

Lecture Notes, 2010-2011. Code: Med-02.04-v3-11.10

Medical Law

Topic 2 (of 10), **Lecture 4** (of 4):

Introduction to Medical Ethics (4):

**(i) Ethical Principles common to various theories; and
(ii) Justice & the allocation of scarce medical resources**

Aim:

To provide an outline explanation of: (i) the basic principles of medical ethics; and (ii) to examine possible approaches to the problem of how to allocate scarce medical resources.

Objectives:

After careful study of this topic you should be able to:

1. Outline the meaning of the ethical principles relating to: autonomy; beneficence; and non-maleficence;
2. Provide a basic meaning of justice as applied in medical ethics and a very basic outline of some of the principal theories of justice;
3. Discuss the legitimacy, or otherwise, of basing a decision to allocate scarce medical resources on the age and lifestyle of the intended recipient.

(I) Four Basic Principles of Medical Ethics.

Whether one is a deontologist or a consequentialist, four basic principles appear to be of fundamental importance in medical ethics, viz; autonomy; beneficence; non-maleficence; and justice.

1. Autonomy: (i.e. Respect for the Principle of Autonomy)

If one accepts the non-religious deontological theory expounded by *Kant*, which takes the line that persons are ends in themselves and should not be used as a means-to-an-end by other persons, then one *must* accept the significance of the principle of respect for autonomy. This may be an *absolutist* principle leading to an award for damages when it is infringed as in the case of (say) a non-consensual blood transfusion, as in *Malette v Shulman* (1990) or, *prima facie*, when a claim of therapeutic privilege is made in response to a charge of depriving a patient of information prior to obtaining that patient's 'real' consent to a medical procedure: *Sidaway* (1985).

Faulder says that:

“To think of persons as ends in themselves gives them an intrinsic value which demands respect, even if we do not always approve of their actions or the judgments’ on which they are based. [‘The patient has a right to be wrong:’ per *Prowse J* in *Hopp v Lepp*]. The principle of autonomy does not . . . [mean] that human beings must always and at all times act autonomously without any consideration of other people’s equal claim to autonomy. Provide we *freely* concede our autonomy to a *legitimate authority* for specific purposes, as we do in a democratic system, then our fundamental autonomy is preserved.”

Sub divisions of autonomy

Gillon says that the concept of autonomy may embrace three sub-divisions, viz;

Autonomy of thought [which] embraces the wide range of intellectual activities that are called ‘thinking for oneself’, [and it includes] making decisions, believing things, having aesthetic preferences and making moral assessments.

Autonomy of will (or perhaps *autonomy of intention*) is the freedom to decide to do things on the basis of one’s deliberations. [And, thirdly]:

Autonomy of action, which as a general rule, is based on autonomy of thought and will and is limited only by the requirement of noninterference of anyone else’s autonomy.

Benson described autonomy as a state of character manifesting reliance on one’s own powers in acting, choosing and forming opinions. Evidently, autonomy is a characteristic possessed by people in varying degrees.

General Acceptance of the Principle of Respect for Autonomy.

The principle of respect for autonomy is, essentially, the moral requirement to respect *other people’s* autonomy. There is a *significant qualification* to this, however, as “In the case . . . of autonomy of action the need for some restriction on respect for autonomy is obvious; otherwise we should be morally required to respect any deliberated course of action no matter how horrible the results might be for others.”

Consequentialists and deontologists both accept the principle of respect for autonomy. *Mill*, (a *Utilitarian*), advocated that respect for the autonomy of others was required in so far as such respect did not harm others and in so far as the people thus respected possessed a fairly basic level of maturity [measured, perhaps, by a patient having the capability of understanding the nature of the treatment proposed by his doctor]. *Kant*, (a *Deontologist*), argued that both autonomy and respect for the autonomy of all other autonomous agents were necessary features of rational agency itself and thus of any rational agent.

2. Beneficence: The duty of doing good for the benefit of others.

Beneficence has a positive aspect: the duty of a doctor to do good for the benefit of the patient; and a negative aspect, which is the duty to *prevent* harm. Beneficence is a fundamental tenet of the *Hippocratic Oath* as in: “I will prescribe regimen for the good of my patients according to my ability and my judgment ...” The problem, is:

“Who is to decide what are the best interests of the patient? ... If beneficence is left entirely to the subjective judgment of doctors it too easily becomes an excuse for paternalism. [D]octors must tell their patients what they think is in their best interests ... but this should not prevent them from seeking also to see things from their patients’ perspective.” (per **Faulder**).

