

# Editorial

*Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.*



Medical practice is an ethical profession. By this I do not mean simply that we abide by a code of ethics, but that ethical considerations are the foundation of our discipline. Although ethical thinking has evolved since the time of Hippocrates, our everyday practice is guided by principles that we take for granted.

Patient-centred practice is based on respect for autonomy, evidence-based medicine is grounded in the desire to do good, while at the same time, causing the least possible harm. Our public health care system and subsidised medical care is founded on the principle of justice.

Although both the medical and the lay media tend to focus on the ethical complexities of high profile medical drama – such as separating conjoined twins, or the use of drugs for recreational or other non-medical purposes by high profile celebrities, or the rationing of expensive treatment procedures for uncommon but serious medical conditions – it is our daily interactions with our patients in our consulting rooms that has the greatest impact on the health care of the community and, from time to time, it behoves us to reflect on the ethical nature of this practice.

Since returning to practice in New Zealand a little more than two years ago I have become increasingly concerned that some of our basic ethical foundations appear to be being nibbled away. These might be small nibbles but it seems to make sense to attend to these before the rot sets in.

I am concerned that a vast amount of data is being collected by third parties about patients' personal health

status and care. Professor Evans, in this issue, comments on this with respect to research, but it is not just for research that data is being collected.

Government agencies, funding bodies, provider organisations, insurance agents and welfare organisations all request information. I am not always sure what the purpose of this is, but I am certain that sooner or later there will be a breach of confidentiality.

I am concerned that patients are encouraged to make choices about their primary health care providers, but that their decisions are often uninformed. This inevitably leads to fragmentation of care as I am unable to communicate satisfactorily with another primary health care provider if I do not understand the rationale that directs their care.

I am concerned that patients are unable to access secondary care appropriately for conditions that managers (in the broadest sense) seem to view as low priority.

I am concerned that recent changes to the structure of primary health care services determine that access to care is inequitable. If we believe that distributive justice is an important principle in the provision of health care services we ought to be saying so loudly and clearly. It simply does not make sense that patients with similar health care needs and similar socio-economic backgrounds are advantaged or disadvantaged as

a result of differences in funding streams.

Enough of my concerns, I do have more and I could also comment on what I consider to be some very positive changes in the provision of health care in this country, but that is not what this editorial is about.

The theme of this issue is intended to stimulate reflection on such matters. Campbell Miller provides a personal overview of how ethical thinking guides our practice at four different levels.

I spent several years working with Campbell teaching medical ethics to Muslim students. What fascinated me was how universal these concepts are and that ethical reasoning could be

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used by students from a culture quite different from their tutors to discuss options and outcomes and the impact of these on medical practice. Contrary to the belief of many people that I have talked to from Western cultures, the concept of autonomy is clearly understood

by Muslim women despite their cultural tradition being paternalistic and directed by Islamic decrees.

Don Evans discusses how to balance the potential beneficence of medical research with the need to respect the autonomy of individual patients.

It is a privilege that one of the world's leading researchers on medical error in primary care, Sue Dovey, has written a paper defining this con-

cept and discussing how we can best research this for the benefit of our patients. Errors will occur. They can be reduced but will not be eliminated.

I cannot help adding another concern, which is about how the culture that has developed in New Zealand of seeking an individual to blame and persecute has taken precedence over improving faulty systems. I suspect that this has, in part, been encouraged by those who plan and establish health care systems divesting themselves and their organisations of any responsibility. We have recently had frequent examples of this and medical practice is no better off for it.

Tony Baird provides us with the rationale behind the New Zealand Medical Association's ethical stand on euthanasia. All of us in general prac-

tice have been involved in the care of the dying and we have all had to walk that fine line between helping to relieve suffering and appearing to hasten death. Research, which appears to show that general practitioners support euthanasia, needs to be very carefully interpreted.

Even our CME section has a focus on ethical matters. Elective Caesarean section, including that performed for non-medical reasons, is discussed by Sue Belgrave. Faye Clark provides us with her views on partner abuse. It might be of interest to compare these views with the research paper by Felicity Goodyear-Smith and Tannis Laidlaw, which is concerned with a strategy for preventing abuse situations. No doubt there are ethical issues in every other paper in this is-

sue, including the POEMs, after all ethics underpins our practice.

As editor, I would like to encourage readers to send in contributions to the *NZFP* for consideration. For those who submit original scientific research papers we have an experienced group of referees who provide useful feedback about how to improve a paper for publication. Please refer to the Instructions for Authors at the back of the journal. We are happy to receive contributions reflecting on issues relevant to general practice. Feedback is encouraged and appropriate letters will be published in our Readers Write section. Swamp Rat also gives you a chance to get something off your chest. Potential contributors may contact me directly for advice at [tonytownsend@xtra.co.nz](mailto:tonytownsend@xtra.co.nz).

# The ethics of rationing

## A SHORT SELECTION OF COMMENTS FROM THE MEDICAL LITERATURE

'No doubt, rationing is a difficult moral problem because it requires judgements that potentially conflict with personal values...medicine's professional ethic demands that all who might profit from care be cared for. As physicians, we have entered into a social contract that accepts the equal worth of every life, independent of economic or social stratification. That inequalities exist and will continue to exist is not at issue. The moral position advocated here supports the attempt to attain equality within a universe of limited choices. On this view, rationing takes on a moral imperative as part of medicine's general ethics.'

*Tauber AI. MJA 2003; 178:454-457*

'For many elderly patients it will be decided that cardiac surgery is not clinically indicated. But the use of the phrase "not clinically indicated" often conceals and confounds two quite different points. The first point is that the operation is not of overall benefit to the patient – for example, the risk of death during the operation outweighs the likely benefit of the operation for the patient. The second is that it is not the right allocation of available resources to use them for this patient. Both these statements have important ethical dimensions, and they require separate analysis.'

*Hope T, Sprigings D, Crisp R. BMJ 1993; 306:379-381.*

'Doctors are less shocked by rationing than is the public. They have been at it for years. Decisions have regularly been taken not to continue treatment of terminally ill people not only because it would be kinder for the patient but also because it would be a waste of resources. Patients above a certain age have been denied admission to intensive care units; diabetic patients have been refused renal dialysis; and alcohol misusers have been turned down for liver transplants. Often the rationale for these decisions has been clinical – because doctors feel happier making clinical rather than ethical decisions. But by converting ethical decisions into clinical ones they are deluding themselves, a process in which managers and politicians are happy to collude: taking such decisions in full public view is acutely uncomfortable.'

*Smith R. BMJ 1991; 303:1561-1562.*