Papers and Originals

Medical Ethics*

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Codes of professional ethics, like the Highway Code and the Ten Commandments, receive very little consideration once the "L" plates are taken down. This is not because they are ignored, but because they have been absorbed and have become part of our way of life which we do not think about and feel that we have no need to think about unless and until a crisis is upon us. The precise definition of "adultery" or of "a patient" is of no interest until it becomes personally urgent. What constitutes advertising in the pejorative sense becomes a matter of concern only to those who are experiencing the desire to advertise or suffering the effects of some other practitioner's efforts in this direction. What is true of individuals holds for the profession in general. When the profession as a whole has to face new and difficult problems such as abortion, euthanasia, or the transplanting of organs there is a sudden revival of interest in the code of ethics in the hope that in the code there will be found a solution to the individual practitioner's difficulties. The medical profession is approaching a crisis of this kind at the present time. The Western World is changing over from a community or communities based more or less firmly on what is called the Christian Ethic—which, however vaguely defined, is and has always been perceived as a powerful force in shaping conduct of all kinds—to one based on humanist or sociological principles. These are even less clearly perceived or defined but have one clear-cut consequence.

Decisions as to conduct can no longer be referred to a generally accepted set of principles but have to be taken afresh in each individual case by each individual practitioner. It may be that in the eye of history it is an important advance that individual man should take full responsibility for his own destiny, but it leads to an alarming proliferation of problems. The widespread and renewed interest in medical ethics which can be observed in the journals and in recent publications is the natural response of a profession groping for solutions of new difficulties which are continually arising; but whether this is the right place to look for those solutions may be open to doubt.

Professional Ethics

One of the purposes of this paper is to consider this question, but we shall make no progress until we are clear in our minds about the real functions and limitations of professional ethics as we know them at present.

The existence of a code of ethics is often regarded as one of the most important characteristics which distinguish the occupations known as professions from all others. So clearly is this recognized that one of the first steps taken by any body or group which aspires to recognition as a profession is to establish one, and to set up some form of disciplinary tribunal to deal with members who offend against it and then to seek from Parliament statutory powers to inflict sanctions on them. Why is this? And what really distinguishes a profession from other types of occupation?

The late Mr. Justice Brandeis,[1] of the U.S. Supreme Court, defined what he called the peculiar characteristics of a profession in these terms:

> First. A profession is an occupation for which the necessary preliminary training is intellectual in character, involving knowledge and to some extent learning, as distinguished from mere skill.
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> Second. It is an occupation which is pursued largely for others and not merely for oneself.
>
> Third. It is an occupation in which the amount of financial return is not the accepted measure of success.

Several inferences may be drawn from this definition of a profession. Firstly, a professional man does not meet his patients or clients on equal terms. He is consulted for his special knowledge and experience by people who are in no position to make an informed or valid judgement about his skill or ability or integrity. This situation is explicitly recognized by the two words one or other of which is invariably used to describe the persons who consult professional men. "Patient" is derived from the Latin word *patiens*, meaning one who is suffering. It also means one to whom things are done—that is, the passive party. "Client" is derived from the Latin *cliens*, which originally meant one who listens and which later acquired the more technical meaning of a plebeian who was under the protection of a patrician—that is, a person under protection or a dependant. "Customer" is an altogether sturdier individual who simply makes a habit of buying where he gets the attention he demands. Secondly, the discipline of the market, which, at least in theory, controls the conduct of the trader, is quite inappropriate to control though not by any means wholly without effect on the conduct of the professional man.

Functions of a Code of Ethics

The primary function of a code of professional ethics is to adjust the balance of power so as to protect the patient or client against the practitioner who has the immense advantages which are derived from knowledge and experience. This is not, of course, exclusively a professional problem, nor is it in any way new. One of the functions of the City Guilds was to protect the public from exploitation by the various tradesmen on whom it was dependent. At the present time the problem of consumer protection in commerce is constantly under discussion and various attempts are being made to achieve it, including the elaboration of codes of various kinds.

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But what really distinguishes the professions seems to be the fact that they have developed their codes spontaneously in response to a general feeling in the professions themselves of the need for a professional discipline.