It is uncertain as to whether beneficence is a moral **obligation** or merely morally commendable **virtue**. What does seem certain to **Gillon**, however, is that there is no substance to the claim that ‘the patients interests always come first’ nor should there be any desire to pursue such a claim. ‘[I]t is, ... unthinking absolutism to state that any one person’s or group’s interests always come first.’ Nevertheless, two of the three constraints on beneficence focus on respect for the principle of [a patient’s] autonomy.

Three Constraints on Beneficence.

- i. The duty to respect another person’s [the patient’s] autonomy;
- ii. The duty to do no harm [non-maleficence]. Respect for the principle of autonomy is of significance here in that, for example, “one person will choose laryngectomy and a 60% three year survival rate for vocal cord cancer, whereas another will prefer radiation to save his voice at the cost of a three year survival rate of only 30-40%.” [**McNeil et al**, *Speech and Survival - tradeoffs between quality and quantity of life in laryngeal cancer* (1981) as quoted in **Gillon**, p77] Thus, if the patient would prefer the latter option, the doctor is not to cause his patient harm by carrying out the former.
- iii. Beneficence is subject to the provision of justice. Some doctors may agree that they should have nothing to do with ‘justice’ in the sense of decision-making relating to the distribution of scarce medical resources: that their duty is governed by the **Hippocratic Oath** under which they swear to act for ‘the benefit of *my* patients’ - not the benefit of all patients. The argument is that patients suffer when doctors start to qualify their obligation to their own patients with any conflicting considerations of fairness or justice; e.g. if there was sufficient of a medical resource to successfully treat one patient, a sharing of it between two patients would not be beneficial to either of them. **Gillon** compares this with the position ‘of a barrister who does his utmost for his client and assumes that the other side will be equally partisan and that justice will result from such an adversarial system of advocacy.’ However, the provision of ‘practice-budgets under the **National Health Service and Community Care Act 1990** made the medical profession become more aware of cost benefit analysis. *There is no doubt that the economics of health care is fast becoming an integral part of medical ethics.*’

3. The Principle of Non-Maleficence.

The principle of non-maleficence imposes on the doctor what is said to be his primary duty of not *doing* his patient any harm, as opposed merely to *preventing* harm (an aspect of beneficence, as just noted). **Faulder** says this ‘applies particularly to the doctor’s duty to act with due care and avoid negligence’.

The translation of the Latin ‘*Primum non nocere*’ as first (or above all) do no harm, appears to give priority to this principle over that of beneficence. Indeed, this led **Foot** to claim that

‘other things being equal, the obligation not to harm people is more stringent than the obligation to benefit people.’ However, this is only a superficially attractive claim. Whereas there appears to be what Kant would call a perfect [or, perhaps] *prima facie* duty to *all* other people *not to harm* them, there is *no duty to benefit all* other people. Moreover, as *Gillon* notes: ‘it is incoherent to talk of a duty which is impossible to fulfil. Thus at most we can have a duty only to benefit *some* other people (an imperfect duty), while we have a perfect duty to everybody not to harm them.’

4. Justice

‘That doctors can somehow legitimately evade any need to concern themselves with justice is ... [un]tenable’ per *Gillon*. For example:

“The doctor who stays in theatre to finish a long and difficult operation and consequently misses an outpatient clinic is probably relying - implicitly or explicitly - on some sort of theory of justice whereby he can fairly decide to override his obligation to his outpatients in favour of his obligation to the patient on the table. So is the general practitioner who spends 30 minutes with the bereaved mother and only five with the lonely old lady who has a sore throat.”

Another example of *moral justice* is the prohibition on medical involvement in torture as contained in The Declaration of Tokyo. The GMC engages in specifically *legal* aspects of justice when hearing a case of serious professional misconduct under *s.36* of the *Medical Act 1983*.

The Meaning of Justice

The difficulty in defining the meaning of justice stems from the fact that the Greek word for ‘justice’ originates from the same Greek word for ‘equality’. However, *Aristotle* denied that, with respect to ‘justice’, equality of treatment was to be interpreted as meaning an equal division of (say) whatever scarce resource was being distributed, for ‘*the origin of complaints and quarrels (is) when either equals have and are awarded unequal shares, or unequals equal shares*’. Aristotle argued that equality of justice meant fair or proportionate treatment. His formal principle of justice is that: ‘*equals should be treated equally and unequals should be treated unequally in proportion to the relevant inequalities*’.

