ETHICS MAN **Daniel K Sokol**

# "What does the law say?"

Although consideration of the law has a place in ethics, moral problems should not be reduced to legal questions

As a PhD student I worked every Friday night as a "table hopping" magician in a restaurant. By far the most common—and least amusing—question I was asked was, "Can you make my wife disappear?" "That'll cost you extra," I would reply with a strained smile. As a teacher of medical ethics the equivalent question I get from students and clinicians is, "What does the law say?" My answer seldom varies: "Let's work out the ethics first, then we can look at the law."

In the minds of many medical students and doctors, the law holds not only an intimidating, menacing authority but also a certain magical quality. Legal knowledge can make the complexities of a moral dilemma vanish. Can it be lawful to override the wishes of a 15 year old Jehovah's Witness who refuses a blood transfusion to treat her leukaemia? Yes, consider the case Re E [1993] 1 FLR 386. Whoosh, problem gone. The danger here is legalism or, as the US philosopher Daniel Callahan writes, "the translation of moral problems into legal problems." Although clinicians should be familiar with the relevant legal injunctions—not least because acting contrary to the law is itself a moral reason (though not necessarily a conclusive one) against a contemplated action—over-reliance on the law and even the guidelines of professional bodies tends to stifle moral deliberation and reflection and reduces ethics to an exercise of memorisation: this statute says A, B, and C; the General Medical Council recommends X, Y, and Z, and so on. That is not ethics, and it is misleading to call it so.

This "law as ethics" approach is also found on some clinical ethics committees. "Where there has been a lawyer on the ethics committee," write Cohen and colleagues, "everybody looks to one end of the table where the lawyer sits and asks: 'What is the answer?' or 'Is that legal?' and the lawyer says: 'Yes, it's legal, it's fine,' or 'No, it isn't.' That, in some cases, will end the discussion." Ethics committees should certainly consider the legal aspects of any decision, such as the laws regulating advance directives or the practicalities of getting a court order; but again, to do so at the expense of ethics is undesirable. Ethical analysis of a case, with all its particularities, requires a nuanced, individually sensitive approach that the blunt instrument of the law may be helpless to provide. De Ville, an academic medical lawyer, explains that "in the interest of objectivity and consistency, the legal process, training, doctrine, and tradition have tended to downplay humanity and individuality" (*West J Med* 1994;160:478-80). Thus Lord Justice Ward in the case of the conjoined twins, Jodie and Mary, whose separation would entail the survival of Jodie but the death of Mary, declared: "This is a court of law, not of morals." Humanity and individuality, sidelined in law, are key considerations in ethics.

Moreover, the legality of an act is no guarantee of its moral permissibility and vice versa. Consider the title of Boris Vian's 1946 novel *I Shall Spit on Your Graves*. That is not a nice thing to do, and nor is laughing at the misfortune of a dying patient, but the law does not forbid it. The law often represents the lowest level of acceptable behaviour, and clinicians should surely strive for higher standards than the bare minimum. It is also well known that in some cases the law permits flagrantly immoral acts. In certain countries, for example, doctors have lawfully detained political dissidents in psychiatric institutions.

Medical educators are partly responsible for what seems to be the growing conflation of ethics and law. The standard format of examinations at medical schools, driven to some extent by a concern with objectivity and the limitations of staff time (several medical schools still do not have a full time academic in medical ethics and law), is ill suited to assessing ethical knowledge. Short answer questions and multiple choice questions, although appropriate for clinical subjects and perhaps some aspects of law, are too superficial and fact oriented to do justice to ethics, which usually requires elaboration, justification, and subtlety.

