reduction occurred in the numbers of exchange transfusions (46 in 1983 and 23 in 1984) and deaths due to kernicterus (two in 1983 and one in 1984). Thus this study shows that early detection reduces the incidence of exchange transfusion, kernicterus, and death due to kernicterus.

In our survey the incidence of G6PD deficiency was unexpectedly high among the Malays. The incidence is known to be high among the Chinese; results similar to ours (3%) have been recorded for Singapore Chinese.[1] The incidence among the Indians was 1·3%. This could have resulted from intermarriage between the Indians and other ethnic groups, as could the higher incidence among the Malays. Thus it seems that we need to continue screening all ethnic groups in Malacca and perhaps in Malaysia. Early detection of G6PD deficiency with appropriate management can prevent mental handicap and related developmental disabilities.

I thank all my colleagues in the nursing home and private practice for participating in the study and Dr R Mahathevan, director of Health and Medical Services, Malacca, for his full support. My thanks to Mr Yong Yoke Foo for performing the laboratory tests and to my secretary, Miss Lim At Chiu, for typing the manuscripts.

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(Accepted 14 October 1985)

Philosophical Medical Ethics

"The patient's interests always come first"? Doctors and society

RAANAN GILLON

That doctors have a special moral obligation to their patients has been a recurrent theme in this series, and one to which I shall return in the next article. In this article I wish to pursue briefly some implications for medical ethics of the social context in which doctors practise. Such implications often contradict a common and absolutist medicomoral cliché that "the patient's interests always come first."

In earlier articles I have indicated how even if doctors are interested only in the welfare of their own patients there may be times when moral obligations to others supersede their moral obligations to a particular patient. The most obvious example is when a doctor can satisfy one patient's requirements only at the expense of another's. Such examples multiply when the interests of one doctor's, specialty's, hospital's, or health authority's patients are incompatible with the interests of some other group of patients, and some principle of justice is needed to decide which patients' interests are to come first, and which are not. Given the vigorous disagreement among doctors and within our society generally about how to resolve such conflicts, given that doctors have no special skill in the matter, and given that most of the resources for satisfying the interests of any patients are being provided by a democratic society, there seems little doubt that society's representatives should be closely concerned with making these decisions, and indeed the structures for such decision making increasingly ensure this.

Similar considerations apply when we look at the potential medicomoral gap between the medical profession's obligations to its (collective) patients and the interests of sick people in general. The profession has long asserted in its official ethical codes that a doctor's primary moral obligation is to his patients,[1,2] and although it avows a principle of "service to humanity"[2,3] and even that "it is the mission of the medical doctor to safeguard the health of the people,"[4] it is clear that "the health of my patient will be my first consideration."[2] Although such medicomoral priority for our patients is laudable, it tends to leave people who are not patients out in the cold, often literally, and societies have become increasingly concerned to develop systems to ensure that all sick people can become patients and thus obtain the special moral concern of the medical profession. Nevertheless, vast areas of the world remain virtually without doctors, and in others, including our own, the distribution of medical services is uneven and the medical care of "the people" suffers accordingly.[5] Even if it is unrealistic to expect the medical profession to take seriously the sort of transnational moral obligation to all sick people extolled by Sir Theodore Fox in his Harveian oration[6] (which would certainly demand a radical restructuring of our attitudes, including perhaps some sort of compulsory international medical service during professional training to meet such an obligation to the otherwise undoctored sick) we should at least acknowledge sympathetically a legitimate area of social concern to achieve equitable distribution of medical care.

Society versus obligations to patients

In practice the medical profession accepts, at least implicitly, a broad range of social obligations that may override the interests of individual patients. The British Medical Association groups doctors' professional relationships into three categories[7]: therapeutic, impartial expert, and (non-therapeutic) medical researcher. The category of the medical researcher is implicitly justified by allowing medical obligations to non-existent patients of the future to take priority over medical obligations to existing patients. Preventative medicine (regarded by the BMA as an aspect of "impartial expert" medical work) implicitly acknowledges that medical concern for potentially sick people may in some circumstances take priority over therapeutic medicine. If the profession really believed that the patient's interests always come first then it presumably would not allow medical time and effort to be diverted away from direct therapeutic activity.

