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MEDICAL ETHICS

The relevance of medical ethics to daily practice should be obvious to all doctors, but the relationship between 'ethics and practice' raises many complex moral issues. 'Medical ethics is not a new subject, but a vital aspect of all medical practice, the implications of which must be made explicit throughout medical education'. The key word is 'explicit', because morality is a serious and abstract topic, even in medicine. Some doctors recoil from it, because of the jargon associated with it. Samuel Butler once said 'The foundations of morality are like other foundations; if you dig too much about them the superstructure will come tumbling down'. I will try therefore to be both explicit and short-lived, and will not dig too deeply into the moral foundations, just enough to prepare students and young doctors for moral decision-making.

The question may be asked sometimes, who should we blame but ourselves if we take wrong moral options? We should all like to shift the blame by shouting at and accusing someone else. That is not a feasible solution. My contribution is to try and express effectively an acceptable and practical framework of ethical principles which could provide a basis of moral reasoning in medical practice. The recently published report of an Institute of Medical Ethics Working Party on the teaching of medical ethics in British medical schools has found many deficiencies and made new recommendations for change.

Professional attitudes are often determined by ethical principles and moral values, which determine in our minds and conscience whether our actions are considered to be morally right or wrong. By medical ethics I do not mean standards of professional competence or conduct, but rather as Dunstan has defined 'the obligations of a moral nature which govern the practice of medicine'. The words 'ethics' and 'morals' are used interchangeably.

Philosophy is firstly about the critical evaluation of assumptions and arguments, and secondly about the clarification of concepts being evaluated. Natur-



ally, I hesitate before plunging into the deep waters of philosophy and moral philosophy, not being properly trained to do so. In all its aspects, philosophy is a peculiar and at times ambiguous activity, which means different things to different people at different times and places.

Doctors understandably do not take kindly to spending valuable time in abstract debate about the meaning and function of words and phrases. Yet it is necessary to do so, as rationality is common to science and philosophy. By definition moral philosophy is concerned with the critical study of morality. It examines the basic principles, norms and values which underlie moral judgements. Raphael believes that it is not practical in any real sense. It cannot and does not tell us what we should do. We must decide that for ourselves. His advice is 'Do not expect moral philosophy to solve the practical problem of life or to be a crutch on which you can lean'. This might appear at first glance to be contrary to my hypothesis, but moral philosophy cannot exist in a vacuum. It must examine real life problems and in this context be used to assist doctors both to be effective clinically and to take correct moral options.

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ETHICAL PRINCIPLES AND CODES OF BEHAVIOUR

In order better to understand the application of moral reasoning to practical issues, I start with a summary of general ethical principles, doctrines and specific codes of behaviour, which teaching experience has shown to be essential learning, before proceeding to consider case examples. The Hippocratic Oath was probably written in the 5th century B.C. A doctor who takes the Oath swears above all to try to benefit his patient and especially not to harm him or her. He also swears never to divulge what he sees or hears in the course of his profession. The Declaration of Geneva is the modern restatement of the oath drawn up in 1947 by the World Medical Association and amended in 1973 and 1983. Other specific codes of ethics soon followed which are listed and described in the *BMA Handbook of medical ethics*: Sydney in 1968 defined the criteria of brain death; Oslo in 1970 discussed the criteria for therapeutic abortion; Tokyo in 1975 adopted guidelines for doctors concerned with torture and punishment; and Lisbon in 1981 discussed patient rights and confidentiality. All these codes provide abundant guidelines on specific issues, but they do not resolve adequately the conflict between the claims of the individual and the wider requirements of society.

The general principles so important in applied ethics are as follows:-

Beneficence. One should do good to the patient. This needs to be tempered by the next principle.

Non-maleficence (Primum non nocere). Above all, one should do no harm. This is more stringently enforced than the first principle.

Respect for the authority of the patient. A patient should be free to determine his own actions and give consent to the treatment offered. Essentially autonomy is the capacity of the patient to think, decide and act on the basis of such thought and decision, freely and independently and without 'let or hindrance'. The duty of beneficence or 'doing good' has to be moderated by the duty of respect for autonomy.

Truth. The principle of telling the truth cannot be regarded as an absolute moral principle, but it is an ideal to be pursued to enhance trust and confidence. Ethical principles conflict at times in relation to truth-telling and it is sometimes necessary to deceive a patient for his own good. Generally speaking, however, deception conflicts with one's desires to preserve patient autonomy and a sound healthy relationship.

