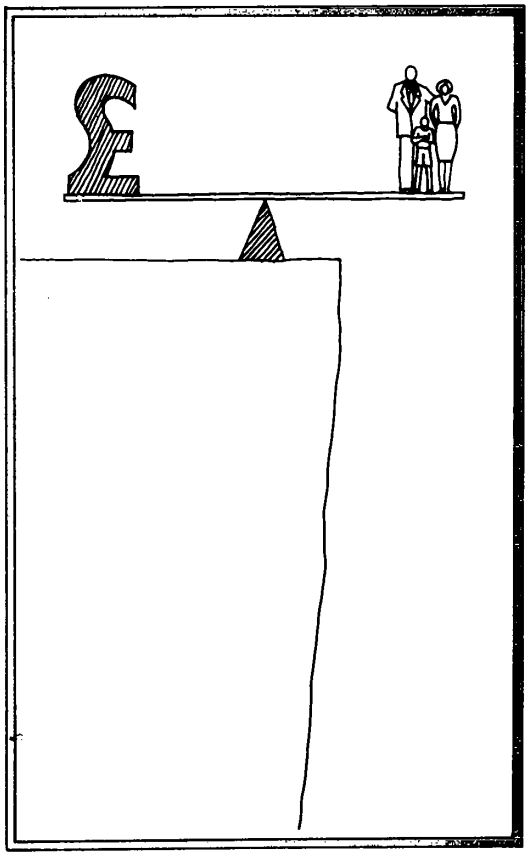
ETHICS

AND THE HEALTH SERVICES MANAGER



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For Tony Dale

PREFACE

This book is intended to be used as a practical handbook. It makes no attempt to discuss ethics from a philosophical position. Instead it takes everyday dilemmas which any manager might face in the health service today, and examines them within a simple ethical framework.

The book can also be used in the classroom where discussion of ethical issues is becoming a more frequent event on management courses. The Case Studies are of particular use in this respect. They are open-ended and allow course members to explore what might be done. The accompanying text does not directly answer the questions posed but acts as a parallel commentary on the particular area of ethical concern. So the class members might grapple with the case study first and then read the relevant chapter.

There is a danger in writing a book of this kind in so down-to-earth a manner. But as a practising manager, I feel that though philosophical and academic discussion can help aspects of our work there is also a need for practical assistance. Ethics are not remote and abstract; on the contrary, as managers we face the challenge of doing what is right every day in our hospitals and our offices.

I would like to thank many colleagues over the years who have helped me wrestle with many of the issues discussed in this book. Could I also say thanks to those patients whose misfortunes have provided the Case Studies with the hope that what happened to them may be subsequently avoided.

I would also like to thank my close friend Maureen Dixon for suggesting I might write the book, and Werner Seehoff for his forebearance.

Andrew Wall

1 ARE ETHICS THE CONCERN OF MANAGERS?

THE question posed in the title of this chapter may be puzzling. The answer must be yes because all health service managers imagine they are concerned with ethics. Having said this, however, further enquiry may not elicit more than the most generalised observation of the need to act with propriety in the common interest. Ask the same question of a doctor or a nurse and the answer would be much more specific. Why should there be this difference? Presumably because ethics are a fundamental component of professionalism; those that lay hands on patients need a code of practice not only to protect the patient but themselves. Does it really matter if a manager makes 'right' or 'wrong' decisions given that they are unlikely to affect patients, except in the most general way?

This assumption that ethics are only the concern of professionals is too narrow. Ethics are not just a framework of protective rules. If that were so, discussion would be limited to what those rules are or what they should be and how far they have been obeyed or infringed. Rules can be said to be merely the presentation of a consensus that may exist at any given time. This is an inadequate explanation of ethics. It also has to be said that ethics are not necessarily the same as the law. Later we will see that what may be legally correct, that is conforming to statutes, can be ethically doubtful. From time to time, doctors have been in difficulty with the law because they have felt ethically bound to withold information about a patient. Ethics appear to claim a higher ground, to exemplify standards beyond the scope of rules or statutes. It has been said that ethics are about a sense of obligation to each other which is what makes humans different from all other species.

But are we dealing with a set of absolute truths which will stand the test of time and remain constant, or are ethics an embodiment of more practical concerns which, although permanent in intent, nevertheless change in detail to suit circumstances? There is a dilemma here. The absolutist view assumes a greater truth which will withstand the compromising attacks of everyday situations. By contrast those who see ethics as guidance to govern relative values will argue that their view is dynamic and responds to the ever-changing values of a developing (or regressing) society.

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This book will not attempt to address the notion of ethics from the standpoint of the moral philosopher; its aim is more modest. To date the debate on ethics within the framework of health care has largely been the concern of professionals, particularly doctors and nurses. Discussions on ethics in the business world assume a highly normative stance – for instance, that honesty pays the best dividends. What is lacking is a book somewhere in between for the use of practising managers in health care which examines their own ethical dilemmas.

Some managers will feel inclined to opt out of such considerations, believing that matters of moral philosophy in health care are best left to others – particularly doctors, but maybe to health authority members acting in their capacity as arbiters of the public good. Nonetheless, even if matters of philosophy can be avoided in this way, matters of managerial practice still challenge the manager's view as to what is right or wrong. Consider the typical description of the manager's role: to lead, develop, control and evaluate or, more simply to interfere in the common interest. What legitimises this interference; who said they could?

In the NHS there has been a managerial revolution over the last forty years. In 1948 the managerial role was largely undertaken by doctors and nurses; specialist managers were scarcely to be seen. During the next 20 years, managerial doctors, usually medical superintendents, atrophied or were done to death by their colleagues. Nurses progressively withdrew from their non-nursing duties to concentrate on the developing demands of their profession, culminating in the Salmon report (1966) which inaugurated an extended nursing hierarchy. A vacuum was left which, by degrees, was filled by administrators, the predecessors of many of today's general managers. With this change came a more proactive approach. No longer was it solely the job of the manager to provide a suitable environment for the professions to work in; managers had to make more fundamental decisions that were not just the consensus of other opinions, even if that were possible. Now general managers have to have minds of their own. It is important that they are equipped to deal with the greater demands of their role and, to do this adequately, they must work within an ethical framework. The rest of this chapter deals with managerial tasks from a theoretical point of view and examines them for their ethical components.

Leadership

No discussion of organisational theory or description of an organisation can proceed far without a view on the nature of leadership. Its characteristics are enshrined in myth and anecdote; its heroes and villains are equally interesting, at least in retrospect. But for today's health service manager the experience of leadership may be both more mundane and less alluring.

The first question is whether the concept of leadership can really be sustained in an organisation as complex as the NHS? Who is the leader? Where is leadership found? Is it in the manager whose leadership role is formally sanctified by the authority of the general manager, or is it in the chairman – the head of the authority? Alternatively, given the purpose of the NHS, is it not misleading to suggest that anyone but a clinician can really be the leader? Furthermore is it not ethically wrong to allow people without a professional code of good practice to have any responsibility, however indirect, over the welfare of patients?

The dilemma is easy to state, less easy to resolve. A sensible way, however, has to be found to define the nature of leadership in the health service setting because without it there would be little sense of order and a potentially dangerous ambiguity would fail to sort out who was to be responsible for what.

First let us look again at the candidates for the leadership role. The doctor is closest to the patient and is bound by an ethical code to do the best for the patient. Can the doctor lead more than the team of people concerned with the patient? Will other leadership roles within the orgainisation compromise this responsibility for the patient? There can be a conflict here. For the medical superintendent of a sanatorium in the past or the head of single specialty hospital today, combining the particular with the general might be possible. But a doctor who becomes a general manager is forced to abandon all but the most general statements about patient care and treatment.

The argument here is that leadership of an organisation as complicated as the NHS can only operate from a generalist base. If this is true, should it not be the health authority itself who should provide the direction and the vision? The ambiguity of the authority's corporate persona makes this difficult. Is the DHA 'it' or 'them'? If a single identity, how can it integrate the views of disparate mem-

bers; but if plural, how can they lead from a position of multiple, and sometimes conflicting views?

Leadership therefore seems to be a characteristic vested in individuals, not groups. Indeed the Griffiths revamping of the NHS assumed that for the organisation to work effectively it must be clear who is in charge. But there are two candidates for this role – the chairman and the district general manager (DGM). Can they both be leaders and, if so, how do they relate to each other as far as the rest of the organisation is concerned? These two people appear to share the leadership role. The chairman will normally lead the authority and, in political terms, will present the authority to its public and beyond. All contentious matters are finally left with the chairman whose leadership role is both symbolic and practical. But there are ethical problems. From what base does the chairman operate? Being appointed by the secretary of state seems to imply a sense of obligation to the political master, to the government of the day. Disobedience can lead to the sack. Feeling very strongly that a particular aspect of government policy is detrimental to the main purposes of the health service, does the chairman stand up to be counted or work quietly to change the government's opinion? Visible leadership might require protest but in practical terms martyrs can only go to the stake once; a gradual attempt to bring about change is likely to be more successful in the long run. This can lead to disappointment for those people who are looking to the chairman as a fearless spokesman. There is more discussion on this topic in Chapter 9.

It is customary to say that health authorities decide on policy and arrange for its implementation. This is to beg the question as to where policy comes from. Often it is the product of the organisation itself and is formulated not by the authority but by the staff and presented by their leader, the DGM.

This bottom-up depiction of the DGM's role is somewhat inadequate. If the reconciliation of policies and setting them in a realistic resource framework were all, it would scarcely be more than some sort of advanced process work. There are more elements to leadership than this. First the DGM has to give coherence to the purposes of the organisation. It is fashionable to talk about the mission of the organisation and it is certainly valuable to endeavour to define the prime purpose. Is it to provide treatment and care for the sick or to give employment to health care professionals? Before

automatically assuming the former, contemplate why a 'no cuts' campaign has so much force. The loss of employment is for many staff just as important an issue as the loss of facilities for patients. Intrinsic in the provision of health care is a declaration of a value system even if, with constant repetition, it seems somewhat trite: 'We are only here for the patients'. The DGM has a responsibility for incorporating that statement into the health district; that task has ethical significance.

By what means is this done; what is the management style? Again tradition suggests that leaders lead from the top or the front. Both images have ethical implications. The top suggests a hierarchy with its implicit assumption that the person at the top knows more than those lower down. From this position the manager has the power to design a suitable management structure. Leading from the front conveys a slightly different image, locked as it is in a campaign style metaphor. It implies that leaders know where they are going and that the troops will follow. Both these mental pictures of leadership have limitations from an ethical point of view. To be top of the hierarchy is to be depicted as a one person élite. No NHS managers are likely to see themselves in this way, if only because their knowledge-base is likely to be too limited. Leading from the front may be slightly more acceptable, given its emphasis on direction. But even this can only be established after considerable and detailed study of the map and the terrain.

Other representations of leadership have drawbacks. Leading from the middle is uncharismatic and looks a lot like our old friend (or enemy) consensus management. Leading from the back suggest some sort of manipulation because the leading is surreptitious.

The point of looking at these simple images of leadership is that the manager has to feel right about the management style. If you believe you are superior then you will see your purpose in life as showing the less fortunate the way. But if your claim to leadership is less obviously substantiated, you will consider rather more fundamentally the basis of your right to lead and how that affects the rights of others. This discussion is scarcely academic given the current emphasis on accountable management.

There is therefore an ethical basis for leadership which cannot be accepted without discussion and negotiation. In establishing the legitimacy to manage, the manager has to appear to be worthy of that position, demonstrating not only knowledge but also skill in

handling others and an ability to solve problems by agreement. Good managers, by common consent, are those who demonstrate these characteristics. In persuading other people to do what needs doing, managers have to show commitment to those they manage; this is more than a passive obligation to staff. Concern is demonstrated through the process of defining objectives, discussing means for their attainment and helping staff overcome the difficulties they face in the process. Failure to engage with subordinates' needs renders the manager not only less effective but also ethically suspect.

In conclusion, leadership is widely acknowledged as essential to good management. All managers need to explore their leadership style to ensure that their practice of management is not only effective but also, in an ethical sense, good. This discussion has assumed that leadership is only invested in the most senior managers; this is obviously not the case. It is a characteristic essential to every managerial position. Nevertheless it should be said that much of the discussion in this book is seen from the perspective of the district or unit general manager on the assumption that that is where the ethical problems for managers are seen most clearly. Only a little adjustment is needed to adapt the discussion for managers at lower levels of the organisation.

Coordination

Good leadership alone will not ensure an organisation's success, particularly in the NHS where charismatic leadership is regarded with suspicion by clinical staff and with anxiety by politicians who sense that the reputations of their policies may suffer in the process. One of the prime reasons for having managers is that large organisations cannot arrange their work spontaneously; objectives overlap, there are different time limitations, and uncertainty about resources. Managers are seen as useful people who will undertake a clarifying role. If this was all they did, they would be a sort of organisational domestic, tidying up the mess of professional householders. Clearly this is not the case. To begin with, management is not a solely reactive process; it has strong proactive elements as well. Planning today is a way of avoiding confusion tomorrow and the manager's visionary capacity should be a highly valued characteristic, not only helping the organisation to steer clear of

catastrophe but uniting everyone in a common purpose. Here again this can scarcely be done without working from the basis of a discernable value system.

An essential ingredient of effective coordination is good communications. Any group of health service staff asked what is wrong with their organisation will answer: 'Not enough resources and bad communications'. The manager can give reasons enough for the former but may feel somewhat hopeless about the latter, describing vainly the committee structure, the briefing groups, the departmental meetings, the newsletters, the staff consultative arrangements and the in-house training. Staff will still sit in judgment on the failure to communicate effectively. When thought about in more detail, the manager will realise that it is a more complex issue than at first appears, not only logistically but ethically.

So, for instance, what information do the staff have a right to know and should the staff have a right to know about major changes before the public? All managers will be familiar with the problem of discussing options, some of which will be highly unpopular. If this is done openly it may well alarm the staff unnecessarily. In turn they may go to the press which will lead to a public outcry, and all as a result of a 'what if' proposal. But to keep silent (even if this were possible) would be to deny the staff and the public a right to know what is likely to affect them. The right to know is a crucial aspect of our civil liberties and public servants deny that right at their peril.

As managers understand only too well, not everyone is able to make a mature decision on a given set of facts. Often the staff and the press will exploit the situation in a manner inimical to management. So who is right? There can be no clear answer. Suffice it to say that, given the public nature of the NHS, managers have an ethical obligation in their custodial role of the common good, to manage as openly as possible. There will be a practical need for secrecy on some issues but it is easy to abuse this to protect managers from the glare of staff and public opinion. Coordination therefore is not only a practical aspect of management but also allows staff, patients and public the right to contribute to decision making.

Control

Implicit in the need for coordination and communication is the need for control. Managing within constraints is a particular characteristic of a cash-limited public service. But it is not just a matter of controlling resources; it is also a matter of controlling organisational behaviour.

What is the basis for controlling resources? Simply that no organisation, or indeed an individual person, can deny the imperative of living within means. To spend other people's money – even the government's – without permission is reprehensible because it is taking what is not yours; it might even be considered theft, one of the more fundamental crimes against society and the individual. In practical terms, spending without control leads to organisational anarchy. For health service managers this state of affairs is more common than might be imagined and is a clear demonstration of two ethical perspectives being in conflict. The doctor justifies spending solely in the interest of the patient, but the manager aims to protect the general interest. Both views are valid but which is right? We will be returning later to this fundamental dilemma.

In an attempt to impose order for the common good the manager defines rules and procedures. These include not only written instructions, such as standing orders regarding the handling of financial matters, but personnel policies which ensure that staff will be dealt with in a uniform and therefore fair manner. Systems for performance review can correct the somewhat arbitrary subjective assessment of performance by establishing a clear set of criteria by which an individual can be judged. An unjust organisation works less well and managers begin to lose control of their prime resource, the staff.

Evaluation

Finally, a manager justifies the success or failure of the organisation through the process of evaluation. Were objectives met and was the quality of the service maintained? Crucial to this process is the setting of standards. While there may be some danger of a lack of reality creeping into the definition of quality, it is still an ethical obligation to ensure that patients have a level of service on which

they can depend. Failing to undertake this managerial function is to fail those for whom the service was set up. Poor results are therefore ethically dubious.

The individual or the group

Before concluding this preliminary discussion let us return to the wider issue of the ethical principles which should guide a public service such as the NHS. Is there one overall principle which can govern practice?

Some would say that managers appear to exemplify utilitarianism, somewhat crudely summarised as the greatest good for the greatest number. This is not the place to discuss whether this statement is an adequate summary of the views of the 19th century philosphers, Bentham and John Stuart Mill; it is enough that managers recognise that they often claim that they are trying to accomplish comprehensive benefits for as many patients as possible. But a little thought would show that this is scarcely an adequate explanation of what managers often do. If it were, they would keep mentally handicapped people in hospital in order not to upset the neighbours. They would also fill every operating list with the repair of hernias and varicose veins to the detriment of more heroic surgery. Can it really be right for 100 people to have a limited service and deny ten people a cure? What would be the answer if the equation were palliative measures for 1000 patients or cure for one? It is clearly insupportable to espouse the principle of quantity rather than quality because the rights of the individual would be profoundly abused in the process.

Doctors often avoid this dilemma by refusing to acknowledge the rights of those patients not yet referred to them. They can therefore limit their concern to the number of patients for whom they have resources. Managers have no such luxury and have to resort to other means to sort their priorities without betraying the patients. So, for instance, some managers will be attracted to the idea of QUALYs (quality adjusted life years) which attempt to estimate the value of medical intervention in qualitative terms. Others will have been influenced by the economist's concept of opportunity costs – that every decision in favour of one course of action is also a decision against alternatives. Whichever way managers endeavour to rationalise their decisions, they cannot disguise the

fact that they have a value system which will influence all those decisions. Deep down each of us will have views as to the relative worth of a baby or an 80-year-old. The baby has a life ahead and will presumably have the capacity to contribute to the common good. But the elderly person has given a life of service and should be rewarded with an old age as free from suffering as possible.

Case study no 1 – The waiting list

There are 5000 people on the waiting list in your district. Government policy has determined that priority should be given to those who have waited the longest. The medical staff of the district in which you are the district general manager have said that priority should be given to those who are most likely to benefit.

How would you deal with this conflict of views?

What we must acknowledge is that individuals have a pre-eminent right to be recognised as unique. This is not compromised by their status. A mentally handicapped person has the same rights as any one else. Not to accept this is to accommodate a pecking order of human value which has been the hallmark of some of the worst tyrants in history.

This book will not provide answers to the dilemmas facing health services managers, but it will rehearse some of the more common situations they face in order to try to improve the quality of their thinking about what should be done. At times the author, himself a practising health manager, will put forward views which others will find wrong-headed. He will be happy to have raised that degree of dissension; only by debate can we ensure that the attempt to do the right thing remains a daily challenge.

2 ETHICS AND THE PATIENT

THIS chapter, the longest in the book, is concerned with patients and the way ethical considerations affect their care and treatment. General ethical principles provide a framework for protecting them as individuals but the application of these principles varies according to the specialty or other care groupings. These will be looked at in turn.

Principles

Who is a patient? Does the transition from healthy to non-healthy person require a change in ethical outlook? I shall take the view that the general principles are those which operate for all of us, sick or well, but have a specific significance when applied to patients. Patients can be described as people whose health requires the help of others with special skills. The patient may ask for this help or be perceived by others as needing it. Another way of describing a patient is to say that anyone seen by a doctor is a patient, although with the increasing opportunities for autonomous practice by other health professionals, this neat definition is no longer so secure. Establishing patient status is important, particularly when the person/patient may deny that he or she needs care and to impose it might constitute an infringement of rights. Instances will be given later.

The principles that help our discussion overlap somewhat; for instance, all could be said to honour the fundamental imperative of safeguarding the rights of the individual. Nevertheless it may be useful to attempt some classification. Patients have a right to expect:

that their individuality will be respected;
that their privacy will be safeguarded;
that no unreasonable harm should come to them;
that nothing should be done to them without their consent;
that those looking after them should exert their best skills on the patient's behalf.

Let us look at these in more detail.

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Individuality

Fundamental to all discussion on ethics is the assumption that the individual has rights. Such rights are often described in terms of equality and justice. In the NHS we stress the need to treat all patients the same, whether they are attractive young people or disagreeable geriatrics. The more unattractive the patient, the more staff will be reminded that that person has rights and must not be discriminated against. Not all staff succeed when faced with patients who are not only unattractive but are part authors of their own ills. This particular group will be discussed later.

Case study no 2 – An individual's right to sex

A mentally handicapped man of 24 lives in a mixed hostel in your health district. He has a girl friend in the hostel. The nurse in charge discovered them attempting sexual intercourse in the room he shares with two others. This distressed the nurse who is now asking for one of them to be removed.

What action would you take?

For managers, practicalities often unwittingly rob patients of their individuality. Look again at the term 'geriatric'. A geriatric is not an individual, but one example of a group which is itself difficult to define except to say that a geriatric is someone who has seen a geriatrician. Similarly, mentally handicapped people are described as *the* mentally handicapped. When discussing health policy it is easy to fall into generalities as a sort of managerial shorthand but this has its ethical dangers, leading as it does to unconscious discrimination.

