

Professional ethics—for whose benefit?

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Editor's note

In a wide ranging paper the author, a barrister, considers medical ethics in the context of divided loyalties, particularly those of a doctor employed by the National Health Service and those of doctors in occupational medicine. He argues for more specific professional codes of medical ethics, especially in relation to the need to obtain patients' explicit consent before medical details are transmitted to third parties. On the thorny question of when, if ever, can the good of society override the doctor's special duty to his patient of confidentiality, he urges medical organisations to be more explicit at least on how members can set about resolving such dilemmas – mere assertion that a problem exists and that individual doctors must resolve it according to their consciences is not good enough, he says. Extolling honesty and openness as fundamental values he ends by suggesting that part of a binding code of medical ethics might be a requirement that doctors display in their waiting rooms information about their personal moral stances concerning major dilemmas of medical ethics. The paper was given as the Lucas lecture under the aegis of the Royal College of Physicians' Faculty of Occupational Medicine, in whose journal it is also published.

I can hardly think of a more daunting task than to deliver a named lecture on a subject about which one knows precious little, in succession to an inaugural lecturer of the stature of the President of your Royal College, Sir Douglas Black (1). When I was first asked, my immediate reaction was to run for cover, and to refuse the invitation. Even now, I do not know what eventually moved me to accept – whether it was my long-standing affection for Sir Douglas, my amateur interest in occupational medicine, my semi-professional interest in ethics, or just plain vanity.

But now I am here, only too conscious of Sir Douglas' minatory quotation from the Duke of Wellington: 'I never speak of what I know nothing'. Let me therefore at least pretend that I know something, however little it may be, of that of which I am about to speak.

I want to speak about professional ethics. It is a subject about which much has been said over the centuries, and yet there is still much more that can be said about it. When the 1980 Reith Lecturer

chose 'Unmasking medicine' as his general theme (2), he devoted one of his lectures entirely to medical ethics, and the subject pervaded most of the other five. Although, like Mr Kennedy, I am by training a lawyer, I do not share his missionary zeal to put your profession in its place. Nor would I be as sure as he seems to have been where that place is: his consistent use of the pronoun 'we' to cover all the rest of the population other than medical practitioners troubled me quite as much as it troubled Dr Conor Cruise O'Brien (3).

So, in speaking about professional ethics, I shall try to avoid polemics, and concentrate instead on analysis, at least to begin with.

What are ethics?

First, of all, what are ethics? Your Faculty's Ethical Guidance Committee, in its 'Guidance on Ethics for Occupational Medicine' (4) – may I call it 'the FOM Code'? – contrasts ethics with science, and defines the contrast by asserting that 'the answers to ethical questions can be neither logically demonstrated nor experimentally verified' (5). Now I am afraid that that is the kind of statement which has the same effect on me as some fences have on some horses: I shy at it, and then I have a closer look before I decide whether I can safely cross it, and move on. To keep the metaphor at the same zoological level, it may be that for me to criticise this statement in this company on this occasion is a case of biting the hand that feeds me. But I must attempt it for it is important for my purposes.

First, it is not the case that the answers to ethical questions cannot be logically demonstrated. Logic is no more than a set of rules for deriving conclusions from premises. Given any premises not inconsistent with each other, logic will help you to reach consistent conclusions from them. Without premises, nothing can be derived, whatever the rules. And that holds true for science just as much as it does for ethics, except that the premises of science tend to be more deeply buried. They include such initial axioms as that there is a material universe outside ourselves, that it conducts its affairs in some orderly fashion, that we can discover the patterns of that order and state them in the form of 'laws of nature', that those laws can be tested by reference to certain standards of invariance and consistency, that the principle of induction is a

valid basis for predicting the unobserved future from the observed past, and so on.

The only difference between science and ethics in this respect is that the premises of ethics are less deeply buried, and more obviously controversial. If, for example, I postulate the ethical axiom that 'everyone should so conduct himself as to achieve the greatest good for the greatest number', and add a ranked list of goods, the rules of logic will derive perfectly consistent conclusions in most given situations. And so they will if my initial axiom is that 'everyone should so conduct himself as to conform with the teachings of the Decalogue' – or, come to that, the New Testament or the Koran. In ethics, unlike physics, the arguments are seldom about the conclusions, but more frequently about the premises. However, given agreement about the premises, logical conclusions unfailingly follow.