**"The law often represents the lowest level of acceptable behaviour, and clinicians should surely strive for higher standards than the bare minimum"**

If essays are out of fashion or impractical, why not introduce a variant of the method favoured by some humanities tutors at Oxford University? The tutors hand an unseen poem to the candidate a few minutes before the admissions interview, the candidate examines it outside the room, and both parties discuss it. We can replace the poem with a medical ethics case. The dialogical nature of the exercise is ideally suited to the assessment of ethical argumentation while also allowing the factual recall of legal norms and professional guidelines. At St George's Medical School we have recently experimented with a new method of assessment. Medical students are offered an ethically contentious statement weeks in advance, given one side, and then they present in 10 minutes their ethical and legal arguments in a debate, before responding to questions.

Few would question the value of legal knowledge to medical students and practising clinicians. It would be unwise to let clinicians loose without the most basic awareness of the medicolegal landscape. But we should not coalesce ethics and law completely, lest we make ethics vanish altogether.

**Daniel K Sokol is a lecturer in medical ethics and law, St George's, University of London**
**daniel.sokol@talk21.com**

Cite this as: *BMJ* 2008;337:a617

NHS AT 60 **Jon Snow**

# How the media are failing the health service

The overwhelmingly negative slant that the media give to reporting of the health service in Britain does not reflect the experiences of newscaster Jon Snow or those of people he talks to, he recounts

What is it about the NHS that stimulates such an appetite in the media for bad news and almost none for the good? For me, this issue came to a head with the reporting of the outcome of the great "deep clean" of hospitals. In any other walk of life, 94% of all hospitals having been deep cleaned by the target date would have been regarded as a supreme achievement—but not, it seems, when it comes to the NHS.

Inevitably, we in the media wanted to know the identities of the 6% that had failed. We wanted to name and shame them. So did ministers. Inevitably the attitude of the media to the NHS is strongly influenced by ministers' behaviour. Unqualified condemnation of an individual hospital becomes a free-for-all for irresponsible and slapdash journalism. News reporting of the failure of Hospital A goes no further than the failure itself. The photographer will be dispatched with a mission to show the place in the worst possible light. You can almost hear it: "Crop the new wing on the left, go for the Victorian bit." So the possibility for qualification—even for praise of some aspects of the institution—is obliterated by the wholesale requirement, often led by politicians, to expose the place for its failures.

A few weeks ago I wrote in the *Financial Times* about how I had had an unexpected opportunity to see how a random hospital in a random town was coping in the new NHS world. A friend had been admitted with pneumonia to the Royal Berkshire Hospital in Reading. When I went to visit him I was struck by the cleanliness of the place, particularly on what was early evening on a Friday. The insistence, on closed circuit camera, on a full hand scrub dispensed from a unit outside the ward was impressive. So were the cleanliness of the wards and the attention of the nurses inside.

Since the article appeared I have been contacted time and again by people with similar instances of their own experiences of finding the health service nowhere near as bad as its media profile would suggest. Mind you, when I recount such experiences to doctors and consultants I meet, they immediately start to try to qualify what I have said. "You should have tried a London hospital," one said. "What do you expect of a rich area like Berkshire?" said another.

But I would also argue that the lack of reporting of good news about the health service extends beyond hospitals right into the core of primary care. For 30 years I have been lucky to be registered with the Caversham practice in Kentish Town, north London. Admittedly it has always been a model centre for good practice, so I have had to offset my albeit limited experience of it, as a patient and a parent. Not only has the Caversham been moved to purpose built, state of the art premises, but its regime and its resources have been transformed in the past decade. For a start, you can get to see a doctor, even if not your own, on any day between 11 am and noon. That's not a bad deal. You can often make a same day, fixed time appointment. To see the doctor of your choice is harder but can be done within about 10 days. In the meantime there are practice managers, nurses, physiotherapists, and more.

This practice is providing a better service than we ever dreamt possible. Have I simply struck lucky—or is my experience actually a more realistic picture of the health service than that provided by the hospital infections scandal or the tedious reminders that many doctors never wanted the NHS in the first place?