Three reasons for the widespread acceptance of Aristotle’s formal principle of justice are:

- i. it requires an equality of consideration.
- ii. it requires fairness in the sense that disputes are to be resolved by mutually agreed principles of justice; and
- iii. it requires impartiality in the sense that equalities of treatment cannot be arbitrary (i.e. based on mere opinion, preference, or partiality) but must be justified on the basis of, and in proportion to, relevant inequalities.

Aristotle’s formal principle of justice has been given different interpretations by the different theories of justice. However, it would appear that irrespective of whether one

considers (say) Utilitarian theories, Marxist theories or Rawls's theory of justice, Aristotle's formal principle of justice is, at least, implicitly accepted by all of them.

(II) Justice and the Allocation of Scarce Medical Resources to Individual Patients.

Gillon confirms that: "... Aristotle's formal principle (equals should be treated equally, unequals unequally in proportion to the relevant inequality) and the impartiality and fairness it entails are widely accepted in different theories of justice whose substantive contents vary considerably." However, with regard to the allocation of scarce medical resources, it is to be noted that: 'Justice is not achieved simply by basing a scheme for resource allocation on a good theory of justice. Its decisions must be implemented.'

That Aristotle's formal principle of justice is accepted by each of the various theories of justice, leads to two significant implications regarding resource allocation:

1. ***Resource allocation is made on moral grounds.*** There is no scope for partiality or any other arbitrary method of allocation. That the courts are not the appropriate forum to determine the allocation of scarce medical resources has been confirmed in a series of cases from *Hincks* (1979) to *Walker* (1987) and *Collier v. West Midlands Health Authority* (1988). This principle was challenged again in 1993. Then it was 'successful,' but only to the extent that it was declared unlawful for a health authority to close a unique unit as a result of its failure to comply with its statutory duty to consult: *Daniels v. Riverside HA* (1993). Thus, there is no legal obligation to provide other than a 'reasonable' service, but once a service is provided there must be adequate consultation before it is withdrawn.
2. The requirement of fairness, based on mutually agreed principles of justice, gives rise to the further requirement that ***not only must justice be done it must be seen to be done.***

The difficulty now is in agreeing what the moral principles are and which should take precedence or, to quote *Gillon*, 'What are the relevant inequalities that justify giving more to some and less to others.' That the emphasis is on *scarce* medical resources must always be borne in mind because, as noted by *Mason & McCall Smith*¹ :

"In practice, many decisions are made instinctively and without the need for profound analysis - thus, the single-handed doctor will unhesitatingly choose the patient in greater pain for treatment despite the fact that this will simultaneously delay the treatment of those in lesser pain. There may well be moral arguments against such a policy - it does, for example, act to the detriment of the stoic - but the circumstances are acute and, with comparable urgency, the doctor has selected a single criterion on which to base his judgment. The moral agonising is, therefore, reserved for the treatment of chronic, life-threatening diseases not only because they offer the opportunity for analysis but because they attract the use of expensive resources and will consume these resources for a long time - at which point, the dilemma relates not only to the allocation of resources but also to their withdrawal. The treatment of chronic renal diseases and of brain injury provide good examples on which to base discussion."

¹ *Mason & Laurie* (2005). *Mason & McCall Smith's Law and Medical Ethics*, 7/e. Oxford: OUP, p428.

However, it is submitted that since the early-to-mid 1990s, two factors have been given far more emphasis in discussing the allocation of scarce medical resources, viz; the age of a patient and a particular aspect of a patient's lifestyle, i.e. whether (s)he was a smoker and, if so, whether that should disqualify her/him from particular treatment. Age has been described as one of the 'twin issues which cloud virtually every allocation option' [the other being] 'the quality of life achieved by treatment.' Principles of allocation will, in essence, be based on these factors.

Yet, from this basis, there is no universally accepted path to the allocation of scarce medical resources. Indeed, from the construction of theoretical models that resources may be allocated according to 'merit' or 'equally' or on the basis of 'need', it is submitted that there are at least six different principles or values on which the decision to allocate scarce medical resources may be made. Clearly, they aren't independent or mutually exclusive: there is some degree of overlap amongst them. As to which, if any, of them is the most acceptable, is a question that probably reduces to being no more than a matter of one's own opinion. The principles are:

