Ethical decision-making in professional bodies

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In the preface to the *Fundamental principles of the metaphysic of morals,*[1] Immanuel Kant reminds us that Greek philosophy was divided into three sciences: physics, ethics and logic. All rational knowledge is *material* or *formal.* The material is about some object, while the formal is concerned only with understanding itself and the universal laws of thought. Formal philosophy is logic. Material philosophy has to do with objects and the laws to which they are subject. These are two-fold: either laws of nature or laws of freedom. Physics (or in Kantian language, natural philosophy, and hence the PhD degree) is a material philosophy. Ethics (or moral philosophy) is the second branch of material philosophy. To express this differently, natural philosophy is concerned with what is, whereas moral philosophy is concerned with what ought to be. Both physics and ethics have doctrines which are *a priori*, ie not based on what is observed in experience. Both require concepts and principles – hence a metaphysic of nature and a metaphysic of morals. Mainly, however, they are empirical. Thus physics determines the laws of nature as an object of experience; while ethics determines the laws of the human will, so far as it is affected by nature. We can express this simply by saying that physics is concerned with facts, and morals (or ethics) with values. And it is a truism to point out – as David Hume did so memorably[2] – that one cannot derive the one from the other. As the slogan says, you can't derive an 'ought' from an 'is'.

Against this simple classification, we might consider public policy issues. Policy must be informed by facts: evidence, the stuff of empiricism. But policy itself, by which I mean advocating what must be done, is about moral judgement. Consider from this perspective the nature of most medical reports produced by learned bodies such as the Royal College of Physicians (RCP). A report on smoking or alcohol or even on stroke or persistent vegetative state contains a wealth of factual material. The frequency of the condition or the social problem or its effects are described and tabulated in some detail. But at this point a value judgement is made. The facts are considered important because the consequences of ignoring them is judged to be morally unacceptable. Something must be done. The report goes on to say what the doctor should do or what government or other bodies should do. Because the objects of the policy are generally widely accepted by the community producing the report, they are not thought morally contentious. As a result, it is easy to obscure the moral judgement and consider it a scientific one. It isn't. Once a course of action is advocated, the realm of morality has been entered. Morality or ethics is about what should or ought to be the case, not what is the case. Its purpose is to change the world, not to reflect it.

So in advocating that governments do something about smoking or alcohol or the use of animals, or that doctors do something about stroke or chronic fatigue syndrome or persistent vegetative state, a professional body such as the College is making a collective stance on a moral issue.

Stated like this, it is hard to see what is controversial in the analysis. In most cases a wide degree of consensus can be assumed. Of course, we do not know whether doctors (or Fellows of the RCP) do actually agree with the anti-smoking policies advocated by the College. Presumably 20–30% of them do smoke and may not be keen on increased taxation or other controls that have been advocated; and there may even be others who have libertarian objections to the 'nannying' that they see involved in some public health measures. Smoking – as a paradigm example of an unacceptable practice – now carries a certain anti-social tag so that objectors may also feel cowed into silence.

Division and neutrality

End-of-life policies produce far more vocal discussion. The facts can be established regarding the symptom control at the end of life, the prognostic implications of certain diagnoses or what patients ask for in such circumstances, but there is often vigorous discussion about the implications of such facts for policy. Ethically it appears highly divisive. Feelings run deep: it is socially and personally divisive too. One response to this is to suggest that professional organisations and other public bodies should therefore refrain from expressing views. Rather they should adopt a position of studied neutrality. 'Neutral positions by organizations ... show respect for the diversity of views among their memberships and encourage members to struggle with the deep and not easily resolvable issues involved.'[3] Organisations should comment only on the 'practical' implications of a proposed policy.

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One problem with this superficially attractive position is that organisations with experience of the facts can easily refrain from discussing their views on their implications as well. This is because the implications are impossible to separate out even in principle and also views on them are too varied among their members. Consider as an historic example the Abortion Act of 1967. The Act carries a conscientious objection clause which permits doctors to refuse 'to participate in any treatment authorised by the Act'. In the Janaway case, a doctor's secretary refused to type the referral letter for an abortion and claimed the protection of this clause. The case went to the House of Lords where judgement was given that suggested that doctors could not claim exemption from performing the preparatory steps to arranging an abortion if the request meets the legal requirements.[4] Patients' rights under the law and doctors' conscience and integrity come into conflict. The objecting doctor is legally compelled to be complicit in arranging the abortion, even though a doctor can refuse to carry out the procedure itself. Those who support such legislation and those opposed to it are very likely to have different views on how such conscientious objection is to be handled.

Similar considerations apply if patient-assisted suicide (PAS) or voluntary euthanasia (VE) by doctors becomes lawful. Many doctors who object to such proposals will believe that referral to another doctor represents complicity in killing another human being. Again, those who object and those who support such proposals will have different views on this highly practical issue. After all, if a patient has a legal right to euthanasia, it can hardly be argued that implementing that right should depend on the accident of their doctor's opinion. Replacing a view on the desirability of a policy with studied neutrality, and instead offering a view on its practical consequences does not avoid moral argument. Rather it replaces one set of moral concerns with another. At the same time, setting out to discuss the 'practical' implications (which actually turn out to be moral ones too) does rather give the impression that such legislation is accepted.

