BOOK REVIEW

Principles of health care ethics
Edited by Raanan Gillon
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(Principles of health care ethics is available at the library of the British Council Division of the British Deputy High Commission, Bombay. The figures in brackets refer to the call number at this library for this book.)

Introduction

This monumental text deserves a detailed discussion. Limitations of space disallow this. In this review I have concentrated on the first part of the book and indicated some of the topics dealt with in the other four parts that also need close study.

The authors

After doing his BA in philosophy Dr. Gillon proceeded to graduate in medicine and then became a Fellow of the Royal College of Physicians in London. He describes himself as a general medical practitioner and serves as Director of the Imperial College Health Service and Visiting Professor at St. Mary's Hospital Medical School. He also edits ***Journal of Medical Ethics.***

Dr. Gillon has enlisted the help of a galaxy of ethicists and medical consultants, including such eminences as Dame Cicely Saunders and Sir Douglas Black. Apart from the expected numbers from the United Kingdom and United States, one encounters names from Australia (Justice Michael Kirby), Canada, Denmark, France, Germany, Greece, Israel, New Zealand, the Netherlands, Norway and Sweden. Contributions have also been procured from Egypt (Dr. G. I. Serour on Islam and the four principles), Chile (Dr. M. H. Kottow on Stringent and predictable medical confidentiality), Pakistan (Dr. K. Zaki Hasan on Islam and the four principles - a Pakistani view), Swaziland (Dr. Peter Kasenene on African ethical theory and the four principles) and Thailand (Dr. R. E. Florida on Buddhism and the four principles). It is sad that Dr. Gillon was unable to find any author able to write on classic and contemporary Indian philosophical thoughts on medical ethics in general and the four principles in particular.

The four principles

In his preface, Dr. Gillon answers the question, 'Why this enormous book?' which takes off from Beauchamp and Childress' elaboration, in 1979, of **beneficence, non-maleficence, respect for autonomy** and **justice** as the governing principles of medical ethics and, in fact, of all moral issues. (The Belmont Report on biomedical research [1978] had enunciated three principles, **beneficence/non-maleficence** being grouped together.) In chapter 28, Dr. Gillon rebuts arguments offered in some of the preceding chapters against the four principles approach. In an aside, Jonsen (page 17) reminds us that the word ***principle*** is derived from ***primum*** (first) and ***capere*** (to take). A principle thus takes the first place in discourse and rules the process of thinking, permitting discussion around itself. Jonsen also reminds us that the mere invocation of principles does little to resolve practical problems. Solutions require an understanding of the basis for principles and the will to apply them purposively. "Moral principles are not unlike the skymarks used in celestial navigation: a position is determined and a course marked by reference to fixed points, suns, stars and planets. At the same time, the navigator must look, not only to the skymarks, but to visible landmarks and to the wind and waves... Principles alone do not lead to ethical decisions; decisions without principles are ethically empty." (Jonsen, pages 18, 21)

Dr. Gillon's introductory remarks (pages xxi- xxxi)

Deep thought is in evidence in Dr. Gillon's introductory remarks, some of which effectively sum up entire sections of the book. Take for example those on autonomy: "Respect for autonomy is the moral obligation to respect the autonomy of others in so far as such respect is compatible with equal respect for the autonomy of all potentially affected. Respect for autonomy is also sometimes described in Kantian terms, as treating others as 'ends in themselves' and never merely as means.. .Keeping promises is (also) a way of respecting people's autonomy for an aspect of running one's own life depends on being able to rely on the promises others make... Respect for autonomy also requires us not to deceive each other... Respect for autonomy even requires us to be on time for appointments we make... Autonomy requires (us). . . to communicate well with patients and clients - including... listening..."

Likewise, when dealing with **beneficence** and **non-maleficence** Gillon emphasises that whatever we offer actually constitutes **net** benefit for **the particular** patient and not for patients in general. He considers justice under three heads: fair distribution of scarce resource, respect for the rights of people and respect for morally acceptable laws. He illustrates concepts with examples drawn from his own practice.