Preservation of life. Phillips and Dawson argue that maintaining respect for life is not synonymous

with preserving life at all costs. The principle of trying to preserve life by any means gives rise to many modern dilemmas.

Justice. The principle of justice refers to the fair distribution of scarce resources within society and in its application may conflict with one's absolute moral principles and duty to individual patients. A true believer in utilitarianism would argue that resources should be deployed to the most cost-effective techniques in which benefits are clear in relation to costs. The fundamental paradox of health care is that medical advances so often breed further needs and increase further requirements for care. The further life expectancy is extended, the greater becomes the pressure to allocate more resources to geriatric services. The ideal of trying to provide health care for all needs is laudable, but it is impossible for the Exchequer to meet all demands and some form of rationing of resources is inevitable.

Confidentiality. The principle of confidentiality between doctor and patient is venerated in the Hippocratic tradition. The nature of professional confidence varies according to the form of consultation or examination. The doctor is responsible to the patient for the security and confidentiality of the information given to him. Even after death a doctor must preserve secrecy on all he knows.

THE MAJOR CATEGORIES OF ETHICAL THEORIES

In America for some years past, persons concerned with ethical matters have plied their trade in hospitals and medical centres. Have they been doing anything useful, or what are they supposed to be doing? To answer these questions we come to examine and discuss the two major types of ethical theories.

Deontological theories of ethics are based on the 'rights and duties' of persons (*deon* is the Greek word for duty). In this group the consequences of one's actions are not taken into account. Much theological dogma common to the great Christian religions expects absolute obedience to moral rules, for example, the Ten Commandments. The orthodox religious view is that all human beings are morally equivalent and have equal natural rights: a right to life, a right not to be killed, and a moral duty not to kill others. Others do not believe that people intrinsically possess absolute moral values and have inherent moral rights. These opposing views conflict in moral judgements of everyday events, so that sometimes what may appear on superficial examination to be utilitarian, may on closer inspection turn out to be absolutist, and vice versa. The great religions probably postulate that moral decision-making should

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often be taken out of the sole hands of doctors and clear guidelines should be laid down by the State having listened obediently to the spiritual and moral teaching authority of the Church on behalf of humanity.

The second category of major ethical theory is that of *utilitarianism*. Put in its simplest Benthamite terms, it is about maximising happiness and pleasure and minimising misery, pain and suffering as a consequence of action taken. The theory was subsequently modified in the 19th Century by John Stuart Mill to the moral concept of the 'greatest happiness for the greatest number'. It would be difficult to persuade people today that a human being's ability to feel pain and pleasure was the sole fundamental moral criterion by which to judge his actions. Mill saw the ultimate goal in life as an existence as free as possible from pain and misery, and as rich as possible in enjoyment, in quality and in quantity.

It is necessary to complete our conceptual framework by mentioning briefly several more doctrines :

Acts and omissions. A small minority of doctors might advocate voluntary euthanasia for patients who desired to die to end prolonged suffering. As Arthur Hugh Clough said, 'Thou shalt not kill, but need'st not strive officiously to keep alive'. The doctrine of 'acts and omissions' needs to be examined in this context. Is there a moral difference between the act of killing and a failure to act which leads subsequently to the death of a patient?

In 1981, members of Life instigated legal procedures against a Derbyshire paediatrician, Dr Leonard Arthur, accusing him of the murder of a newborn infant with Down's Syndrome rejected by his mother. Dr Arthur was acquitted although he had only prescribed dihydrocodeine and nursing care to relieve suffering. He did not adopt any extraordinary means of resuscitation to keep the baby alive when it became gravely ill, because the parents did not wish it. He made a judgement based on clinical and compassionate grounds. This case posed many moral problems. AH doctors would recoil from actively killing an infant for fear of the moral outcry and the legal consequences of being accused of infanticide. Many would, however, support Dr Arthur's actions.

A patient of mine, a man aged 92, who had enjoyed good health for over 90 years, was admitted to hospital with a refusal to eat much food for several weeks. He developed marked weight loss and became helpless, bedridden and dependent. Routine radiological and blood investigations revealed nothing abnormal and he continued downhill. It became

apparent that he had lost the will to live and was in a state of terminal depression. Let us suppose he had a coronary thrombosis in the presence of the ward consultant, who decided not to intervene with the mobile care unit, and the patient subsequently died. Was this omission morally acceptable or should he have striven officiously to keep him alive by resuscitation?

