

PAPER

What is good medical ethics? A clinician's perspective

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ABSTRACT

Speaking from the perspective of a clinician and teacher, good medical ethics needs to make medicine better. Over the past 50 years medical ethics has helped shape the culture in medicine and medical practice for the better. However, recent healthcare scandals in the UK suggest more needs to be done to translate ethical reasoning into ethical practice. Focusing on clinical practice and individual patient care, I will argue that, to be good, medical ethics needs to become integral to the activities of health professionals and healthcare organisations. Ethics is like a language which brings a way of thinking and responding to the world. For ethics to become embedded in clinical practice, health professionals need to progress from classroom learners to fluent social speakers through ethical dialogue, ethical reflection and ethical actions. I will end by discussing three areas that need to be addressed to enable medical ethics to flourish and bring about change in everyday clinical care.

INTRODUCTION

I remember as a medical student in the 1980s sitting in a lecture theatre captivated by a lecture celebrating the bright new future heralded by the genetic modification of crops; this new science would be a transformative force for good, addressing the problems of malnutrition and starvation worldwide. Potential technical challenges were acknowledged, but ethics was not on the agenda or even the postscript. A few years later two-stage antenatal screening for Down's syndrome was being introduced—a simple maternal blood test would enable clinicians to identify pregnant mothers at high risk who could then proceed to amniocentesis for a definitive diagnosis. This would replace the previous policy of only offering amniocentesis to older mothers and would enable a national screening programme that would dramatically reduce the incidence of Down's syndrome. I remember being shown tables demonstrating the cost-effectiveness of screening for Down's syndrome; a national screening programme would pay for itself through savings on the care of people with Down's syndrome who would otherwise have been born. No one then questioned cost-effectiveness as a driver for a national policy on termination.

Much has changed since then. Over the past four decades, in the UK, USA, Europe and elsewhere, medical ethics has moved into the mainstream. Since 1993 medical ethics has been a compulsory part of undergraduate medical

education in the UK,¹ and in 1999 the World Medical Association recommended that all medical schools should teach medical ethics.²

In this paper I approach the question of 'what is good medical ethics' from the perspective of a clinician and teacher in the UK, focusing in particular on ethics in relation to everyday clinical practice. In the first section I will reflect on ways in which medical ethics has had a positive impact on healthcare, but argue that ethical reasoning often fails to translate into ethical practice. I will argue that good medical ethics needs to address this gap between what we think we should do and what we do in practice. In the second part of this paper I will outline and discuss three factors that contribute to the gap between theory and practice and propose ways of bridging this gap.

DOES MEDICAL ETHICS DO ANY GOOD?

What makes medical ethics good? Elegant reasoning, engaging argument, articulation of previously unasked ethical questions are all features that attracted me to medical ethics. But, as a physician and clinical teacher, good medical ethics needs to make medicine better. It can do this in many ways: helping clinicians reflect on everyday ethical issues, ensuring ethical values are integral to the development of policy in healthcare and medical science, embedding ethics into the culture and organisation of our healthcare and academic institutions, empowering clinicians as advocates for patients and empowering healthcare users to engage with and benefit from ethical debate and discourse.

During my career, medical ethics has contributed to changing practices. As a student, the idea that we should gain consent before performing a vaginal or rectal examination under anaesthesia was still fairly novel. Today, ethicists contribute to health and science policy and healthcare users have an increasing voice in healthcare development and delivery. Conscious of the need to distance themselves from eugenics policies of the past, antenatal screening programmes focus on parental choice and non-directive counselling.

Cynics might argue that changes in the way clinicians approach these issues are more a reflection of wider cultural changes in society—the organisation of minority and disadvantaged groups into communities whose voices are better heard, the rise of consumerism and increasing emphasis on rights and entitlements in ethical discourse—than achievements of medical ethics. These cynics might ask for the evidence that 20 years of medical ethics education and compulsory postgraduate medical



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competency domains in ethics and law have produced more ethical doctors. Certainly, I have been privileged to work with many excellent clinicians with no formal teaching in medical ethics who deftly negotiated the art and science of medicine and for whom the skill and habit of reflection and normative reasoning were interwoven into their clinical practice. Nonetheless, I would argue that ethical discourse has helped shape the cultural changes in society and that teaching medical ethics will ensure more of our future doctors have the skills (and hopefully motivation) to respond effectively to ethical issues that occur in everyday practice.

How, then, to respond to the shocking failures of patient care at Mid-Staffordshire NHS Trust³ and more recent healthcare scandals?⁴ If we look into the mirror after the Francis Report on these failures, surely those of us who champion the importance of medical ethics must admit that, currently, medical ethics is not good enough? Medical ethics has been part of the undergraduate curriculum for two decades. Health professionals will have had access to the widely available array of ethical guidance, frameworks and toolkits. Yet, in spite of this, the views, rights and welfare of patients were not given the recognition and priority due to them. While the factors that led to the events at Mid-Staffordshire NHS Trust are multiple and complex, it seems fair to say that there was a failure to translate ethical reasoning into ethical practice.