He emphasises the need to ensure that no action puts a patient at a disadvantage because of personal prejudice. Punishing the patient with alcoholic cirrhosis or the smoker with chronic bronchitis by refusing treatment is unjust, hence unethical. Likewise, prescribing a more expensive drug or procedure when a cheaper alternative would be equally effective is a waste of scarce resources and violates the principle of distributive justice.

We are exhorted to analyse all our actions, weighing personal biases and convictions against the four principles, trying, at all times, to ensure that the latter prevail. Having gone through this exercise myself, I know how difficult this can be. (Bernard Hoose, offering a Roman Catholic view of the four principles, addresses another aspect. "The integrity of those involved in health care must not be ignored by their superiors, their patients or themselves... the meanings which actions and things have for them are of enormous importance. Nobody should be forced to do something against his conscience...certain actions (can be performed) only by doing violence to ... moral integrity. ")

I learn something new each time I re-read this essay. Here, for instance, is the crux of the solution to hysterectomy in mentally handicapped women: "The autonomy of even quite young children and of severely mentally handicapped persons ought prima facie to be respected unless there are good moral reasons not to do so... Where those decisions appear to be against their interests, important issues arise about who should be regarded as proper proxies to make decisions on their behalf and on what criteria..."

In addition to these introductory remarks, Dr. Gillon introduces each part of this book in separate essays.

Part I: Approaches to applied health care ethics

We learn from Beaudhamp's essay that Thomas Percival provided in 1803 an early perspective on non-maleficence. Discussing a patient to whom a truthful answer might prove fatal, Percival argued: "He (the patient) has the strongest claim, from the trust reposed in his physician, as well as from the common

principles of humanity, to be guarded against whatever would be detrimental to him...The only point at issue is, whether the practitioner shall sacrifice that delicate sense of veracity, which is ornamental to, and indeed forms a characteristic excellence of the virtuous man, to this claim of professional justice and social duty..." Percival's book on medical ethics served as the pattern for the American Medical Association's first code of ethics in 1847, many passages being taken verbatim from it.

Albert Jonsen (pages 12-21) shows that bioethics has been a separate discipline since the development of chronic haemodialysis in the 1960s and the advent of heart transplantation. The need to decide 'who should live, who should die' forced scholars in moral philosophy and theology to contend with these issues. Conflicts (such as that between the principle of doing the greatest good to the greatest number and the time-honoured injunction to the doctor against doing anything that might harm his particular patient) had to be resolved.

John Finnis and Anthony Fisher of Oxford (pages 3 1-44), discussing a Roman Catholic view of the four principles, emphasise 'the preferential option for the poor' which commends special care for the poor, underprivileged, powerless and the desperate. They also suggest mercy as a component of justice, calling us to go beyond the principles of justice and non-maleficence and ask whether 'mercy-killing' is the truly compassionate way to treat those in severe pain, or incurable illness or coma. "Far from contributing to death with dignity, support for euthanasia promotes a culture which whispers to the old and infirm 'Your condition is intolerably undignified. You would be better off dead. We would be too, if you were dead. You may even have a duty to acquiesce in being killed.' "

Avraham Steinberg provides the Jewish perspective. The entire legal system of Judaism is based on the Halakhah derived from divine revelation, and its interpretations. Decisions on ethics are made by the triad - physician, rabbi and patient. The relation between physician and patient is a covenant and not a freely contracted association. 'If the physician withholds his service it is considered as shedding blood.' Steinberg discusses problems relating to priority between the four principles. "In case of conflict, which should override? Under what conditions? Who decides?" Jewish law obliges the patient to seek healing but permits autonomy in refusing obviously ineffective therapy or that which imposes great suffering. "The Jewish perspective against maleficence includes not only a prohibition to harm others, it also prohibits harmful actions against oneself.. . Suicide is absolutely forbidden and strongly condemned... Triage decisions are primarily decided according to the following rules: first come, first served... if two patients present simultaneously, the one who is in greater danger takes priority; if both are equal in their medical needs, a hierarchy based on social worth is stipulated."