> **"I have been contacted time and again by people who have found the health service nowhere near as bad as its media profile would suggest"**

Dare I add to all this by touching on my experience as chairman of a project rooted in the voluntary sector? The New Horizon Youth Centre caters to some of the most vulnerable and excluded adolescents in Britain—homeless teenagers in London's West End. By definition they come from no single local authority or primary care trust. When I worked at the centre in the early 1970s we were quite simply excluded from all care but the drug treatment centres. We were confronted with the bizarre reality that only the minority of our young people who were addicted to hard drugs had access to the NHS. Today we have our own nurse, fully funded by the NHS, and a mental health worker, partly funded by the state and partly by the private sector. Ten years ago we had neither the posts nor the funding. Our capacity to make a difference to young people's lives has been radically improved as a result.

Don't worry, I'm off to take a cold shower. It should be possible to lay into the health service soon enough somewhere in the media. But for the moment I'm allowing my personal experience a little air.

**Jon Snow is a newscaster for Channel 4 News, London**
**Jon.Snow@itn.co.uk**

Cite this as: *BMJ* 2008;327:a572

**See EDITORIALS p 1, FEATURE p 18, ANALYSIS p 25, VIEWS & REVIEWS pp 55, 56**

## WHAT'S NEW ON BMJ.COM

This week's bmj.com marks the NHS's 60th anniversary with the final instalment of Tony Delamothe's acclaimed series on the service, and whether its founding principles are fit for purpose in the 21st century. There is also extensive coverage of Lord Darzi's long awaited report on the NHS in England. And even closer to home, we've moved to continuous publication of content on bmj.com.

### NHS at 60

The joint BMJ/King's Fund debate to mark the NHS's 60th anniversary, held in London last week, is now available to view as a video and to listen to as a podcast.
One hundred and twenty three people watched the live webcast.

### Lord Darzi's report on BMJ TV

Health minister and surgeon Ara Darzi's long awaited review heralds a renewed focus on service quality. Visit bmj.com to find out what the proposals mean for clinicians working in different sectors. There will also be reaction from doctors and other health service commentators and a BMJ TV interview with Darzi himself.

### Little and often

This week marks the launch of continuous publication on bmj.com. This significant step means we will be populating bmj.com with lots of new content on a daily basis, instead of using the weekly print issue as the catalyst for a mass upload of articles.
The home page will change more frequently (as well as the pages showing latest news, research, comment, and education), and there will be a rolling table of contents that will show every article published in the past seven days.

**To find out more, read bmj.com editor David Payne's blog at http://blogs.bmj.com/bmj. It links the editorial on continuous publication, published last week. There is also a link to some more detailed FAQs.**
**Here is a snapshot of articles published since continuous publication went live on Monday:**
**Secular decline in mortality from coronary heart disease in adults with diabetes mellitus: cohort study**
**Neuromuscular training and the risk of leg injuries in female floorball players: cluster randomised controlled study**
**Association between muscular strength and mortality in men: prospective cohort study**
**Head to Head: Should geriatric medicine remain a specialty?**


### Latest on BMJ TV

"US systematically tortures detainees" Watch BMJ TV's interview with trauma therapist Christian Pross, whose assessment of suspected terrorists held at US detention facilities in Iraq, Afghanistan, and Guantanamo Bay concluded they were "systematically subjected to torture and ill treatment."

**Last week bmj.com poll asked:**
Are the NHS's founding principles still relevant in 21st century Britain?

**You replied:**
**YES** 496 (70%)
**NO** 215 (30%)

## MOST READ LAST WEEK

Key opinion leaders: independent experts or drug representatives in disguise?

Editor's choice: Key opinion leaders, your time is up

Recent changes in the management of community acquired pneumonia in adults

Predicting cardiovascular risk in England and Wales: prospective derivation and validation of QRISK2

Psychiatrist admits plagiarism but denies dishonesty

## MOST RAPID RESPONSES

**Are international medical conferences an outdated luxury the planet can't afford?**

**Key opinion leaders: independent experts or drug representatives in disguise?**

**Deficiency of sunlight and vitamin D**

**Continuous publication**

**Cardiovascular risk tables**