Privacy

Another threat to individuality is the loss of privacy. Health service managers are probably more aware of this ethical dilemma than

most others and will have impressed on everyone the importance of not discussing an individual patient's affairs with other people. While this may reduce the top-of-the-bus gossip it scarcely diminishes the chattering about patients which is the life-blood of coffee room socialising in a hospital. Managers, themselves, whose contact with patients is usually confined to difficult patients and to

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Case study no 3 – The visit to casualty

Three men have been admitted to casualty between 11pm and 1am with cuts to their hands and forearms. One gives a story of fighting in a pub, another of an incident at home, and the third claims he has had a car accident. The police are asking the nurse in charge for information on anyone with such injuries as they are investigating a break-in involving the theft of £100,000. The doctor says the information should not be given and now the police are contacting you, the manager, for help.

What help, if any, should you give the police?

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complainants, share patient anecdotes in a similar manner to care staff. Ethically, such scant regard for the patient's right to privacy might be seen as reprehensible, but most people in the organisation would feel that so severe a judgment would be counter-productive. After all, such conversations contribute not only to the education of the carers but help to build up a sense of corporateness which in itself can improve the caring environment. The principle of privacy has to be mitigated by sensible rules which protect the rights of patients but do not impose impossible strictures on the staff. It is also worth making the obvious point that observing privacy should not become an impediment to the proper care of patients. Not revealing important information about a patient to another professional or caring agency may lead to poor decisions. In these circumstances the respect for privacy fights with the other ethical principles, particularly the one which commands professionals to use their best skills in the interest of the patient.

Protection from harm

Considerable effort has gone into setting up procedures and policies aimed at protecting patients from harm. These include measures to ensure proper practice in the operating theatre, the administration of drugs and other medicines, and protocols to govern research on patients and their illnesses, all of which are relatively easy to deal with. Less easy are those situations where

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Case study no 4 – The wrong dose

A staff nurse has given a baby double the normal dose of a drug. The baby had a slight reaction but has now recovered. The clinical nurse manager of this part of the hospital feels that the nurse should be suspended from duty and reported to the UKCC.

As the unit general manager, what advice would you give?

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protecting the patient is difficult to ensure, either because of the obscure nature of the risk or because the cost would lead to an unreasonable reallocation of resources. For instance, how far ethically speaking should managers endeavour to ensure that patients do not become infected while in hospital? Is it ethically wrong to allow operating in a theatre that is not equipped with a modern plenum ventilation system? How far should we go in protecting patients from the risk of fire, particularly if some of the measures work directly against others aimed at respecting the patient's right to individuality? Here managers often face pressing ethical dilemmas without support from professionals, who may have more self-interested reasons for emphasising the risk of harm. In other words, a doctor may use risk as the presenting reason for obtaining the latest piece of techno-medical equipment.

The courts are left to judge whether patients have been exposed to unreasonable risk but cases presented to them are few. For managers, there are almost daily questions on what to do to diminish risk to patients and how strenuously to take action to improve levels of patient safety. Can they reasonably be expected to make

decisions about what is an acceptable risk and what is not? What are the issues? First, risk is relative. No one can be protected from all risk but we do have a right not to be exposed to risk that could reasonably be avoided. The definition of what is 'reasonable' is therefore crucial. Expending large sums of money to avoid a remote risk is unreasonable using the opportunity costs argument – too many other opportunities will be denied in the pursuit of this one act of risk-avoidance. Managers have difficulty in assessing the severity of the risk described by clinicians. Habitually doctors and others caricature the degree of risk in order to pursue their demands. Only close questioning will reveal the truth and a refusal to be influenced by shroud-waving arguments of the 'My patient will die unless...' variety. Nevertheless, it has to be faced that some patients will get considerably less than optimum treatment because of a lack of resources. A manager is often in a stronger position to make the crucial decision because he or she has no personal contact with the patient. This is not to ignore the daily decisions that doctors make which may deprive the patient of the 'best' treatment. It is worth saying that patients may be more philosophical about risk than might be assumed if the dilemma is adequately explained to them.

Consent

Patients have a fundamental right over their own body which may not be invaded without their permission. This, of course, can lead to difficulties when it is not clear what the risks of treatment are going to be. Nevertheless, every attempt must be made to explain what is likely to be the outcome of medical intervention. Current consent arrangements are somewhat cursory and rely very much on the conscientiousness of professional staff to ensure that patients really understand the nature of the proposed treatment. It is not unknown for doctors and nurses to push a consent form under a patient's nose with only the most superficial explanation. Patients, cowed by the prospect of surgery or some other unpleasant procedure, may feel quite unable to ask questions. In such cases the patient and the professional together have betrayed the principle of informed consent. Of course, consent is not just about agreeing to operations; the patient must have the illness described, be told its likely prognosis, and share in discussions on care and

treatment. The proper management of the dying patient, discussed later on, gives a clear indication as to how this principle can be honoured.

Case study no 5 – The misread smear

A cervical smear was misread as negative by a medical laboratory scientific officer. The patient went on to have a second pregnancy which she would have been advised not to do if the positive smear had been known. She subsequently developed cancer and is now seriously ill. Her GP feels that to tell her now that a mistake was made would be psychologically damaging as her prognosis is uncertain. There is clearly a danger of litigation and substantial damages against the hospital if she is told.

As the DGM, do you: tell the patient; tell the spouse; neither?
If you do tell, do you tell:
now; when the doctor advises; only if the patient dies; only if the patient gets better?

Professional expertise

Last in this discussion of fundamental principles is the right of patients to benefit from people who are appropriately trained and working within the limits of their skill and expertise. This principle is rooted in the idea of moral obligation and its outcome, duty. Health care professionals have spent considerable time in formulating declarations of their standards and have sanctions to ensure that they are honoured.

The principle is easily stated but the practice less so. There are situations where the patient does not get the benefit of the professional's expertise but the incident is too trivial to make an ethical meal of it. For instance, ignoring a patient's request for a bedpan is not sufficient to get a nurse struck off the register, although it is an

example of a failure to honour the patient's right to be comfortable. The patient is unlikely to judge the nurse too harshly in this case, which is scarcely more than a common human failing to be kind and considerate. But there are much more serious examples of health professionals acting beyond their skill. A ward sister allowing a nursing auxiliary to do the work of a trained nurse, or a consultant failing to supervise a registrar in the operating theatre – are both examples which carry an ethical penalty.

Case study no 6 – Incident in the outpatients' department

A sister in the outpatients' department reports that a patient asked to speak to her confidentially yesterday about an incident the patient says happened to her last time she visited outpatients. She was seen at the end of the session which over-ran. The consultant had assured the nurse on the clinic that this was a simple follow-up and he was happy to see the patient on her own. The patient now alleges, some weeks later, that the consultant sexually assaulted her. She does not wish to make trouble, however, and does not want the matter to go further; she just thought sister should know.
The consultant is very senior and highly respected and the sister has worked with him for years.

Sister tells you this story: as UGM what do you do now?

Having looked at the principles in a general manner, we now have to examine the particular categories of patients on the assumption that the manager has a duty to ensure that these principles are honoured, even though the professional care staff are intermediaries.

Acute patients

These are typically in and out of hospital in a short time, an advantage and a disadvantage when considering the principle of indi-

viduality. On the one hand, their individuality is likely to be respected because the urgent nature of their admission requires considerable attention to be paid to the patient over a short period. On the other hand, once diagnosed there is a danger that they will acquire a pseudonym derived from their condition. Thus the patient with abdominal pain in due course becomes 'the appendix in the third bed on the left'.

The degree to which individual rights are respected can also be judged by examining how much attention the patient is given and at what cost in resources. Private patients seem to benefit from more attention and, in so far as their rights are being respected over and above NHS patients' rights, there is an ethical dilemma. This is one reason why managers prefer to keep the two groups separate. But the attention paid to private patients may be more apparent than real as there is no evidence that the outcome of treatment for the two groups is significantly different.

Another test for examining patients' rights is to look at what criteria are used for deciding on high cost, high technology treatments, such as a heart transplant. Managers need to press for a protocol in such cases. Whether this is based on an economic device such as QUALYs, or a more subjective judgment, is less important than making an explicit decision which will stand scrutiny.

Whereas transplantation has an aura of necessity, cosmetic surgery does not. Removing tattoes or lifting chins are procedures readily dismissed as vanities. But before the manager accepts the general disparagement, it is important to establish why the patient is demanding the operation. Some cosmetic surgery may be needed to overcome psychiatric problems caused by the patient's concern for personal appearance. A woman who wants surgery to reduce the size of her breasts should not be condemned to the sniggering judgment of staff. It may be necessary for the manager to remind staff that every patient requiring treatment has the same right, so that a patient undergoing a sex change should be treated with the same respect as one having a gallbladder removed.

Acute patients will normally be quite happy to acknowledge that they have been in hospital so long as their illness is not one with some stigma attached. This does not remove from staff the need to honour their right to privacy. In practical terms, of course, there has to be considerable exchange of information within the team if continuity of care is to be ensured and a proper diagnosis obtained.

The dilemma of who should know what is well illustrated by a patient suffering from a disease which is surrounded by social disapproval and fear.

In this context, AIDS is a useful case study. AIDS appears to be a fatal condition which weakens a patient's immune system with increasingly devastating results. The virus which attacks the immune system is not particularly contagious and survives with difficulty outside the body. Proximity is not therefore a problem, nor is the common use of household objects. Transmission is through blood, semen and (maybe) other body secretions. Despite this, the fear that surrounds the disease, in society and even in the NHS, has been widespread and has threatened appropriate care. If we treat the patient in a normal manner, quite a few staff would be privy to the diagnosis because it would be referred to in various medical records and on request forms. But with AIDS such working arrangements have, for the time-being, to be modified. The ever present risk of media intrusion and resulting hysteria would seriously compromise the patient's care. It is right therefore to make more elaborate precautions to protect the patient's privacy, even though departing from usual practice may in itself alert others to the unusual nature of the case.

But where does this leave the staff? Do they not have a right to know what they are dealing with? Clearly they should not be put at risk, and the manager will have to ensure that procedures exist to indicate how blood and other specimens should be handled. A simple way of overcoming this problem is to have an instruction about behaviour without giving a reason. In the case of AIDS, the instruction to staff can be 'treat as innoculation risk'. Hospital staff exposed to the full ingenuity of the popular press may not be able to protect the patient from intrusion. The manager has a particular responsibility for protecting staff unhappily trapped in this situation.

Acute patients are more prone to procedural risks and the manager therefore has to check that agreed systems are not allowed to decay. Under pressure, or with a blasé attitude arising from habit, standards can slip. There are still too many incidents when harm comes to patients even where procedures for marking the operation site, or for the double checking of names or doses, have been in existence for years.

But protecting the patient in the operating theatre or at the bed

side is not all; risk can be more widespread. Measures to monitor and control infection do not figure high enough on the agenda of clinical staff and, at the risk of interfering in areas considered outside those normally within the managerial remit, the manager should nevertheless check what attempts are made to record all instances of cross infection. In recent years, outbreaks of food poisoning and of legionella have involved the manager more specifically. The manager's ally will be the microbiologist and the community physician, who may need the added weight of the manager to bring suitable pressure on clinicians. In a major outbreak, coordination of a plan of action will require the manager's active involvement.

Risk to acute patients may be increased because staff are in training. This is where doctors and other professional staff spend most of their training years. Managers therefore must ensure that staff are not left without adequate supervision. This can be a bone of contention, particularly with learner nurses who can be left in charge of wards with only minimum supervision. The introduction of new education arrangements under Project 2000 will improve this situation – learner nurses will be largely supernumary to the ward staff. Junior doctors should also always have access to more senior staff when emergency duties are being undertaken.

Finally, the risk which arises from the incapacity of a member of staff is covered in Chapter 5. It may not always be easy to get professional staff to be frank about a colleague who is putting patients at risk, and the manager has to be pressing. The codes of conduct of the United Kingdom Central Council are better at safeguarding the patient than are the medical procedures, where confidentiality is sometimes mere secrecy.

We have already looked at some aspects of consent. In acute medicine there can be problems when a patient refuses to have the treatment prescribed. The manager may be contacted in an endeavour to resolve the problem. Certainly it is very unwise to proceed without consent, even where the patient is at risk. So what can be done? The manager should go over the risks with the doctor and ascertain that the patient and his or her next-of-kin are aware of them. If there is still a refusal it may be sensible to ask the patient to sign a disclaimer that, in the event of a future claim of negligence, the doctor's advice was not taken. This may not protect the hospital or the doctor entirely but could be helpful in a court of law.

Dying Patients

Dying patients are often inadequately cared for, due to a failure of the staff to honour individuality. Often the truth of their condition is kept from them. Some patients may not wish to know the worst, and if told could become demoralised. But research has shown that most patients either know their fate already or certainly wish to be told. Letting the next-of-kin know in lieu of the patient is ethically unsatisfactory and can seldom be justified. What is the relative to do with such information? Tell the patient themselves; be particularly kind to the patient; or check the will?

Telling the patient is not easy, particularly, as usually is the case, when the doctor is very busy. Increasingly, hospitals are making arrangements to provide specialist staff to support the dying patient and their relatives. This is not just a question of giving appropriate care to ensure that the patient is relatively pain free, but is also to ensure that spiritual support is provided. This is not necessarily within a particular denominational context, where a chaplain or a local priest can be used, but more generally to help combat the fear which often accompanies the prospect of death.

How far is it possible to make special arrangements for the dying patient? The traditional corner bed in the ward may increase privacy but it can take on a rather superstitious aura once other patients have seen that the bed is used in this way. On the other hand, dying in the middle of the ward is equally upsetting. A side room is to be preferred if it exists. Still better the patient should go home or be transferred to a hospice. The manager, supported by a recent circular, should be involved in these matters.

So far we have only addressed the patient who is expected to die in due course. Another situation in which the manager may become involved is the termination of life by switching off a life support machine. Most doctors are now well able to discuss such a decision with relatives and come to an agreement, but some involvement of the management may be necessary where the case is manifestly hopeless but the relatives still entertain hope. If agreement cannot be reached, the manager would be well-advised to arrange for a second opinion on the state of the patient so that, in the event of subsequent difficulty (even litigation), the health authority can maintain that they acted reasonably and the patient was undoubtedly beyond resuscitation.

Throughout this discussion, emphasis has been put on the involvement of the patients themselves as far as that is possible given their terminal state. This is particularly important in deciding the limits of care. The extent of medical intervention is as much a decision for the patient as it is for the doctor. Ethical precepts, such as not officiously keeping patients alive, are useful. But euthanasia as the law presently stands is illegal, although it is known to happen. A manager can only advise that to purposefully terminate life, for whatever humane reasons, is criminal and can have no official support. This, however, is a very difficult area where the law may prove inadequate to higher considerations about the relief of suffering. Ethically such matters have to be left to the doctors; this is an area where the manager has no place ultimately.

This discussion has assumed that patients and their relatives have a right to expect that professionals will always use their special knowledge and skills for the benefit of the patient. But it should be said that there is a limit – and playing God is beyond that limit.

Mothers and babies

One of the more important lessons learnt by professionals and managers alike over the last few years is that having a baby is primarily the affair of the parents. It is no longer considered appropriate to commandeer the mother and remove her independence. The attendance of the father at the birth is now common practice, acknowledged by the hospital authorities, midwives, obstetricians, paediatricians and anaesthetists alike. This recognition of the patient's individuality is easier than in other areas of care because the patient is not normally ill and therefore more easily asserts her rights. But does this respect extend to the baby, and what happens if his or her rights compete with those of the mother?

In the last century, with a very high perinatal mortality rate (stillbirths and deaths within the first week of life), the matter was simpler: the mother's rights were pre-eminent, if only for the practical reason that she could have another child. Now the situation is more complicated. Because maternal mortality is almost a thing of the past there is no tension to the choice of mother or baby. Parents are not prepared for anything but a perfect baby and are unwilling to be fatalistic about the outcome of the birth. So a grossly handicapped baby will be treated as having the same rights as a strapping

eight-pounder. Is this right? Should large sums be spent on babies with poor prospects? Paediatricians, unwilling to accept defeat, strive to make them viable, but in doing so may ignore the financial consequences. Consequently, managers are faced with ever-increasing demands from the staff involved in neonatal care and may have to look at the opportunity costs of increasing resources, asking what other developments would have to be foregone as a result.

Ethically the dilemma remains acute as parents are often unwilling to face the situation realistically and ask for efforts to be made which are beyond the bounds of reason. This exposes the staff to extreme pressure which they may pass on to the managers in the form of demands. In return the manager may have to ask what has been said to parents faced with a child whose future is poor. Are they aware of the burden the child may be if it survives? Do they really want staff to struggle against the odds to save their child? Or can they be helped to see that it may be kinder for the child to be relieved of suffering without too much interference from the clinical staff? If the parents cannot face this, the hospital has little alternative but to do its best – whatever the long-term consequences. It has to be said that the lives of both child and parents may turn out to be better than would have been thought possible.

Ethical problems do not begin at the point of birth. *In vitro* fertilisation (test tube babies) has taken the ethical boundary to the point of conception. Many managers, worried about increasing demands on limited resources, may feel that straining to overcome the deficiences of nature is straining too hard. But before rejecting the rights of the childless couple, it is worth stating that managers are constantly endorsing the correction of similar problems. Ethically speaking, is the correction of congenital malformation after birth any different from attempting to overcome infertility? It might be argued that to go looking for trouble is rather different, but the rejoinder could be that if professional skill can overcome infertility, then childless people are entitled to its benefit. Managers are secondary to such decisions, but they have an obligation to understand their ethical implications and to make sure that faulty reasoning does not deny patients their rights.

Some people are unhappy at the prospect of impending parenthood and seek abortion. For the manager, classification of the pro-

blem is needed. Is the abortion therapeutic or social? It is easy to argue that the therapeutic abortion should have priority when resources are scarce, but the legitimacy of such an argument may be more practical than ethical. A grossly handicapped baby will be a problem to its parents and to society, so if the parents are agreeable an abortion is a practical solution. But the social problem of an unwanted pregnancy may be just as pressing. Take, for instance, the single teenage mother from a poor social setting. The prospects for the child may be as bad as for the handicapped baby. The indication for an abortion is not easily arrived at, and certainly the simple classification into a therapeutic or social reason needs to be approached with care. But this is not all. Does the unborn baby itself have any rights? Some, usually speaking from a religious standpoint, would argue that once conceived the foetus has the same rights as any other living person. Others say that to accept such an argument implies that the sperm or the ovum also has rights which, given the generosity of their production, would seem absurd. Whatever the argument, managers must be assured that the beliefs of patients are not abused and their consent to abortion not automatically assumed.

Children

Whereas it is easy to argue that the child in the womb is part of its mother and not therefore eligible to be discussed as an individual, once it is born the position changes. The child as an independent being (more or less) has rights of its own. In some countries these rights are modified and total autonomy withheld until the late teens. This effects the child's power to make decisions on its own behalf.

So what rights does the child have? Does the child belong to the parents and can anyone else intervene in this relationship? The recent focus on child abuse illustrates some of the dangers in accepting too readily the parents' custodial role. Clearly there are circumstances where the parents can no longer be trusted to look after the child and protect its individuality. Child abuse, whether sexual or not, is predatory, does harm physically or psychologically, and is, of course, without the consent of the child, despite those cases where the abuser maintains that the child colluded with the abuse.

The manager may get involved in this difficult area when it becomes apparent that doctors and social workers are seeking to remove a child from its parents for its own good. Given that this has to be legally undertaken through the courts, it is important that health authorities are seen to be reasonable and are satisfied that their doctors are competent. This will require some attention to the opinions of others in the caring team. The manager must also ensure that procedures protect both the patient and the staff. Careless allegations can cause a great deal of harm to either party and must not be left unresolved. Guidance will cover the examination of the child, the involvement of other members of the team before a diagnosis is confirmed, and providing a clear account to the parents of the proposed action, however vehemently they may be opposed to it.

Happily, not all involvement with children is so stressful. Health authorities in their public health role will have policies for immunisation and vaccination. To date, these have not covered enough of the population to eradicate the diseases. For instance, in an average year over 100,000 children suffer from measles in the UK compared with a few thousand in the USA. There are two issues here for managers. Can the rights of the individual child be over-ruled in the general interest of the population; and what is the duty of the manager to ensure that the total population is covered?

One way of ensuring good take-up of vaccination is to make it compulsory. In some states in the USA it is a condition of entry into school. In this country such an officious requirement would be frowned on. In any case, some parents, and even some doctors, have reservations about some vaccinations, notably that for pertussis (whooping cough) where a small number of children have developed convulsions following the injection. Ethically, therefore, it seems obvious that nothing should be done to a child without its parents' consent, particularly if there is a risk, however slight. But research has shown that the risk from whooping cough is as great or even greater than developing convulsions after vaccination. What should a health authority do? Avoid the greater risk, defined as a risk to the total population, or respect the individuality of the child? Ethically the former course of action seems to carry more weight. Parents must be allowed to withhold their consent, however, provided that they do so in an informed manner and are

aware of the balance of risk. They then carry the ethical responsibility.