A secondary but no less important function of a code of ethics is to protect the main body of practitioners who comply with its provisions against exploitation by the black sheep who are prepared to defy them. This is the aspect of professional ethics which receives most attention in the press and consequently is the aspect of which the public is mostly aware. Undue attention to it produces a distorted picture and leads to the use of such emotive words as "restrictive practices." Rules which are designed to prevent exploitation of the public or of law-abiding practitioners are only restrictive in so far as they restrict undesirable activities. Professional codes, like all regulations, however, inevitably contain rules which become out of date when the conditions that gave rise to them no longer exist. Such obsolete rules may produce truly restrictive practices if they continue to be enforced.

This, then, is the real stuff of professional ethics. They are codes emanating from a general consensus of each profession and reflect the profession's own sense of the need for a discipline, primarily to prevent exploitation of the public by its superior power of knowledge and secondarily of the profession itself by its dissident members. In this country the professions can justly claim to have succeeded to an impressive extent in this exercise of self-discipline and to have retained the respect of the public. It is to be hoped that the investigation which is at present being conducted into the professions at the Government's request by the Monopolies Commission will vindicate this claim.

In some important respects, however, professional codes have failed to develop as fully or as quickly as they might have done. In medicine the code provides guidance to practitioners in a therapeutic relationship with individual patients. It has never dealt adequately with problems outside this sphere, though it is fair to observe that until recently it was not often called upon to do so. For example, no definite guidance has been forthcoming on such classic dilemmas as the duty of the doctor who has a patient with a staphylococcal infection who insists on working in a food shop in spite of the doctor's advice ; or a patient suffering from epilepsy who insists on driving his car and is known to be irresponsible about taking his anticonvulsants ; or a patient under treatment for syphilis who insists on sleeping with his wife. In all these cases the duty to the patient conflicts with a possible duty to other members of society, and the doctor has to find his own solution to the dilemma.

Professions and the Welfare State

Much the same phenomenon can be observed in the ethical relations between the professions and the Welfare State. The professions tend to regard the public as a collection of individuals, and their ethical codes deal with the relations between the profession and individuals. But the National Health Service and the Legal Aid Scheme have introduced a third party into this relationship—the public in its role as the State and the paymaster. So far the concept of ethical obligations to the State has developed slowly. It is perhaps too soon for these difficult gestatory processes to have produced anything significant, or it may be that the existence of statutory rules, statutory terms of service, and special statutory disciplinary bodies has inhibited the spontaneous development by the professions themselves of a code of conduct towards the State. It is none the less unfortunate. As the costs of litigation and the costs of medical treatment escalate there is a risk that the State, for its own protection, will be tempted to try to control professional decisions by regulation, unless codes of professional behaviour develop spontaneously that include not only duties to the individual but also duties to the State. There is a risk that the fashionable notion of cost-effectiveness may be imposed on both professions.

There have been, however, some hopeful developments. Lawyers are much closer nowadays to the facts of life in private practice than most of the medical profession and have from the beginning of the Legal Aid Scheme felt the need of some guidance to replace the limits imposed on their professional advice by the depth or otherwise of the fee-paying client's pocket. Most of them regard their duty to protect the Legal Aid Fund seriously and hesitate to advise a course which is going to be very expensive unless it is crucial to the client's success. Most try to adopt as their standard a fee-paying client whose means are just enough to permit him to litigate in an economical way and to pay the costs of the other side if he loses without being ruined but no more. In this way they try to withhold the advice they might give, on the one hand, to a "cost no object" client, and, on the other, to a client who would be ruined if he were to lose his case. They are also slowly and painfully evolving ways of resolving the conflicts of interest which sometimes arise between their clients and the Fund—for example, when an assisted client refuses to accept a modest though not unreasonable offer of settlement. But as time passes and the qualifying limits for those entitled to legal aid are raised, the number of lawyers with experience of the rigours of private practice, with all the restrictions imposed by their client's inability to afford to litigate on first-class standards, will diminish and memories of the harsh facts of real life will fade and the need for a new professional ethic to deal with these problems will become more pressing.

Both professions are rightly jealous of interference by the paymaster in their professional decisions, but their very fear and resentment of this so-called outside interference may be inhibiting the spontaneous development of a new ethical code which will take account of the undeniable fact that the State is no longer a mere outsider.

Analogous developments have taken place in the medical profession, but as yet there have been virtually no authoritative pronouncements by the disciplinary bodies of either profession on this aspect. In consequence the ethics of this new situation are still inchoate and undefined.