Secondly, it is not the case that the answers to ethical questions cannot be experimentally verified. One way of looking at ethics is to regard it as the study of morality – that is, the observation of how other people resolve moral problems in particular situations, and the construction of consistent theories to explain what is so observed. If, for example, one observes that Dr X consistently refuses to terminate pregnancies in any circumstances whatever, one may infer from that observation the hypothesis that he regards one moral principle as dominant over all others – that is, that he will always resolve moral problems in favour of the continuance, rather than the termination, of human life in any form. And that hypothesis is perfectly capable of both support and falsification by experiment: all one need do is to present him with a cyanosed neonate suffering from major genetic malformations, and then observe how many of his hospital's resources he mobilises in order to ensure its survival for the longest possible time. Such an experiment will certainly test the theory, and its outcome will either support or falsify the hypothesis in the best scientific tradition.

Those considerations lead me to a more general proposition about ethics, namely that its central field of study is how people behave when they are faced with a *conflict* between two or more moral principles to which they subscribe. It is often not sufficiently realised that, without such conflicts, there are no moral problems. By subscribing to the moral principle, 'Thou shalt not kill' I create no moral problem for myself, nor do I by accepting that it is right for me to defend my Queen and country. But if Britain goes to war, I join the armed forces, and I eventually find myself at the safe end of a rifle of which the dangerous end is pointing at a blameless father of six who happens to be wearing the uniform of the Queen's enemies, the two principles will collide sharply – and that is the point at which the ethicist behind the neighbouring sandbag will start to get interested, and try to

discover how I decide whether or not to pull the trigger.

You may think that is a far-fetched example – and, in these days, perhaps even an irreverent one. But I give it only in order to make a point, and the point is that ethics is not a subject which scientists can simply disdain as a form of unscientific speculation, a mere game of abstractions for academic speculators. It is a subject quite as disciplined as any natural science, quite as complex, and quite as dependent on precise observation, rigorous logic, and intellectual – as well as moral – integrity. And it is a subject that can be deadly serious in the literal sense, for it often concerns matters of life and death – especially in medicine. However, today I shall avoid the temptation of discussing the medical ethics of life and death, an area which would lead me into some controversy with the views of a good many people, including last year's Reith Lecturer. In the context of occupational medicine, I would rather talk about an aspect of medical ethics to which Mr Kennedy devoted curiously little attention; and that is the moral problem presented to a practitioner of a learned profession when he finds that he owes different obligations, at the same time and in the same circumstances, to different people with conflicting interests. And that is the area I intended to point to by the Delphic title which I chose for this lecture.

Professions and ethics

The classic model of medicine is that it takes place in a single relationship between two people: the doctor and the patient. The patient, being by definition the weaker party, owes the doctor hardly any obligations, apart from paying the fee if there is one, if and when he can afford it. By contrast, the doctor's obligations to the patient are heavy. He takes full responsibility for the patient's health so far as it is in his power, and for the consequences of the treatment he gives or prescribes; he must use a high degree of skill and care; he must preserve total confidence about the patient's affairs; he must be ready to turn out at all hours if the patient needs him; and so on.

That is the unequal two-party model on which not only medical ethics, but the whole of the traditional common law (that is, judge-made case law) of medicine has been based. In its essence, the relationship is one of a private contract for the supply of professional services. So one-sided is it that the law imposes all these burdensome obligations on the doctor, and gives the patient the right to sue in the civil courts if he suffers any damage as a result of the doctor's breach of any of them, but the doctor is given very few rights in return. In the old days, a physician had not even the right to sue for his fee – as in the case of the barrister, the law treated that as an honorarium, a debt of honour only, and nothing so demeaning as a commercial price, recoverable by legal action (6).

Given that the law prescribed all these obligations, why was it necessary for the profession also to develop a set of rules of professional ethics? The reason is, I think, important, since it provides the clue to the real difference between a true profession and many other important and worthy occupations. The professional practitioner holds great power over his patient or client. In the case of the doctor, it is ultimately the power of life and death – and so it was too in the case of the lawyer, until the death penalty was abolished. Today, the lawyer's power may still affect liberty or imprisonment, as well as financial success or ruin. And the parson, the third of the trio of traditional professionals, was at one time universally believed – and is still believed by some – to mediate the greatest power of all: that of eternal salvation or damnation.