The greater ethical obligation is to ensure that everything is done to protect and promote the health of the nation. The manager in endeavouring to achieve this has to ensure that immunisation programmes work efficiently and reach their target population.

There are other ways of promoting health, particularly in children, by the routine process of screening. At each significant stage in their development, tests will show how well they are doing. This traditional way of ensuring the steady progress of the child is now being questioned because it is costly. In a time of improving social conditions and increasingly scarce resources is it not wasteful to undertake total population screening? Would it not be better to select children known to be at risk, such as those in single-parent families on low incomes, and target them specifically? However, this exposes an ethical problem, that of discrimination. It is not sufficient to say that because the intention is benevolent, the discrimination is justified. Nor is it more than a semantic quibble to approve 'positive' discrimination. The single-parent family may feel unhappy about its lot already without the automatic assumption that its children are particularly at risk, no matter what statistics appear to show. The ethical advantage of total population screening is that its very generality ensures equality. Nevertheless, the relatively high cost of looking at a largely normal population is bound to force some managers to consider whether the overall public interest is best served by spending significant resources to find a small number of abnormalities, even though some of them may prove to be costly if left undetected until later in the child's life.

Finally, we must recognise that children have special needs when they have to be admitted to hospital. Due to the pressure exerted by parents and other people, managers and professionals alike can no longer get away with treating children in an adult setting. Children's wards with their own régime and with facilities for parents to remain with their children are now standard. But this respect for children's rights can sometimes be fragile and constantly needs endorsing. The easiest way is to appoint specially trained staff who understand children's needs and to promote support groups who will act as guardians of children's interests.

Mentally ill people

This is a group of people whose incapacity has sometimes made them victims of the organisation. The acutely ill patient, the mother or the child, have many advocates, but the mentally ill person is less well served. Managers have a particular obligation to ensure that their rights are respected. Perhaps the fundamental problem is one of classification. Is the concept of 'madness' permissible in ethical terms? If it is, does it lead to different ethical rules for those who are 'mad' and those who are not? Using the criterion of individuality we can test the ethical status of the person who is deemed 'mad'. 'Mad' is used to describe persons whose command of reason is insufficient for them to know consistently who they are and how they relate to others; where they are and what behaviour is appropriate to that environment. These simple checks on reality can be used to establish a patient's condition. If the results are unsatisfactory, then the person can be categorised as having a diminished response who will need his or her rights protected by health professionals, health authorities and their managers, and the law.

There have been considerable difficulties in the past in ensuring that the rights of an individual have not been too easily transferred from the person to the authorities. The Mental Health Acts of 1959 and 1983 attempted to make it more difficult for anyone to remove the rights of a mentally ill person but lead to problems in balancing the rights of the individual with the need to protect society from bizarre or dangerous behaviour. Some people are of the opinion that over-emphasis of the rights of the individual has led to the abuse of society as a whole. There has been a backlash and, increasingly, even health professionals are asking for a return to the principles of asylum discredited for many years. The careless discharge of patients into the community does not honour the individuality of the mentally ill person, nor does it protect them from harm. Indeed, our five principles – individuality, privacy, no harm, consent and professionalism – might be said to be affronted by deluded expatients living down and out on the streets of our major cities. Nowhere is there a clearer example of the ethical implications of social policy.

Despite these worries, mentally ill people do have their protectors. The Mental Health Commission, set up under the 1983

Act, is a body drawn from a wide range of informed laymen and professionals. They safeguard the rights of mentally ill people in hospital, particularly those who are detained under the orders of the 1983 Act. They supplement the work of the Mental Health Review Panels. It is for managers to ensure that the procedures operate smoothly and that professional opinion is scrutinised by these bodies. For instance, the scrutiny of individual patients held under a detaining section of the Act is not always undertaken as thoroughly as it might be by health authority members in their statutory role of hospital managers. These members may be in awe of medical opinion and are prepared to accept a prognosis without question because of a mistaken sense of clinical supremacy. A good clinician will not resent questions. It is an accepted principle in our society that professional judgement should be exposed to the scrutiny of the lay person.

Ethical considerations are not reserved to that small group of mentally ill people whose liberty is restricted. Most patients enter hospital voluntarily. Once there, however, aspects of their treatment may be unacceptable to them. The most obvious example is ECT (electro-convulsive therapy). This procedure administers high voltage electric shocks to the patient under a short-term general anaesthetic. It is justified on the grounds that many patients feel better after a course of treatment even though they are likely to suffer some short-term amnesia. Nevertheless, feelings run high on the ethical justification for the treatment. Nationally there are pressure groups who seek to ban ECT on the grounds that it causes permanent damage to the brain cells, that its efficacy has been overstated, and that it is fundamentally a primitive assault on the patient. Advocates, however, while admitting their uncertainty about why it should prove effective physiologically, point out the benefit to people with depressive illnesses, who often feel better after treatment. Can the ends justify the means? Is this physical assault any different from an extended course of drug therapy?

A manager faced with these questions can only approach them systematically. Because the manager cannot ban or promote a clinical procedure, private views on ECT are irrelevant; however, it is incumbent upon the manager to check that the procedure is being carried out with a proper regard for ethical considerations. There must be informed consent, although the patient may not be well enough to give it. In this case, the next-of-kin must be involved,

but, if there is any doubt, the treatment should not be given. The patient's subsequent reaction to treatment should be monitored to ensure that the efficacy of the treatment has been established.

Another difficulty with mentally ill patients is restraining them from self-injury. Before the development of today's drugs, physical restraint was commonplace. All mental hospitals had the now notorious 'padded cell' and used other physical methods of control, such as the strait-jacket. Drugs may have made such methods unnecessary but has the ethical position changed? Is there really any difference between inducing quiescence by pharmacological rather than physical means? Probably not, except that the pharmacological methods may lead to a more humane response from the staff. Physical restraint can coarsen their skills. Either way, the staff are still required to practise their skills in the best interests of the patient, minimising the symptoms of illness and maximising the opportunities for recovery. Even if physical seclusion is accepted as a way of modifying challenging behaviour, professional staff have constantly to evaluate its effect on the patient to make sure they come to no harm.

On occasions, the staff themselves become a problem for the manager. In the treatment of mentally ill and mentally handicapped people there can be considerable professional rivalry. The doctor's traditional supremacy as head of the team is sometimes challenged by others – the psychologist, the social worker or the nurse. What is the role of the manager in such arguments?

Again we must return to the patient. The manager's responsibility to the patient is as demanding as that of the professional. If professionals are quarrelling the manager must become involved, no doubt attempting to act as a go-between trying to understand the dispute and to offer compromises towards a solution. However, if reasonable behaviour is not forthcoming a more determined stance will be needed, even the disciplining of individuals. These disputes are never easy to handle and are seldom resolved spontaneously. For a manger to abdicate the duty to protect patients' rights in these circumstances is unethical, even if it means supporting one view against another. Notorious hospital scandals in the 1970s were characterised by managerial faint-heartedness.

Mentally handicapped people

Challenging medical supremacy is not always a bad thing. Good results can be observed when looking at what has happened to mentally handicapped people over the last 20 years.

Freed from the over-emphasis on diagnosis, they have largely been able to recover their rights as individuals. It is now common policy for health authorities to accept that mental handicap is not an illness. Despite this, protecting mentally handicapped people from exploitation is not easy. They are at risk from public opinion which constantly lags behind the more enlightened views of professionals. A mentally handicapped person living at home in the community is not the end of responsibility for the professional or the manager, but a new beginning. How does this supervision fit into the idea of a normal life which, for most of us, does not include the monitoring of our daily routine?

Here the ethical framework may help. The mentally handicapped person has the right to be treated as a citizen like the rest of us. This fundamental respect for individuality is not compromised by mental handicap which, for instance, can make it impracticable for the person to record a vote. This is an important point: because you cannot avail yourself of a right does not mean that it no longer exists for you. All arguments using lack of capacity as a justification for reducing the rights of mentally handicapped people must be viewed as suspect.

For similar reasons great care must be taken when considering the sexuality of mentally handicapped persons. As adults they must be assumed to have a sexual drive like the rest of us. Ignoring it is unsatisfactory, and treating it as aberrant behaviour is wrong. Many professionals have found it easier to treat mentally handicapped people as though they were children, which may be kindly meant but can lead to difficulties, particularly with their sexuality.

How should the manager advise staff who are worried about the sexual lives of mentally handicapped people in their care? Is it best to let nature take its course or should staff help them to have more fulfilling sexual lives? To leave matters alone may lead to socially unacceptable behaviour (such as masturbating in public) which, if unchecked, could be a justification for removing a mentally handicapped person from ordinary life. It is important, therefore, to help the person to understand some rules about the time and place

for sex. However, talking is one thing, showing how is another. Most professional staff (and this is a task where the formality of their professionalism is particularly important) will find it difficult to be involved. A manager should remind staff of the basic human rights of the people in their care and alert them to the sensitivity of a situation in which it is easy for actions to be misinterpreted. Staff should never act on their own initiative and whatever practical help is to be offered should be discussed beforehand and suitably documented. Because the Mental Health Act makes sexual interference with a mentally handicapped or mentally ill person a criminal offence, it is best, on the whole, to leave sexual instruction to staff who have been specially trained in this work.

Sexuality causes other problems. How ethical is it to protect a mentally handicapped woman from pregnancy? There may be sensible reasons why she should not have children. She may not be able to look after a child in a satisfactory or even safe manner. Some form of contraception is therefore necessary. What if the level of understanding is insufficient to manage contraception, either the pill or other practical methods? Does this give a doctor the right to sterilise her?

Certainly it is a low risk, practical solution, but what of her rights? There can be no clear answer, and action in the end may have to be determined by a compromise of values. Sterilisation without her informed consent (because she may not understand the implications of what is being said) is an assault. In other circumstances the doctor would rely on the consent of the next-of-kin. But next-of-kin, often the parent, can scarcely be said to be dispassionate. Some parents have great difficulty acknowledging the sexuality of their mentally handicapped offspring and by sterilisation may be seeking to maintain the adult woman in permanent childhood. However, if no other form of contraception is likely to be satisfactory, sterilisation will be the only answer. Managers may be involved in this ethical dilemma, if only to ensure that some sort of code of good practice exists and solutions to problems are not arrived at casually.

In other respects professionalism can be seen as a bane for mentally handicapped people. Their lives are seemingly beset with a process whereby normality has to be designed rather than just happen. But professionals feel, understandably enough, that they have responsibilities that protect the 'patient' from harm. This is not an

easy dilemma to resolve. How can a professional help a mentally handicapped person to lead a normal life that is not exposed to risk? Should such a person be allowed to go to the shops unchaperoned and risk, like the rest of us, being knocked down by a car? To be too protective is to deny mentally handicapped persons their rights; but to be too relaxed might expose them to risks over and above the normal because of their inability to protect themselves.

For the manager, this dilemma is well illustrated by the question of fire precautions. A group of four mentally handicapped people may live in an ordinary house in an ordinary street. Inside, some additional aids to living have been fitted, but otherwise the house looks like its neighbours. Advice from the Department of Health says that the inside should be modified to provide additional safety in the event of fire. This will include additional doors at the top or bottom of the stairs – doors with added fire protection which makes them heavier and more difficult to open. An alarm system is also stipulated. In no time at all the house starts acquiring all the traditional institutional paraphernalia, thus compromising its 'normality'. What then is the manager to do? Likely to be held accountable for any untoward incident, the manager must make an ethical judgment which is explicit about the risks involved. It might read as follows: 'Despite the slightly increased risk of fire which exists where handicapped people live, the threat to individuality of modifying the house to conform to institutional fire precautions is greater'. Managers who render themselves 'fireproof' usually do so at the cost of someone else's autonomy. Here we can see that there is no absolute right or wrong way of dealing with the problem; but there is an absolute obligation to do the best you can in the interests of the mentally handicapped person.

It is for this reason that a stand has to be made against public prejudice. The most frequently observed reaction against mentally handicapped people is when a family-sized group moves into an ordinary house in an ordinary street. Ethically speaking, how far should we prepare for this event? Clearly the mentally handicapped people themselves should be carefully prepared for the change in their lives and acquire some basic housekeeping skills. As a group they will have to be balanced so that they are reasonably happy as a proxy family. But what of the community in which they are going to live? There is a view that it is right to involve the neighbours in the resettlement, which would be fine if the neighbours

could be relied upon. Too often, they cannot. They do not protest, they say, because they are against the idea in principle but because the street is not appropriate for a variety of reasons – including car parking, that great proxy for prejudice. Public meetings are demanded and, if held, give vent to half-formulated fears to do with bizarre behaviour, unfortunate sexual habits and so on. Some people are unashamedly self-interested, claiming that the value of their property will fall.

Faced with this opposition what should the manager of mental handicap services do? Concern for the individual suggests that public opinion has to be considered and an attempt made to find a compromise. Personal experience will determine whether such a course of action will produce reconciliation. My view is that it is seldom possible and that there is great danger of betraying the rights of mentally handicapped people by exposing the issue to public discussion. Rooting the argument in the idea of normality, would you be happy if the neighbours had a public meeting because you moved into the street? Indeed, if you are black such a meeting might offend race relations legislation. A manager who acknowledges the legitimacy of such a meeting is, in effect, endorsing discrimination against another citizen. There is an argument that having a public meeting may reduce prejudice. The balance is a fine one, but in the end the rights of mentally handicapped people are best preserved if public opinion allows them to take up a position in society as unexceptional as the rest of us, black or white, male or female, English or foreign. Although managers may feel that they have to reflect public opinion, they have also an overriding ethical obligation to respect the rights of mentally handicapped people. As always, judgment is the pivot of the ethical dilemma.

The elderly person

Prejudice against small groups of people such as the mentally handicapped is obvious when it occurs. For elderly people, public attitudes are so all-pervasive that it is difficult to see where rights are being infringed. The main concern of health service managers may well be that very generality which reduces all elderly people in care to 'granny' status. Being regarded as an individual seems at times to be the perogative of the over 18s and the under 75s – at

either end of the continuum of life individuality is threatened. A day-room full of elderly people is even less attractive than a school-room full of children, but at least the children are being educated. The practicalities of looking after elderly people make some sort of generalised response almost inevitable.

Who are the elderly? It appears that for most people of whatever age the old person is someone else, even someone younger than yourself. 'I don't want to go in there', says the 85-year-old, 'it's full of old people'. So age itself is not always a good indication of who needs care, although statistically we know that it is the very old who make the most demands on health facilities. In this case, it could be said that the predilection of health authorities for planning services by care group is unfortunate because the generic group is far too large to be dealt with practically as one group. The needs of elderly people are too various and diffuse to be dealt with generally. Paradoxically, geriatrics as a specialty arose out of a perceived need that elderly people's care and treatment should be dealt with more effectively. When GPs were left to look after the elderly, they sometimes missed clinical signs with an airy 'What can you expect at your age?' Consultants may also have missed the inter-relationship of problems being presented by the elderly patient. Geriatrics, a specialty scarcely 30 years old, arose to protect the individuality of the elderly patient. It is ironical that the term should now be used pejoratively by doctors and patients alike.

This may be something to do with organisational politics, and here managers need to explore personal attitudes if ethical considerations are to be incorporated into decision making. How far do geriatricians with their bigger case loads need extra support from the manager to ensure that they get a fair share? Should this advocacy encourage geriatricians to compete with their other general medical colleagues if that means elderly patients are exposed to the full panoply of high technology medicine which may do little to enhance their quality of life? Is scanning the over-80-year-old patient a good thing? Should a hip replacement be undertaken on a 90-year-old? The manager is often the nexus of conflicting views of what can be ethically justified.

There is a more profound argument about the right of elderly patients to have treatment. Rigorous exponents of cost effectiveness will argue, if they can avoid charges of inhumanity, that the elderly are no longer productive and therefore should not expect

the level of treatment available to those who are still contributing to the nation's wealth. Under this set of values the elderly become second class citizens because they are not productive. This way of thinking has its own relentless logic but ethically it is clearly open to challenge. Those who have contributed to the common good in the past should be rewarded with the benefits of care in old age. This, it must be assumed, is the principle from which health care professionals and managers alike now operate. But there is a problem for both in quantifying the benefits available for elderly people. The first step is to aggregate need. This should not be left to the professionals alone who may have difficulty (indeed who does not?) in differentiating between needs and demands. Needs for the elderly are often mundane and do not always claim adequate attention. Managers may find that the provision of good chiropody and an adequate hearing aid do more for the quality of life than sophisticated medical interventions.

One of the practical difficulties of providing care is to ensure that there are neither gaps nor duplications. Health authorities and social services departments endeavour to plan and provide services in an equitable manner. Despite this, failures occur which need the attention of the manager. One problem arises from the classification of the patient. Can everyone agree on the difference between the mentally confused person in the elderly mentally infirm ward of a hospital and the ambulant, wandering, confused person in a residential home? Managers without an axe to grind may observe these problems more clearly than their professional colleagues. Their ethical concern is to articulate the questions rather than solve the problems, although in due course they may be required to start inter-agency negotiations.

Managers have responsibilities of a more practical kind when it comes to protecting elderly persons from their relatives. There comes a time when many elderly people in hospital are no longer able to manage their own affairs. Next-of-kin can be distressingly greedy, assuming concern for largely selfish reasons. The manager, with the social worker and other professional staff, must be careful to see that the elderly person is not exploited. Pension money may be syphoned off into a relative's pocket or, on a grander scale, there may be attempts to acquire the patient's house or other major assets. The Court of Protection can become the guardian of the patient's affairs and managers may be asked to arrange this.

Community care

Most elderly people never require hospital care but they may have needs if they are to continue living satisfactorily at home. What ethical dilemmas does this cause? A fundamental one concerns the right to interfere with a person's life-style. At what point should a professional register concern at the way an elderly person is living and suggest intervention. In these circumstances, how far do we respect the person's right to privacy and individuality? In practice an elderly person should be allowed to continue to live at home providing two principles are observed. The first is that their life-style should not interfere with the liberty of others. So if rubbish is filling the garden and causing a public nuisance, something must be done. Secondly, if the behaviour of an elderly person is disturbing the neighbours at all hours, it is reasonable to try to modify it. But a dirty house is not in itself a reason for calling in the home help or the district nurse. Unless the person is inflicting harm on him or herself, there is no need to intrude unduly. The community physician will be called upon by social services, housing or other health professionals if things appear to be getting out of hand and a compulsory removal under the conditions of the Public Assistance Act is necessary.

The sanctity of a person's home is the guiding principle which any professional carer must bear in mind, no matter what difficulties may be caused by reluctant elderly people. Consent is as important with elderly people as with anyone else, so attendance at the day hospital needs to be agreed with the patient first. It might be argued that even the most intractable person will benefit from attendance and that some coercion is justified. Such reasoning is dangerous. A more tactful approach would be to point out that attending the day hospital may avoid admission into hospital, which the patient is likely to dread even more.

It is by no means unusual for elderly people to fall out with their families. This sometimes causes trouble for carers and managers but they should refrain from taking sides in order to avoid accusations of unethical conduct. This may be difficult, as already mentioned, when predatory relatives are involved. The case conference is the place to discuss such predicaments. Professional carers should be advised by their managers not to take unilateral action without first checking with other members of the thera-

peutic and carer teams. This is also an important point for all staff working in the community who, by the very nature of their work, are often largely unsupervised.

Health promotion

Community care is not just about individuals. There are larger issues that the manager may have to be involved in, notably the need to have health policies which aim to maximise the health of the community and minimise the risk of infection and disease. To some extent health authorities are helped by statutory provisions such as the Control of Pollution Act 1974 and the Health and Safety Act, although, as an employer, the health authority may find their requirements onerous.

How much should the NHS be concerned with health promotion and the prevention of ill health? A requirement was built into the 1946 Act but most health authorites give scarcely more than lip service to active health promotion programmes; well under one per cent of the annual budget is spent in this area. The reason is probably due more to practicalities than ethical concerns. Managers tend to allocate money to what will produce tangible, prompt results, not to those things which seem to be unproven with uncertain outcomes. Healthy eating campaigns may increase public awareness of the value of more fibre and less fat in their diet. But the outcome measure of reduced heart disease is governed by other factors dictated by illness-oriented doctors, making it difficult for the manager to invest resources in such campaigns. In the end the manager, in common with most other people, is content to honour in a largely symbolic manner the idea that it is a national *health* service rather than a national *sickness* service.

But it is this very faint-heartedness that has failed to achieve even the achievable. Only now is there an attempt to overcome infectious diseases through an enhanced immunisation programme. Progress to date has been slow and, ironically, ethics have been used to justify a non-achieving consensus approach. Other major campaigns need the involvement of managers if they are to succeed. The medical profession has failed so far to put their full weight behind health promotion. Given the revenue raised by taxes on alcohol and cigarettes, it is not surprising that the path to a healthier nation seems to be always uphill and often very steep.