Professor Serour, discussing the Islamic perspective, recalls that the first known documents dealing with medical ethics are Egyptian papyri (16th century BC) in which, as long the doctor followed the rules, they were held to be non-culpable, should the patient die. If the doctor transgressed the rules and the patient dies, the doctor paid with his life. Hammurabi set fees according to the social status of the patient. Codes were laid down for physicians and surgeons.

Serour cautions those who presume to judge acts of others from a different culture. Ethics is based on moral, philosophic and religious principles of the society in which they are practised. Ethics may differ from one culture to another. He also counsels those with a strong religious background to differentiate between medical ethics and humanitarian considerations on the one hand and religious teachings and national laws on the other.

What is legal might not be ethical. The law rarely establishes positive duties such as beneficence and can be, and is, used not only to deny justice but also to deny respect to persons and to do harm.

Serour emphasises that ethical norms are guidelines. The context must govern judgement. He adds a fifth principle: The human being should not be subject to commercial exploitation.

Islam is governed by the Sharia which, in turn is based, in chronological order, on the Holy Quran (the word of God), the Sunna and Hadith (sayings of the Prophet Mahomet developed by jurists), the unanimous opinion of Islamic scholars or Aimma (Igmaah) and finally, by analogy (Kias). If an instruction on a certain issue is provided in the Quran, it is the one to be followed. Islam permits flexibility, adaptation to the necessities of life and shifts in ethical stands based on the current culture.

Dr. K. Zaki Hasan describes Unani medicine as a synthesis of the ancient Greek, Indian and Persian systems. Its practitioners, along with the teacher and cleric shared a common role and culture with a primary social, not monetary, objective.

He underlines the basic deficiency in developing countries: medical ethics does not form part of the mainstream thought process or even that within the medical profession. There is an almost total lack of dialogue on the subject. Leaders of religious thought are out of touch with advances in the philosophy of science and pay little nttention to medical ethics. The young, in these countries, have thus no desire for social equity, altruism and idealism.

Alastair Campbell's essay *Ideals, the Four Principles and Practical Ethics* (pages 241-250) is especially welcome for its emphasis on practical ideals. He starts off with a question: 'Is there a place in health care ethics for actions beyond the call of duty?' and explains: "Of course, acts in excess of what the principles require may be seen as admirable, exemplary even, but they cannot form part of that general morality which is to be expected of every moral practitioner. Ideals are for the exceptional few." He considers *The case of the foolish doctor, The case of the errant patient, Love's Labour lost,* and *Angels, heroes and practical idealism* and concludes: "Principles (of ethics) become devoid of useful moral consent unless they are made to intersect with a set of ideals which are beyond the call of duty."

Part II: Relationships and health care ethics

This section deals with the relationships between 'health care workers' and their clients, the patient/client forming the focus.

Donald Evans emphasiscs the need for the medical attendant to do his best to correct the inequality in his relationship with the patient. The possession of complex and specialised knowledge, a prestigious position in an institution of health care, the role of a potential benefactor to the patient and the fact that the services of the doctor are in great demand put the doctor in the driver's seat and the patient at a great disadvantage. Evans notes that thc following criteria have been set for obtaining informed consent:

1. There must be evidence of choice.
2. There must be reasonable outcome of the choice.
3. The choice must be based on good reasons.
4. The patient must have the capacity

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to understand the issues in question.

5. The patient must have actually understood the issues when giving consent.

Barring the first, each of these is prone to injection of bias and consequent failure of objective. The medical attendant must be aware of this and do his best to minimise such failure.

Justice Michael Kirby discusses the issue of consent and the doctor-patient relationship in considerable detail (pages 445-455). Discussing 'malpractice explosion' he starts off by quoting an instance from Scotland. He illustrates the change in public attitudes by quoting an elderly Scottish judge who noted, nearly a hundred years ago; "This action is certainly one of a particularly unusual character. It is an action for damages by a patient against a medical man. In my somewhat long experience I cannot remember a similar case earlier."

Christobel Saunders, Michael Baum and Joan Houghton discuss consent in the context of research. They suggest that consent should include:

a) the purpose of the trial

b) benefits to the patient and to society

c) possible risks of treatment

d) alternative treatments available

e) the right to refuse or withdraw from the trial at any time without prejudicing further treatment in doing so

f) implications of randomisation.