Suppose instead the consultant had sent for the coronary care team and after some delay the old chap had been kept alive but unconscious on a mechanical ventilator. Fearing brain damage from anoxia the consultant orders the machine to be switched off and the patient dies.

Judged by the basic principles enunciated of beneficence and non-maleficence, the moral consequences of the omission in the first instance, and the commission in the second case, are the same. In utilitarian moral terms a patient with anoxic brain damage would not have obtained benefit by being kept alive as a vegetable. The moral position must, however, be based on more than these considerations. As Gillon says, 'there is little doubt that both the consequences of an action and the doctor's beliefs and intentions about what he is doing are relevant to moral assessment'. The crucial issue underlying the 'acts and omissions' doctrine is therefore the understanding and intent with which the doctor acted. Had he withheld treatment in a younger adult, his omission would have been regarded as morally indefensible. It is generally agreed, however, that it should not be for the law to decide the criminality of one decision or the other. Clinicians should be free to take these difficult ethical decisions without becoming defensive and living in fear of being arrested.

Ordinary and extraordinary means. Linked to the above doctrine is that of 'ordinary and extraordinary means'. Pope Pius XII in 1957 applied this to answer moral questions about the use of mechanical ventilation in cases of brain death. It was sufficient in serious illness, he said, to use only ordinary means to preserve life and health. This was obligatory in moral terms. The use of respirators was classified then as 'extraordinary means' and morally optional depending upon the special circumstances of the patient and the wishes of his family. So 'extraordinary means' may be defined as treatment which involves a great burden for the patient and/or next-of-kin. There would be no moral distinction, however, between ordinary and extraordinary means if it was in the patient's best interests to be kept alive.

Double effect. This doctrine is designed by theologians to ease moral decision-making in situa-

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tions when intended good effects are likely to be nullified by unintended but foreseeable bad effects: for example, a doctor may administer medical treatment which is required to save the life of a pregnant woman even though this results in the death of the fetus, since the death of the fetus was not itself sought; a hysterectomy may have to be performed on a pregnant female who has an advanced cancer of the uterus.

APPLIED ETHICS

It is increasingly recognised that doctors cannot escape making a variety of ethical judgements in their practice. These vary from mundane practice decisions about accepting or rejecting difficult or unwelcome patients, perhaps unkempt, bedraggled and socially undesired by all, to issuing certificates against one's moral principles, to life and death issues. Students still receive insufficient formal education in ethical reasoning to help them prepare for such predicaments. It is just hoped and assumed that bedside teaching and scientific training will somehow equip them to make the right or the most professional decision without there being any clear idea of what 'right' or 'professional' means in this moral context.

Terminal care of the dying patient is an area that illustrates well mutually exclusive ethical courses of action. It is taught formally in the fourth year of the Queen's medical curriculum by close collaboration between the Departments of General Practice, Geriatric Medicine, Mental Health and Oncology, with various health and social work professionals, ministers of religion, and doctors and nurses from the Northern Ireland Hospice. Telling the truth gently is more morally complex than appears at first sight.

We try to make clear to students different and conflicting ethical positions, and discuss some mutually exclusive principles. These principles come into play in telling the truth to dying patients and may conflict if applied categorically. Two cases will illustrate the different moral dilemmas.

A 26-year-old doctor, Campbell Moreland, became ill in 1980 and died of testicular cancer in 1982. His paper 'Whose choice? Whose consent?' was published by the Faculty of Medicine and used since for student reading. It gives a poignant account of his illness, treatment and suffering. His experience shows that some doctors still practise in a pragmatic way without any sense of moral values. He used denial at the start of his illness despite a period of extensive investigations and at various stages in its course even after orchidectomy. At that stage he did not want to hear a specific diagnosis. He just drifted along in a state of depression hoping that it would soon be all

over. Yet twelve months later when he was recovering from abdominal radiotherapy he bitterly resented being told a blatant lie by an unfortunate young doctor that his chest X-ray was perfectly normal, when he was riddled with lung secondaries and denial had been cast aside. He knew that he was terminally ill. He was physically frail, but intellectually active.