Now it is of course immediately obvious that all this must put the holders of such powers under some rather stringent obligations. The first is that plainly it would be iniquitous if they used their powers merely to promote their own advantage, to feather their own nests. And so the first rule for all such professionals is that the interests of their clients must always take precedence over their own. Their availability must be total; and if ever there is a conflict between their personal interests and those of their clients, that conflict must always, and uncompromisingly, be resolved in the client's favour. The cardinal sin for any lawyer is to advise his client to conduct a lawsuit which will earn him fat fees, but which he knows the client will lose in the end. The cardinal sin for the doctor is to prescribe an expensive course of treatment from which the patient will derive no benefit. For parsons, the question is more difficult: I suspect that if rich men had not been encouraged to subscribe to church building funds in the hope that this would help them to emulate the unlikely process of camels passing through the eyes of needles, we would today have few ancient churches to show to our tourists.

But it was also realised early on that powers as great as these could not be allowed to remain constrained merely by the rules of a law of contract largely developed to regulate commercial transactions between merchants, each seeking to extract the maximum personal advantage from their bargains. Precisely because of the inequality of bargaining power between doctor and patient, lawyer and client, and parson and penitent, the practitioners of those recondite arts were required to submit themselves to two critical constraints.

The first of these, which I have already mentioned, is that unlike the merchant or the tradesman the professional must not use his superior power to drive the best bargain he can for himself; on the contrary, he must put the interests of the other before his own. The second is that the true professional is subject to the overriding constraint of serving some 'noble' cause. The parson is bound to the service of God

himself, the lawyer to the lesser (but still noble) cause of justice, and the doctor to the preservation of life and the promotion of health. While, in each case, they are bound to do all that is in their power for the interests of their clients, the paramount obligation to serve the noble cause prescribes limits even for that. So, for example, the parson must not mediate God's forgiveness by giving absolution to a penitent whose contrition is merely feigned, however much that might be in the interests of the penitent's immortal soul. The lawyer may not knowingly mislead the court, even if that will surely save his client from the gallows or the gaol. And the doctor must not help his patient to dispose of his enemies, however much that might enhance the patient's prospects of healthy survival.

Now constraints of that kind cannot be enforced by any law of contract, which must allow bargains to be freely struck and can only enforce them by giving relief, after the event, to one of the parties if the other one has not performed his part of the bargain. But penitents are unlikely to sue their parsons for refusing to give absolution, prisoners their lawyers for refusing to lie, patients their doctors for refusing to supply arsenic for onward administration to others. Such limitations on the contractual duty to do one's best for one's client can therefore only be imposed by the moral conscience of the practitioner, and when that conscience becomes collectively articulated the result will be, at one and the same time, a code of professional ethics, and a profession defined by the acceptance of the constraints which that code imposes on its members.

And so one can, I think, define a profession as being composed of people who are experts in a discipline that confers power to do both good and harm, who practise that discipline for the benefit of others, who choose to give the interests of those others consistent precedence over their own, and who seek to limit the harm they might otherwise do by submitting themselves to a set of ethical rules designed to serve the paramount interest of some noble cause.

Now it is true that, in recent times, the word 'profession' has been used rather more loosely than that. There are two obvious reasons for this. One is the great increase in the level of skill needed today to carry on many occupations which used to be quite simple. Another is the very understandable desire of some people, who know that they are doing an important job which requires a good deal of expertise, to achieve levels of social status and pay comparable with others whose jobs may not seem to them to be any more important, nor their skills any greater. That is how dustmen have become refuse disposal contractors, and ratcatchers rodent operatives. And I would not wish in any way to be thought to diminish their worth to society by saying that whatever else they may be, they are not professionals in the sense in which I use that term –

at all events unless and until they accept the two fundamental constraints which distinguish the true professional: the subordination of his own interest to that of his client whenever those two come into conflict, and the collective submission to a code of ethics which sets limits to the exercise of his skills through the service of a noble cause.

Serving more than one master

So we have already moved some way from the simple two-party model of medicine reflected in a contract for the rendering of services. A third party has come into the act, in the form of some abstract 'noble cause' whose interests set some limiting ethical boundaries to what might lawfully be done under that contract.