The issue of 'managerial paternalism' is discussed in considerable detail in two essays by Elliot Shinebourne and Andrew Bush; Robert Veatch and Carol Spicer. The few instances where such paternalism may be justified (such as on grounds of ability to make the best assessment in the patient's interests) deserve further debate.

'Entrepreneurship in medicine', being advocated as the fashion of privatisation, rages the world over and deserves close attention. R. S. Downie warns against doctors seeing themselves as businessmen, accepting only those patients on whom profitable services can be foisted, whether or not they are strictly required. This warning has, in fact, already been overtaken by events at the private hospitals in Bombay.

Rabbi Julia Neuberger discusses the real relationship that should exist between patient and attendant: one based on healthy respect involving the attendant as healer, scientist, technician, educator and, most important of all, friend.

The weighing of benefit for the client/patient versus that to others also deserves study. Most societies give a higher priority to the general good over that to the individual. This issue has been brought into sharp focus by AIDS. Does the individual infected by the HIV virus have a right to remain ignorant of such infection?

Neuberger, Baum and colleagues discuss the threat to traditional doctor-patient relationship posed by medical research. Financial inducements to patients to participate in clinical trials can sway the judgement of one already under the stress of illness. The clinician who is also a researcher may face situations where the demands of research could prompt breach of ethical principles. There is no substitute for honesty in resolving such a dilemma.

M. H. Kottow focuses on medical confidentiality and differentiates between it and secrecy. He discusses the suggestion that confidentiality may be breached for the sake of more important goals that would be menaced if disclosure was not made. The related concept of absoluteness of confidentiality is briefly reviewed. (Sir Douglas Black deals with this in greater detail.) He concludes that if confidentiality be breached too readily, sexual perverts, sufferers from venereal diseases (and AIDS), child abusers, drug addicts and potential killers will cease to confide in doctors, making inaccessible precisely those patients that society is trying to bring under control.

Jennifer Jackson discusses a related issue - keeping promises made to patients - and suggests that breaking a promise is a wrong whenever it betrays trust, even when this does no obvious harm. Conflicts of duties (as when relatives request the doctor not to reveal a fatal diagnosis to the patient who, in turn, demands this information) are well discussed. Jackson's essay is followed by one on lying or telling the truth with little in defence of the former.

Part III: Moral problems in particular health care contexts

Here we encounter a mixed and, at times, unrelated lot of topics. They include abortion, other ethical issues during pregnancy, the treatment of infertility, dilemmas around the time of childbirth, straining to keep every baby alive (and deciding where a line has to be drawn), problems in pediatrics, psychotherapy and psychiatric ethics, medical education and publication of papers/books, health care of the elderly (without or with dementia), the do-not-resuscitate order (DNR), the dying patient and euthanasia.

Several vital questions are dealt with here. Readers will gain considerably from a study of relevant papers.

Part IV: Health care ethics and society

This relatively brief section (pages 797-943) contains Robert Maxwell's thought-provoking essay subtitled *Are ethics relevant* (in health care management)? The politics of health care and the call to account publicly how resources are spent pose conflicting demands. Whilst the issues are not the same as in clinical medicine. Maxwell concludes that ethics has an important contribution to make.

Other essays deal with economics, medical technology, epidemiology, occupational health and medical research. Drug addiction and AIDS are also dealt with here.

Part V: Ethical problems of scientific advance

This section will be of particular interest to those in medical institutes, dealing, as it does with genetic engineering and counselling, fertilisation in vitro, organ transplantation and death. David Lamb asks and answers the philosophical question : 'What is death?', concluding that the definition of death must refer to a recognisable and irreversible physical phenomenon, must be selective (as death is not an event but a process), must be holistic and universally applicable.

Arguments for and against the use of 'brainstem death' follow.

The section also contains two essays on animal experimentation.

This is, most certainly, **not** a book to be studied at one stretch. It is, at once, a work of reference and a collection of essays that present a range of facts, opinions and conclusions on carefully selected topics.

Dr. Gillon and his band of contributors deserve our sincere and prolonged applause.

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