Truth-telling in my student days in a similar situation was a matter of practical expediency to be avoided at all costs. Deception was the name of the game so as not to damage patient morale or shorten life or indeed offend the consultant in charge, whose policy of communication in these situations was usually not known. The young doctor lied in the wrong circumstances and rejected the patient's autonomy and right to be informed of all the options and consequences. Campbell Moreland expresses this vividly: 'So often the doctor confuses his privileged position in the doctor-patient relationship with what he considers a right to choose for the patient'. He has no moral right to do so in many instances. He is simply caught between two conflicting options – that of preserving life and that of relieving suffering.

Recently I was privileged to receive from a cleric a diary kept by a spouse in the practice, whose young husband had died. She had known for six months that the prognosis was hopeless but withheld discussion of the fact because her husband never seemed to consider that he was gravely ill and battled on bravely to meeting his daily commitments. He discovered the truth from his doctor only when close to death. He was quite shocked because he had always expected to recover. She wrote— 'He has been ill many times, had suffered bravely and without complaint, but he had always recovered'.

She was torn with guilt and anguish that she had not told him sooner, but was afraid that by doing so she would have undermined his confidence or shortened his life. The patient had been well supported in his terminal illness by his wife, his family, the Church, a cancer specialist and the family doctor. When he was close to death, his wife asked him if he was very lonely thinking about death and he said he was. She wrote 'That night my husband had a struggle. He could not accept death and that the end was close. He said "We'll fight it. The doctors were not right before". I just held him closely to comfort him'. Unfortunately, the doctors were right this time and he died soon in a coma.

This case illustrates the anguish for the doctor of balancing deception and truth-telling in the interests of the dying patient, of infringing autonomy yet maintaining confidence and morale. Yet one must walk the tight-rope of honesty to achieve spiritual

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contentment and trust and confidence in the doctor-patient relationship to the very end.

The primary care setting provides a great array of problems which require ethical decision-making. Prominent among these are problems related to reproduction, including abortion, birth defects, infertility, contraception, sterilisation and sexual issues in general, and also pain control and patients' rights.

NATURE OF CONFIDENTIALITY

General practitioners are familiar with the problems confronting a family doctor who prescribed contraceptives to a 15 Vi -year-old girl who is having illicit sex with a mature male. She is determined to continue the relationship, prefers the pill to alternative methods of birth control and refuses consent to her parents being informed. In 1980 the DHSS (London), in a Health Service Notice, issued guidelines for doctors in this type of case: 'A doctor was entitled in exceptional circumstances to prescribe contraceptives to a girl under 16 in England and Wales without the consent of parents'. Many people maintained that the circular encouraged or condoned unlawful intercourse. Mrs Victoria Gillick challenged the DHSS guidance in the courts on the grounds that the notice made doctors accessories to a crime and infringed the rights of parents over their children. In court the judge upheld the DHSS guidelines provided the doctor thought the girl competent and mature enough to understand all the issues involved. Mrs Gillick then contested this judgement in the Court of Appeal and in 1984 her appeal was allowed. The Court held that the ethical position in law was that parents are the best arbiters of the child's interests and ignored patient autonomy. The see-saw legal battle continued and the Law Lords in 1985 upheld the DHSS appeal against the Gillick judgement and reversed the Court of Appeal's ruling.

The Law Lords defined the five exceptional circumstances under which a doctor could prescribe contraceptives to a girl under age as: (1) the girl understands; (2) she cannot be persuaded to tell her parents; (3) she is likely to begin or continue sexual intercourse with or without contraceptive treatment; (4) unless she receives treatment her health will suffer, and (5) her best interests require treatment without parental knowledge.

The ethical implications of all this for doctors are three-fold. The BMA maintains the principle of confidentiality to be paramount, but opponents claim that secrecy has no intrinsic moral value and would argue that it was more immoral to maintain the girl's confidence and deceive her parents. Gillick supporters argue that hormones are dangerous drugs and the

supply of contraceptives infringes the principle of non-maleficence, is liable to harm the health of the patient, and encourages early promiscuity. Thirdly, under the Sexual Offences Act 1956 if a man has intercourse with a girl under 16 (England and Wales) he is criminally liable. Some may feel that a doctor would be acting immorally to collude in prescribing contraceptives, thereby transgressing the moral law of God and the law of society. Professor Kennedy states that the doctor could be regarded in law as an accessory to crime only if he prescribed contraceptives in collusion with the male partner to encourage the under-age girl to have sexual intercourse.