That model served quite well for a good many centuries, and it still remains the starting point both in the law courts and in the medical schools. But in fact it bears very little resemblance to the circumstances in which medicine is actually practised in any modern developed country. In the UK, it will just about do for the few remaining GPs who practise entirely outside the NHS, and for the consultants in private practice to whom they refer their patients. But for the bulk of British medicine today, it leaves out some vital new components.

The principal one of these is the Secretary of State for Health and Social Security. Not only does he own all the physical assets of the NHS and control its entire finance, but (through the Health Authorities) he employs all its staff – including its hospital doctors directly, and its GPs indirectly. That brings into play a quite different branch of the law of contract, previously unfamiliar to medical professionals – the contract of master and servant. Now there is no longer any contract between an NHS patient and his doctor, at all events in the hospitals: in law, the only *contractual* obligations for a NHS hospital consultant or registrar are to the Secretary of State, not to his patients. True, the law still imposes a duty on him to exercise due skill and care, but under the head of tort and not of contract. If something goes wrong, the patient cannot sue the consultant or registrar for breach of contract: he must sue the Health Authority on the ground that one of its servants behaved negligently in the course of his employment.

And the introduction of the law of master and servant into the practice of medicine has had some remarkable consequences, not all of which may have been foreseen when the NHS was created. Take, for example, the matter of confidentiality. It has always been the law, as well as part of the medical code of ethics, that a doctor must safeguard all the secrets of his patients that he discovers in the course of his practice – and most of all, of course, the clinical data he acquires when he takes the patient's history, or on his examination. That was a term which the law always implied in all contracts between doctors and

patients, even if nothing was said about it when they were made: the patient had no need to say: 'Doctor, you won't tell anyone about this, will you?'

But it so happens that, under the law of master and servant, anything the servant is paid to bring into existence, and which he brings into existence in his employer's time or with the use of his employer's property, belongs to the employer. So, when the doctor in the NHS hospital makes his clinical notes in NHS time, on NHS paper (and, as likely as not, with an NHS ball-point), both he and the patient may believe that the information he writes down is protected by professional confidence. But, as a matter of the law of master and servant, the piece of paper with the record made on it are the property of the Secretary of State or his Health Authority – and, as a matter of law, the Secretary of State and any of his authorised officials are entitled to look at it, even if they are not medically qualified (7).

Nor is that just one of those accidental and uncovenanted quirks of the law, having no practical consequences. Those of you who saw the Granada TV programmes on medical ethics in 1980 were probably as astonished as I was when a senior hospital administrator said, apparently without turning a hair, that as a civil servant and the custodian of the hospital's records on behalf of the Secretary of State, he was perfectly willing to exercise the discretion vested in him to give a senior police officer information from those clinical records if he judged that this could assist in the detection of a serious crime. He added that, in order not to cause any unnecessary embarrassment, he would neither invite the consent of the consultant who had made the record, nor tell him of the disclosure.

So, in the NHS today, the doctor no longer serves his primary master, the patient, to the exclusion of all other interests including his own, constrained only by the ethics of the noble cause which he also serves. Today, he has two masters: the patient and the State, whose interests will often coincide, but may also sometimes conflict. True, the State has often asserted that, in its contract of master and servant with the doctor, it will not seek to limit the doctor's clinical freedom – that is, his freedom to do what he judges to be in the patient's *medical* best interests. But even that is not quite accurate, for the State has to provide the resources for medicine in the NHS. And those resources are finite, being limited by what the taxpayer can be made to contribute to them. So, for example, if a committee of civil servants at the Elephant and Castle – which may or may not include doctors – were to conclude that cost-benefit analysis calculations could no longer justify open-heart surgery, and that the corresponding resources would produce a better return in public health if they were diverted to renal dialysis, the result might well be a substantial interference with the clinical freedom of cardiac surgeons.

And, outside the limited area of clinical freedom, the contract says nothing about conflicts of interest.

Two-master ethics

It is obvious that serving more than one master at a time can lead to situations where two or more moral principles come into conflict – the very sphere to which the study of ethics can contribute. How then can medical ethics in particular contribute towards the proper resolution of such conflicts? Of all the specialties, that of occupational medicine has the longest experience of that problem area, for occupational physicians have always had to live with possible divergencies of interest between their patients and their employers.

