Ethics and Health

Ethics and health services: the debate continues

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As technological options continue to proliferate, so do questions about choice of treatment. The author reviews some of the values and priorities on which decisions can be based. Since these are matters that affect societies as a whole, they must be fully and openly discussed, with the active participation of all concerned, including the public for whom the health services exist.

Even in an environment like Switzerland’s, which remains materially very well endowed, the choices to be made in allocating resources for health are difficult, and the public needs to be aware that priorities must be established. We are moving from a time of “being able to choose” (with the dramatic increase in possibilities produced by progress over the last half century – which we managed to finance) into a time of “having to choose”. When this need for choice arises, it is seen as a cutback in care and services, and as such is unpopular both with health professionals and with the public. If these choices are to be seen as acceptable they have to be made openly and explicitly. The public must therefore be willing to participate in a genuine discussion of the issues involved.

I would like to make the following comments on Dr Liisberg’s interview with Professor Bankowski and on the article by Dr Davis and Ms Stark, both in World Health Forum Vol. 16, No. 2, 1995 (1,2) and both of which focus on ethical questions arising in day-to-day health work. First of all, I am grateful to these authors for stressing the need for professionals to work with non-professionals (auxiliary personnel who have not had the benefit of extensive training) in a spirit of mutual understanding and respect. Dogmatic approaches, such as the refusal to discuss unorthodox types of care, can have grave consequences in that, if nothing other than professional care is deemed acceptable, the underprivileged can find themselves with no care at all. In fiction and drama we are sometimes shown situations in which physicians state that, if the patient will not be treated by the methods they advocate, no other care will be provided – even in matters of life and death. That is not usually the way things are in reality, but we must always consider the environment in which we work, especially the sociocultural environment, and keep today’s truths in perspective, since they might conceivable be the errors of tomorrow.
Broadening participation

An ethical feature that some of these situations have in common is the separation of functions. For instance, those setting standards of care are not usually those who have to manage resources economically. Thus the standard setters often do not see it as their problem if insistence on sophisticated standards means that patients are left with no care at all rather than cheaper and simpler forms of care. It is rightly stressed today that health care depends on teamwork, and that we must all learn to collaborate with different partners. In this context, our understanding and practice of interdisciplinarity must include non-professionals, the patients and their families, and many sectors other than health.

Concerns about how the health services ought to work fall into the following two broad categories.

- Mainly moral (and in part legal) considerations such as: what do we have the duty to do, what are we allowed to do, and what should we definitely not do? This includes, for instance, questions arising currently about terminal care and dignity in death, and the need to know the ethical and legal limits within which diagnosis and treatment must take place.

- More managerial considerations such as assessing needs and distributing resources appropriately. What is the best use of resources in response to the variety and intensity of proven needs? And what is the right way to decide between competing demands?

The need to raise these matters with students and to get them to discuss specific situations is increasingly recognized in medical faculties and training centres for other health professions, especially nursing. However, this awareness has not yet been adequately translated into action. Although staff see the value of teaching about ethics, they find it hard to make room for it among the traditional subjects on the curriculum, partly because, as we know, every teacher is convinced that his or her own area is the most important. Furthermore, the teaching of ethics needs to be interdisciplinary, and this approach to teaching is slow to catch on.

The matters should also be broached in the schools, for example in the subject area known variously as civics or "citizenship education". In this connection, a report for the French National Committee on Ethics in Life Sciences and Health Sciences states the following:

The value of making pupils aware of the ethical issues raised by current research in biology, medicine and health is universally acknowledged... It is therefore important that, from school onwards, future citizens should be better equipped to understand the dilemmas raised by scientific research today, and to appreciate the significance of the personal and societal choices they will have to make. There is an ethics of the individual and an ethics of society. In the 21st century, our society will not continue to be genuinely free and democratic unless it shares knowledge and reaches agreement on a minimum of basic values (3).