In 1986 the last DHSS Guidelines were issued spelling out 'exceptionally, in cases where persuasion to tell the parents fails, the doctor should be free to prescribe without parental knowledge'. There the matter rests for the time being, but let me remind you of the BMA's five exceptions to the principle of *not breaching confidentiality* (BMA *Handbook of medical ethics*): (1) when the patient gives consent; (2) when it is undesirable on medical grounds to seek a patient's consent, but it is in the patient's own interest that confidentiality should be broken; (3) when the doctor's duty to society overrides the principle; (4) when required for the purposes of medical research; (5) when required by due legal process. Secrecy is ultimately destructive of honesty and trust. Yet if the GP had informed the girl's parents without her consent, there would have been a family crisis. It is sometimes well-nigh impossible to choose a course of action which meets the teenager's health needs and at the same time does not violate the doctor's honest relationship with her parents. Underlying the Gillick arguments is the question of who should decide for the young. Lord Scarman revealed that the decision to override parental rights and responsibilities was not entirely a question of a doctor's discretion. He warned that a doctor must exercise his judgement properly, otherwise there could be possible criminal consequences, if he went outside the exceptional circumstances already defined by the Law Lords. Parents should normally decide, but how can they exercise this responsibility if they are in a state of ignorance of their child's sexual behaviour. In these circumstances it is difficult to avoid the conclusion that a doctor who knows the parents is the person to exercise this responsibility, because he is the one to whom the girl has gone for medical advice.

THE SELECTIVE TREATMENT OF BIRTH DEFECTS

Early in my career in the Jubilee Neonatal Unit I was confronted with the ethical problems posed by the treatment of severely malformed infants with spina

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bifida and hydrocephalus. Many can be saved now from death by surgical treatment. Modern surgical advances and medical technology have brought great benefits but have blurred concepts of life and death and created huge ethical dilemmas for doctors. Lorber, a Sheffield paediatrician, assessed the results of early surgical treatment of spina bifida in babies ten years ago and identified the sharp ethical problems in management. He chose babies with 'initial adverse criteria' after careful research and follow-up and put them into the 'non-treatment category'. This meant selecting some babies early on for nursing and medical care only – in other words, they would be kept clean and comfortable, and fed only on demand, but no measures would be taken to prolong their lives, such as restoration of fluid balance. He was supported in this ethical policy by the recommendations of a Working Party under the auspices of the Newcastle Regional Hospital Board, which laid down clear guidelines for doctors to follow in the selective treatment of spina bifida in infants. Many would still argue that this policy is not moral. Lorber, however, makes it clear that he is against infanticide or active euthanasia, which he regards as both brutalising and illegal. He argues that less than half of all babies born in Britain with spina bifida survive to three years of age. In fact the less severely affected survive and most of the others die, often after many operations and much discomfort. Thus his severely affected babies, selected for non-treatment, would even if operated on have a very high mortality. Medical dominance in decision-making is being challenged by society, but many paediatricians plead for doctors to be allowed to retain primary decisional power even if the chosen course of action involves the death of the infant.

Lorber's selective treatment includes an assessment of the severity of the abnormality, of the likely effects of this upon the future quality of life of the infant after surgery, and of the likely burdens upon family and society. He argues further in justification of his utilitarian moral stance that survival of severely affected babies may disrupt family life, cause mental breakdown, suicide and even family break-up in some instances. Ranged against him, however, are the moral arguments of many philosophers and theologians. Harris, a philosopher, sees selective treatment as morally indefensible and in his view no different from active euthanasia. The right to life of severely handicapped newborn infants should be accepted without question. Gillon believes, however, 'that it is because the newly-born infant is not a person, that it is justifiable in cases of severe handicap to allow it to die'. Thus we see the conflict of

moral views even amongst those concerned about ethical matters. In law the distinction that exists in medical practice between active and passive euthanasia is also recognised. The doctor who brings about the death of his patient by some positive slip is guilty of murder. In the case of the severely malformed infant, the doctor who withholds treatment is criminally liable only if there was a duty to provide treatment. If the child was likely to die in natural circumstances the law would regard treatment as merely postponing death. Cases on the quality of life have not to my knowledge come before the courts, and in the absence of legislation doctors and patients are still left to make these difficult ethical decisions about life and death in the treatment of severely handicapped infants.