Let me therefore turn again to the FOM code (8) and let me lavish some heartfelt praise on it in the area of the confidentiality of records. Here, I am happy to see, your Faculty is uncompromising: ‘Access to clinical records of an individual’, the Code says, ‘should not be granted as of right to other people, whoever they may be or represent, and whether or not they are professionally qualified’ (9). And that stand is fully supported in the Ethical Guidance for the Occupational Physician published by the BMA: ‘The personal medical records of employees maintained by an occupational physician are, like other clinical records, his own confidential documents, and access to them may not be allowed save with the consent of the employee concerned or by order of a competent court or tribunal’ (10).

That is splendid and strong. But now I fear I must again take the risk of being accused of biting the hand that feeds me. Having already found myself shying at the very first fence some time ago, I fear I shall have to shy at a few more.

The first is probably no more than a minor quibble. The FOM Code says that many questions of medical ethics ‘are concerned with what the doctor *ought* to do rather than with what he *must* do’ (11). (The italics are in the original.) I am not sure that I appreciate the difference. Perhaps I am being obtuse. If, in a position of moral difficulty, I conclude that the right thing for me to do, at that time and in those circumstances, is to pull the trigger and kill the hapless father of six in the wrong uniform, because my duty to serve my Queen and defend my country takes precedence over my duty not to kill other people, then that is what I not only ought to do, but must do. Once the answer is clear enough, it becomes a moral imperative. To say that I ought to do X, but in fact I shall do Y, is only to say that the moral arguments for doing Y in fact outweigh the arguments for doing X, and so in the event I have concluded that I ought to – in fact *must* – do Y. (I may still do X in the end, perhaps because I am too lazy, or too selfish, or too frightened, to do Y; but, I shall have done wrong.)

There is of course another sense in which ‘must’

can be used, namely a command by some secular authority such as the State or the law. But if I were to come to the conclusion that, as a matter of morality or ethics, it would be wrong for me to obey that command, then I would conclude that I *ought* to refuse it – that, in all conscience, I *must* refuse if I am to do what I believe to be right, and take the consequences which the law or the State will visit on me.

My next fence (and I suspect it is not unconnected with the previous one) is rather stiffer to cross. It says here that ‘the [ethical] guidelines for [a doctor’s] conduct are the approval of his colleagues rather than the avoidance of official censure’ (12). I do not detect in that proposition much trace of the noble origins of professional ethics in selfless service to the patients, and service to the noble cause. Instead, it seems inward-looking and defensive. I shudder to think what the 1980 Reith Lecturer might have made of it. I would venture to suggest that physicians, and occupational physicians at that, could afford to adopt a rather more courageous stance. If you are convinced, having thought about it thoroughly, that something is right, I for one would hope that you will do it quite regardless of whether it will result in official censure. And I would hope that in considering what is right, you will frequently consult those of your colleagues whose ethical principles you respect, but that what you will ultimately take into account is what is best for your patients, and for life and health in general – neither of them factors which are mentioned here, though they are the most important of all – and that the *approval* of your colleagues will take a pretty low third place after those two.

I also hope that not too many of you have chosen this profession because of the esteem that it will earn you within the Faculty or the College. You are here to prevent, alleviate and if possible cure human suffering. If that sometimes seems to put you on a moral spot, I am sure you will make every effort to work out for yourselves what is right. However much you will consult your colleagues, their views cannot ultimately override your own informed conscience. And, once you are convinced that you know what is right, you must – yes, I mean ‘must’ – do it, quite regardless of whether you think your colleagues would approve. Safety there may be in numbers, but moral virtue there is none. That is the prerogative of the individual.

Quite rightly, therefore, the FOM code next brings in the occupational physician’s conscience, but quickly dampens that momentary foray into individualism by a rapid retreat to ‘what is professionally acceptable to his peers’ (13). That may help to educate and form the conscience of the young recruit to the profession, who is rightly advised to ‘discuss particular matters with senior colleagues’. But surely the whole point of a conscience, once one has painfully learned how to use it, is that it becomes

the single ultimate determinant of one's moral conduct, regardless of the consciences of others?

And just why do the Defence Societies (14) come into the act at this point? Surely their function is to advise their medical members on the law, and to diminish the risk of being sued or prosecuted? I confess I had not previously appreciated that they had a function to perform in the field of forming a doctor's ethical conscience.