The Francis Report painted a bleak picture at Mid-Staffordshire NHS Trust of healthcare staff who were uncaring and rude. However, if we accept that medical ethics cannot take all the credit for improvements in clinical practice, is it fair that it should be blamed for the failings of clinicians and healthcare organisations? Medical ethics can provide the reasons why a particular course of action is the most appropriate, but is it reasonable to expect medical ethics to make people do the right thing—to make uncaring people kind and good?

It could be argued that the events at Mid-Staffordshire were simply a failure to show common decency to patients and relatives. However, beyond the individual narratives of rudeness and neglect, choices were made: the choice not to speak out, not to prioritise patient welfare among other competing claims within the organisation, to look the other way, to reconcile oneself to poor patient care. Ethics is about the reasons that guide our normative choices. From the testimonies of staff at Mid Staffordshire NHS Trust, it seems likely that the majority of health professionals were committed and dedicated clinicians; individual health professionals described frustration and distress with the situation. Few, I suspect, would have considered the situation ethically acceptable, but 21st century medical ethics did not equip them to put things right.

The evidence given by staff in the Mid-Staffordshire inquiry described low morale, feelings of helplessness and an organisation that did not listen or care for its staff. Perhaps, then, the blame should lie with the institutional structures that created the culture at Mid-Staffordshire rather than expect medical ethics to provide the solutions? However, if I look at my own subspecialty, the diabetic foot, there are strong grounds for arguing that medical ethics should carry at least some of the responsibility.

Diabetes is the underlying cause for the majority of lower limb amputations in high income countries. Significant advances have been made in our approach to managing diabetic foot disease. However, huge geographical variation in amputation rates has been demonstrated across Europe, and within the UK a 20-fold difference in major amputation rates has been reported between the best and worst performing health trusts.⁵ Leaders in diabetic foot disease see as their responsibility the need to

address the individual and institutional barriers to adopting best practice, to enable patients to recognise good quality care and how to access it. Similarly, those of us doing medical ethics need to take responsibility for translating ethical reasoning into ethical practice.

Within undergraduate medicine, it is not enough to ensure that students can reflect on competing ethical values and propose an ethically appropriate course of action in the classroom. Our future doctors need to feel confident to put those discussions into practice. Barriers such as fatigue, high work load, hierarchy within medicine and the pressures of career progression need to be acknowledged as relevant to ethical practice. Leaders in medical ethics need to address how to provide students and doctors with the knowledge and skills to overcome these barriers. Without these skills, medical ethics risks being seen by clinicians as an intellectual luxury at best or, at worst, a waste of valuable time.

TRANSLATING ETHICAL REASONING INTO ETHICAL PRACTICE

In this section I focus on three areas which I see as central to equipping practitioners with the skills and culture to translate ethical thinking into ethical practice: creating an ethics community, nurturing our moral imagination and resisting tick-box ethics. The common underlying theme is a failure for ethics to become an integral part of what we as health professionals or healthcare organisations do. Ethics is like a minority language: the primary social language of the interested few and, for the majority, a classroom language put to one side once the examinations have been passed.

Creating an ethics community

Medical students and junior doctors commonly perceive unethical behaviour but feel unable to speak up or feel that speaking up will be ineffective.^{6,7} Healthcare organisations need to nurture a culture that supports health professionals raising concerns. When healthcare professionals are in a system that ignores patient distress or allows financial pressures to take priority over human dignity, individuals find themselves doing things that do not reflect the kind of person they want to be. Their moral identity is eroded and ethical practice becomes difficult to sustain. However, to take a stand is difficult and takes courage.⁸ We should therefore be humbled by the story of Julie Bailey, whose mother died at Mid Staffordshire. Julie Bailey founded and led the campaign group Cure the NHS which was, in turn, instrumental in bringing the failures at Mid-Staffordshire to light.⁹

Julie Bailey's story demonstrates the importance of creating a community and how such a community can provide the collective determination and strength to make a difference. Medical ethics similarly needs a large and vibrant clinical-academic community which will promote ethical dialogue and give individuals the skills and confidence to speak up and bring about change in clinical practice.¹⁰ A thriving community will provide the critical mass to enable the language of ethics to flourish and to move out of the classroom into everyday clinical discourse.

There is already a strong academic community in medical ethics. However, few clinicians see themselves as potential members of this community. Most clinicians will have little knowledge of the wealth of excellent ethics research. In the absence of a strong academic-clinical community, clinicians may feel that such research is inaccessible or of little relevance to everyday practice (eg, high profile discussions about human cloning, genetic enhancement or physician-assisted suicide).

An ethics community that brings together clinicians and academics can help inform the direction of ethics research and help translate research into discourse relevant to everyday clinical practice. For example, there has been substantial work around the ethics of clinical trials in low income countries.^{11 12} At first sight this may seem of little relevance to a busy GP in an inner city practice in the UK. However, the ethical analyses around global justice, ethical duties to assist and the fiduciary relationship between doctor and patient all have a bearing on how that GP should approach the familiar ethical dilemma of the care owed to patients from resource-poor countries who are not entitled to NHS treatment.