INFERTILITY AND FERTILISATION

There are serious moral problems raised by the 'reproduction revolution' brought about by the use of in-vitro fertilisation techniques. Soon in Belfast 'GIFT' techniques will be in use to overcome unexplained infertility in women with patent fallopian tubes. Gamete Intra Fallopian Transfer, which introduces sperms and ova into the tubes, poses fewer moral problems than in-vitro fertilisation or implantation of a fertilised embryo into the uterus. In respect of the latter, for the moral purposes of this lecture I will stick to the Warnock Report recommendations.

The birth of Louise Brown at Oldham in 1978 following IVF techniques to overcome the mother's infertility heralded a new era in the treatment of the disorder, which causes great psychological dysfunction, but rarely suicide. The success rate of IVF remains disappointingly low. Replacing three or four embryos in the uterus offers the best chance of success, about a 25 per cent chance of pregnancy and a 14 per cent acceptable multiple pregnancy rate. It is also regrettable that only one of the 25 British IVF centres is operated under the NHS, the rest being privately managed. Experimentation over the past 10 years has brought into existence many left-over embryos, called 'spare embryos'. Speaking euphemistically they have died by the process of being washed down the sink. The temptation to do some form of research on these has proved irresistible to the scientists. The genetic material of the nucleus can be replicated into an infinite number of clones. Professor Ian Donald of Glasgow thinks such breeding to specification 'is indeed a threat to human life': what he calls 'a sort of scientific cannibalism'. The only possible moral justification has to be expressed in utilitarian terms – the greatest good for the greatest number from the research. Yet it is

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virtually impossible to separate in moral terms issues of experimentation from therapeutic techniques of IVF because they are inter-dependent. Critics of the Warnock recommendations in this respect point to the lack of Christian judgement and the lack of emphasis on moral and spiritual aspects of the situation. There is some truth in this criticism because secular society was considered and a majority of members favoured a utilitarian position. They were undoubtedly deeply influenced by the potential benefits to mankind from research on human embryos. These range from enhanced knowledge of the process of conception, and of male infertility, to the genetic diagnosis of the embryos, to providing spare parts for a recipient of organ transplants in order to minimise the chances of tissue rejection. They seemingly elevated the advances of infertility treatment above concern for the welfare of human embryos. A compromise was adopted that embryo experimentation should be accepted up to 14 days after fertilisation only under licence, and unauthorised use would constitute a criminal offence. The cut-off point at 14 days is arbitrary in moral terms because, as Cameron says, 'if sentience, the ability to feel pain, is ultimately to be the criterion it is something which is readily capable of subjection to anaesthesia'. This view, stressing the point in embryonic brain development, when the embryo becomes a 'human person', is rejected in moral terms by Christian theologians, although it must be taken seriously.

Society must lay down some new ground rules to deal with the new technology and its consequences for mankind. Gillon poses the moral question 'What do we mean by the term human being?' This is relevant to all the major moral issues of life today including abortion and switching off life-support machines. This raises further questions: 'When does life begin?' and 'Is the embryo a person?'. Orthodox Christian theology teaches that the zygote, the fusion of sperm and egg, is a human being equipped with a unique genetic package. Holbrook maintains that our respect for the human embryo must be absolute and must not be qualified by consideration of the benefits for research. Cameron believes that 'our definition of what is distinctly human must be broad enough to encompass the product of conception from its earliest days'. Tomlin argues that human embryo experimentation is a blatant violation of the Kantian principle that 'one should never treat a human being as a means to an end, but always as an end in itself'. My understanding of Roman Catholic theology from the evidence presented to the Inquiry was that people are special, because human beings possess a soul

from the time of 'ensoulment' at conception. Unfortunately, there is still disagreement in Christian circles as to when precisely this occurs and this was reflected in the oral evidence received. The problem in the Inquiry was that no moral consensus could be found, which reflects all the views of society itself. A narrow majority held that the fundamental moral questions (about life itself, already mentioned), were not susceptible of straightforward simple answers. Warnock says 'the answers to such questions are complex amalgams of factual and moral judgements'.