So much for the Introduction to the FOM code – and introductions are important, since they provide the framework, and set the tone, for documents such as this. But now let me get to the meat, where I hope to find the distillation of many decades of experience of serving two masters, which could help doctors in the NHS to resolve some of the similar problems with which they are faced. And indeed the FOM Code has all the right headings: Confidentiality of clinical information and of scientific information; Routine examinations and clinical investigations; Relationships with other agencies; and 'Any other areas where conflict of interests might arise'. And under each of those headings, many wise and sensible things are said. But I am afraid I look in vain for any clear statement of general principles, for a ranking of priorities among conflicting duties. Nor do I find any guidance on *how* the occupational physician should go about resolving problems of this kind – what one might call the algebra of ethics.

Nowhere, for instance, does it say: 'Put yourself, successively, into the positions of the different people who are making conflicting claims on you. Try to work out what it is they really need if their interests are to be served. See first whether you can supply all those needs without doing anyone any harm. If you think you can, tell them what you are minded to do and find out whether they have any objection. See whether those objections are reasonable – in their terms rather than yours. And above all, try not to disappoint the expectations which any of these people have of what you are likely to do, what they may even believe you are bound to do. Make your decisions openly, after full discussion with everyone concerned, so that everyone knows what to expect.'

Suppose, for example, you are attending your Company's sales manager's party, and you watch him pouring his fifth gin with a shaking hand and the tell-tale twitch at the corner of his mouth. You might well say to him: 'George, you ought to watch it a bit.' No problem about that. But suppose a week later the Chairman asks you in confidence whether you think George would be suitable for promotion to the main Board. You naturally temporise. You say: 'Well, JB, you are a much better judge of that than I could be'. 'Quite so,' says the Chairman, 'but before I decide I want you to tell me whether you know of any medical factors which might put his suitability in question'.

At this point, you remember that the FOM Code

enjoins you to confine your advice to 'ability and limitations of function', and that 'findings should be expressed in general terms rather than as specific measurements' (15). If you have had a chance to look at the parallel Code prepared by the American Occupational Medical Association, you will know that this follows suit: 'Employers are entitled to counsel about the medical fitness of individuals in relation to work, but are not entitled to diagnoses or details of a specific nature' (16).

So what do you say? 'He drinks a bit, but so do many salesmen, so I don't think that limits his functions'? Or 'I don't think he has any problems he can't learn to control – at least with my help and his active cooperation'? And would it make any difference if the Chairman were a rabid teetotaler?

The example is of course deliberately one of some levity – though the promotion could make all the difference to George, his marriage, his mortgage and his children's education, and perhaps also to the Company's commercial future. I am sure it is a problem with which you are all familiar, and you have all learned a variety of tricks for resolving it. But that is the process which Mr Kennedy called 'education by osmosis'. Is that really good enough? If there is to be a code of ethics specially devised for occupational physicians – and of particular importance because of what it has to say about serving two masters, as so many other physicians now also have to – should it not set out rather more explicit rules for deciding questions of this kind?

Let me pass on. In the next paragraph, I read that 'in certain medical examinations . . . it can be inferred that the individual agrees to disclosure of the result by submitting himself for examination' (17). Now there are some things in life – and in science – that have to be inferred, but that is only because they cannot be established by more direct and reliable means. Why, I wonder, is it necessary – let alone scientifically legitimate – to infer a person's wishes when that person is himself present, conscious, sane, competent and able to answer questions? Why not say instead 'The result of a medical examination may never be disclosed to a third party outside the physician's own medical team without the express consent of the patient. If the patient refuses that consent, the refusal alone may be reported to the authority on whose behalf the examination was conducted'? (18) That might result in some HGV and PSV licences being withheld, or in some applicants for food-handling jobs not being employed, but then they would know in advance – or could be told – that this would be the consequence of their refusal. What I do not follow is why any doctor should be entitled to infer anything about the consent of a patient on those occasions when the patient is there, and perfectly capable of giving or withholding it expressly.

Let me raise one more Aunt Sally before I turn to more general questions. Later in the FOM Code, I

find an interesting ambiguity. It says here that the occupational physician should report to a patient's own doctor 'any relevant facts . . . which have a bearing on the interaction between his work and health' (19). It goes on: 'The individual should be informed that such information is being passed on' – though it is not clear whether that is before or after. But should not his consent be sought and obtained *before* there is any such disclosure? Why is it assumed that doctors are always free to talk to each other about a patient? The patient may have some perfectly sound reason – at all events, one that seems perfectly sound to him – for not wanting his GP to know something. His faith in his GP's discretion, for example, may on past experience be less than complete. Surely it is he, and not the occupational physician, who is entitled to decide who else should know what about him?