In its turn, this raises yet another difficult issue. For many people, even to discuss a certain viewpoint is to give it credibility or even respectability. Thus radio listeners say on *Feedback* that representatives of the British National Party should not be given air time; or that proponents of certain ethical views in medicine should not be allowed to lecture – a position of some embarrassment for the distinguished bioethicist, Peter Singer,[5] who was indeed prevented from lecturing on euthanasia in severely deformed neonates at Dortmund and Marburg universities.

The result for the wider public is that it is less well informed. If the profession fails to discuss the issues for fear of exposing its divisions, it has abnegated its responsibility, for its experience is unique. The wider public might expect that doctors would have a great deal to contribute to discussions about what is being proposed as an extension of *medical* practice. In fact, there has been little discussion of whether VE and PAS should be permissible by those other than doctors. Whereas PAS and VE by non-doctors is a matter for society, as is the final decision on law making itself, it might be expected that medical organisations would express some fairly trenchant views on proposals for doctors to engage in this – either for or against or even both – and to express an overall judgement. On this particular issue, the Royal College of Anaethetists and the Royal College of General Practitioners have done just this, as did the RCP on the first draft of the current Bill.

The second difficulty is that by withholding any public judgement, the advocates of change will interpret such neutrality as acceptance. By commenting only on the 'practical' consequences of a change in policy, the hidden assumption is that there is going to be a change in policy. The suggestion that comment is only made *in case* there is a change is too subtle for media bodies to appreciate. So studied neutrality is interpreted as either tacit support or, at least, as indifference. It is no surprise that the advocates of change are also the advocates of studied neutrality, as in Quill's paper.[3] For having failed to persuade a professional body of the need to support a change in policy, neutrality is surely a good second best. Neutrality in practice is not neutral at all.

Democratic legitimation in ethics

Populations are divided on almost everything. Unanimity of view when millions are involved is impossible. Within the democratic nation state, the first step to accommodate this division is by empowering representatives, rather than attempting to determine policy by plebiscite. The second step is a party system, so that policy can be consistently developed and applied, even while allowing individual party members to register dissent on specific issues. Such is the stuff of political philosophy. Democracy is, of course, far more than a right for law-abiding citizens above a certain age to vote for which dictatorship of the simple majority they want. It also encompasses freedom of expression, minority rights and so on. How might this apply to bioethics and to professional bodies that might wish to formulate a view upon them?

Any socially or economically complex society constantly has to choose among ethically optional alternatives. As O'Neill comments,

> *neither fluoridation nor non-fluoridation of public water supplies … may be intrinsically wrong, but nevertheless public policy must settle for one or the other. It is implausible to think that … everything can be a matter for individual autonomy.*[6]

That is a result of living in a society. She goes on to argue that many discussions of policies affecting health suggest that they need additional democratic scrutiny or support. Democratic legitimation, however, is ethically unreliable. Public opinion as expressed by opinion polls or public consultations – such as that in the state of Oregon on healthcare rationing – fail to support action that is ethically needed. In the Oregon example, low priority for funding treatments for unpopular conditions, such as mental illness and HIV/AIDS, was expressed, especially where these conditions were associated with life styles that were condemned. In this example, democratic legitimation conflicted with basic equity in healthcare provision. In the UK, public opinion has apparently been strongly supportive of capital punishment and one suspects that a fairly illiberal policy on immigration or support to refugees would result from a policy based on referenda or opinion polls. Moreover, simple questions on complex issues

are unsatisfactory. Representative democracy has the advantage that the decision maker is accountable to the constituency while being better informed than the average voter.

Professional bodies are not parliaments. There is no party system in medical institutions such as royal colleges and no slate of policies to vote for. On the other hand, decision-making bodies such as councils of colleges do have a representative role. In the RCP, for example, voting members of Council are elected by all the Fellowship, thus legitimating policy. The necessary lack of a party system might suggest a greater need for constant soundings of opinion by representatives. I think it fair to say that enormous effort is expended in doing just that, although the voices that are heard may not always represent the extent of the division of opinion. It is noteworthy that the correspondence on the RCP's position on the Assisted Dying for the Terminally Ill Bill has been almost exclusively opposed to the Bill, yet there are good reasons for believing that opinion among the Fellowship is far more divided. It also needs to be said that governing bodies, like national governments, must sometimes advocate or pursue policies that their constituency may not support, especially during the initial stages. They must show leadership and with it a certain courage. The response of many doctors to developments – such as the broadening of the Fellowship itself (an historical example) or physicians' assistants (a current example), to take examples from the RCP – may well be strongly negative until the concepts and implications are better understood.

Professional bodies therefore do express and act on viewpoints on moral issues. Since they are not primarily scientific research bodies, that is probably their main function. They do believe standards *should* be high and act to promote that, even if divided on what that might mean in practice. Those viewpoints will often be divided, but that is not in itself a reason for neutrality. It is, in fact, the reason for having governing bodies like a council whose collective wisdom will reflect on opinion but not necessarily be mandated by it. Opinion should be sought and the simplicity of the single (often biased) question avoided. That is as true of issues seen as 'ethical' as of other public policy issues that are (mistakenly) not construed as such. Division should not mean paralysis or silence. It does, however, carry a moral obligation to ensure that significant dissenting voices are heard. In that respect, the Warnock Report,[7] which set out a clear view on proposed policy in the field of assisted reproduction, with its dissenting chapters, sets an admirable precedent.

References

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