Having tiptoed through the tulips of the Warnock minefield, where does this leave the busy doctor? First, it has to be understood that experimentation on human embryos is something which has already happened and has resulted in IVF techniques being used to produce hundreds of babies. A recent Edinburgh survey of attitudes of women of reproductive age to IVF procedures and embryo research showed that 94% thought that IVF treatment should be definitely allowed in Britain and much the same proportion wanted it available and free on the NHS. This may mean that Britain is more a secular than a Christian society, but clearly each doctor must follow his conscience in the matter; regardless of personal morals he must seek to make specialised advice in this field available to any female patient seeking a remedy for childlessness when the new techniques are appropriate. This causes great moral embarrassment to some young doctors who argue that by doing so they are in fact colluding in murder – the same, of course, applies to therapeutic abortion. Personal moral values have to be weighed against values of human compassion and contractual responsibilities to one's patient.

TEACHING MEDICAL ETHICS

Gillon's intensive survey of the teaching of medical ethics in the CJSA revealed much more formal pre-clinical teaching than in Britain. Informal ethics teaching takes place as in the British Isles at the bedside in the clinical years. There is general agreement that theory and practice should be integrated as early as possible. My own survey of medical ethics teaching in the CiK showed that medical deans could not quantify or comment on the quality of the teaching. A successful prototype course was first run by Len Doyal, a lecturer in philosophy, at University College, London, in 1985/86. It was the first of its kind developed in response to the 1980 GMC recommendations with regard to medical ethics teaching. The format of each session is a short lecture or film followed by a large group discussion with 45 students. The course has been revised in 1986/87 to

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contain the following topics: moral reasoning and medical ethics; the rights and duties of doctors; morality and scarce health service resources; morality and paediatrics; the ethics of medical experimentation; a return to personal autonomy and individual rights; the ethics of prevention versus care; medicine, morality and under-development; medical ethics and education. Some of these issues are covered in our embryo 4th year ethics teaching sessions at Queen's and we use clinical situations to explore many more moral issues.

Baroness Mary Warnock believes that teaching of moral reasoning should take place in schools before entry to universities. This is not universal here and is unlikely to become so. By the time students reach medical school, their moral character has been formed. We can, however, provide them with ethical knowledge and interpersonal skills to enhance their ethical behaviour. Furthermore, we must bring home to them the practical importance of ethical issues for the whole of society. We should encourage them to come to their own conclusions and help them to resolve conflict. Simple health economics must be taught, especially about the just distribution of scarce health service resources.

The time has come to make recommendations about the teaching of the topic in the future. My thoughts are best summarised in two recommendations of a Working Party of the Institute of Medical Ethics, a group convened by the General Medical Council and the Nuffield Foundation.

Medical ethics teaching should recur at regular intervals throughout medical training, and time should be set aside within existing teaching for ethical reflection relevant to each stage of the student's experience.

Clinical teaching of medical ethics should normally begin from clinical examples. Such teaching should be exploratory and analytical rather than hortatory. Adequate provision should be made for small group discussions. Discussions should be supported by critical reading of relevant papers on medical ethics.

No one could gainsay either of these recommendations. They are met, albeit to a limited extent, in present formal teaching of medical ethics in the 4th year Joint Course in the Queen's medical curriculum. We seem to have got the format right and we have interested teachers. From time to time it may prove necessary to involve moral philosophers and representatives of the legal profession, much as we have done with spiritual advisers in care of the dying.

In conclusion, I have made explicit the relevance of medical ethics to clinical practice and offered a

practical method of applying general ethical principles and moral doctrines to solve medical moral dilemmas. Your reaction and response will settle whether or not I was wise to choose such an abstract yet important topic in the wake of the I.M.E. Report. I found it a daunting task, conscious that doctors do not like theoretical lectures on moral philosophy. I will blame the choice on the vagaries of a professor of general practice, a peculiar hybrid by any standards. Universities and general practice are very different in structure and function. The former are intellectual and increasingly research-orientated, the latter is more intuitive and pragmatic. If I have managed to overcome to some degree the difficulties of my academic post it is in no small measure due to the enormous support of my colleagues in hospital and general practice, and the staff in the Department itself. Medical ethics is a vital aspect of medical practice. To summarise the theme of this address I quote Longfellow, 'Morality without religion is an empty shell, a kind of dead reckoning, an endeavour to find our place on a cloudy sea.'