Here, the BMA's Code is commendably unambiguous: 'As in all cases where two or more doctors are so concerned together,' it says, 'the greatest possible degree of cooperation between them is essential at all times, *subject only to the consent of the individual patient concerned*' (20). And it goes on: 'When he makes any findings which he believes should be made known to the employee's GP, in the employee's own interest, the occupational physician should pass them on, *having first obtained the written consent of the employee*' (21) – my emphases.

Finally, let me get to the most difficult issue of all. The FOM Code mentions a dilemma which is currently the subject of much debate: the dilemma between the doctor as clinician and as citizen. 'When safety or public health may be in jeopardy', it says, 'the physician may sometimes find that he has a greater obligation to act in the common good' (22).

I must confess that, if I were a clinician, I would find that sentence decidedly unhelpful. It hedges all the bets and tells me nothing, except that the problem was one which the authors of the Code were unable to resolve – in common, one must say in all fairness, with the BMA and just about every other official medical committee that has thought about it.

Who is to decide where the common good resides? Is not that supposed to be Parliament rather than the individual citizen? Parliament has already laid down by law at least three occasions when doctors are bound to inform the authorities of the State about their patients' clinical condition: Part V of the Public Health Act 1936, s. 168 (2) of the Road Traffic Act 1972, and s. 11 (1) of the Prevention of Terrorism (Temporary Provisions) Act 1976. If Parliament does not believe that the common good requires any more disclosures of private medical matters to the public authorities than these, why should any individual doctor's judgment of the common good be any better? If the doctor, as a professional, is bound by the obligation of professional secrecy, can he alone dispense himself of that obligation because another and quite unprofessional

part of him, the citizen, feels an urge to serve the common good? I can assure you that in my profession – the law – that would be out of the question. If I ever had a client who told me in my chambers that he had committed a murder, or even one who told me he was about to do so – and I hasten to add that nothing of the kind has, fortunately, ever happened to me – I would be bound by my profession's ethics to resist any temptation I might feel to alert the authorities. And if I failed to resist it, though there is nothing the law could do to me, my professional bodies would take a very dim view indeed. That is the stuff of professional ethics.

Now I am not for a moment saying that every code of professional ethics must dictate total silence at all times about all clients' affairs, come what may, and even if the heavens should fall as a result. I fully understand the dilemma of the doctor – and especially the psychiatrist – whose patient tells him that he is planning to set fire to his neighbour's house, or that she batters her baby or is smuggling heroin, or that he has already killed six prostitutes and intends to continue whenever the moon is full until someone catches him at it. Although, as citizens, we all feel an obligation to support law and order, as professionals the dilemma is even greater for the doctor whose noble cause is the preservation of life and the promotion of health, than for the lawyer whose concern is only the proper dispensation of justice for those with whom the law has already caught up.

But what I *am* saying is that professional codes, if they are to be worth anything, cannot merely confine themselves to asserting that there is a problem, and leaving it at that – let alone leaving it to individual members of the profession to solve the dilemma as best they can, after consulting their unguided conscience and perhaps a few respected colleagues. At the least, such a code must say something about *how* to approach this kind of problem. And nothing that I have yet seen begins to do anything of the kind.

I harbour the unworthy suspicion that this is because all those who have been given the unenviable task of drafting such codes have found such problems beyond them (23). If that is right, they deserve all sympathy, and they certainly have mine. But, seen from the point of view of those who look to such codes for guidance in their own professional affairs, that will hardly do.

Worse, it will not do at all for their patients (or, in my case, clients). As a confirmed individualist, I rather like the idea of leaving everyone to make his moral decisions according to his own conscience – indeed I have already said so here in another context. That is splendid for the freedom and moral autonomy of the person whose conscience it is. But what about the others who will be affected by his decisions – especially if he is a professional, who by

every definition exercises great power over those who depend on him?

And that brings me to my last point in this already over-long, discursive and somewhat combative lecture. At the end of his fourth Reith Lecture, Mr Kennedy sent out a ringing call for better education for doctors about their professional ethics. There is much in those lectures with which I would disagree, but that call is not one of them. Indeed, I would echo it fully. But I would go further in one very important respect.

