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Medicine for Managers

Dr Paul Lambden BSc MB BS BDS FDSRCS MRCS LRCP DRCOG FIHSCM

Rights and Responsibilities

No-one escapes the need for medical care and medicine has made enormous strides to alleviate pain and infection, treat disease, restore function and prevent illness. Doctors may not consciously reflect on legal and ethical principles whilst practising, and yet they make moral judgements throughout the working day. The population expects doctors and other health professionals to work to the highest moral and legal standards.

The United Nations Declaration in **1948** articulated fundamental human rights and was influential in the development of moral and legal standards in the second half of the twentieth century. The Declaration identified these rights as being universal.

> ***Article 25*** states that:
> *Everyone has a right to a standard of living adequate for the health and well-being of [himself] and [his] family, including food, clothing, housing and medical care and necessary social services.*

Since then, of course the rights of women, children and other vulnerable groups have been recognised. Other organisations and institutions have also had profound influences, including the ***UK Parliament*** and ***The European Court of Human Rights***. ***The Human Rights Act*** includes the right to life and protection from inhuman or degrading treatment. These changes, from the medical perspective, shifted the emphasis from professional obligations to patients' 'rights'.

More recently, in 1995, ***The Patient's Charter for the NHS*** set out the rights for patients. Of course, the continuing influence of the ***National Health Service*** since its foundation in 1948 has resulted in many further changes.

Medicine is governed by a self-regulating statutory body. The ***General Medical Council*** must ensure the high ethical and legal standards of the medical profession. Its duties are:

- To maintain a register of doctors
- To oversee medical education
- To oversee medical practitioners' conduct

The GMC publishes ***Good Medical Practice***. The 2024 edition details a host of responsibilities with which doctors should comply to provide the appropriate standards of clinical care.

The document now has over 100 numbered and subdivided paragraphs prescribing in great detail what doctors should and shouldn't do, under four principal domains:

- Knowledge skills and development
- Patients, partnership and communication
- Colleagues , culture and safety
- Trust and professionalism.

Many feel that the document could be summarised by saying, do what is moral, ethical and right.

April 1999 saw another important development in healthcare with the creation of the ***National Institute for Health and Care Excellence (NICE)***. Introduced by Frank Dobson, the then Secretary of State for Health in the Blair Labour Government, its stated primary aim was to introduce formal cost-effectiveness in prescribing by helping practitioners and commissioners to get the best care for patients while ensuring value for the taxpayer. The organisation has tried to achieve this difficult balancing act by:

- Providing guidance for practitioners in health and social care
- Assessing new products and technologies
- Making recommendations for care
- Encouraging best practice

NICE has now been operational for twenty-five years and has produced a deluge of advice and recommendations, perhaps only hampered by the comprehensiveness of the documentation which can make simple understanding of options and best practice difficult to establish for the hard-pressed practitioner or organisation.

Hippocrates and beyond

There is evidence that, well before the time of Hippocrates, the early physicians used often self-imposed standards when providing care for patients. Historically, moral standards governing clinical practice have centred on the importance of doing good (***beneficence***) and not doing harm (***non-maleficence***). These continue to form the bedrock of the highest quality of medical care, although sometimes judgement may be clouded in situations where good and harm are difficult to distinguish, for example in some terminal care or the use of medication which might help a patient but which have severe side effects.

The two principles were supplemented in the late 1970s by the addition of the previously neglected principles of ***autonomy*** and ***justice***.

Autonomy is respect for the person’s capacity to determine what happens to them at the hands of the clinician.

> *In simple terms, the patient must understand the risks, benefits, consequences and the different options for any proposed care and it is the responsibility of the clinician to explain those elements to the patient so that he or she can make a decision about how they wish their care to be managed.*

Patients have the right to control what happens to them and the decision must be theirs, even if, after careful discussion, it is not felt to be the best decision by the clinician. In some circumstances, for example, a patient may select the option of no treatment when the view of the clinician might be that the treatment option would be most appropriate because it would perhaps provide a reasonable chance of improvement, recovery or prolongation of life. Self-determination must be respected.

Justice is the requirement for patients to be treated without prejudice, irrespective of gender, race or class.

Justice requires that resources are distributed fairly, based on need rather than income or status.

The elderly, sick or disabled have as much right to medical care as the young and healthy.

Indeed, how well that care is provided for the most vulnerable and needy in society is regarded in itself as a mark of the well-being of the community and the country.

Ethical standards have tended to concentrate on the obligations of healthcare professionals in providing healthcare.

However, the situation has rather changed with the emergence of ***patients' rights***. The recent rights-based moral approach contrasts with the more traditional paternalistic utilitarian approach of the past.