Quite apart from acknowledging that obligations to other patients, sick people, sick people in the future, and even merely potentially sick people may conflict with obligations to current patients,

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Br Med J (Clin Res Ed): first published as 10.1136/bmj.292.6517.398 on 8 February 1986. Downloaded from http://www.bmj.com/ on 13 March 2024 by guest. Protected by copyright.

the medical profession also acknowledges implicitly that other legitimate demands of society may sometimes override doctors' obligations to their patients. In my discussion of medical confidentiality I outlined several exceptions, including legal requirements, in which, according to the British Medical Association and the General Medical Council, the patient's interest could legitimately be subordinated to the interests of society. When doctors ration scarce lifesaving medical resources (such as renal dialysis) they subordinate the patient's interests to those of society. When mentally sick patients are locked up against their will under the Mental Health Act because they are a danger to others the patient's interests are subordinated to those of society. Other examples include a wide range of medical interventions designed to protect society, such as medical examinations for driving and flying licences, military medical assessment of fitness to fight,[8] and medical examination of police suspects to detect drunkenness and excess blood alcohol or illegal drugs and weapons hidden in various body orifices.

Thus the medical profession does at least implicitly accept in practice that though its members have a strong obligation to their patients this is not an absolute obligation and may in some circumstances be overridden by their obligations to society. But despite this acceptance doctors often talk and think as if they believe that they invariably give absolute moral priority to their patients over the moral demands of society, as if indeed "the patient's interests always come first." It is a contradiction that needs to be confronted openly.

There certainly is a case to be made for doctors to give an absolute moral priority to their individual patients, but it carries with it various implications. Among these are the rejection of the currently accepted medical practices indicated above in which doctors do in fact give moral priority to their social obligations and acceptance that when conflict between the requirements of patients and those of others does arise non-medical individuals or organisations should be given the task of weighing up the competing claims fairly to try to ensure that justice is done.

Alternatively, the profession may decide to acknowledge that it does have moral obligations to the various social networks of which it is a part and that it is obliged to balance these obligations against its obligations to its individual patients and its members. Such weighing up is not easy, but a necessary condition for doing it is that the profession makes itself aware of what the various competing moral demands made by society on it actually are. That too is a difficult task, given that there is no single entity "society" but only a complex interlinking network of relationships between groups of people. It would surely be made easier if the profession welcomed, far more than it already does, into its deliberations about its moral obligations various representatives of these networks, as well as those whose professional expertise includes understanding these social networks and their interaction.

Medicine's hidden relations with society

Three more hidden aspects of medicine's relation with society are worth special mention as being at least indirectly relevant to medical ethics—and possibly leading to conflict with the interests of the individual patient. The first is the contribution of social factors to the causation of disease and illness, health, and wellbeing. The second is the contribution of social factors to doctors' attitudes about a wide range of issues, not least to their attitudes about medical ethics. The third is the struggle for power between the medical profession and other social groups.

The first of these aspects is relevant to medical ethics as it indicates an area of appropriate medicomoral concern that is widely ignored by the medical profession. If death, disease, and illness are caused by social factors; if changes in these social factors are both possible and can prevent or ameliorate these maladies; and if doctors as a profession are morally committed to these objectives then it follows that part of the medical profession's moral obligation is to understand and try to prevent the social causes of death, disease, and ill health.[9-11] It is, of course, an obligation that is well appreciated by some sectors of the profession, as shown by medical concern with, for example, the medical effects of nuclear warfare,[12-17] poverty and social class,[5 18 19] unemployment,[20 21] etc.

The second sociological factor of relevance to medical ethics is the influence of class on the medical profession's collective and individual attitudes. I have already suggested that decisions about what abnormalities are classified as diseases are in part determined by social evaluations and that doctors' evaluations are likely to be firmly within the norms of the ruling class, whatever it happens to be. Recall Professor Engelhardt's charming example of "drapetomania": a "disease" spotted by a doctor in the American south which caused slaves to keep running away from their masters.[22] In a plural society it seems particularly important to be aware of such socially determined attitudes, which are usually hidden, and to heed the warnings provided by such obviously unacceptable medical assumption of ruling class norms as in Nazi Germany,[23] Chile,[24] South Africa,[25] and Russia.[26] Nor need such hidden sociological influences on medical attitudes be dramatic ones to be resented by those who do not share them—medical assumptions of class superiority were criticised in a Department of Health and Social Security report on the doctor patient relationship.[27] Although there is enormous variation among doctors, it is probably reasonable to say that in Britain medical norms are biased towards those of the white middle class conservative Englishman.

There is nothing necessarily wrong with such norms, but nor is there anything necessarily right with them. Like all other attitudinal norms, they need to be assessed critically. To do so the first requirement is to discover what they are, for in many cases we are simply unaware of them, or of their power. Only when we have become aware of them can we give them the critical assessment that we expect and wish to give to the overt social demands made on us as a profession—for example, by parliament, the law, the media, and pressure groups.