I happen to have a profound belief in the values of honesty and openness. And that is something about which I find little in the 1980 Reith Lectures, and less – I am sorry to say – in all the codes of medical ethics that I have looked at, including your Faculty's. The relationship between doctors and patients may be unequal, as is often that between lawyers and clients, parsons and penitents, and for all I know dispensers of hearing aids and the deaf. But is that not all the more reason why we, the professionals who wield the power, should take our feckless dependants into our confidence, and at the very least tell them what our ethics are, and what they may therefore expect from us?

In order to leave you with a thought to chew over in the still hours of the night, let me give you an example of what I mean. All the codes of medical ethics that I know of in Great Britain, including your Faculty's, leave the dilemma between medical confidence and good citizenship to the conscience of the individual physician. I have explained why I think that this is somewhat pusillanimous, but so be it – that is what the codes at present say. But how many patients know that that is what they say? Worse, how many patients know how the conscience of their personal physician functions – if, that is, he knows it himself?

How, I wonder, would you react to the following provision in a code of ethics, binding on every medical practitioner in the UK:

Every practitioner shall ensure that there is brought to the personal attention of every one of his patients, preferably by telling him at his first interview, but at the least in the form of a written notice posted up in the waiting room (copies of which shall be available free of charge for patients to take home and study), how the practitioner has chosen to resolve problems of medical ethics which are left to his own conscience, and in particular:

- 1) The circumstances in which he will terminate life before birth;
- 2) The circumstances in which he will fail to take active measures to support life after birth;
- 3) The circumstances in which he will dispense with his patient's free and informed consent to treatment;
- 4) The circumstances in which he will communicate confidential information given to him by his patients to public authorities in the performance of what he believes to be his obligations as a citizen;

5) The circumstances in which he will refuse to tell his patients the truth about themselves or lie to them.

I suspect that few of you would take kindly to such a requirement. You will also say, with some justice, that the patients in your waiting room have quite enough on their minds already, without having their confidence shaken or their minds confused in advance about the ethics of the doctor they are about to see.

All the same, something on these lines might do much to encourage doctors to submit their intuitive consciences to rather more rigorous examination – and perhaps even to help patients to exercise a more informed judgment in the choice of their doctors.

References and notes

- (1) The spirit of occupational medicine. *British medical journal* 1979 Dec 22/29.
- (2) Kennedy I. *The unmasking of medicine*. London: Allen & Unwin, 1981.
- (3) O'Brien C C. Lawyer unmasks a doctor's plot. *The Observer* 1981 Feb 15: 13.
- (4) *Guidance on ethics for occupational medicine*. Faculty of Occupational Medicine, Royal College of Physicians, 1980.
- (5) See reference (4) p2.
- (6) *Allison v Haydon* 4 Bing 619. It seems from this case that a surgeon *could* sue for his fees – but not if they were for medical treatment, unless he was also an apothecary.
- (7) *Report of the committee on data protection (Lindop Report)*. Cmnd 7341. London: HMSO, 1978: para 7.11.
- (8) Review of *Guidance on ethics for occupational medicine* (see reference (4)). Described *Lancet* 1980 July 19 as 'the most comprehensive guide so far produced'.
- (9) See reference (4).
- (10) *The occupational physician*. British Medical Association, 1980: 19, para 3.3.
- (11) See reference (4) Introduction p2.
- (12) See reference (4).
- (13) See reference (4).
- (14) See reference (4).
- (15) See reference (4) p3.
- (16) Code of Ethical Conduct for Physicians providing Occupational Medical Services. Committee on Ethical Practice in Occupational Medicine. *Journal of occupational medicine* 1976 Aug; 18 (cover).
- (17) See reference (4) p3.
- (18) See reference (10) p14, para 36.
- (19) See reference (4) p7.
- (20) See reference (10) p13, para 20.
- (21) See reference (10) p18, para 2.1(a).
- (22) See reference (4) p8.
- (23) Editorial. *Hospital doctor* 1981 Feb 19. Unlike, that is, medical journalists. The leader writer in the journal cited, for instance, had no such difficulty. According to him, 'The medical profession holds a special position in society . . . but its members are citizens first and doctors second'.