Even where there are attempts to improve the early detection of disease it is by no means certain that the right targets are being lined-up. Screening for cervical cancer is a good example. The issue here is the balance of cost against risk – a recurring theme. How much should be spent to avoid the risk of ill health? Screening may prevent 2,500 deaths a year, but at what cost? Some health economists have estimated that the cost of a positive smear is over £200,000 when the cost of doing all smears, the great majority of which are negative, is taken into account. This may be a somewhat contentious way of looking at the issue. Others would argue that a negative result is still a result and it is unreasonable to load the positive result with the full cost. Ethically, however, it is true to say that the cost of avoidance has to compete with the cost of treatment, and in that context it is scarcely surprising that treatment usually wins against prevention. Interestingly, in this case there is a consensus to spend money on avoidance, even though it is known that there are other cancers with higher death rates which would also respond to screening procedures. The avoidance of disease is likely to attract less interest than the treatment of illness. The manager can do little about this, even if it appears to be a somewhat unethical position to take.

A sub-division of health promotion is health education which excites a certain amount of discussion about ethics. Take for instance sex education. How far should health and education authorities pursue this subject when we have already established that respect for the individual and for privacy are both fundamental ethical principles? Should sex education be restricted to anatomical and physiological descriptions, or should there be discussion of the behavioural and moral aspects of sexual relations. How far can there be discussion (particularly in the light of recent legislation) of those aspects of sexual behaviour which concern minorities such as homosexuality? Is discussion on incest allowable? Health education staff have few rules to guide them. In view of the requirements of the somewhat notorious Clause 28 of the Local Government Act 1988, they will have to ensure that they are not discussing aspects of sex in a way which causes problems for their teacher.

This recent example of the intervention of government shows how delicate is the ethical balance in matters concerning health promotion. On the one hand, health authorities and their health promotion staff would appear to have a clear ethical duty to pro-

mote a healthier society; on the other hand, they are circumscribed by the wishes of parliament which, in a democratic state, must be assumed to represent the will of the people. For the health care professional, balancing the ethical demands of the individual against the demands of the State is not a new dilemma. But the manager, who is not covered by a professional code of practice, is in a more equivocal position. An instrument of government, the manager is likely to be a conformist who will, occasionally, take a cue from health care professionals and press for initiatives which appear to be outside current government policy, arguing that it is a manager's duty to promote health. Without this tension there would be no need for a discussion on ethics and health service managers. In the end no manager can be freed from the dilemma of deciding what best to do in the interests of the individual and of the community.

... for their teacher.

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3 ETHICS AND THE PUBLIC

THIS chapter explores the relationship between the health services manager and the public. As a public servant, the manager has obligations to the public which can lead to ethical problems, particularly when the common good, often called the public interest, is in conflict with the views of professionals. However, the running of the health service should not be seen only as a power struggle between those with special knowledge and those wanting to represent the public. There is room for the involvement of the public in a more comprehensive way. At its crudest this may be through public opinion, a somewhat fickle agent; it may be through the process of being a nominated member of the public, or as a self-appointed volunteer. The important point to note is that neither managers nor health professionals are free to organise health care on their own. In this respect, the NHS is no different from other public services where experts are subject to the scrutiny of lay people.

But who are the public and how do they express their needs? Since the public is everyone, is it realistic to address such a generality? It is current orthodoxy to define the public by the demands they make; we are all consumers. In health terms this way of defining public need is somewhat simple-minded. A person demanding health care is not the same as a high street shopper. Health care cannot be offered comprehensively on these terms. If it were, there would have to be considerable over-provision to allow for the whims of the shopper. This would lead to waste. In our present relatively efficient NHS some ranking of priorities is inevitable. This does not mean that the NHS is anti-consumer but that in order for true need to be met some demand must wait or be dealt with outside the system. There is justifiable criticism that the NHS is insensitive to its consumers in ways which could be avoided. Unexplained waiting is one of the more notorious and frequent examples, and one which the manager can resolve, working with the medical staff. A steadily increasing dissatisfaction with the NHS has led more people who can afford it to go to the private sector, not because they feel that they will get better medical treatment but because they believe that their individuality will be treated with more respect.

Describing the NHS as an embodiment of patient demand is only one way of looking at it. The NHS is also a public institution. It was set up for the use of the public and belongs to them. The NHS Act 1946 speaks of the right of people to expect an improvement in their physical and mental health through services that should be, with a few exceptions, free at the point of use. Most members of the public still support these basic principles, although many would also support the right to choose private care if they wanted it. Indeed, they are currently being encouraged to exercise this choice by government policies on the one hand and imaginative insurance schemes on the other. For those who choose the NHS it operates as its own insurance scheme and people are content to know that it exists even if they do not use it very much.

The public also seem to be happy for the most part to leave the management of the NHS to a few public spirited people sitting as members of health authorities or community health councils. Do these members have any power or are they merely a symbolic representation of a seemingly democratic process which appears to involve the public but in fact leaves the real decisions to the experts? What do these authorities do? Is it practical to involve them in the decisions necessary to the proper running of such a large organisation? Managers have to judge what to involve members in and what to deal with themselves or with their officers and other staff. Their judgment may be subject to pressure when political matters are under review; this will be discussed in more detail in the last chapter.

The most difficult task facing the manager is to decide what is in the public domain. At what point should a major issue be on view to the public? If it is proposed that a hospital be closed for financial reasons, should this first be discussed in private? Is this feasible given that preparatory work will have to be done and a leak may occur. Staff will have to be reminded that confidentiality should be observed, if only to allow the health authority to fulfil its duty to discuss the matter in an informed manner rather than reacting to what would undoubtedly be poor press publicity. In due course the public will wish to hear other views on the issue and it is here that community health council comes into action.

Community health councils

CHCs, unencumbered with the responsibility of distributing resources, are able, on the face of it, to represent the public view. This is not as easy as it sounds. How do they gather views, how do they reconcile differences, and how do they incorporate the single-

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Case study no 7 – The place of delivery

After considerable pressure from women's groups, the district has agreed to keep open local maternity units. This policy can only work efficiently if a strict booking policy is adhered to which means that all low risk mothers will have their babies in local units, thus removing any choice to go to the consultant unit in the district general hospital. The CHC is now campaigning for mothers to have the choice restored even though this will lead to a waste of beds and midwives as local units are likely to run at low occupancies.

On reflection, should the DGM agree with the CHC's view that mothers should be able to choose where they have their babies, even if they are low risk?

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mindedness of some of their members drawn from pressure groups into a useful corporate opinion?

It may be better to accept that their function is principally to educate the public in the issues at stake. Managers may need some persuading that the public can be educated to understand the elements of key issues. Priority setting tests this process to the utmost. It is obviously not reasonable to encourage a view that everything is possible when in fact one choice rules out another. How can anyone choose between more staff for the special care baby unit and additional domicilary care for the elderly mentally confused; they have nothing in common but are equally deserving. CHCs are perhaps even less likely to grapple with this than health authorities. But to make no choice is to abdicate responsibility. Faced with the problem, CHCs and health authorities alike often

adopt tactics to deal with the situation. First they ask the officers for more information, but how much is enough? Information itself is relatively inert until activated by intent. This being the case, the first step to making a decision is to have a sense of what is desired and then use the information to support the case. The second step is to realise that making decisions is largely a political process and here the CHC may have more freedom than the health authority. They can speak their minds with relative ease, acting almost as a second opinion.

The relationship of the manager to the CHC is somewhat tricky. On the one hand their legitimacy as the public watchdog can be accepted without much difficulty but, on the other, their potentially rival status to the DHA tests the manager's loyalties. What should they be told? How much information should be offered spontaneously? Too much may lead to quarrels between the CHC and the DHA, but too little pays insufficient attention to the CHC's statutory role as representative of the public.

The voluntary sector

It is not only through the formality of the health authority and the CHC that the public seeks to be involved in the health service; far more widespread is the involvement which comes from the voluntary sector. This somewhat general term covers considerable variations, from service-giving to fund raising, from local self-help groups to national pressure group lobbying of parliament. Managers (in private) express reservations about voluntary effort, especially as it seems to be viewed as more estimable than paid work. Furthermore, a lack of a contract to formalise voluntary effort can lead to ethical problems.

Voluntary organisations broadly fill several functions. Voluntary effort may be pioneering. The need for a new service is perceived and it is necessary to raise the consciousness of the public and professionals alike. This is more innovative than the traditional role of voluntary bodies, supplementing and complementing existing provision. Voluntary groups also act as pressure groups aimed at changing the way things are done. The moral basis of voluntary effort is that it is an altruistic impulse, largely given free. Ethically speaking, however, it is also possible to construct a far less favourable picture. Voluntary effort can be seen as unac-

countable, highly selective to the point of discrimination, patchy, unreliable, patronising, inflationary, exciting demand where there is little need, lowering standards and, finally, taking work away from paid staff.

What ethical problems could there be for managers? Volunteers working with individual patients are not controlled by the codes of conduct which are typical of the professions. If care is inappropriate, or confidentiality breached, there is little that can be done retrospectively to redeem the loss of rights suffered by the patient. Voluntary effort is selective, often choosing the easier path. For instance, raising money for high technology hardware is easy compared to supplementing the transport system for elderly mentally ill patients going to a day hospital. Appeals on behalf of children elicit the basic sentimentality in all of us, but care for the mentally ill can leave us unmoved. It is commonplace to observe that many volunteers are of a different social class to those they seek to help. This may lead to insensitive handling of patients who are often trapped in the relationship because of their disability. Finally, volunteers can be used to undertake work which otherwise would be done by paid staff – for instance, making beds or giving out meals.

Given this indictment how can the managers rescue their reputation? It is certainly possible to produce a code of practice for volunteers whether it be for buying equipment, financing new buildings or being directly involved with patients. The appointment of a paid voluntary services coordinator may help.

One of the basic principles governing our ethical practice is protecting patients from harm. This remains an imperative whether the patient is involved with a member of staff or a volunteer. Take the question of counselling. This rather loosely-used word covers a spectrum from the session with a volunteer who may have very little specialist training to an interview with a trained psychotherapist. The manager must make sure that volunteer counsellors are not undertaking work which might upset the patient's therapeutic programme. Careful selection of the volunteer is important. Motivation must be examined because talking about other people's problems may be a way of avoiding your own. On the other hand a volunteer counsellor can bring a refreshing burst of common sense to a situation which has become over-professionalised.

With proper safeguards most patients will benefit from contact

with volunteers. But it should by no means be automatic, and managers should not see them as a soft option – particularly with inarticulate patients at risk from subtle condescension. Mentally handicapped people benefit from the commonsense of young people, often untrained, but this can quickly go wrong if volunteers do not share the ideals of normalisation and treat mentally handicapped people as a race apart.

Another group of volunteers that managers will often be involved with are the leagues of hospital friends, often a formidable group! Most leagues are concerned with fund-raising where care must be taken to ensure that priorities are not being distorted. New buildings or new equipment should always be genuinely needed; nothing is worse than an unwanted present. Every manager involved with leagues will need to learn how to look gift horses in the mouth without blenching.

Finally there is the issue of access. Volunteers provide a useful contact with the outside world. Gone are the days when hospitals, particularly those for the mentally ill and the mentally handicapped, were out of the public gaze. Now all staff have to be prepared to have their work observed by members of the public. This can only be in the patient's interest. Exposing the workings of the hospital to visitors is a good way of monitoring standards.

The press

Managers are unlikely to prove convincing educators of the public in health matters; their role is facilitative. They do, however, have to attempt to use that other great public educator, the press, in a constructive manner. This is often very difficult. The press is not homogeneous. Some journalists have high ideals and see themselves as educators of the public, but others are in the business of selling their newspapers, come what may. The manager, ever mindful of his or her ethical responsibility to the patient, has to attempt to control the relationship. The casual release of news about patients will seriously threaten respect for individuals and their right to privacy, and can lead to harm.

Information should never be gratuitously offered although it is normally reasonable to acknowledge that the patient exists. Take a road accident for instance. It is my view that managers and other staff should not offer names of patients to the press but that it is

reasonable to confirm names given by the press if they are correct. This may seem unduly careful. But supposing Mr Jones is in an accident with Miss Smith in a part of the country he seldom visits – and unbeknown to Mrs Jones: it is scarcely part of the hospital's role to fuel a potential marital drama. Treating the patient is the hospital's only responsibility. The press can scarcely be taken seriously if they assume, as is habitual, that they need to know in the public interest. What possible interest can be at stake in establishing Mr Jones's infidelity?

Uncovering scandals of negligent care is a different matter. Here the press can claim with some truth that, but for their assiduousness, scandals would be supressed. Managers are in something of a dilemma here: is it their ethical duty to withold information or release it? Confessing negligence in the public interest could tell against the health authority in a subsequent claim for damages. There are other problems, such as the patient's right for privacy. Not all patients want to be the centre of a lurid story about conditions in a long-stay hospital, even if exposure may bring about change. A recent case concerning relatives of the royal family in a Surrey mental hospital went so far beyond the ethical standards which should control the press that the patients and their rights were abused to a reprehensible degree. A complaint was made to the Press Council, although it must be said that many people find the Council relatively ineffectual in maintaining ethical standards, at least as far as patients' rights are concerned.

Another difficulty arises when the manager is to blame for the scandal and is tempted to release a partial account of events with limited information. In those situations no manager should be allowed to act alone. The chairman must be involved and the region's public relations staff can help with the media.

So how are scandals best dealt with? First the manager must be confident about the facts of the case. Then the information has to be assessed for its implications. Will it harm the patient in any way? If so, some reticence may be justifiable. However, it is wrong for the health authority to withold information to protect its own interests. As a public institution the authority has to accept the responsibility of its own actions and those of its employees.

The police

The police are also guardians of the public. What principles should control their relationship with the health authority and its hospitals? First it must be said that the health authority and its employees are there to treat patients not to judge them. It would be intolerable for patients to be submitted to the moralising of the staff. It is immaterial what the patient has done: his or her right to treatment and care remains paramount. It follows that the police must be kept at arms length. A patient attending casualty with a cut hand may have sustained it in a burglary but it is no part of the staffs' duty to ring up the police and tell them. The doctor will usually assume the role of custodian of the patient's right to confidentiality, but nursing and managerial staff also have to be clear about the patient's rights.

More serious crimes, murder or acts of terrorism, put the hospital under greater pressure. The law separates the two. A suspected murderer must be assumed innocent until proved otherwise which means that access to the suspect can only be given to the police after there has been a careful assessment of the situation. A suspected terrorist is not safeguarded in this way. Legislation limits the rights of individuals under suspicion and it is illegal to withhold information which might lead to their capture. Here the law has overthrown other ethical considerations in the interests of the common good.

It may be difficult for staff to keep a distance from the police in the way I have suggested. But they should be reminded that their only interest is the welfare of the patient and it is entirely unacceptable for them to compromise that interest in the light of the different principles that inform police behaviour. Here managers have a particular responsibility to ensure that standards are maintained.

Complaints

Things do not always go right for individual patients. Managers have a particular responsibility to ensure that there is an adequate complaints procedure to convince the public that the rights of patients are being honoured. It is difficult, however, to define what a complaint is. Some authorities attempt to define a complaint by insisting that it be written. This seems unduly bureaucratic,

indeed ethically unsound in that it discriminates against patients who find writing difficult or cannot write at all. Defining a complaint in this manner is inappropriate. A better definition of a complaint is a situation where something appears to have gone wrong and the patient, relative or friend wishes the matter to be investigated. This usually eliminates the little gripes about immediate problems, such as a cold meal.

It is by no means easy for managers to pursue complaints without appearing to betray their own organisation and the staff. For this reason, the complaints procedure must be seen to be part of the ethical framework within which managers work; this depersonalises it.

Complaints must not only be dealt with by managers and other staff. They would appear to be protecting themselves and denying patients their rights. All procedures should be graduated to allow appeals. If the complainant is not satisfied at the first level then authority members should be involved. The community health council can also act as a patient's friend. If all else fails, patients must be told about the functions of the Health Service Commissioner. Care taken with complaints can avoid litigation; a cavalier approach will force patients into the arms of the solicitors.

Conclusion

This chapter has endeavoured to examine the nature of public involvement in health care and the particular responsibilities of managers to encourage it. A similar concern is not found in the private sector, although there are other substitutes. There, the manager has to fulfil the needs of shareholders, even if this is not of the same order of ethics as protecting the common good in the NHS where the manager is both the servant of the public and of the patient.

It is not always easy to maintain ethical standards when their observance causes the manager more work and more stress. Pressures can be mitigated to some extent by a clear understanding of those ethical principles which not only protect the patient but support the manager.

4 ETHICS AND BELIEF

MANAGERS may be in the business of health care because they are fascinated by the processes and challenges of management and enjoy the power to influence events. Many are action-oriented people stimulated by change. Such managers can be admired for their energy yet if they act in an ethical vacuum their subordinates may well become disorientated, not knowing what is right and what is wrong. The nature of leadership was discussed in the first chapter, but here, in the preamble to a discussion on belief and the manager, it is worth repeating that managers need to have a recognisable set of values stemming from their own beliefs, both concerning individuals and their consciences and, more universally, concerning the community at large. So, a manager who believes that people do not value what they have not paid for, may be at odds with the prevailing value system in the NHS. Subordinates will also find this belief difficult to handle, endeavouring on the one hand to be loyal to their boss and, on the other hand, wanting to honour a basic tenet of the NHS that it should be free at the point of use. A wise manager incorporates various value systems into the team in the belief that a plural approach strengthens rather than weakens the group. But not all beliefs can be assimilated in this way; some may interfere with patient treatment or the working of the organisation.

First a general point: ethics and belief are not synonymous. We have already defined ethics as being concerned with rules controlling the conduct of people in relation to others. Belief, in the context of this chapter, is less a social matter than a characteristic of the individual's relationship to others. Belief may be demonstrated by religious views which, in so far as they stipulate a clear set of rules of conduct, may be easy to accommodate. But other beliefs are not religious in origin and have no obvious connection with a sense of God. They may be just as genuine. The difficulty for the manager is to know what can be reasonably acknowledged and what cannot. Belief which constantly interferes with the process of looking after patients may have to be challenged.

Euthanasia

First, which problems arise from the patients themselves? In Chapter 2 we briefly looked at the ethical issues associated with dying patients. I shall now develop that further in the context of euthanasia, the purposeful termination of the patient's life to relieve suffering. Is it right to preserve human life whatever the consequences for the patient? Those holding Christian beliefs may well feel that there are no circumstances when life can be shortened by intervention. Suffering, for Christians, is part of human experience and God's order of things, giving humans an opportunity to share what Christ himself experienced. Through suffering lies redemption. This fundamental view is challenged by others on the basis that it cannot be right to allow people to suffer pain. Patients in pain may have little capacity to contemplate the infinite through the analogy of Christ's suffering on the Cross. Common humanity will lead health professionals to relieve pain where they can. But how far should they go? Should the patient be drugged into unconsciousness and, if that far, why not into death itself?

Around the world the debate about euthanasia continues. Some countries have attempted to set guidelines. In the UK, the BMA has recently produced a report and in Canada there has been legislative change. These initiatives attempt, among other things, to justify the not uncommon practice of letting the patient die when suffering seems to have become insupportable. It might be argued that this is an area where the manager has no place. But there are at least two reasons why he or she should be concerned with the overall principles if not the individual cases. The manager presides over an organisation which needs rules to ensure that it operates in a reasonable fashion and which can be supported under public scrutiny. These rules must be generally understood by professional staff. It is clearly unsatisfactory if doctors are observing one ethical code and nurses another, perhaps leading to arguments at the bedside.

The second reason is more practical: it is important that the health authority is not seen to be liable for malpractice. It is true that where a doctor lets a patient die and is subsequently sued for negligence, it can be argued that the authority was not involved. However, this would be an unusual way of conducting the case and the court might ask what rules the authority had for the guidance of

staff concerned with dying patients. But can there be rules to cover euthanasia, which is illegal? It is really a matter of degree. There are situations that are not against the law: for instance, switching off a life support machine.

The rules – perhaps guidance is a better term – should first repeat that the patient retains rights, even when *in extremis*, and professionals must do all in their power not to abuse the patient's individuality. Protection from harm is a difficult principle to honour when the action contemplated will lead to death. Nonetheless, harm in these circumstances can be interpreted, with justification, as relief of suffering. At all events the patient must be consulted or, if that is not possible, the next-of-kin. Their beliefs will be an important consideration. It may appear more humane to let the patient die without discussion but ethically this cannot be justified: informed consent must still be sought. The prognosis and the quality of life will be potent arguments in the discussion. Much less acceptable, even if important to the manager, will be the cost of maintaining life when the prospects are very poor. Such a practical approach will certainly be seen as being insensitive.

Should there be agreement, after discussion, that it is reasonable to allow the patient to die, risk of legal action can be avoided by having two doctors make the decision, the medical record making it clear that the patient's interests were paramount and the relief of suffering the guide to the doctors' action.

Hastening the end of the life of an elderly patient is easier to contemplate than allowing the newly born to die. Special care baby units are full of babies who, until recently, would not have survived. Today, paediatricians and staff fight to save even the most handicapped babies, whatever the consequences for later life. Ethically the staff can do little else provided they know what the parents want. Parents are sometimes reported as saying that they enjoy their handicapped child more than their other children. They find the experience of looking after this dependent person in some way ennobling. Here belief comes to the relief of those who might have been expected to rail against fate.