This is not a criticism. It is simply the observation of the highly significant fact that when conflicts arise between the doctor's duty to his patient and his duty as a citizen to society the professional code has not evolved satisfactory solutions. The traditional response to this situation, which is, of course, to stress the overriding duty of the doctor to his patient, is no solution, because it disregards his obligations as a citizen and ignores the profession's very real sense of conflict. Hitherto it has been possible to resolve the ethical (and legal) problems raised by abortion or sterilization by insisting on the essentially therapeutic quality of either operation, and so to contain them within the existing limitations of the code. But this has led, especially in the case of abortion, to such an attenuation of the therapeutic element that it is no longer tenable.

New Problems

If this analysis of the functions and contents of professional codes of ethics is right, it is obvious that solutions of the new problems arising out of the new role which medicine is being called on to play in society will not be found in the existing code, which, as I have said, has been developed to deal with the therapeutic relationship. These new problems arise out of the changing attitude of society to such things as abortion, and possibly euthanasia, and from new developments in medicine in matters such as transplantation of organs, clinical trials, the contraceptive pill and other devices, and cosmetic surgery. All those have one thing in common. Each involves a relationship which is medical in nature but non-therapeutic in essence.

When the problem is stated in this way it becomes immediately apparent that there is little to be gained by looking for solutions to an ethical code which has been evolved to meet an entirely different situation. Nor is development by analogy, that dangerous growth process so beloved by lawyers, likely to do more than mislead when attempts are made to extrapolate the rules applicable to one situation to a fundamentally different one.

This conclusion seems to be generally accepted, but there are wide differences of opinion on how to deal with these new problems. There have been disturbing indications that some members of the profession are disposed to resolve the problems by abdication. In the discussions on the Abortion Bill there have been suggestions that if so-called social grounds were to be introduced as a justification for termination the decision should be made by some non-medical person or body. Similarly it has been proposed that lay committees might be set up to decide which patients with chronic renal disease should be put on permanent dialysis. It is easy to understand the motives behind these proposals and it would be quite wrong to dismiss them as discreditable attempts to pass the buck. It is much more to the point to inquire whether they would in practice achieve anything.

In the last analysis the decision whether to insert the curette or put the patient on the dialyser or to submit a patient to a clinicial trial must inevitably remain with the practitioner. It is inconceivable that the profession could tolerate a situation in which it is told to undertake procedures of this kind by any other person or persons. Liberty to refuse to act against conscience (which means much more than against religious scruple) cannot be taken away. This immediately reduces the role of the lay committee or expert to, at most, authorizing the procedure if the practitioner agrees to undertake it. In fact, with the exception of the social worker in cases of abortion or euthanasia, the lay committee would be wholly dependent on the medical profession for advice and guidance, so that the decision would in practice remain with the profession.

It is difficult to see how any outside body can do more than protect the doctor in his positive decisions and expose his negative decisions to criticism. The role of such lay persons can never be more than advisory. There are, of course, advantages in being able to discuss such difficult decisions with other people who may have different views or different sources of information, but the doctor cannot share the decision any more than the judge. This is, I think, clearly recognized in the recent report of the Committee of the Royal College of Physicians[2] over which Sir Max Rosenheim presided, but, if I may respectfully say so, I have some difficulty in agreeing with the view of that committee that the ultimate responsibility for the proper conduct of clinical trials rests with the hospital or medical school authorities in whose premises such trials are conducted. It may be that a patient who has suffered damage in such a trial would be able to sue the hospital or medical school as employers of the doctors concerned, but the hospital would undoubtedly be entitled to look to those doctors to pay the resulting damages and costs.

Difficult Problems

So far these observations have been almost entirely unconstructive ; but it is necessary to clear the ground, and I am afraid that I have no ready-made solutions to these extremely difficult problems with which the medical profession are going to have to live in the future. It may help, however, to analyse more closely the framework within which solutions may be found. The conclusion which has emerged so far is that the ultimate decision to undertake or to refrain from each of these non-therapeutic procedures must be made by the practitioner himself. The important problem is, therefore, how he is to guide himself or, in lawyer's language, how he should direct himself when he is considering how to exercise his discretion. The first step is to fix the limitations within which his discretion must be exercised. The extreme limits are set by the law, because in a civilized society ethical decisions must not involve unlawful conduct. The criminal law is the limit on one side, prescribing what must not be done ; on the other the civil law determines what must be done in discharge of the doctor's obligation to his patients or other people with whom he is dealing. In other words, certain actions will be unlawful and prohibited—for example, a termination of pregnancy for reasons not recognized by the law ; the removal of a kidney or a cornea from a cadaver before the law was changed to permit it ; the amputation of a finger to enable a man to avoid military service.

