics is bound and justified by some more fundamental moral principles. What, however, are these "laws of humanity?" In the next two articles I shall consider two types of moral theory—deontological and consequentialist—that attempt to answer this fundamental question.

The texts of all statements by the World Medical Association are available from the World Medical Association, 28 Avenue des Alpes, 01210 Ferney-Voltaire, France.

## References

1 British Medical Association. *The handbook of medical ethics*. London: BMA Publications, 1984:69-81.
2 Duncan AS, Dunstan GR, Welbourn RB, eds. *The dictionary of medical ethics*. 2nd ed. London: Darton Longman and Todd, 1981. (See Declarations.)
3 General Medical Council. *Professional conduct and discipline: fitness to practise*. London: GMC, 1983.
4 Black DB. Iconoclastic ethics. *J Med Ethics* 1984;**10**:179-82.