Moral resources and moral imagination

In his moral history of the 20th century,¹³ Glover describes the human tendencies of sympathy for human suffering, respect for others and sense of moral identity as our moral resources that help restrain us from unethical actions. Good medical ethics should equip us to reflect on and harness our moral resources to support ethical actions when faced with difficult situations.

Glover's book reflects on atrocities from conflicts in the 20th century and considers the factors that contribute to the failure of our moral resources to constrain barbaric behaviour.¹³ The recent scandals in NHS healthcare cannot and should not be likened to the wartime atrocities that scarred our recent history. However, the moral resources shared by the vast majority of healthcare professionals and managers failed to prevent individuals and healthcare institutions from mistreating those under their care. Robust philosophical reasoning is essential in deciding how we should act, but good medical ethics should also invest intellectual effort into understanding why, as in Mid Staffordshire NHS Trust and elsewhere, our moral resources sometimes fail to constrain unethical behaviour.

Medical ethics has been criticised for reaching conclusions that fail to square with clinical experience.¹⁴ This mismatch is also likely to contribute to the gap between ethical thinking and what we do in practice. Our ability to reason is a valuable human characteristic, but so too are our emotional responses which underpin our innate sympathy for the suffering of others and tendency to show respect for other people. Our emotional responses, combined with reasoned reflection, form what Glover describes as our moral imagination.¹³ The quality of ethical reasoning will be constrained by the limits of our moral imagination. Limitations in our moral imagination may explain why sometimes apparently sound ethical reasoning provides unsatisfactory conclusions for clinical practice. Conversely, a rich moral imagination carries a deep visceral component which may be critical to ethics becoming part of who we are rather than just something we do.

Good medical ethics should therefore develop our moral imagination as well as our moral reasoning. There is growing evidence demonstrating the value of medical humanities in the development of moral identity and moral imagination.^{15 16} As part of his work exploring the ethical value of the human body,¹⁷ Campbell reflected on the parental narratives from the Bristol Royal Infirmary Inquiry.¹⁸ These narratives convey the profound emotions experienced by parents on discovering that their children's internal organs had been removed and retained at post mortem without their consent.¹⁹ As such, the narratives provide rich food for the moral imagination, particularly for doctors working within a culture dominated by a dualistic approach to the human body.

Tick-box ethics

A language thrives when it serves a function. If ethical reasoning does not help health professionals to work out what to do in real-life situations, it will remain a classroom language. The tendency to reduce ethical reasoning to a checklist of a priori statements risks it becoming like a cheap phrasebook: looking good on the shelf but of little practical help.

Principlism—and, in particular, a simplistic version in which it is reduced to a flowchart approach denuded of nuanced reasoning—seems to have become dominant in medical ethics, at least among health professionals. Furthermore, within the four principles approach, autonomy is often assumed to have overarching value. Dawson has criticised the lazy use of autonomy as a substitute for real ethical thinking.²⁰ Ethics should be a reflective process which adapts to new challenges and the nuances of individual circumstances. However, the temptation is for flowcharts to become a quick fix ethical shortcut. Used in this way, flowchart principlism can yield unsatisfactory conclusions.

For example, should a doctor simply accept the informed but poor choice of a patient on the grounds of respecting autonomy? Or is there an ethical obligation to persuade him otherwise and, if so, where does this obligation arise from? A more nuanced use of the four principles yields a more sophisticated response, but does not acknowledge morally important factors such as the virtues of a good doctor or the special nature of the doctor–patient relationship, which are likely to underpin the actions of the doctor in reality.

The current culture of medical education, with its focus on competency-based outcomes, assessment-driven learning and students as free market consumers, presents a challenge to those teaching medical ethics.²¹ Similarly, healthcare has become dominated by a culture of measurable targets and outcomes. Ethical practice is interpreted as adherence to flowcharts and completion of tick-boxes. The language of ethics becomes subsumed into the management speak of quality improvement targets and key performance indicators; the ethical basis and, more importantly, the ethical reasoning for these targets and indicators are forgotten.

CONCLUSION

Medical ethics has come a long way over the past 50 years. In my own career I have seen it move from an extracurricular special interest topic to a compulsory component of the medical school curriculum. I have argued that, to be good, medical ethics needs to make medicine better. Medical ethics has improved healthcare but, within the sphere of clinical practice, medical ethics could and should do better. Medical ethics needs to concern itself not just with ethical reasoning but how that reasoning can be put into practice by clinicians on the ground. Creating a dynamic community of academics and clinicians will inform academic discourse and help translate this discourse into clinical practice. Good moral reasoning needs a rich moral imagination. Just like cardiothoracic surgery or diabetes care, moral reflection and moral imagination need time, intellectual effort and practice. Without a rich moral imagination, our moral resources are liable to wither and fail us. Recent healthcare scandals suggest that our moral resources often lack the strength and depth to maintain ethical practice in pressurised environments. We need a medical ethics community to ensure that moral imagination is nurtured and that the language of ethics becomes integral to the language of healthcare.

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