Other actions will be required to be done to avoid a finding of breach of duty. Some of these limitations are reasonably clear ; others are ill-defined and even speculative. At common law maiming was a criminal offence, and there is a theoretical possibility that to remove a kidney from a healthy donor might amount either to maiming or to the offence of causing grievous bodily harm. The question has never arisen for decision and probably never will, because it is inconceivable that any doctor who performs such an operation in good faith—that is, without some dishonest motive—would ever be prosecuted. Indeed, it is almost certainly wrong, though customary, to formulate the problem in this way. I agree with views expressed by Professor Daube at the Ciba Symposium on Ethics[3] that the law should and would approach the removal of a paired organ from a donor as part of a single therapeutic undertaking designed to cure or relieve the recipient and regard the law about maiming or grievous bodily harm as irrelevant. These, then, are the extreme limits and leave so wide a field that they afford little help.

The field can be narrowed a good deal further by the law of trespass—that is, it is an actionable wrong to interfere bodily with another person without his consent in the absence of clear therapeutic indications. This raises a dilemma which has been the playground of jurists for centuries and which looks like becoming a medical nightmare in the twentieth century—"When is consent not consent ?" The jurists have produced many learned but unsatisfactory answers ; the doctors seem at present to be about to repeat the same sterile disputation. It is extremely difficult to produce any satisfactory abstract answer. Phrases such as "real consent," "informed consent," etc., merely raise new questions—what is meant by "real," what is meant by "informed" ? But in practice and in the individual case it is not very difficult to decide whether someone has or has not effectively consented. Judges or juries manage to do it many times a year. If the consent has been obtained by trick the law will treat it as no consent ; on the other hand, failure to provide all the relevant information will not necessarily invalidate it.

The law of England, being essentially pragmatic, sets different standards for different cases. For example, it is almost impossible to obtain an annulment of marriage on the ground that consent to marry was obtained by deceit, so heavy is this burden of proof of non-consent. The reason is that otherwise it would lead to innumerable nullity suits. Apparent consent is treated as real consent. On the other hand, a girl under 16 may in fact consent to sexual intercourse but it is no consent in law. Generally speaking, the law puts a heavy burden on the party who asserts that his apparent consent was not valid. In certain special cases where one party is in a peculiarly weak position in relation to the other the law requires *uberrima fides*—that is, good faith and disclosure of all relevant facts. The relation of doctor and patient is one of these. Underlying the law's approach is the presumption that in general people over 21 are grown up and must take their own decisions. The law is not concerned with the motives or even the pressures which lead to their decisions unless the latter are so severe as to overwhelm their minds.

Rights of a Patient or Donor

These reflections may help to clarify the doctor's difficulties. The person concerned should, surely, be treated as a responsible adult whose right it is to make his own decisions unless there is some good reason to believe that he is in some real sense incapacitated from doing so. He will be entitled to demand a bona fide statement in broad terms of the risks to life or future health or of pain and discomfort involved in the contemplated procedure or to a frank admission that in the given circumstances these cannot be assessed with any accuracy. He must also be given a fair appreciation of the probable value of his sacrifice, to the recipient if he is to be a donor, and to medicine in general if he is to enter a clinical trial. If after that he is prepared to submit to the procedure or to enter the clinical trial, and the doctor is prepared to undertake it, that should be enough. The greater the risk the greater will be the obligation on the doctor to ensure that the patient understands. The lesser the risk the lesser will be the onus on the doctor. It is merely pedantic to insist that the patient be fully informed of a mass of facts which he cannot assimilate or assess.

It is sometimes said that the doctor should ensure that the consent is not only "informed" in this sense but that it is "free"—that is, given without undue pressure from other sources. An example of this is the proposed kidney donor who may be under strong pressure to consent either from affection for the patient or from the other members of the family. It is, I believe, the practice in certain centres in the U.S. to require the proposed donor to be interviewed by a psychiatrist in order to determine whether he is under pressure and if so to counteract it. I suspect that the advantages of this practice lie mainly in its value as an insurance policy against litigation rather than in the validation of the consent.