This discussion has attempted to show that the proper care for the dying tests the ethical standing of the organisation and those who work in it. Personal belief about the sanctity of life may help staff but not if it usurps the feelings and beliefs of patients and next-of-kin. Staff therefore need guidance as to how to deal with

situations where there is an option to let the patient die without further intervention, or even to hasten death by humane means. The manager's role is to ensure that this guidance is available and that staff are not thrown onto their own devices. It seems unlikely that the government will pass legislation on euthanasia, so each health authority and each professional body needs to establish its own approach, always honouring the basic ethical principles outlined in this book.

Religious differences

Religious conviction may interfere with treatment. Patients and staff alike may have beliefs which prevent them accepting the normal processes of care. Well known is the reluctance of Christian Scientists to receive conventional forms of treatment and Jehovah's Witnesses' refusal of blood transfusions. What advice can medical staff be given when a patient refuses treatment? First there should be positive evidence that the patient understands the nature of the treatment proposed and the consequences of refusing it. This might be called informed non-consent. From the health authority's point of view it is wise to obtain a written undertaking from patients or next-of-kin that they have rejected the advised treatment in the knowledge that this may be harmful. Crucial to this process is that the patient is in a position to make an informed decision. Without a patient's consent, does the decision of the next-of-kin carry the same weight? Probably not. The doctor has to endeavour to establish the patient's wishes, and may also have to take account of the relative's bias. Even more difficult is the relationship of parent and child. Does the parent own the child's destiny? Has the child no independent rights? In this country it would be unlikely for a court to find against a doctor who over-ruled parents in the interest of a child. But the court would need to be persuaded that the treatment being offered was clearly beneficial and that no other reasonable alternatives existed. It would be gratuitous to offend deeply held beliefs for some trivial improvement in the patient's condition.

Every effort should be made to honour the beliefs of the patient or, if the patient is incapable, the next-of-kin. This is not only in matters of life and death; it also covers other religious practices, such as serving kosher food to Jews, tolerance of the Sikh's turban,

or respect for the Asian woman's modesty when making a clinical examination. Such observances may cause practical problems, but it must be emphasised to staff that these matters are not fads – they arise from profoundly held beliefs. Similarly some staff may hold beliefs which affect the days they work or their uniform. These can be tolerated if dealt with sensitively.

Case study no 8 – Christian services on the ward

A Muslim patient has complained that Christian services are being conducted on the ward where he is an orthopaedic patient in traction for several weeks. The ward sister is a devout Christian.

As the UGM, what action should you take now and in the future?

Abortion

Certain beliefs held by staff and patients can cause problems for the manager. Termination of pregnancy is the most obvious. Fundamentalist Protestants and Roman Catholics believe that abortion is wrong, and indeed that most contraception is an interference with God's will and the natural order of things. What then is to be done for a woman whose repeated pregnancies are threatening her health and affecting her capacity to be a caring mother? If she will not accept artificial contraception and will not use natural methods of avoiding pregnancy, such as having intercourse only during the safe period of the menstrual cycle, is it reasonable for the doctor to undertake sterilisation on the grounds that it will safeguard her health? Despite good medical reasons it has to be said that it is ethically suspect to proceed against the patient's wishes, even if, as in this case, she may appear to be acting against her own best interests. It is debatable whether the husband's consent is essential for his wife to be aborted or sterilised. The radical woman's view

would undoubtedly be that she should have absolute autonomy over her own body. However, it would be unwise for a hospital to proceed without the involvement of the husband. In the case of male sterilisation it is usual for both partners to be consulted before the man gives his consent.

If contraception has failed and pregnancy results, can the woman refuse an abortion in all circumstances or is her medical condition the determining factor? If she is set on having her baby her wishes are paramount. The doctor's ethical position is to explain the consequences and to be sure that the patient understands them: more he cannot do.

So far we have been discussing abortion and sterilisation from the patient's point of view, but staff may also have views which have to be taken into account. Or do they? Is it reasonable for a member of staff to hold beliefs which might interfere with the treatment of patients? Should nurses be allocated to family planning clinics or gynaecological theatres if they have recorded their objection to contraception and abortion? Is it right ethically for a nurse to assume a sort of autonomy that allows her to withdraw from duties which otherwise would have been allocated to her and determined by the doctor to be in the patient's interests?

It is now accepted that the nurse has a right to record her objection to being involved with certain gynaecological procedures because of her religious belief. She can do this as professional partner to the doctor and, therefore, cannot be instructed to obey the doctor against her conscience. But it is probable that ruling only applies at present to a very limited set of circumstances. A notable case in recent years sought to establish whether it was reasonable for a nurse to assist in the administration of ECT (electro-convulsive therapy) when he felt that the treatment harmed the patient. The managers experienced considerable difficulty in coming to a decision. After some discussion they took the line that the nurse was, in these circumstances, the servant of the doctor and must work to orders. The nurse refused to do so and was subsequently disciplined.

The argument was whether or not this was a reasonable case for conscientious objection; it did not arise from a religious belief and challenged the assumed superior clinical knowledge of the doctor in a way that could be threatening to the patient's wellbeing. The nurse argued that clinical opinion was divided about the efficacy of

this treatment, with some people – including patients who had received ECT – claiming that it did harm. The reasonableness or otherwise of the nurse's action was never satisfactorily resolved, partly because the case quickly assumed other complications when it became clear that the nurse had other fish to fry in challenging medical supremacy in the treatment of mentally ill people in that particular hospital. Nevertheless, the case did shift the boundaries of conscientious objection and it is now unlikely that a manager would force a nurse to assist at ECT sessions who had expressed reservations about the procedure. This is because the treatment is undoubtedly controversial. Some patients benefit, but physiologically the reason is obscure. Others complain of loss of memory and feelings of strangeness.

The cases discussed so far allow the professional carer to object to being involved in a certain type of care provided there are suitable safeguards for the patient. In other circumstances the health care professional does not have the right to object. For instance, it is unreasonable to object to being involved with a patient because the carer could be put at risk from infection. A doctor or nurse refusing to care for an AIDS patient would be considered to be acting unprofessionally and subject to discipline. The manager's duty is to safeguard members of staff by ensuring that they have been properly instructed in how to deal with such patients. Once this has been done, staff can have no cause to complain. It is not only a matter of combating discrimination, but of straightforward employment discipline.

Is this being too hard upon the professional carer who may believe that the homosexual male with AIDS has become ill because of sinful sexual practices? Is it right for carers to be placed at risk (as they believe) and to condone the patient's lifestyle? Here we have to separate personal response from formal ethical responsibility. All ethical codes make it clear that the professional has a duty to look after patients, no matter who they are or what they have done. Illness contracted from sexual activity of whatever kind is therefore no different from any other kind of illness or injury. To act otherwise would be to assume a superiority which is difficult to justify ethically and, indeed, impracticable to administer. Who would decide which patient had led a blameless life and should take priority over the guilty? It is impossible for anyone to hold a consistent set of values which judge some patients 'guilty' and some

'innocent'. Obviously, the patient with venereal disease has acquired it from another person, but it is not feasible to judge whether the sexual activity was 'sinful' or 'innocent'. The idea of sin is not at all practical; it is more a metaphor for a certain sort of human behaviour. Staff need to be helped to think their way through the natural human instinct to pass judgment on each other, particularly where a patient's care and treatment might suffer in the process.

Not all problems concern patients. Others may arise from beliefs which prevent staff from doing part of their prescribed job; for instance, the civil defence planning expected of some managers. This is probably of low priority at present but, nevertheless, all health authorities are expected to designate an officer responsible for civil defence issues, in particular plans in the event of nuclear war. Do managers have a right to object to this sort of work and what would be the consequences? Pacifism is allowed in some societies and not in others. In this country pacifists were imprisoned in the first world war but allowed to do non-combatant duties in the second, after an examination of their beliefs by a tribunal. Thus a principle has been established in our society that such beliefs can be tolerated as long as they are not subversive or a danger to national security. It is reasonable, therefore, to allow a manager to record the wish not to be involved in civil or nuclear defence work on the grounds, debatable though they may be, that such planning assumes that war is likely and predisposes this country and others to its possibility. Practically the health authority has to fulfil national policy and a manager in a key position holding these views cannot stop the work being done by others. It is the manager's ethical duty to see that satisfactory arrangements are made for the work to be carried out.

This touches on another dilemma which will be examined in the final chapter: how loyal must a public servant be to government policy; and are there rights which transcend this loyalty?

All the cases covered in this chapter indicate clearly that ethical standards change, that there are no absolutes other than the basic principles outlined in chapter 2. Indeed, what may appear ethical in one situation may be the reverse in another. The context is important but so is the manner in which the issue is examined. The guiding principle is that there should be space for alternative views in an open society; therefore institutions should allow for this

diversity but guard against self interest masquerading as conscience. For instance, a nurse refusing to take part in the termination of pregnancies is in a different position from a nurse who refuses to care for a patient with AIDS because of the risk of infection.

The manager is often in a key position in the discussion of belief and its effect on patients. Having a public duty to ensure that staff care for patients, managers must be able to assess the nature of these beliefs and, if they are admissible, arrange for alternative care. The detached position enjoyed by managers should help them to be dispassionate.

5 ETHICS AND EMPLOYMENT

DISCUSSION so far has centred on the patients and the public, but in day-to-day terms managers are more likely to spend most of their time with staff. This chapter looks at the ethics of employment on the assumption that there are good and less good ways of being an employer. Does it matter how people are recruited, what happens to them subsequently and how, if at all, their problems are dealt with. The underlying belief here is that dissatisfied staff are bad for patients. The manager in protecting patients from harm therefore has an ethical duty to ensure that staff are happy in their work given that some aspects of their employment are outside the control of their own health authority. This is no excuse, of course, not to treat staff properly.

Recruitment

Much has been done in the last 20 years to improve the process of recruitment. It will be usual for jobs to be advertised with a job description drawn up beforehand. Less frequently, the specification sets out the special characteristics required for the job. The somewhat over-optimistic hype: 'We are looking for a well-motivated person who is achievement oriented and has well developed people skills...' says more about the organisation than the real quality of its managers. Recruitment is a more painstaking process than this.

The manager's inital task is to specify the nature of the job and the qualities required – personal, academic and practical. Only then is it time to advertise. A preliminary question to be asked is whether or not the job should be advertised internally first. Many staff feel that managers should show their commitment to them by giving the staff the opportunity to apply for jobs before open advertisement. Managers may be somewhat chary of this on the grounds that organisations which promote largely from within become inbred and may succumb to organisational inertia. But what is the ethical position?

Some large corporations operate a closed system and build up considerable corporate loyalty as a result. In the NHS, however, the corporation is the health service as a whole and most managers

feel that competition for jobs should be open at least to all health service employees. For many professional staff there are few other opportunities anyway. Discrimination in favour of NHS staff would not be seen, therefore, as ethically dubious. On the contrary, it demonstrates commitment to those who have devoted their working lives to the NHS. On the managerial side, the options are wider. The Griffiths reorganisation in 1984 brought in some managers from outside the service. The fact that this initiative has not been particularly successful does not invalidate the idea that opening up organisations from time to time can be healthy. The employing authority therefore has to balance the advantages of honouring the commitment of long-serving staff with the freshness which outsiders may bring.

Where the advertisement is placed will determine who applies. In the interests of fairness, health authorities may use national newspapers but they are very expensive and can be financially wasteful unless the potential applicants are properly targeted. Because the concept of fairness is somewhat debatable, managers need to be quite sure it is right to widen the market before doing so. Advertising in a weekly professional journal is probably fair enough.

Another important aspect of fairness in recruitment is the attention paid to equal opportunities. Gone are the days of gender specific advertisements. But this may be only a superficial change. A review of the gender of particular groups of staff will demonstrate that some jobs in the NHS are assumed to be for males and some for females. Managers themselves are an example, as most senior managers in the NHS (and indeed elsewhere) are male. A smaller, if no less important, group are those of a different race, the majority of whom will be generically called black. For complex sociological reasons, including frank discrimination, black people have less opportunities for employment than white people. The number of black employees in the NHS is an indicator of the employment market as much as any other organisation. More black people will be found in less popular working areas, such as the inner cities, and they will be found in the low paid jobs – domestic assistants, for example. Ethically speaking, at this basic level of employment managers have a long way to go to correct seemingly inherent instincts for negative discrimination against gender and colour.

This discrimination is seldom crudely stated, of course; the law

has made that difficult. But women are still asked questions about their domestic arrangements which are not asked of men. Supporters of this line will claim that it is only practical since it is unreasonable to appoint staff who will stay at home at the first sign of a domestic crisis. Managers will no doubt be able to give examples of this happening. Nonetheless, this is a clear case where ethical values are needed to overcome pragmatic considerations. It may be understandable to discriminate against women in this way, but that does not make it right. It denies women not only the opportunity, which is the first stage of the process, but also the possibility of fulfilling the opportunity. We must not pay lip service to the principle without putting it into action.

The large number of potential women employees makes this the major area of concern when discussing non-discrimination. Smaller groups are even more likely to be discriminated against and care needs to be taken to separate the principle from the prejudice. For instance, there is no reason not to employ a self-acknowledged homosexual man as a care assistant for mentally handicapped children on the grounds of his sexuality. This would be to assume that homosexuals are less able to behave appropriately than heterosexuals. It also seems to suggest that all homosexual men are attracted to children. This is clearly not the case; indeed the records of child sex abuse show it to be largely a heterosexual problem.

Managers may feel uncomfortable in these situations and seek through conformity to avoid having to face such problems. It takes some spirit to argue the case for a candidate against the prejudice of other members of the interviewing panel. Managers should watch for the subtle ways in which prejudice is expressed. 'I like him but he wouldn't fit in with the rest of the department' may be a reasonable assessment but it could be unalloyed prejudice. Discrimination creeps into our dealings with staff just as much as with patients and may more often be found at interviews.

The process of interviewing can hinder or help the positive acknowledgement of individuality, one of our basic ethical principles. Poorly conducted interviews with self-answering questions and insensitive responses to candidates' answers, deny candidates the opportunity to show the panel who they are and what they stand for. Poor appointments follow. Many would argue that reliance on the interview as a way of discovering the most suitable

candidate is in itself a poor process because it enhances some of the candidate's characteristics over others which has a distorting effect. There are other ways of assessing candidates. Currently popular is the psychometric test which not only examines intellectual and reasoning skills but the nature of the candidate's personality and temperament. Ethically it is clear that such tests should never be undertaken without the explicit agreement of the candidate on the grounds that the results may be unexpected and disturbing. Whether or not the candidate is successful, the option of feedback must be guaranteed.

Dealing with unsuccessful candidates is part of the interviewing process. It is pleasurable to congratulate the successful person but, in the moment of euphoria, the needs of the other candidates can be forgotten. At more senior interviews feedback can be offered on an individual basis by the assessor or the manager. For other jobs the personnel officer is likely to be more appropriate. Some managers find this feedback difficult and rely too heavily on a standard response: 'You were very good. Maybe next time...'. This is unfair on the candidate who may have been unsuccessful before. You cannot be 'very good' yet repeatedly fail to be appointed. It may well be that there is a personal characteristic which is off-putting but difficult to talk about, such as a flippant manner; or something in the application which questioning reveals as unsatisfactory. However difficult, the person undertaking the feedback has to face up to the situation. The reward will be the candidate who says 'Thank you; that's the first time someone has been frank with me and I really appreciate it.'

Following the interview comes the medical. Is it right to offer a job subject to a medical or should the candidate have to wait for clearance? The practicalities of the situation require the job to be offered with this proviso but the candidate must be told that medical clearance is a requirement. In turn, the findings of the occupational health doctor must be frank; a proxy judgment (turning someone down for other than the main reason) is unethical, is bound to lead to trouble and possible charges of discrimination. This can be difficult when dealing with a disabled person who has a right to be treated fairly but whose disablement makes them unsuitable for the job. It is important for there to be a clear understanding between the doctor and the manager about current or previous medical conditions that would make a candidate unsuitable

for a particular job. For instance, is mental illness in the past or a history of back trouble a reason for turning down a candidate?

Managers as well as appointing staff are called upon to write references for people wishing to move on. These references are almost always favourable and a poor candidate will be indicated by what is not said rather than by what is said. Being frank tends to be damning, which is unfortunate. Ethically, standards have slipped to the extent that a written reference is of little value. It is therefore worth offering a verbal report although this can be dangerous because it may be ill considered. Nevertheless, it offers a greater opportunity to test each judgment. It goes without saying that giving a good reference to get rid of someone is unethical and, in any case, impractical; next time you may be the person who suffers from another's want of candour. Candidates sometimes feel that they should see what has been written about them. In an age of increasing rights to see what is said about you this may seem to be good practice, but it can lead to anodyne comment of little practical value.

Not saying too much in a reference might be said to be protecting the right to privacy, but this is somewhat disingenuous. The candidate can be assumed to have given implicit permission to the release of information by naming a referee. Enquiries not associated with references for jobs need to be dealt with more discreetly. Giving staff addresses to third parties is a dubious practice. It is safer to say you will send on the letter. Similarly it is wrong to release payroll information to insurance agents or to others pursuing business without the permission of the staff concerned.

Continuing employment

If managers are inadequate in the interviewing process they are unlikely to be much better in the continuing relationship. What is the nature of the contract between manager and subordinate? Does it specify hours and duties or does it allow or expect variations? On the whole junior posts are more prescribed; duties are set out, often in writing, with a set number of hours in which to accomplish them. The hours of work in a contract for more senior people are a guide but they are usually exceeded. Is it right for an employer to expect these staff to work habitually beyond their contracted hours? Should an employee who 'works to rule' be disciplined?

Clearly not on these grounds alone, although more general criticism about the person's approach to their job might be justified. It is generally accepted that more senior managers show their brand of professionalism by working relatively long hours in return for higher salaries. In the end there can be no rules except that the most senior managers should be careful about putting 'moral' pressure on their subordinates to overwork, with its attendant threat to lifestyle and family.

Some staff may use their willingness to exceeding prescribed duties in a manipulative manner. The medical secretary who makes herself indispensable to her clinical department may well be exceeding the duties laid down in her job description. This puts the manager in a dilemma: should the secretary be paid for what she is doing or should the manager insist that she sticks to her job description? Resolution is virtually impossible because job descriptions only deal with what is to be done, not the opposite. You must deal with each case as best as you can hoping to find a balance between basic requirements and enhanced commitment. Doctors usually give more than their contract requires and this must be taken into account when discussing rigid adherence to timetables. Arriving late at outpatients' may hurt the hospital's reputation but is excusable if the cause was an emergency. Managers have to be careful not to antagonise highly committed staff. Ethically they have a duty to know their staff and to reward them by recognising good work. Officiousness threatens the proper recognition of the individual.

Making the most of staff while keeping an eye on the work to be done is one of the fundamental tasks of management. Characteristically, many organisations fail to do this in a systematic manner, relying instead on arbitary judgments about good or bad work. Research has shown repeatedly that staff feel their work is undervalued by their boss; not only is praise lacking, but help with difficulties.

Various attempts have been made in the NHS to address this problem, the latest being individual performance review (IPR). Launched in 1986 by the newly formed NHS Management Board, IPR sets out a framework within which staff are assessed and their development needs discussed. It is concerned with both person and performance. The principles supporting IPR are simple. First people need to know what is expected of them. Second, they want

to know how they are doing. Third, they wish to be able to discuss their present needs and future aspirations.

It may be surprising that such obvious requirements have not been previously met, despite attempts at using other appraisal systems. These systems were too often laborious, mechanical and judgmental. Managers found the process exceptionally demanding in personal terms. The ethical implications of a good performance review are considerable. Listening closely to what people are saying, dealing with their concerns and sometimes with their criticisms of your own performance, requires strength of character. It is not surprising that excuses about the time needed, or cavilling at aspects of the procedure, have been used as proxies to avoid undertaking the review.

Properly done, IPR provides clarification of purpose by reaching agreement on what the job is about and by which criteria the jobholder is to be judged. It provides feedback on individual success and failure in a reasonably fair manner based on objectives that have been previously agreed. IPR gives a sense of direction to both person and organisation. The process commits the manager and member of staff to each other. Instead of imposing demands on the subordinate it allows them to be part of the shaping of their future at work. IPR demonstrates clearly how the relationship between the employer and the employed is based on mutually shared goals, mutual trust and mutual respect. In this way it provides an ethical framework for the crucial employer/employed relationship.

IPR is a formal method for which time is set aside on a systematic basis. This does not remove from the manager the more general responsibility for the welfare of staff. For instance, the observance of the requirements of the Health and Safety at Work Act is particularly important. Some managers may feel that this sort of concern smacks of nineteenth century paternalism; they think that staff should be more personally notivated to look after themselves. The balance is delicate.

Real concern is demonstrated not so much in cosmetic support for the sports and social club, or concentrating on fringe benefits, but in a continuous commitment to developing staff, whatever their innate ability and position in the organisation. A continuing education programme that enables staff to update their skills and enlarge their education will pay dividends for management and be ethically right for the value it gives to the individual.