1. **Cost-benefit.** The scarce medical resource is allocated on the basis that the patient who is to receive it will be able to contribute most to society. So, for example, a 30 year old educated man in gainful employment could be expected to contribute more by way of taxation over the next 30 years than a 30 year old man who is unskilled and who lacks academic qualifications. However, problems with this approach include: comparing the *potential* contribution to be made by (say) a 30 year old man with the actual contributions made by a 50 year old man of the same skill and academic qualification; and comparing the worth of (say) a tax payer with a 'housewife' or a child. Secondly, if the cost-benefit analysis was based on a purely utilitarian perspective and money was the scarce resource, then it may be preferable to spend the money on (say) performing ten hip-replacement operations rather than one heart transplant operation. Yet this would amount to solving the problem of (say) the recipients being ten 'little old ladies,' and having to deduce how this 'cost-benefit' could be compared with the loss of life of a young executive who is a high salary earner and family man.
2. **Reward for Merit.** If a patient has made a contribution to society by way of, for example, being a successful 'Captain of industry' and creating employment, he will be given preference over (say) one of his employees. A composer of popular music and/or a successful lyricist might be given preference over a bit-part actor. The problems here include those of selecting the criteria and of giving them appropriate weight in the decision-making process.
3. **Medical Success: QALYs**
Gillon notes that: 'Medical resources should ... be allocated according to probability of medical success. This adds to the criterion of medical need one of efficiency and ... corresponds roughly to the welfare maximising objective of utilitarian theories of justice.' However, as well as containing the same evaluative problems of medical need (see *infra*), there is the added complication of deciding what constitutes 'medical success'. Decisions have to be made as to what criteria are appropriate and how they

are to be measured. Consideration has to be given to the quality and quantity of life which may be expected to follow from the allocation of the scarce medical resource. To this end, **Alan Williams** of the University of York developed the concept of the QALY in the mid 1980s. He said that:

The essence of a QALY is that it takes a year of healthy life expectancy to be worth 1, but regards a year of unhealthy life expectancy as worth less than 1. Its precise value is lower the worse the quality of life of the unhealthy person (which is what the 'quality adjusted' bit is all about). If being dead is worth zero, it is, in principle, possible for a QALY to be negative, i.e. for the quality of someone's life to be judged worse than being dead.

The general idea is that a beneficial health care activity is one that generates a positive amount of QALYs, and that an efficient health care activity is one where the cost per QALY is as low as it can be. A high priority health care activity is one where the cost per-QALY is low, and a low priority activity is one where cost-per QALY is high.

However, **Mason & McCall Smith** (7th edn., pp432-433) note that:

“QALYs seem to be doing little more than expressing the intuitive findings of the competent clinician in a mathematical formula. And, therein lies the rub - for the 'quality scoring' will still be founded on a 'best interests' assessment made by a third party and the paternalistic element in that assessment has been scarcely modified. It is, for example, hard for a middle class doctor not to see a middle class life as being of higher quality than one spent 'sleeping rough'; ... It is .. apparent that a QALY can only be truly evaluated with the patients co-operation; it can then be used to decide between two possible treatments for the same condition. ... used in this way, QALYs may actually augment the patient's autonomy by explicitly involving him or her in the process of rational consent to therapy.”

It would appear that if there is no generation of a positive amount of QALYs when treatment is given to a smoker who refuses to give up his habit of smoking, then, perhaps, there is little point in treating him. [Q1: To what extent, if at all do you agree with this assertion? Q2: What evidence is there that this attitude is/is not supported by the medical profession?].

Mason & McCall Smith (7th edn., p433) go on to note three 'specific objections to QALYs, as they are currently understood:'

- [i] they operate to the disadvantage of the aged;
- [ii] they measure only the end-point of treatment without considering the proportional loss or gain in the quality of life; ... [and]
- [iii] the QALY sets no value on life *per se*.

Emily Jackson expands on the list of 'the usefulness and fairness of the QALY approach to resource allocation'². She lists half-a-dozen potential shortcomings of QALYs, viz;

² **Jackson, E.** *Medical Law: Text, Cases and Materials*, 2nd edn., 2010. Oxford: OUP, pp45-47

“First, according to the logic of QALYs, the purpose of a health service is to generate the maximum number of quality-adjusted life years at the lowest cost. QALYs therefore assume that society is neutral as to how these health benefits are distributed across society, and are concerned only with ensuring the maximization of health gains. It makes no difference, for example, whether the years of healthy life go to people who are already in good health or to those whose health is poor.

“Thus, QALYs have a tendency to ignore the fairness of distribution in favour of an approach concerned only with the total aggregate health improvement. ...

“Secondly, the emphasis upon maximizing health gains is explicitly *utilitarian*. QALYs measure units of lifetime, as if they are interchangeable, rather than treating patients as separate individuals who value their own lives, and those of people they love, especially highly. ...