Finally, the fairly powerful sociological status of doctors and the medical profession is likely to have important effects on our behaviour and the behaviour of others towards us. We need to understand, for example, the self interested and power maintaining aspects of our professional norms and rigorously avoid conflating them with aspects aimed at protecting patients.[28 29] When, for example, we insist that doctors must not advertise their services both components are present,[30] and in relation to medical ethics professional self interest is of comparatively little weight. Sociological investigations, aggravating though they may be, are surely a necessary antidote to a professional tendency for complacency and self deception about what we as a profession are really doing, and perceived to be doing. The debate between those who, like George Bernard Shaw, see the profession as a conspiracy against society[31] and those who, like Robert Louis Stevenson, see doctors as the flower of all mankind[32] continues unabated.[33-36] As usual, there is some truth in both points of view; although many of us doubtless prefer Stevenson's account, it is important to understand how and why our behaviour as a profession provokes such rejection as it does.

Social and psychological influences on medical ethics

I should perhaps end by addressing a likely objection. At the outset of this series I declared that philosophical medical ethics was not a sociological, psychological, anthropological, historical, or religious enterprise, yet here I appear to be leaning heavily on such perspectives. There is no contradiction. Although I stand by the original claim, in pursuing the "critical evaluation of assumptions and arguments" that is at the heart of philosophical inquiry it is important to be aware of the genesis of those assumptions, which so often form the premises of the arguments under assessment. We know, for example, that some social and cultural loyalties and pressures, some religious attitudes, and some psychological factors (including some aspects of self interest and partiality) can lead people to beliefs, assumptions, and arguments, moral and otherwise, which more detached analysis repudiates. To distinguish between the acceptable and the unacceptable variants of such social and psychological determinants it helps to be aware of both their existence and of their characteristics.

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Occupationless Health

Financial and local action to help the unemployed

RICHARD SMITH

Most unemployed people, and particularly those with families, have incomes much lower than when they were working, and many slide into poverty.[1-3] More than anything else poverty may be the link between unemployment and poor health[4]; so raising the living standards of the unemployed may be one of the most effective ways of improving their health. This can be achieved by increasing benefits and their uptake and by reducing the price of travel, entertainment, educational facilities, and the like for the unemployed. The Archbishop of Canterbury's commission also makes the important point that how benefits are made available matters as well as how much is given.[5] At the moment the experience of claiming benefits is becoming steadily more stressful and humiliating.

Benefits for the unemployed

The government recognises that our outdated social security system is falling apart under the enormous strain and has embarked on what it has called "the most fundamental examination of our social security system since the second world war."[6-9] The present system, it says, is too complex, fails to support those who need it most, and leaves many people trapped in poverty and unemployment. The aim of the suggested reforms is thus to simplify the system and get more benefits to those who need them most. But another important aim is to create a "secure financial base for the social security system," and many groups are suspicious that these much trumpeted reforms are in fact a cost cutting exercise. Critics are worried that the introduction of the reforms in April 1988 may increase the gap between the rich and the poor, a gap that has been widening steadily in Britain since the second world war.[6]

The main proposals relevant to the unemployed are the replacement of supplementary benefit by income support and of the family income supplement by family credits; housing benefits are also to be substantially reformed and simplified. In addition, dozens of existing benefits will be replaced by the social fund, which will make loans rather than grants. What will happen to unemployment benefit is not yet clear, and a government study is now in progress "to see what improvements can be made to the arrangements for paying benefits to the unemployed."[9]

What matters most to the unemployed is whether they will have more or less money under the new system, and this will not be known for sure until the new system begins. But the government has calculated that the families of the long term unemployed will be £1·40 a week better off under the new system. The Policy Studies Institute, however, says that the long term unemployed with families will be either no better or worse off.[10] This is because many of the single payments currently made—for items such as furniture, bedding, and cookers—are to be replaced by loans that will have to be repaid. The institute says that the average family claims £3·20 a week in such payments and so will be £1·80 a week worse off. The National Consumer Council has made similar calculations and also concludes that unemployed families will on average be £1·60 a week worse off.[11] This may sound like a paltry sum to those who regularly spend this amount on a lunchtime gin and tonic, but the proposed basic rate for unemployed couples is £48 a week; those with children will get a family premium of £5·75.

The council also points out that under the new proposals it will still be very difficult for the unemployed to do any casual or part time work without losing benefit.[11] At the moment they can earn £4 without losing benefit, and under the new scheme it will be increased to £5. If it had been uprated with inflation since 1975, the council points out, it would now be worth £10. Another snag for the

British Medical Journal, London WC1H 9JR
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