Retirement

Given the importance of work in people's lives, retirement needs to be recognised as a special event. Before it happens, employees should be offered specific courses to prepare for retirement, both practically and psychologically. The emptiness of days no longer filled with work is often miscalculated. Friends and colleagues do not help with facetious remarks about life shortly becoming one long holiday. Managers should introduce a note of reality by helping staff to face the challenge of increasing leisure at a time of decreasing means – both financial and, ultimately, physical – to enjoy leisure.

The occasion of retirement should be somewhat ceremonial with a testimony to past work and gifts from colleagues and the organisation. It is particularly important that all staff are dealt with in the same way. Managers must correct any bias against 'backroom' staff, such as the stoker or the bottle-washer. Demonstrating publicly that all staff are equal in terms of the contribution they have made is important evidence of corporate values.

Problems

I have so far concentrated on the positive aspects of employment and their underlying ethical principles. It must be recognised, however, that there are problems which can seriously affect ethical standards.

When it is difficult to get staff, health authorities may be forced to turn to agencies and pay more than the national rates. Agency staff can create other problems. Permanent staff resent having to carry them since they are rarely employed long enough to learn their jobs properly.

Managers unable to recruit below the market rate sometimes regrade the post in order to compete. Although NHS pay differentials are generally anachronistic, interfering with them for a short-term advantage can prove expensive, not only in cash but in the loss of confidence among staff.

What principles should guide the manager in these circumstances? Clearly fairness is at risk, but so may be patient care. It may be acceptable to use agency staff to overcome a short-term problem. However, compromising pay scales by regrading is danger-

ous. It will put the service at the mercy of the market and increase costs, contrary to the market economists' claim that competition lowers costs. To be fair to their staff, managers must show respect for everyone's individuality by dealing with them according to an explicit set of values. Unfortunately, this principle could be undermined by performance related pay which encour-

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Case study no 9 – Paying over the odds

The general manager has not had a permanent personal secretary for over two years. It appears unlikely that she will ever be able to recruit someone suitable. She decides to regrade the post in order to compete in the market.

Is she right to do so given the knock-on effect on the other secretarial gradings in the hospital?

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ages a more secretive approach and is based on the specious assumption that financial incentives alone encourage people to word harder.

The privatisation of services in order to avoid NHS pay constraints is an option when staff shortages threaten the work of a hospital. Is it ethical to farm out part of the organisation to someone who may not observe basic ethical principles? There is no easy answer. The duty of a health authority and its managers to honour the best principles of employment practice is arguably secondary to their duty to care for patients. If the only practical way of providing care is through a private agency, it is clearly right to do so. Health authorities have always employed contractors for some parts of their business. It would be wrong, however, for a health authority to neglect sound employment practice by using a private contractor and not insisting that staff rights are to be protected.

Health authorities have been tempted sometimes to privatise services in order to avoid industrial action. This cannot be guaranteed of course but fewer union members in the private sector make industrial action less likely. Strikes in the NHS put patients at risk. Who is responsible – the staff or the management who, presum-

ably, failed to meet the staff's grievances? It is easy to take the view that blame should always fall upon the staff; after all, they have broken a contract. But this is to simplify the issue. The staff are in a relatively poor bargaining position. They feel that patient care is being used to blackmail them while their own concerns are being ignored. Disputes on nurse grading in 1988 showed clearly how employers, from the government down, used the welfare of patients as a device to stop nurses taking industrial action. But do staff have any other option than to threaten to withdraw their labour? Ideally, matters should not be allowed to get to this point, but if they do, it is difficult to deny staff their right to take industrial action if all else has failed. To do so would be to deny them the recourse to justice which is a basic ethical right in any organisation.

It is as wrong for management to use patients as hostages to stop staff taking action as it is for staff to use patients in negotiations. The manager's role is in fact quite straightforward: personal opinions must be set aside for their prime duty, which is to protect patients from harm. This will mean finding alternative ways of looking after patients, even if they lead to 'strike breaking'. Senior managers would be unwise to do the work themselves unless they feel that this symbolic action has some value. Unions would probably enjoy the prospect of senior managers demeaning themselves, but this is unlikely to produce a good climate for reconciliation. During industrial action, managers should always tell the unions what they are planning to do, although agreement on a course of action is usually impossible. Temporary staff, volunteers and other staff not involved in the dispute, can be used to cover the situation. It might be argued that finding alternatives is wrong on the ground that staff in dispute should be faced with the consequences of their action and that management would be colluding with staff by arranging alternative cover. There is logic in this, but it has already been said that the manager's code of ethics does not allow patients to come to avoidable harm, so alternatives must be found. Bluff and counter bluff, which have their place in the process of negotiation, should never lead to our regarding the loss of support for patients with equanimity.

In recent years major disputes have become less frequent but individual or small group grievances still remain. Every health authority should have a procedure which allows a member of staff to formalise a grievance in a way which ensures a fair hearing. Such a

procedure will have several stages working up through the organisation and leading, if unresolved, to a final panel of authority members. Managers can minimise the sense of personal powerlessness felt by individual staff members so it is important that staff are offered formal support against the power of the hierarchy. Yesterday's authoritarianism ('If you are not happy here, I suggest you leave...') is of course no long acceptable anywhere, although some managers are said to believe that it still exists in the private sector. If it does, it is no cause for envy.

Similarly, appeals procedures are necessary for staff who feel that they have been dealt with unfairly, either in a matter of discipline, or salary grading or re-deployment. The guiding principle must be that the manager cannot be judge and jury. A third party must always be involved to ensure that the rights of the individual are honoured. Besides grievances and appeals procedures, other policies are needed for a good relationship between management and staff – dealing, for instance, with complaints challenging behaviour, smoking and drinking at work, and, of course, accidents and other incidents.

Not all staff are paragons and one of the manager's more difficult tasks is to deal effectively and fairly with someone whose performance is unsatisfactory. If the person fails, apparently for want of personal capacity, to deal adequately with their job, the manager should ensure that the elements of the job are clearly understood; then, the individual's skills must be checked against the demands of the job. Where skills are lacking or have deteriorated, training should be supplied. Until this course of action has been tried, no attempt should be made to demote or transfer. A difficulty is to discern the true cause of the problem: is it a lack of capacity or a lack of motivation? If the latter, poor performance is by no means inevitable and probably staff need firmer handling.

Staff taking extended periods of sick leave must be treated with the same concern as a patient. The organisation cannot be expected to cover them indefinitely, but at what point can the manager seek to resolve the problem? It is bound to be a long process which should not be rushed. The person must first be referred to the occupational health doctor for what will be in effect a second opinion to the staff member's own doctor. If the health authority doctor's prognosis suggests that a return to work cannot be expected, the manager will be able to sign the person off at the end

of their sick leave with an assurance that, should they get better, they could be reconsidered for employment provided a job is available. A member of staff with sufficient service for a pension may find it more advantageous to retire on grounds of ill-health in order to qualify for some degree of state disability allowance.

Case study no 10 – The long serving employee

A head of department in his mid fifties had early promotion 20 years ago but now seems to have run out of steam and is causing endless minor difficulties for management. Marrying late he still has three young children and his wife is an asthmatic.

Is it right to contemplate retiring him in the interests of the service?

Proving incapacity in senior doctors is a more delicate process. Other staff are understandably hesitant about reporting doctors who they feel are not working safely. A profession which jealously guards its clinical autonomy also protects its own members from outside criticism. It may be some time before a manager hears that there is a problem. The system set up to deal with this eventuality is known as the 'Three Wise Men'. It allows for the doctor to be judged privately by his peers. The manager is unlikely to know more than the outcome of the process but will be justified in seeking assurances that patients are not at risk. It can happen that these assurances are unsatisfactory, in which case the manager, from an ethical point of view, is bound to take the matter further. This means discussing the case with the authority chairman and putting it before the regional medical officer with a full account of the manager's concern. Fears that this may exceed the manager's authority must be subordinated to protecting patients from harm.

Doctors' professional discipline is controlled by the General Medical Council and cases of malpractice must be reported to them. Similarly, a nurse, midwife or health visitor is subject to the disciplinary code of the United Kingdom Central Council

(UKCC). These professional bodies will judge whether or not a person should be struck off the register, either permanently or for a stated period. As a result they will be unable to practise: indeed it would be a criminal offence if they were to do so. Knowing the severity of the professional bodies, it is sometimes difficult for a manager to report a nurse or a doctor. Ethically, there is little choice; patients have the right to expect to receive the highest quality of professional care.

Managers are sometimes faced with the dilemma of what to do when a member of staff is facing a criminal charge. Do they have the right to terminate employment immediately or should they wait outcome of the trial? The difficulty is that criminal proceedings sometimes take months to come to trial and to suspend a person on full pay for a long time might be seen as an unreasonable use of resources. It is reasonable to terminate employment if the member of staff has clearly offended against their contract, no matter what the outcome of the trial, but care must be taken not to be unjust. If someone has been reported to a professional body, its judgment must be awaited before action is taken to terminate. It can be reasonable to move a person to other duties in order to avoid a lengthy period of suspension on full pay. For instance, a midwife reported for malpractice as a midwife is not prevented from undertaking other nursing duties appropriate to her RGN qualification.

This chapter has shown how managers can demonstrate their ethical obligations when dealing with staff. Patients will have little to fear in an organisation which underpins its employment policies with a concern for ethical standards.

6 ETHICS AND ADMINISTRATIVE PRACTICE

A NARROW view of managerial ethics would see them as being solely concerned with proper administrative practice, ensuring that the committee procedure is correct and that public money is not handled corruptly. The health service managers' role has grown to such an extent that they may think these matters trivial compared with the wider application of ethics to the overall provision of health care. Nevertheless, good administrative practice remains important, if only to ensure that resources are not misused and that people – members of authorities, staff, contractors – do not suffer allegations of wrong-doing. This chapter looks at the elements of ethical administrative practice, beginning with bureaucracies and how they keep corruption at bay.

The principles of bureaucracy

Bureaucracies have existed throughout history, but the definition of the modern bureaucracy has been ascribed to Max Weber, who lived at the turn of the century. He described a bureaucracy as a rational process to establish order, maintain continuity, observe rules, and ensure an impersonal and objective approach to work and its problems. The first three characteristics are still relevant but the fourth seems to be at odds with today's thinking about the importance of humanity in organisations. But let us be clear about what Weber meant. He was at pains to point out too much individuality in an organisation can lead to confusion about objectives and to unfairness towards staff who may disappoint their boss by failing to meet his expectations. An impersonal organisation is rational and methodical. Everyone knows what is expected of them and how to relate to others. Ambiguity is avoided, clarity is paramount. Ethically speaking this sounds fair and admirable, but is it an appropriate model for today?

The problem with Weber's bureaucracy, as he was well aware, is its inflexibility. If everyone knows their place how can we handle a sudden emergency effectively? 'It's not my job' has become a byword for bureaucracies and has led to the word itself being used pejoratively. The most formal bureaucracies give little scope for initiative or opportunities for personal development. This dis-

passionate approach seldom inspires the commitment and enthusiasm which are important characteristics of high achieving organisations and of effective leadership. By removing the possibility of uncertainty, the classic bureaucracy reduces its ability to deal with emergencies. Because everyone is treated consistently, even when demands change, our ethical sense of fairness fights with another principle, that of respecting the needs of individuals and exerting our best skills on their behalf in the process.

Nonetheless, it would be an unwise organisation which failed to recognise the importance of rules that support an unbiased, incorruptible approach to business affairs. For these rules to operate satisfactorily, objectives must be clearly understood and responsibilities allocated. Health authorities must have standing orders and financial instructions; what are their key elements?

The management of health authority business

Health authorities are set up by statute and their membership determined by regulation. At the very least, therefore, the authority must conduct its business in a way which reflects the public interest. Both corporately and individually the authority is accountable to the public. It is important to note that the members are not individually accountable to their nominating bodies, whether these be local authorities or voluntary agencies. This is often misunderstood by the local authority nominees who see themselves as representatives of their political origins. If this were so, it would be impossible for the authority to deal with issues, such as reductions in service for want of money, where a corporate approach is required in the face of public opposition. The health authority cannot always satisfy the public even though it is accountable to it. It can, however, make sure that the issues are debated in public and the reasons for taking action are exposed to public scrutiny.

This can impose burdens on managers which they would often prefer to avoid. To them it may be self-evident that a poorly used facility cannot be allowed to continue in a climate of financial stringency, but the old adage of justice not only being done but being seen to be done holds good. Thus, the authority meeting is a means by which such business is discussed and in the end resolved. The very formality of the meeting appears to support the principle of a

rational, objective and dispassionate approach. Propositions are put, amendments are made and finally the matter is resolved and recorded as agreed in the minutes. There may be a vote, but many health authorities manage to come to agreement by consensus.

Unfortunately this interpretation of the way authorities work is somewhat naive; the process is more subtle. To begin with, what value systems are operating to underpin the items for discussion and their presentation? How did individual members discuss the items; were points of order (constitutional devices) used to control the discussion? For instance, it is possible for a member to manipulate the formal procedures for conducting business and to deflect or even terminate discussion of an item by proposing 'I move next business'. What is the manager's role in all this? Is it merely to oversee the mechanics of committee procedure or to attempt to ensure that the process promotes the proper outcome and does not lead to a conclusion that cannot be implemented? Chief officers who feel nervous at interfering with their authority's manner of doing business, should remember that they have an ethical obligation to ensure that obvious perversions of orderly discussion are avoided and sensible outcomes are achieved. Committee politicians might argue that the officer's views are secondary to their own, but to abandon the support of your officers at a moment of crisis is a perilous course for members to take. It can be demonstrated that local authorities have sometimes come to grief by doing so.

Despite these tensions it remains true that a properly convened and conducted meeting is more likely to obtain good decisions than one which allows backstairs deals among caucuses of members who are attempting to manipulate the committee procedure for their own ends. This can be avoided by managers issuing agendas and supporting papers in ample time to allow proper consideration. Tabling important papers at the meeting is bad practice, although not always avoidable. It carries the taint of being unethical in that it could appear to be a device to obtain a decision without allowing adequate time for consideration and discussion. The authority's right to know is as obligatory as an individual's.

The role of the manager as secretary of the committee, particularly of the main authority meeting, is often assumed to be easily understood and undertaken. In fact, it is neither. On the one hand, the chief officer to the authority acts as its formal secretary, offer-

ing no views until asked and reserving them for matters of procedure or information. On the other hand, this is clearly an inadequate description of the chief officer who feels an obligation to support or oppose matters under discussion and to take an active part in the process of reaching decisions. A manager may also find it necessary to stop authorities proceeding along a line which will lead to difficulties, such as a proposal to agree, as a matter of principle, to overspend. Here the DGM, although a subordinate, must point out that challenging government is unlikely to achieve extra resources and will lead to a state of anarchy that could bring about the demise of the authority.

Besides acting as the authority's chief adviser, the DGM is also publicly accountable for the authority's work and the success or failure of its policies and decisions. The manager must not arrange for contentious or unflattering issues to be discussed in private in order to protect the authority or its managers from public scrutiny.

Case study no 11 – The press embargo

A member of the DHA persistently passes information from the DHA agenda to the press before the DHA meeting, even when items are clearly embargoed. Challenged, he says that as a local authority nominee he has the public interest at heart.

Is he wrong?

In summary, the health authority meeting has to retain a traditional formality if the public interest is to be seen to be served, and the manager in charge, usually the DGM, has an ethical duty to see that this happens, despite the pressures that sometimes occur as a result. Members cannot adequately fulfil their obligations at a monthly meeting. There have to be other ways of doing business. The formal subcommittee (notably a finance committee) although no longer required by regulation is one way. Genuine involvement in the affairs of the authority is more likely, however, if members work in groups which lack the status or formality of a sub-

committee. These take the form of visiting panels, with special interest ad hoc groups, and managers at all levels are there to help them, no matter what may be their reservations about the essentially amateur role of the members in an increasingly professionalised world. It is assumed, for good or ill, that the amateur has particular value in scrutinising the work of the professional who in turn must not resent being held accountable in this way.

Another important role for the member is the hearing of appeals and grievances, and adjudicating in disciplinary matters. As we have seen in Chapter 5, staff have rights which protect them from over-zealous managers. A third party, the authority member, can help to ensure fairness. These proceedings are not always easy to handle and members need to be trained. Senior members have a responsibility to see that such training is available and is conducted realistically within the context of the district's personnel and other policies.

Members also act as third parties in the handling of some patients' complaints, demonstrating that the basic ethical regard for individuality and protection from harm is being honoured. It is not always easy for members to be unbiased, knowing that the possible consequence of an unresolved complaint may be a legal case against the authority itself. Because they often feel under some obligation to be loyal to the staff, members will have to be encouraged to be objective.

Even the relatively bureaucratic proceedings of a health authority require standards that are rooted in our basic ethical principles of respect for the individual and the proper demonstration of professional or managerial skill in the interest, however indirectly, of the patient.

Standing orders

Members and officers are protected by rules such as those contained in standing orders and financial instructions. They give guidance about conflict of interest, for example. As representatives of the community it is inevitable that at times members are faced with a dilemma regarding information that may be of private advantage to them, usually of a financial nature. Curiously, there appears to be a difference between declaring an interest of a material kind from one of a more general nature, such as being

involved with a voluntary body supporting a group of patients under discussion. Because no personal benefit is possible, it is unusual for the interest to be declared, even though the member's views are manifestly partisan.

Financial interest is not easy to establish. Should an estate agent member leave when land sales are being discussed? How practical would that be? The chairman and the DGM will have to consider these matters carefully beforehand. They will have to examine how the estate agent might be unreasonably advantaged, given that land sales are only likely to take place on competitive tender basis. Any hint of public corruption is extremely damaging to a health authority's image and great care must be taken that business is seen to be conducted in a thoroughly ethical manner.

Standing orders spell out in some detail what is meant by pecuniary interest as it affects shareholders in companies as well as buying and selling. Members who do not declare an interest are clearly putting themselves in ethical jeopardy and might be, in certain circumstances, in danger of criminal proceedings. The dividing line is not always easy to establish. Managers can help by providing unambiguous standing orders, financial instructions and well prepared contract documents.

Contracting

Satisfactory contracting has various elements. First there is the specification. It is usual to be comprehensive about the goods or services to be provided. A more general specification that deals only with outcome measures and quality standards simplifies the procedure but is likely to be too open for the public sector. Although amendments to contracts are possible, it is unwise to be loose in the original specification. The next stage is the opening of tenders which should always be undertaken in a standard manner with a senior manager and at least one other person present. In cases involving very large sums of money it is wise to call in a member of the health authority as well. Subsequently the list of tenderers, with the prices offered, are entered into a register and those above an agreed value (limits are determined locally) reported to the health authority and recorded in the minutes.

The ethical basis of contracting has recently come into particular prominence with the move to greater privatisation. Contracts for

the supply of goods have always been necessary, but are considerations different when the service required consists largely of people? It is difficult to extract ethical principles from a matter which has attracted such a high political profile. Health authorities have for many years let contracts for work such as wall and window cleaning. Extending these arrangements would therefore seem to be a matter of degree rather than principle. But to understand the objections to wholescale contracting out of ancillary services we have to return to Chapter 5 and the importance of an ethical approach to staff matters. If a significant group of staff is not directly employed, can we be sure that ethical standards are being observed? Probably not. Any safeguards in the specification will be difficult to monitor effectively; the authority's main concern is bound to be the quality of the service rather than the means of providing it.

Other objections to large scale contracting out arise from the discontinuity of contract staff and the difficulty of ensuring that they will adhere to standards of confidentiality regarding patients. It is understandable that managers become uneasy when they see people working in their hospital who are not accountable to their own standards of good practice and are indifferent to the corporate loyalty of the institution. Despite this, it cannot be said that employing contract staff is in itself unethical.

Managers themselves may sometimes be tempted to bend their own ethical standards, particularly over the issue of hospitality or 'perks'. It is normal in the business world for a potential contractor to offer samples; how, he says, can he sell goods if the customer does not know what they are? Is it not reasonable to invite the customer to a hotel, abroad maybe, to demonstrate the goods? Is it not a matter of common practice to offer customers expensive diaries, alcohol or other gifts? The private sector does business in this way so why not the public sector?

This is dangerous ground for the NHS manager. It does not follow that rules which apply in the private sector, where companies are responsible to their shareholders only, also apply in the public sector where the public themselves are the shareholders. They will always view managers having a 'good time' with suspicion, and wonder what the pay-off is. The link between personal benefit and public good is tainted with corruption. Managers in the public service cannot afford this, nor, of course, do they need to; business

can proceed without the lubricants of special favours and gifts.

But it is not always so simple. There are times, particularly while negotiating the value of a piece of land, when the public sector manager has to do business in a private sector manner, in order to benefit the public sector by ensuring that the highest value is obtained. The ethical debate, as so often, seems to be about means and ends. A notorious case some 20 years ago involving large public sector building contracts finished with two able people, a property developer and a public servant, being jailed. Yet their achievements are around us. Is a high-minded ethical stance justified if it leads to extended planning schedules, poor building timetables and second rate results? The answer appears to be yes, except, of course, that these results are not the inevitable outcome of a proper regard for ethical standards in public management. Ultimately, good management thrives in a climate of honesty and proper practice. Able managers can reach good deals that maximise the public benefit just as well within an ethical framework as outside it. To suggest that it is only by bending the rules that the public good can be maximised is both specious and dishonest.