Establishing criteria

On health policy at country level, it is worth mentioning the work done recently in the Netherlands and Sweden on setting priorities, and the ethical issues involved. In its report “Choices in health care” (4), a committee appointed by the Government of the Netherlands set out criteria for what should be included in the basic health care package. The committee considered that a clear and firm approach was needed, and that it should be possible to "close the door" to exclude certain services or technologies from the basic health.
care package. An assessment system was developed with four filters, each of which is a criterion that must be satisfied before a given service can be included in the basic package. The first three filters select procedures on the basis of their necessity, their efficacy and their efficiency; the fourth excludes care that could be left to individual responsibility.

In terms of biomedical innovation, the committee asks a crucial question that is likely to become even more important in the future: must everything that can be done be done? Their own answer is, in principle, no. Though technological developments offer obviously promising possibilities, they also present certain dangers. Several authors insist on the need to control the processes by which medical technology is developed, evaluated, made available and used. Here again we should consider the criteria of relevance and efficiency, and whether or not the advances could subsequently be applied on a large scale.

One of the greatest challenges to those in charge of health systems is to ensure that resources are distributed equitably and in accordance with needs. In my view, the main dangers confronting all health systems – including European systems designed to cover the entire population – are either the rationing of care or the development of a medical service that runs at two or more speeds. Particular care must be taken to cater for the needs of patients who are less able than others to defend their own interests, such as elderly, disabled and homeless people. Where there is no other way of reaching those who are most in need, WHO's principle of positive discrimination should be applied. According to the Dutch committee, the medical profession should share the responsibility for the efficient and justifiable distribution of the limited resources available. In addition, this debate should bring in other health partners such as consumers and insurance companies, so that the broadest possible consensus can be reached.

**Guiding principles**

A Swedish parliamentary commission has been pursuing similar objectives (5). The four guiding principles often mentioned in the literature are individual autonomy and integrity, justice, beneficence (to do good), and non-maleficence (to do no harm), but the commission found these too general and insufficiently practical. Instead, it suggested the following as principles on which to base decisions about priorities:

- human dignity: all people are equal in this regard, whatever their characteristics or place in society;
- needs and solidarity: resources should be allocated to the persons or services that need them most;
- cost-effectiveness: there should be a reasonable relation between the cost of a measure and its effect, in terms of improvement of health or quality of life.

The commission considered a question that crops up frequently in discussion of the ethics of health care: should the age of patients be taken into consideration? Like others before it, it refused to make chronological age a determining factor. On the other hand, it felt, one could not rule out the consideration of biological age (physical ageing and loss of physical strength) in assessing a patient's capacity to withstand or benefit from a given form of treatment.

Questions also arise in the area of self-induced injuries, such as those caused by sport or reckless behaviour, or disorders resulting from consumption of alcohol, drugs or tobacco. The commission decided that in principle lifestyle should not give rise to discrimination, and the three principles outlined above should apply
to those concerned without restriction. However, refusing to discriminate against patients who are "responsible for their own problems" does not mean ignoring lifestyle as a factor to take into consideration in deciding on treatment. The commission also stressed the importance of ensuring that underprivileged groups are not further penalized by priorities imposed by budgetary constraints. Experience shows that, whatever reforms are brought in, the better off tend not to suffer from them.

In times to come, these difficult questions will call for a great deal of attention from health and social workers, decision-makers and the community as a whole. As Professor Bankowski says, in the broader perspective, if we have rights (and the modern era has made major progress in this area), we also have responsibilities and duties. We cannot have one without the other. Finally, these concerns bring home to us the fact that health care cannot be provided properly without consideration of the moral and even spiritual aspects of the life of society, and that an appropriate balance must be struck between the interests of individuals and the interests of the communities in which individuals live.

References


Media messages in conflict

Children today are increasingly exposed to the press and television. Little control can be exercised over what they read, hear and see. Frequently what is taught in school and at home is in conflict with the messages from the media. Children can, however, be taught to handle media messages in an intelligent way. Understanding advertisements and dealing with conflicting messages are skills to be encouraged by school health education projects.