“Thirdly, it has been suggested that using QALYs to ration treatment will tend to exacerbate existing discrimination against the elderly and disabled, whose QALY scores are likely to be fairly low because of their reduced life expectancy and / or their lower pre-existing quality of life. ...

“Fourthly, the QALY approach is inconsistent with the principle that people with equal health needs should have equal access to appropriate medical treatment. Rather, maximizing QALYs means that people with equal need for treatment will *not* be treated equally. [For example] “ ... systematic discrimination could result against, say, those from ethnic minority groups who require interpreters, [and] those living in poorer housing who might require inpatient stays rather than day surgery ...

“Fifthly, when a new treatment is introduced, at first it may be extremely expensive, but its cost may decrease as the technology becomes cheaper, or as the expense of additional staff training is eliminated. He QALY scale might then discourage innovation in favour of established and currently cheaper treatments, even when their might be cost-savings from adopting the new treatment over the longer term.

“Sixthly, QALYs assume that it is possible to devise an objective and accurate mechanism for measuring the anticipated length and quality of a person’s life. In fact, the medical profession’s predictions of future life expectancy are notoriously unreliable, and speculating about the future quality of a person’s life will also be inherently uncertain”. ...

4. Random Selection.

Here the allocation of the scarce medical resource may be on the basis of ‘first-come first-served’ or on the basis of a lottery. However, the advantage of apparent objectivity is surely more than off-set by the disadvantage of this method taking no account either of the seriousness of the patient’s condition or of any potential medical success. A long waiting list for a particular treatment may mean that a ‘needy’ patient never has a chance of receiving it.

5. Distribute the Scarce Medical Resources on an ability-to-pay basis.

A purported disadvantage of this is that, inter alia, those who are trained at public expense may be required (say) to operate dialysis machines for those in receipt of private medical care, thus depriving those in receipt of NHS care of the skilled personnel they need. Perhaps a more serious injustice(?) arises when, (say), two children are in urgent need of a liver and bowel transplant, and child X has been on the waiting list longer than child Y, but the parents of child Y attract publicity and money by having the plight of their child broadcast on a popular and influential television programme. Is it right / just that child Y then has the transplant and continued publicity by way of reporting on his/her progress while child X appears to get nothing but sympathy once its plight is made known by way of a brief newspaper report?

6. Triage (or Medical Need). In times of emergency arising from (say) a road traffic accident or war, allocation may be made on the basis of 'triage', i.e. the separation of casualties into ranked priority treatment groups ranging over four categories from those whose injuries can be managed by self-care to those who are not expected to survive even with heroic (i.e., extensive) treatment and are, thus, treated with humanitarian care only.

Whereas none of the possibilities emerges as a clearly favoured option, is it a just decision to say in reply to the question 'who shall live when not all can live?' that the answer is "none, unless the voluntary sacrifice by some person permits it?" Is it just that all shall die when the resources are available to save the life / postpone the death of one or some potential recipients? Clearly, this isn't a medical decision: but who should make the decision; and who *shall* live when not all can live?

References

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- Mason, K & Laurie, G.** *Mason & McCall Smith's Law and Medical Ethics*, 7th edn., 2005. Oxford: OUP, Ch.11 (especially pp428-440);
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Examples of Workshop / Examination Questions

1. Tom, Dick and Harriet are in urgent need of a kidney transplant. Each one of them will die unless a successful operation is performed very soon. It has just been announced that a kidney is now available and that it is tissue-compatible and suitable for any one of them. The only information you have on the potential recipients is that:

Tom is aged 26, he is a solicitor and active in politics. He has been waiting for a transplant for four years.

Dick is aged 45, he is a self-employed builder with a thriving business and, early last year, he increased his workforce to seven when he employed another three people.

Harriet is aged 34, and she is a single mother of three young children (aged 9, 7 and 3).

You are the person who has the final decision on who gets the kidney. Explain who you think should receive it and why.

2. Given that the law has no role to play in the allocation of scarce medical resources to individual patients, the allocation must be made on moral grounds, alone. This gives rise to a plurality of approaches and leaves much scope for reform.

Discuss.

3. Doctors who have exercised their own judgments to allocate, or to refuse to allocate, scarce medical resources, have often been accused of 'playing God'. To what extent is the criticism fair and how, if at all, do you suggest it could be overcome?
4. Critically evaluate the appropriateness of the QALY in the allocation of scarce medical resources within the NHS