7 ETHICS AND THE LAW

It may seem strange to be discussing ethics and the law. Are they not synonymous? Is not the law the official confirmation of ethical judgments and procedures? Are not ethical issues legitimised by Acts of Parliament and by judgments in the Courts? The answer is – not really. We have already seen that protecting the confidentiality of a patient may impede the processes of the law. As set out in the statute books, the law aims to be relatively inflexible; indeed, if it were not it would be of little practical use. But the fact that case law is constantly adjusting the law is an indication of changing views in society. For instance, a doctor at the turn of the century was considered in law to be responsible for everything which went on at his operating session, even if he was momentarily out of the theatre when an accident occurred. Today, other professional staff would be held accountable for their own professional practice. A doctor no longer takes responsibility for the incompetence of a trained nurse.

The law has two main functions: to set standards and to make rules. Several Acts of Parliament are relevant to health service managers in the first category. The Chronically Sick and Disabled Persons Act, for instance, sets out a blueprint to which all public bodies are expected to aspire, yet it is a matter of general knowledge that 20 years later many of its conditions have still not been enacted. The other main function of the law is to lay down unambiguous rules in order that infringements can be easily recognised. In this way, the law attempts to control social behaviour by the threat of punishment. It does not always succeed, but at least the culprits know the risks they are taking.

Theoretically, individual managers can be held responsible for lapses in observance of the law by an organisation, but to date the case law in this area is slight. It is difficult to take a black and white approach when looking at professional practice and health care. Put simply, it means that practitioners of all kinds would first have to ask themselves whether they were breaking the law when considering a patient's needs. This contradicts the ethical principle that all professionals and managers are expected to consider the patient's needs first, even if it leads them to condone a wrong-doing in the eyes of the law. A simple example makes the point: we do not

report all drunk drivers in an accident and emergency department to the police because a wrong-doing of that nature is not our affair. But we shall see that the ethical principle of observing the privacy of the patient does not always protect us from the law.

The first part of this chapter returns to the basic ethical principles established earlier and examines how they are supported or not supported by certain Acts of Parliament and their associated statutes. The second part examines the manager's responsibilities in handling litigation.

Case study no 12 – Doing what the law says

The local education authority insists that a speech therapist be provided for a school in accordance with the Education Act 1981. The therapist says this will be possible only if speech therapy time is transferred from an asphasia clinic in the hospital.

As the unit general manager, what would you do?

Some relevant legislation

Despite reservations about the relationship of the law with the ethics of health care, there are many laws that endorse the ethical principles which, it has been argued, should govern professionals and managers working in the health service. First there is the principle of respect for the individual. Generally speaking the law requires that the mass of people conform to certain modes of behaviour. Nevertheless, several Acts of Parliament specifically single out an individual, or perhaps more often a definable group of individuals, for special concern. Disabled people are such a group. They were intended to benefit from the requirements of the Chronically Sick and Disabled Persons Act 1970 that health authorities and others should take action to improve services for them. Despite considerable advocacy from pressure groups, disabled people find that living in society is still beset with too many obstacles, both physical and attitudinal. Managers would do well to go through the Act and

its accompanying circular HC(70)52 to see what has been done to respect the individuality and rights of disabled people, especially those having treatment in health service premises where proper arrangements should have been made by now. This legislation has not in itself been sufficient to ensure that disabled people benefit from a correct observance of their rights as individuals.

Similarly, the Education Act 1981 aimed to improve the lot of handicapped children by reducing their segregation during school years and by requiring them to have proper access to supporting services, such as speech therapy. Resource constraints have limited the response of health and education authorities, leading to complaints from parents and schools.

Some Acts have successfully elicited a change of attitude from health service managers and authorities. The Mental Health Act 1983 has done much to build on the 1959 Act which blazed a trail for a radical shift in the way society dealt with mentally ill people. The royal commission set up in the 1950s revealed that a great number of patients in mental hospitals were there for somewhat specious reasons. Consequently, the population of these hospitals which peaked after the second world war, has now been reduced substantially – some would say too much. The 1983 Act safeguarded the rights of mentally ill people by setting up a Mental Health Commission whose principal duty is to monitor the arrangements made for them, particularly those held under one of the detaining sections of the Act.

The membership of the commission is broadly based, drawn from lawyers, nurses, psychologists, social workers and laymen who work together with doctors. The commission has a wider remit than the Mental Health Review Tribunals whose duty centres on the rights of individual patients. The manager's ethical role is to see that the spirit of the Act is honoured. This may require an insistence on the letter of the law, particularly when a psychiatrist takes a somewhat cavalier approach to a patient's rights. The member managers – a term used to describe three members of the health authority with specific responsibilities – have a right to ask the psychiatrist to answer personally their questions about the patient. In turn the member managers must take great care not to ignore medical advice unless they are quite sure that the patient's rights are being infringed and that society will not suffer if the patient is discharged. Likewise doctors must not attempt to black-

mail the members by suggesting that the patient might be dangerous, unless of course that is their considered clinical view. It has been known for psychiatrists to disclaim further responsibility for the patient when faced with the member managers' decision. This is clearly unethical and the psychiatrist must be told.

The law is not only concerned for the rights of the living patient. The Human Tissue Act 1961 protects the patient after death by controlling the use of the body or parts of it for medical education and research. Managers need to be sure that the provisions of this Act are understood by the staff concerned and that procedures exist for involving the next-of-kin in a proper manner. More recently the discussion on the use of organs has widened. We may think it right to remove an organ from a dead person to preserve the life of someone still living, but, as so often in the ethical debate, the ends do not automatically justify the means. Respect for the individuality of the dead person is central to most cultures, as is respect for the feelings of the next-of-kin. Therefore consent is needed. Unless given by the dead person while still alive, it will be required from the next-of-kin.

The procedure specifies that only a fully registered doctor may remove organs. Managers must make sure that a provisionally registered doctor, possibly acting as a locum, does not undertake this work. Nor should a mortuary assistant, even if supervised by a fully registered doctor. The Act says that managers as custodians of the body, may authorise the removal of organs provided they are satisfied about the deceased person's intentions or that it is the wish of the next-of-kin. Because of the shortage of organs and the need to act promptly to retain their viability, managers are sometimes put under considerable pressure to ignore the requirements of the law; this is ethically wrong.

We have already discussed the principle of privacy. Tension can arise between the manager and doctor over the ownership of medical records which belong to the Secretary of State and held on his behalf by the manager. Some doctors fear that confidential information may be released too readily and managers need to convince them that they too acknowledge the patient's right to privacy. But how far does the law support the doctor or manager in protecting the privacy of a patient, even a patient who has broken the law by drunken driving or, more seriously, by committing rape, child abuse or murder? The Administration of Justice Act 1970 tried to

clear up some of the uncertainties regarding confidence in health care, but it is still not clear whether medical confidence overides management confidence. For instance, my saying in a televised discussion that there are circumstances when the manager might judge the public interest best served by the disclosure of information without the agreement of the doctor met strong opposition from the medical profession. Subsequent discussion did little to clarify the matter. So what are the issues?

Fundamentally the patient has the ethical right to privacy but

Case study no 13 – Helping the police

The police find a newly born baby drowned in a stream. They ask the hospital manager for details of all mothers delivered in the town in the last three months. The manager refuses.

Is he wrong? If he is not, can he tell the police anything?

there are situations in law where this can be overturned, notably in the investigation of terrorist acts. Under the Prevention of Terrorism Act 1984 authorities must not obstruct unreasonably any enquiries about a suspect in hospital following an act of terrorism.

Less dramatic, but more frequent, is the need for medical information to establish whether or not there has been malpractice. At one time this could only be obtained by subpoena, but the 1970 Administration of Justice Act now enables the high court to ask for sight of the records if it seems that the progress of the case will be held up unreasonably without them, a system half way between the subpoena and the casual release of records. Managers may be concerned that early disclosure will give advantages to the apellant in cases of litigation. This will be discussed later in the chapter.

Thus, the right to privacy is not absolute, and there are other situations where it can be infringed in the greater public interest. The Road Traffic Act 1972 (section 161) requires authorities to give certain information about an accident which will enable the police to identify the driver. Managers must be careful, however, to make sure that the information revealed only concerns the driver

of the car. Other injured occupants may have their own reasons for being known only to the hospital: for instance, a companion who has a illicit relationship with the driver.

These exceptions apart, managers have to protect the patient's right to privacy. Indeed not to do so might, in theory, lead to a claim for damages on the grounds that the patient has suffered from the disclosure of damaging information. The recent upsurge in investigations into child abuse has demonstrated the delicate balance between disclosure to protect the child and confidentiality to protect the adult. To reveal names gratuitously to the police could lead to the public defamation of parents; not to cooperate, however, might put children under unnecessary risk. Managers have habitually avoided this sort of dilemma by saying that it is not their business. The Cleveland affair suggests that doctors and social workers cannot be left to shoulder these burdens alone. The unbiased judgment of a manager could protect professionals from the rough justice of public emotion egged on by the tabloid press.

We must not assume that most patients have information about themselves which they are unwilling for others to see without their express permission. In fact, they usually have scant knowledge of their medical records. Only recently has there been a movement for women to hold their own maternity notes. In the light of experience, managers and clinicians still have reservations about this practice. They say that the records may contain information in a form which would damage the patient's morale. Ethically, this is a difficult line to hold. It must be right that information about a patient should belong to the patient, however unpleasant it might be. Concern for the patient's feelings can justify partial disclosure, but never non-disclosure. This principle is partly recognised by the Data Protection Act 1985 which gives people a statutory right to what information is held about them on computers. Information on NHS computers is largely factual at the moment and would hardly surprise an enquirer. In due course, however, more sophisticated computer systems will hold a greater quantity of clinical detail. This Act has been seen as an important step in reducing the seemingly endemic secrecy which many other countries see as a curiously British characteristic.

Protection from harm, another ethical principle, has implications for patients and staff. If either comes to harm they can resort to litigation. There are laws which aim to protect them from

circumstances requiring legal redress. The Registered Nursing Homes Act 1982 sets out clearly how homes should operate and how health authorities must ensure their proper management in the interests of the patient. In practice some managers have found this Act too protective of proprietors. Health authorities attempting to de-register unsatisfactory homes have found that the elaborate process tends to protect the proprietor rather than the patients.

Staff are protected by various Acts covering employment which tend to endorse the principles already discussed in Chapter 5. The important Health and Safety at Work Act 1974 can prove to be onerous to managers. It requires employers to secure the health, safety and welfare of all employees and to positively protect them from hazards. In particular, employers should have a health and safety policy which establishes procedures for involving staff in setting and maintaining a safe working environment. Theoretically Crown exemption can be claimed but the government is slowly removing that bolt hole and expects health authorities to observe the requirements of the Act, meaning that inspectors from the Health and Safety Executive must be allowed the same access as they have in private industry. NHS staff have sometimes used this Act as a means of discussing other aspects of the working of the service, making some managers somewhat chary of the Act faced as they are with a perennial shortage of resources. Ethically there is a danger that this Act is only observed symbolically.

Conscientious objection may involve staff with the law. A nurse's position in the termination of a pregnancy, covered by a specific clause in the Abortion Act 1974 has been discussed already. Interestingly, this only covers a person directly involved in the operation. A medical secretary was sacked for refusing to type letters referring patients for terminations. The high court eventually ruled that the employer was right to sack her on the grounds that she was not directly involved in the terminations; it was therefore a straightforward case of disobedience.

But what of circumstances not so obviously inspired by religion? The chapter on belief examined the manager who has a conscientious objection to preparing for war. Would the position be different if the manager was required to sign the Official Secrets Act? My view is that this sort of legal requirement should not be used unless it is absolutely necessary. It is difficult to imagine what information would come under this category in the normal work of a health ser-

vice manager. Recent modifications to the Act have attempted to clear up some of these ambiguities, yet it still remains a somewhat confused area for public servants. Their accountability to the State, their ultimate employer, will be discussed in the last chapter.

The legal definition of the professional

The term 'professional' is sometimes used loosely, so it is important to know exactly what the law says about it. Since the founding of the General Medical Council in 1858 it has become increasingly difficult to call yourself a member of a health profession unless your training has lead to accreditation by a recognised institution, some with a statutory status. Doctors may only practice if registered by the General Medical Council, and nurses, united as a profession for the first time by the Nurses, Midwives and Health Visitors Act 1979, also have to be registered. This Act set up the United Kingdom Central Council (UKCC) which supervises the conduct of the nursing profession. There are similar regulatory bodies for other health professions, but managers, for the moment at least, have no nationally agreed accreditation body. Discussions are now being held on the possibility of devising a course of training which would lead to the status of chartered manager, recognised by both public and private sectors.

Managers need to know what is required by various professional codes of practice since they are often involved in disciplinary matters which cannot be left to the professions themselves. In this way the manager is protecting the patients' interests.

Litigation

This chapter has not attempted a comprehensive review of all legislation. It is scarcely required in a book of this kind; others already fulfil that need. My purpose has been to encourage managers to approach the law with discrimination in order to assess how far it helps with ethical issues and, indeed, how far it can hinder. Difficulties can occur where acting ethically and according to the law are both contrary to the health authority's interests. Information revealed to a patient, for instance, may help to establish a case against the authority. Ethically, it is right to reveal the information; indeed any court would require it, whatever the consequences

for the authority. This being so, it is imperative that there are clear instructions on the handling of claims of negligence and similar matters. It is particularly important that the matter is not left to the doctor alone, who can scarcely be expected to be objective and is unlikely to safeguard the health authority's position. Doctors are fond of using medico-legal risk as a reason for inaction but it has to be said, often quite firmly, that they cannot act entirely on their own. When something has gone wrong, it is usual, and wise, for the litigant to enjoin the authority in the case. If it proves to be entirely a matter of individual negligence, the authority reaches agreement with the doctor's medical defence organisation to pay the bill. The manager's part is to be sure that an unbiased view is taken and that evidence is collected with due formality.

It must be said, however, that even when something appears to have gone wrong, it is unwise to assume that the patient and the relatives will want to sue. Often they only want an explanation. Failure to satisfy that basic entitlement has led recently to some notorious cases where ethical principles have been clearly ignored in order to protect a doctor. When a young adult remained in a coma after a routine surgical operation, the relatives and even the health authority were hampered in their attempts to find out what had happened by the doctor's medical defence society and his lawyers. The matter was never satisfactorily resolved. Of course, there are situations where information is sought with the specific intention of proceeding with litigation against the health authority and its employees. The complaints procedure is sometimes used in this way, which can lead to difficulties. It is best to try to get an undertaking from the patient that the information given will not be used for litigation. Should this reveal that litigation is intended the staff concerned will know not to condemn themselves. The manager is usually the person who can establish the patient's intentions.

The manager can also make sure that the patient's interests are honoured. The patient's right to know what has happened is established by a systematic enquiry, best achieved by asking for statements from the staff, including the medical staff. Doctors may need to be reminded that the health authority is likely to be included in any claim of negligence even if the case appears to be entirely a medical matter. Doctors, increasingly worried about litigation, take up defensive positions. For instance, the manager may

be told that they cannot be expected to put their patient at risk by working in less than optimal conditions. This should not alarm the manager too much for it is the duty of all professionals to do what is reasonable in the circumstances. There can be little ethical justification for a doctor to deny a patient treatment because an expensive operation or a costly drug cannot be afforded. Similarly a nurse cannot abandon a patient, even if the numbers of nurses on the ward is insufficient to provide complete care.

Managers, though they may be sympathetic, are bound to point out that good ethical behaviour is exemplified by staff doing their best whatever the circumstances. But what if the doctor or nurse feels that by giving poor care they are exposing themselves to the risk of litigation? Is it fair for the health authority to put them in such a position? The manager will have to go back to the previous point and ask, is it right to abandon the patient? In any case the health authority, as mentioned earlier, is likely to be included in a claim for negligence which, in effect, indemnifies the doctor. Medical defence societies make sure whenever they can that damages and costs are shared with health authorities.

Prompt access to medical records, helped by the 1970 Administration of Justice Act, is sensible – witholding them could imply wrongdoing where there is none. Although the medical record is often assumed to belong to the doctor, it is legally in the possession of the Secretary of State. The health authority acts as custodian, so managers play a crucial part in handling the release of a record; ethically they must protect the rights of the patient, even to the disadvantage of the health authority.

Although the patient has first consideration it must be remembered that staff can feel anxious when involved in litigation. Even those who have broken their professional code of practice will need support and managers have a duty to see that help is given, whether or not suspension is necessary during the period of investigation.

When a case does not proceed because the client decides to withdraw or there are insuperable technical difficulties, the manager still has a responsibility to investigate what went wrong. A member of staff may have to be disciplined. Similarly, failure to find against the authority in the courts does not always mean that nothing was wrong or that no one was to blame. It is not unethical for a manager to deal with a member of staff before the case is heard if a lengthy wait is thought to be unreasonable.

ETHICS AND THE LAW

The law and ethics are by no means synonymous. The statute book endeavours to be absolute and unambiguous, but many ethical dilemmas depend for their resolution upon the evaluation of interrelated factors. For most people working in the health service, the law is invoked more to placate anxiety than for any other reason; it suggests certainty in an uncertain and potentially dangerous environment. In such a climate managers need to be able to hold on to ethical principles in order to protect the interests of patients and staff even when the law appears not to.

8 ETHICS AND RESEARCH

MANAGERS are increasingly expected to ensure that doctors and scientists conduct research in the health service within stricter guidelines. It is no longer correct to leave these matters to the experts; public accountability means that each health authority must give assurances that research is being undertaken in a manner which does not offend ethical principles. Before examining the place of research in a health district and the rules and practices which govern it, it will be helpful to ask what research is for, especially as a superficial review might suggest that it is primarily for the advancement of a junior doctor's career!

The purpose of research

There are three main purposes: to advance knowledge, to produce future benefits and to check current practice. The advancement of knowledge is in itself an ethical requirement for any scientist, although the development of nuclear weapons has shown that it is not always for the direct benefit of mankind. In medicine a greater knowledge about the nature of disease is not necessarily beneficial but better care and treatment may result eventually. The most obvious example is cancer, the knowledge of which is increasing all the time but not always to the direct benefit of the patient. The way knowledge is acquired and its application to the practice of medicine is the concern of the ethicist. There can be no justification for research if it is detrimental to the patient and without the possibility of future benefit, the second and arguably the most important principle in medical research. Benefits can be for individuals or for great numbers of people, such as the reduction of pollution.

The effectiveness of medical practice has to be checked as a matter of routine. Research can be by a historical review of past cases or by statistical analysis, but the preferred way is the controlled trial in which half the patients receive the drug and the other half a placebo. Drugs have been responsible for many of the medical breakthroughs of the last 40 years but the most carefully designed trials have not always avoided harm to patients.

Research cannot only be done in the laboratory; it must also involve patients in the clinical setting if it is to be relevant. Uncer-

tainty about the outcome (if it were certain, the research might not be necessary) can clash with the overriding ethical requirement that the patient's individuality is honoured and harm avoided. For this reason, it is important that research is conducted according to clearly understood procedures throughout the world.

The Declaration of Helsinki 1964*

Most countries now recognise the importance of having agreed principles to govern the practice of research. Medical experimentation has been a notorious feature of totalitarian regimes and accordingly the World Medical Association, first at Helsinki and then in a revised statement in Tokyo in 1975, has set out a Code of Practice for all physicians and medical scientists. The declaration describes the purposes of research as 'to improve diagnostic, therapeutic and prophylactic procedures and the understanding of the aetiology and pathogenesis of disease'. It also emphasises three broad principles – that research should be humane in purpose, scientific in practice and properly supervised.

How does this apply to a health district? Having established that the proposed research is clear in its purpose and in its method, we must be certain that patients' interests are protected. It has to be borne in mind that a great deal of research in the NHS is undertaken as much to advance a doctor's career as to push out the boundaries of medical knowledge.

To help patients understand the meaning of the research they should always be given an outline of the research intention so that they feel they are sharing in the project. They must also be given a realistic assessment of the untoward effects they will suffer and which they would not experience in the normal course of treatment. It is unethical to disguise side effects by generalised comments. Remember that patients may be prepared to suffer considerable discomfort once they are convinced that it will help the advancement of medical science. Altruistic behaviour can improve morale.

It can be argued that conducting research on people who are unable to give informed consent is unethical. But if this were accepted without question some important areas of research would

*see Appendix, page 109

have to be neglected. Ways must be found to legitimise research that uses people who through intellectual or physical incapacity cannot give meaningful consent on their own behalf. Parents are suitable guardians of their child's interests and it is sometimes assumed that mentally handicapped people can be treated in the same way. Happily, this is increasingly being seen as inappropriate; mentally handicapped adults are not children and have the same rights as other adults. The ethical requirement is that every effort should be made to help the mentally handicapped person to understand what is proposed. If this is impossible, we should ask whether it is necessary to involve the person in the research at all. The likely justification will be that the research is aimed at improving the lot of mentally handicapped people.