It is doubtful whether the doctor can or ought to concern himself with this aspect. An adult has as much right to donate a kidney to someone he loves as to give up his career for his wife's happiness if he decides to do so. How can anyone but the donor assess whether it is better to do as the family wish or to retain his kidney? This is one of the burdens which life imposes, and there is no possible way in which anyone else can decide whether his future will be made or marred by yielding to or resisting the family pressure. He may need and indeed welcome any help he can get in making his decision, but in so stern a situation nothing is gained by attempting to take the decision out of his hands.

Rights of a Spouse

Termination, sterilization, and "the pill" raise other complications, for a third party is involved—namely, the spouse. His or her consent, if it can be obtained, is invaluable, but if it is withheld a difficult situation will arise. There are theoretical legal risks if it is decided to proceed without such consent, but there are no decisions on the rights of a spouse against the doctor who proceeds with the consent of the patient but without the consent of the spouse. In principle the consent of the patient should suffice, leaving it to the matrimonial law to decide the rights of the spouses between themselves consequent on the decision of one of them. Each of them is a free adult. Neither possesses the right to control the decisions of the other, but each of them has obligations to the other, breach of which may affect their marital status.

Cosmetic Surgery

Cosmetic surgery is a much simpler case, but it has been suggested that cosmetic operations are ethically unjustifiable in the absence of some therapeutic indication. But is there any justification for making it a rule of ethics that such operations should not be performed unless they serve some therapeutic purpose? This is to introduce the therapeutic test, which has failed so dismally in the abortion context, into another field. Will not the only result be another unacceptable attenuation of the concept of therapy? Here again the principle of the patient as an adult should, surely, be applied and he or she should be entitled to have such cosmetic surgery as is desired provided that the surgeon is prepared to operate and can do so without unreasonable risk and with good prospects of success. Of course he must not be a party to some illicit purpose such as concealing identity. Each surgeon should be entitled to decide for himself whether he personally is prepared to operate where there are no real therapeutic indications.

Renal Dialysis

I have not so far mentioned the particular problems raised by long-term renal dialysis or of taking organs from the cadaver. I do not believe that the serious difficulties which arise from these situations are susceptible of ethical solutions. In the case of dialysis the dilemma is essentially economic. It is a question of how to use available resources. But it is unrealistic to assume that the community will be willing to accept an unlimited liability to preserve the life of some of their number at the expense of other communal advantages. Those who undertake the care of these patients are likely, so far as I can see, always to have to make choices between those to whom to offer dialysis and those from whom to withhold it. Such a decision cannot be made on ethical grounds, since there is no abstract principle by which one life can be judged against another. These decisions must therefore be essentially arbitrary. Hideous and difficult as they are they have to be made, and each practitioner in this field will have to accept this responsibility and work out his own guide-lines. There is unhappily nothing new in this situation. In wars and in disasters of all kinds decisions of this type have to be taken, and not only by doctors. What makes the dialysis decision so peculiarly painful is that it must be taken not in the agony of crisis but in the calm of the consulting-room.

The problems arising from the removal of organs from the cadaver are primarily legal and solutions must be sought in the amendment or clarification of the law. In the meanwhile respect for the wishes of the deceased and of the surviving spouse will normally point to the decision.

Conclusion

The only conclusion which seems to emerge from this discussion is that in these non-therapeutic situations both practitioner and patient (for the want of a better word) are free to, and must, make their individual decisions: the practitioner to undertake or decline to undertake the procedure, the patient to submit or not to submit to it. Each must fully respect the right of the other to make his own decision, and, while either may attempt to persuade or advise, neither must in any way seek to force his opinion on the other. To those who look for the help of a prescribed code this is cold comfort. Yet it is the inevitable, logical result of contemporary thought which rejects traditional solutions and asserts the right of each man to make his own decisions about his own life. No useful purpose is served by attempting to blur the stark outlines of the difficulties which are involved in these decisions. It is much better that all of us should recognize and accept the personal responsibilities which we assume when we claim the right not to be bound by traditional ethical concepts.

References

[1] *Business or Profession?* Mr. Justice Brandeis, 1933. Boston.
[2] *Brit. med. J.*, 1967, 3, 429.
[3] *Ethics in Medical Progress.* Ciba Foundation Symposium edited by G. E. W. Wolstenholme and M. O'Connor, 1966. London.