The image of the GP, so familiar to those of us of more mature years, putting (usually) his arm round the patient's shoulder and saying something to the effect of "don't worry my dear, I'll sort it all out for you" has now disappeared.

Confidentiality as part of the ethical standard was, of course, stated in the ***Hippocratic Oath***. (Hippocrates born circa 460BC and died circa 370 BC).

> *"All that should not be spread abroad, I will keep secret and never reveal"*

Undoubtedly, patients attending for a healthcare appointment have a right to expect privacy and confidentiality. Morally, patients will be more content if they know their healthcare practitioner will not divulge information about them or their treatment.

However, with all the patient rights comes ***moral reciprocity*** which, although sometimes forgotten importantly identifies that it is not only the health professional who has responsibilities.

Patients too, have obligations. Patients have an obligation to attend arranged appointments.

Patients should not pressurise clinicians to provide inappropriate or unnecessary treatment that would go against their professional integrity or which was in conflict with accepted best practice.

A clinician has and must retain the right not to provide treatment which is not justifiable.

Rights and responsibilities therefore operate hand-in-hand. A patient will have the need for treatment whilst the clinician will have the skills to provide the remedy to relieve or cure symptoms and illness. The provision of care therefore is a joint activity and a patient-clinician partnership is created which results in the creation of a healthier relationship.

The operation of rights and responsibilities therefore seems straightforward enough, but there are increasingly difficulties and complications.

Issues may arise if, for example, patients pick and choose the advice they accept or reject from the clinician. Can that influence what the clinician will or should do if, as a result, the patient's condition deteriorates or requires additional more expensive treatment?

In a health world constraining the provision of ideal treatment because of limitations of resources, is it reasonable to restrict expensive or scarce options if patients are seen to compromise their own health because of their own actions?

As it is likely that pressure on finances, limitation of facilities and shortages of staff will be exacerbated as demand escalates. Questions might arise; discussions about smokers who develop lung disease, or alcoholics whose livers fail, may include whether '*self-inflicted*' illness should preclude or restrict access to scarce or expensive therapy.

Issues about drug therapy and clinical treatment availability are often more sharply focused in those parts of the world where there is no social healthcare and all provision is chargeable directly to the patient.

A patient who simply cannot afford treatment may produce a dilemma with irreconcilable conflict of need with a doctor's clinical code or ethical approach.

Another challenge may be the law in a particular country or state that bars a particular clinical procedure but which may be seen by the clinician as harmful to the patient.

For example, in Texas, in 2021, a Senate Bill barred all abortions after the detection of a foetal heartbeat. It had significant impact on obstetricians' practice and many have struggled with some ethical issues involving restriction of treatment in some patients.

A professor of Obstetrics in Texas wrote that "*it is frightening to consider the consequences [of the law]*". He went on to say "*Many of these situations confront the ethical and moral impetus head-on in ways that are affronting*".

The advice provided to some clinicians now is that;

> *". . . when you get a hard stop from a legal standpoint, the best thing to do is to take the step to transfer them [patients] to get them the care they need".*

This leaves many doctors feeling very nervous about circumventing the law in meeting their moral principles.

So, how should the clinician of today operate in the face of increasing bureaucracy, increasing costs and the restriction of available medication or treatment?

For doctors, the General Medical Council is the first port of call. Its guidance may appear ambiguous. For example:

14. You must make good use of resources available to you, and provide the best service

possible, taking account of your responsibilities to patients and the wider population.

It is not clear whether providing the best service possible with the resources available allows one to ‘take account of’ responsibilities to the patients.

95. If you are faced with a conflict of interest, you must be open about it with patients and employers, declare it in line with local and national arrangements, and be prepared to exclude yourself from decision making.

Whilst this paragraph clearly relates to commercial conflicts of interest, if guidance or resource conflicts with best patient care, being open is almost certainly best but exclusion from decision making is not normally possible.

There appears to be a grey area where doctors, confronted with situations where their preferred action is constrained, may have either to live with the knowledge that the best option was not provided or possibly ‘bend’ the rules to provide the necessary care. In either scenario, standards are in some way compromised.

The problems of constraint and restriction are likely to worsen as demand increases and finance comes under greater pressure.

Difficult decisions will have to be made and patients will need to understand exactly what is available and what can be provided.

For the committed clinician, failing to achieve what he or she considers best for the patient is likely to be accompanied by feelings of failure…

… whether or not it is possible to overcome the constraints to delivery of care.

As Martina Navratilova so accurately said:

> “whoever said that it is not winning or losing that counts, probably lost!”

paullambden@compuserve.com