Do not assume too readily that children are incapable of understanding what is proposed. Some children with chronic conditions are surprisingly mature about their illness. Pregnant and nursing mothers should not normally be involved in research unless there is a very clear indication that there is no risk to the foetus or the newly born baby, or that the research is only relevant to this group of patients.

Not all research involves patients. Where volunteers are used the full process of consent is required. Paying volunteers has become the practice in some drug trials, although it carries a slightly dubious ethical undertone of inducement. It would be better for the drug company to contribute to an amenity fund or to finance some educational activity.

Animals used in research have their rights too and much that has been said about procedures applies to them as well. Cruelty in whatever cause is ethically wrong and managers with animal houses in their hospitals must satisfy themselves that the animals are properly cared for.

Occcasionally a person comes to harm, even in well set up research. In law, negligence or unreasonable conduct would have to be proved in order to obtain redress. This will not always be possible. It is probably best to arrange for ex-gratia payments to be made in these circumstances. Alternatively it could be argued that provided the District Ethical Committee (described below) has approved the research, patients should be covered in the normal way, the NHS accepting liability without recourse to the insurance companies.

Once the overall intention of the research project has been made clear, a method has to be chosen. One of the most common is the randomised controlled trial which divides patients into two groups on a randomised sample basis, one to be the recipient of the intervention the other to act as the control. Patients do not know to which group they have been assigned. Care must be taken to demonstrate beforehand that the control group is not at undue risk of harm. This may be difficult to prove until the research is completed. Another method of research may have to be used.

Research results are notoriously difficult to interpret and it is hard to avoid false conclusions. The association of one factor with another has to be submitted to rigorous examination to ensure that the correct assumptions are made about cause and effect. Managers have only a layman's commonsense to offer, but this is valuable. Scepticism in research is necessary.

To get the best results, the process must be systematic using a standardised protocol. First there needs to be a statement of the overall objectives with a description of the subjects to be involved. It may also be necessary to refer to patients who must be excluded because they are receiving treatment that would interfere with the results. Next it is important to explain who is going to do what. Vagueness in the allocation of tasks will damage the conduct of the research. Researchers are sometimes indifferent about the work they cause others in the laboratory or the pharmacy. Bad feeling will be avoided by a good protocol. Honorary contracts will be required by people not employed by the health authority in order that they and the patients are covered in the case of accident. The detailed design of the research is particularly important as the wrong design may lead to faulty results. Statistical methods need to be described. An outline of the treatment or intervention will help patients and others to understand the projected course of events. The patient's consent form must include a clause which allows withdrawal from the research, no matter how detrimental that might be to the project. Coercion has no place in properly conducted reseach. Good documentation is essential if the results are to be convincing.

Finally it is important to indicate what follow-up is intended, not only to check the results of the research but to ensure that patients do not come to harm over a longer term.

These matters are the responsibility of the district's ethical com-

mittee to whom all research projects are submitted, sociological and psychological, as well as strictly clinical. Managers sometimes serve on the committee although their contribution is more often limited to the administration of its business. The membership should include not only clinical doctors (bed holders) and other doctors but scientists such as physicists and pharmacists. Most committees will want to include a nurse to keep an eye on the welfare of patients and also two lay people, usually members of the health authority. In university hospitals an academic would be a valuable member.

Case study no 14 – Research: the dying patient

A patient no longer in her right mind is dying of a rare condition. Doctors wish to undertake tests which they feel may throw some light on the disease and how to manage it. Because the patient's husband is taking her impending death very badly, the doctors do not want to ask his consent for tests which are of an invasive nature.

Given that the patient's quality of life is very low, should the doctors be allowed to continue?

The ever-increasing amount of medical research makes serving on the ethics committee an onerous task for members and it is important that alternates should be available to ensure a quorum, which must always include one of the lay members. Chairman's action between meetings should be avoided. People submitting protocols can attend meetings in order to clarify points, either on their own own initiative or at the request of the committee.

Ethics committees are gradually extending their role. They now regularly review the results of completed projects to ensure that the research succeeded in its stated objective. They may also be concerned with bigger ethical issues, such as the allocation of scarce resources. There is no doubt that they help the manager to decide between conflicting demands.

Research is sometimes viewed with suspicion by the public at

large and by managers within the NHS. This chapter has endeavoured to show that providing all the research is conducted in a proper manner, there is little to fear. The advancement of medicine relies on research. The managers' role is to help doctors and others to conduct research in a strictly ethical manner.

9 ETHICS AND POLITICS

SENIOR managers in the NHS are becoming more and more involved in the process of choice. Once they could leave the difficult decisions to others; at a time when financial pressure was not so acute, the assumptions behind the decisions were not challenged. Medical specification of need was then the guiding principle and health authorities, administrators and patients were unlikely to challenge it, except marginally. This acceptance of the doctors' pre-eminent position had its limitations. It assumed a pecking order that put the patient requiring heroic surgery at the top and the elderly mentally ill patient at the bottom, a view of priorities that led inevitably to overspending and a general strain on resources.

By degrees the position of doctors has changed. One of the first steps taken by managers to bring about a different perception of patient need was to espouse the cause of one of the least favoured groups of patients, the mentally handicapped. By building up these people's right to a fair share of assets, managers began to challenge the medical élite in the control of resources. Inevitably this brought conflict and a redoubling of effort by the doctors in the acute sector to publicise the needs of their patients.

This account of recent events in the NHS tells us a lot about its power structure, but on the face of it, little about the possibility for ethical judgments. Choices can be made on a variety of assumptions and medical need is only one of them. Patients can be treated according to their economic value in society so that the working population has precedence over others. Alternatively, it can be argued that elderly people should be rewarded for their contribution to society and go to the top of the queue. Faced with such conflicting views it might be fairer to allocate opportunity for care and treatment on a random basis, allowing no favouritism.

Obviously, choosing ways to spend resources is not a rational process. It is largely influenced by assumptions and powerful groups, all as potent as they are non-rational. Rationality assumes that decisions are based on evidence and proposals on facts. Because evidence determines all that follows, it must be comprehensive and accurate. When decision making gets difficult people usually call for more information, assuming that more will resolve

the problem. This may be true if a vital piece of data is missing, but it can also be used to disguise the difficulty of making a decision. In healthcare the information required is often epidemiological. What, we ask, are the needs of this particular group of patients? What information exists about their state of health, the pattern of their disease, their treatment needs? Doctors usually give us the answers and it is interesting to look at the manner of the telling. Health authorities and their managers are often submitted to a string of assertions backed with little hard fact in the form of well researched evidence. To this concoction doctors add a strong and often piquant sauce of human suffering. All management is required to do is swallow what is offered in one gulp. Epidemiology is not used widely except for individual specialities and it is difficult for managers to do other than what seems reasonable based on what they have been told.

An example is maternity services which have been centralised in the last ten years, the district general hospital increasingly providing the only delivery facilities. This policy, started by the Cranbook report of 1959, has been followed despite opposition from mothers who have continued to support the local unit in the GP hospital, saying that the experience is more satisfying away from the high technology and hurly burly of the DGH. Professionals have argued that delivery is a crisis, no matter how well prepared, and allowing it to happen away from optimum conditions is unwise. Could research help to resolve this conflict and how far should the political process be allowed to interfere? Would ethics help or hinder consideration of the issue?

In fact we know from studies that perinatal mortality is only slightly higher in local units once the skewing effect of abnormal births at the DGH has been allowed for. The ethical dilemma becomes a matter deciding whether a slight increase in medical risk can be tolerated for other benefits to the patient. In the end it is the mother who must make the decision, although her choice will be affected by the facilities the manager can provide from available resources. This shows clearly how medical fact and political wishes are often difficult to reconcile and ethics may or may not help.

Is it possible to apply the principles used throughout this book in a political climate where satisfying public opinion is apparently more important than making the right ethical decision? Local managers find it difficult to make good decisions about resources, but is

the government of the day likely to do better? It seems not: they are just as likely to suffer from the arbitrary effects of pressure as local management. Successive governments have found doctors – who have a capacity to inflame public opinion – difficult to deal with en masse. Governments have much to lose if they appear to be insensitive to public opinion and they are, in any case, often bemused by the complexity of the process of bringing about change in the NHS. It might seem that rationality would be their greatest ally in sorting out priorities, but this can be easily disproved. If rationality were pre-eminent, the government would have long since taxed cigarettes out of existence on the grounds that smoking has been proved to be associated with ill health. Similarly, random breath testing to reduce the cost of alcohol related road injuries would appear to be equally rational. In finding it difficult to intrude to this degree on the autonomy of the individual, the government has ethics on its side in one sense for it does not wish to interfere officiously with the individuality of each member of society. If ethical principles are not to be submerged by expediency, governments must be explicit about the values which underpin their policies. These policies are not necessarily best expressed in rational terms; they may be articles of faith.

Managers are increasingly being required to make decisions in a political setting. How can they do this ethically? Suppose we wish to redistribute staff, giving more to the community and less to hospitals. This is likely to produce an emotional response from local people for whom the hospital bed has become a totem, a powerful symbol of health care. Public opinion in these circumstances becomes a political fact as powerful as any objective data. Ethically it can be argued that the public are right. The NHS is their's in effect and should they wish care to be supplied in a certain way, they are entitled to say so. However, this is a partial and restrictive view of the authority's ethical responsibility to its community. It would be wrong to agree to a use of resources which the management know to be wasteful or relatively ineffective. Nor can it be right to encourage popular attitudes to the provision of health care at the expense of patients such as the elderly mentally ill who are largely ignored by the public.

Managers also suffer from pressure from groups with particular interests. No matter how deserving are the needs of, say, the family planning service or mentally handicapped people, it is unethical to

give way to pressure and deny the interests of other people in the process.

Faced with the effects of politics at local and national level, managers have to do their best to understand the system so that they can at least recognise those situations where ethical principles are threatened. They also need to be clear about their own position in the political process.

Governments, on the face of it, are expected to give everyone a fair share while respecting the rights of individuals. The question of the distribution of benefits is therefore crucial to the ethical position. Unfortunately it is this very issue which causes the most trouble because it is related to the political principles that govern each party. If it were not so, the Black report on inequalities in health published in 1980 would have had more influence on health policy. Inevitably one is drawn to the conclusion that governments do what is politically expedient, whether or not it conforms to a higher principle. Governments are also expected to protect the rights of individuals, but what if these rights conflict with the common good? Is it reasonable to enforce vaccination or the fluoridation of water in the public interest? The answer is yes, provided there are opportunities for conscientious objection.

Amid this uncertainty, managers are left to make the best decisions they can. They will find that it is seldom possible in our complex society to do the right thing for everyone. Choosing to give a patient dying from AIDS an expensive drug could deny other patients access to the drugs they need. In the end, managers can only make decisions based on stated values. Not everyone will agree with the decisions but at least the premises upon which they are based will be explicit.

Politics and the public servant

It might be argued that I have assumed too much autonomy for the manager and that the dilemmas I have described can be avoided by obeying the government of the day. This is a simplistic view of accountability. The district general manager's allegiance is multifaceted; it is to the government, the district health authority, its chairman, the local community, the staff and the manager's own peer group. Is it possible to behave ethically when their demands are different?

The most obvious line of accountability is that of subordinate to boss, in this case the DGM to the chairman and to the DHA. These two are not, of course, quite the same. The day-to-day relationship is with the chairman who decides with the DGM the business of the DHA. We have already discussed the ethical significance of having power over the agenda. Nevertheless, the DHA has the ultimate sanction and can hold the manager to account for public statements

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Case study no 15 – Cuts at election time

It is four weeks before a general election. The district is overspending and the DGM wishes to advise the DHA that a local GP hospital should be closed to save money. The sitting MP, anxious about his marginal seat, accuses the DGM of 'playing politics'.

How should the DGM react?

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on topics of political significance, either local or national. One way to avoid this limitation – if that is what it is – is for the DGM to be the accredited spokesman for their national association, but clearly not all senior managerial staff can fill this role.

What if the health authority itself does not feel loyalty to the government? The chairman, we know, is the appointee of the Secretary of State and most, but not all, the members are nominees of the regional health authority. Nonetheless, the DHA is a statutory body with responsibilies that exceed being merely the mouthpiece of government at local level. Indeed many health authority members feel that they have little allegiance to the government except for overall policies. They prefer to see themselves as representing their own community, the health district.

This can be awkward. To whom should the DGM have allegiance if the DHA were to say that the district should overspend in the interests of patient care? In this situation it is likely that the peer group ethic will assert itself: as a public servant, the manager accepts that the cash limit policy means that public authorities must not overspend. To do so would encourage anarchy, which

would scarcely be in the public interest. If the authority cannot be persuaded to drop the proposal, the DGM's objections must be recorded. This is not disobedience but a well-established code of managerial behaviour with a status similar to conscientious objection.

Usually the DGM has the backing of the authority (it is assumed rather than stated) and shares its values. This helps in negotiations with other agencies, allowing the DGM to improve the legitimacy of an argument with 'My authority's view is...' But does this work when handling contentious issues? Too masterful an approach will bring allegations of arrogance and insensitivity, while a conciliatory approach – especially when resources are the issue – will lead to botched decisions, cynicism and a low regard for the integrity of the authority. Managers must seek a balance if their arguments are to be accepted.

A rational approach does not obtain automatic public acceptance, as we have seen; something more daring will be needed. But is it ethical for the manager to play upon the emotions of the public, even when doctors have been doing so for years? Should managers use the media to enhance their argument? Current regard for the media suggests that they should, although care must be taken not to spend money unwisely on public relations at the expense of more direct patient care. It is through the media that a manager's accountability is most often tested. Newspapers, sometimes masquerading as watchdogs for the public good, avidly seek out wrongdoing in public servants. They are also after a good story and occasionally are not too scrupulous as to how they obtain it. Managers need to remember their ethical obligations to patients before deciding what to tell and to whom. Is it right to withhold information about issues not directly related to individuals, such as a proposal to close a hospital? If it is only a proposal, will not disclosure cause unnecessary distress? It is a small step in the public consciousness from a proposal to a decision and there are good practical reasons for not discussing everything in the full glare of the press. But secrets have a way of getting out, which may be even more damaging. The ethical view for managers must be that everything should be discussed publicly in as wide a forum as possible. This requires careful presentation.

Patients are often used as hostages in these arguments, a rather dubious practice. However, it is a practice that managers find

increasingly difficult to ignore in a world where powerful images are used to convey messages about politically contentious issues.

Conclusion

It is customary to accept that health professionals are governed by ethical codes of conduct which, to a certain extent, protect them from accusations of wrongdoing. In the past, managers were not seen as needing this protection, but the climate in which they now work seems to expose them to almost as many pressures as their professional colleagues. Some would say that they should seek professional status by becoming chartered; others that it is sufficient for them to continue working with the help of the guidelines discussed in this book. The fact that managers do not benefit materially from their decisions protects them from the insinuations suffered by managers in the private sector and equips them to deal with complex issues in a disinterested manner. A thorough understanding of the ethical implications of their work will also enhance their standing and reputation at a time when many health professionals feel threatened, even within the apparent security of their codes of conduct.

This book was written when the objectives of the NHS were under siege. Complaining that health service provision has been politicised is pointless because choice in health care will always be of intense political significance. The manager's ethical responsibility – no matter what pressures there are on the system – is to see that the care and treatment of patients respects the individual and the common good at the same time. Managers are uniquely placed to do this.

APPENDIX

Declaration of Helsinki
Recommendations Guiding Doctors in Biomedical Research Involving Human Subjects

Adopted by the 18th World Medical Assembly, Helsinki, Finland, 1964, and as revised by the 29th World Medical Assembly, Tokyo, Japan, 1975.

INTRODUCTION

It is the mission of the medical doctor to safeguard the health of the people. His or her knowledge and conscience are dedicated to the fulfilment of this mission.

The Declaration of Geneva of the World Medical Association binds the doctor with the words, 'The health of my patient will be my first consideration', and the International Code of Medical Ethics declares that 'Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest.'

The purpose of biomedical research involving human subjects must be to improve diagnostic, therapeutic and prophylactic procedures and the understanding of the aetiology and pathogenesis of disease.

In current medical practice most diagnostic, therapeutic or prophylactic procedures involve hazards. This applies *a fortiori* to biomedical research.

Medical progress is based on research which ultimately must rest in part on experimentation involving human subjects.

In the field of biomedical research, a fundamental distinction must be recognised between medical research, in which the aim is essentially diagnostic or therapeutic for a patient, and medical research, the essential object of which is purely scientific and without direct diagnostic or therapeutic value to the person subjected to the research.

Special caution must be exercised in the conduct of research which may affect the environment, and the welfare of animals used for research must be respected.

Because it is essential that the results of laboratory experiments

be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to every doctor in biomedical research involving human subjects. They should be kept under review in the future. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries.

A BASIC PRINCIPLES

1. Biomedical research involving human subjects must conform to generally accepted scientific principles and should be based on adequately performed laboratory and animal experimentation and on a thorough knowledge of the scientific literature.
2. The design and performance of each experimental procedure involving human subjects should be clearly formulated in an experimental protocol which should be transmitted to a specially appointed independent committee for consideration, comment and guidance.
3. Biomedical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person. The responsibility for the human subject must always rest with the medically qualified person and never rest on the subject of the research, even though the subject has given his or her consent.
4. Biomedical research involving human subjects cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.
5. Every biomedical research project involving human subjects should be preceded by careful assessment of predictable risks in comparison with foreseeable benefits to the subject or to others. Concern for the interest of the subject must always prevail over the interests of science and society.
6. The right of the research subject to safeguard his or her integrity must always be respected. Every precaution should be taken to respect the privacy of the subject and to minimize the impact of the study on the subject's physical and

mental integrity and on the personality of the subject.

7. Doctors should abstain from engaging in research projects involving human subjects unless they are satisfied that the hazards involved are believed to be predictable. Doctors should cease any investigation if the hazards are found to outweigh the potential benefits.

8. In publication of the results of his or her research, the doctor is obliged to preserve the accuracy of the results. Reports of experimentation not in accordance with the principles laid down in this Declaration should not be accepted for publication.

9. In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw his or her consent to participation at any time. The doctor should then obtain the subject's freely-given informed consent, preferably in writing.

10. When obtaining informed consent for the research project the doctor should be particulary cautious if the subject is in a dependent relationship to him or her or may consent under duress. In that case the informed consent should be obtained by a doctor who is engaged in the investigation and who is completely independent of this official relationship.

11. In case of legal incompetence, informed consent should be obtained from the legal guardian in accordance with national legislation. Where physical or mental incapacity makes it impossible to obtain informed consent, or when the subject is a minor, permission from the responsible relative replaces that of the subject in accordance with national legislation.

12. The research protocol should always contain a statement of the ethical considerations involved and should indicate that the principles enunciated in the present Declaration are complied with.

B MEDICAL RESEACH COMBINED WITH PROFESSIONAL CARE (CLINICAL RESEARCH)

1. In the treatment of the sick person, the doctor must be free to use a new diagnostic and therapeutic measure, if in his or her judgment it offers hope of saving life, re-establishing health or alleviating suffering.
2. The potential benefits, hazards and discomfort of a new method should be weighed against the advantages of the best current diagnostic and therapeutic methods.
3. In any medical study, every patient – including those of a control group, if any – should be assured of the best proven diagnostic and therapeutic method.
4. The refusal of the patient to participate in a study must never interfere with the doctor-patient relationship.
5. If the doctor considers it essential not to obtain informed consent, the specific reasons for this proposal should be stated in experimental protocol for transmission to the independent committee.
6. The doctor can combine medical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that medical research is justified by its potential diagnosis or therapeutic value for the patient.

C NON-THERAPEUTIC BIOMEDICAL RESEARCH INVOLVING HUMAN SUBJECTS (NON-CLINICAL BIOMEDICAL RESEARCH)

1. In the purely scientific application of medical research carried out on a human being, it is the duty of the doctor to remain the protector of the life and health of that person on whom biomedical research is being carried out.
2. The subjects should be volunteers – either healthy persons or patients for whom the experimental design is not related to the patient's illness.
3. The investigator or the investigating team should discontinue the research if in his/her judgment it may, if continued, be harmful to the individual.
4. In research on man, the interest of science and society should never take precedence over considerations related to the wellbeing of the subject.

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ETHICS

AND THE HEALTH SERVICES MANAGER

Managers may not be covered by the codes of practice of their professional colleagues, doctors and nurses, but at a time of increasingly difficult choices they too are having to consider the ethical framework within which they work. Is the time honoured principle of the greatest good for the greatest number sufficient guidance in the age of the transplant and the AIDS patient? Are the rights of the individual, such as the mentally handicapped person or the grossly underweight neonate, able to overrule the traditional values by which managers have allocated resources?

This book examines such issues in a practical manner. But it also covers a wider field of concern to managers with chapters on the ethical responsibilities they have to the public at large and to health service staff. The limits of conscientious objection are explored as is the ethical basis for equal opportunities. Finally there are chapters covering research, on the law and on administrative practice.

The author has worked in the NHS since 1955, first on the wards and then as an administrator. He has been District General Manager to Bath DHA since 1984. A Fellow of the Institute of Health Services Management, he also holds a BA in English Literature and a MSc in Public Policy, both from the University of Bristol.

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