Education and debate

Shared ethical principles for everybody in health care: a working draft from the Tavistock Group

The expansion in healthcare delivery over the past 150 years has exacerbated many of the ethical tensions inherent in health care and has created new ones. To answer these problems, many groups of healthcare professionals have established separate codes of ethics for their own disciplines, but no shared code exists that might bring all stakeholders in health care into a more consistent moral framework. A multidisciplinary group therefore recently came together at Tavistock Square in London in an effort to prepare such a shared code.

Introduction

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The great medical sociologist Elliot Freidson defined a profession as "an occupational group that reserves to itself the authority to judge the quality of its own work." He asserted that professions earn that right, in part, through their relationship of trust with the people they serve. Thus, a tight bond exists between the identity of professionals and the self regulatory rules through which they assure that they can be trusted. For professions, ethics and identity are inseparable.

For this reason, among others, professional codes of ethics have a long and distinguished history. New physicians take an oath of professional conduct whose origins are ancient, for example, and the American Medical Association, whose members face regulations and pressures from managed care, has framed a code of ethics for physicians in managed care settings. The American Hospital Association has created a committee on ethics to define ways for hospital executives to formulate codes of conduct. Nurses defend the core role of nursing in the care of the whole person through the American Nurses' Association's code for nurses with interpretive statements.

These separate, discipline based codes of ethics often mark the highest aspirations of the professions they guide and, as such, they deserve our respect. They provide moral platforms on which disciplines can enforce their own standards on their members and from which they can lay claim to the trust of society. But they have another edge to them as well. They can divide a world of health care that badly needs unity in its work.

A year ago, in an editorial in the *BMJ*,¹ several of us stated a case for a shared code of ethics that might be helpful to bring all stakeholders in health care into a more consistent moral framework, more conducive to cooperative behaviour and mutual respect. The alternative, we suggested, was inferior: namely, separate

moral frameworks in which each discipline seeks to gain the moral high ground, failing to recognise explicitly enough that they affect the wellbeing of patients less as separate elements than together as a system of interdependencies. If physicians claim to be the defenders of the "true calling" of medical care, nurses claim to defend care of the whole person, healthcare executives claim to be defenders of inevitably limited social resources, etc, unity of action may suffer and, worse, the dialogue may degrade into contentiousness and mistrust among the professionals. Our patients and our society deserve better.

In our *BMJ* editorial, we proposed the development of a simple shared code of ethics to guide all who influence and deliver health care. With support from the American Academy of Arts and Sciences, the Robert Wood Johnson Foundation, and the Kellogg Foundation, we first surveyed more than 100 healthcare leaders worldwide about their sense of need for a shared code of ethics and received overwhelming encouragement. We then assembled in London a working group of 15 leaders—physicians, nurses, healthcare executives, academics, ethicists, a jurist, an economist, and a philosopher—from four nations (the United States, the United Kingdom, Mexico, and South Africa) to review the need for a shared code, examine existing efforts of similar intent, write an initial draft code of ethics, plan ways to spur debate in many nations on the idea of a unifying code, and, ultimately, map out strategies for implementing the code.

The "Tavistock Group" (as we came to call ourselves, after the location of the London meeting) worked at the meeting and afterward to develop a draft for others to consider and debate. Early on, we concluded that the idea of a code of ethics was too restrictive and ambitious to fit the many circumstances of potential use within and among nations. Therefore,

our draft came to be a basic and generic statement of ethical principles rather than a code. We also began to subject the principles to the test of vignettes—real examples of ethical dilemmas in health care—in which, we proposed, a helpful set of ethical principles would offer clear guidance.

What we sought, and continue to seek, was a clear, strong, and reasonable set of principles for conduct that all stakeholders who give or shape health care can recognise and accept as guides to correct action. We expect and hope that each profession will continue to add its own specific principles to these but that none will reject or contradict a set of shared principles that could unify our actions and help everyone to work across disciplinary boundaries. We also expect that ethical principles may differ somewhat in their framing and interpretation from nation to nation, depending on history, social circumstances, economics, and other local factors, but we hope that some universal principles will emerge as guides to behaviour in healthcare systems throughout the world. We hope that, together, we can describe to patients and our communities what they can expect, not just from each of us but from all of us.

The Tavistock Group is now inviting critiques, suggestions for revision, and, especially, ideas for

implementation from a wider array of stakeholders, ideally from all parts of the world. In this issue of the *BMJ* (simultaneously with the *Annals of Internal Medicine* (1999;130:143-7) and *Nursing Standard* (1999;13(19):33-7)), we present the latest draft of our statement of ethical principles to guide all who give and affect health care. We welcome feedback from readers in all nations and in all disciplines. Comments can be sent to us through Ms Penny Janeway, Initiatives for Children, American Academy of Arts and Sciences, Norton's Woods, 136 Irving Street, Cambridge, MA 02138-1996, USA (email penny@amacad.org).

The Tavistock Group will continue its work for the foreseeable future. Indeed, we doubt that any version of a statement of ethical principles can long be considered final. We wish most of all to induce a dialogue that bridges traditional boundaries and questions unhelpful assumptions of separateness. We firmly believe that those who play any role in giving and shaping health care have shared duties and a shared mission and that we should recognise and celebrate our interdependency and commitment to cooperation in the clearest possible terms.

1 Berwick D, Hiatt H, Janeway P, Smith R. An ethical code for everybody in health care. *BMJ* 1997;315:1633-4.

A shared statement of ethical principles for those who shape and give health care

Tavistock Group

Preamble

Over the past 150 years, healthcare delivery has expanded from what was largely a social service provided by individual practitioners, often in the home, to a complex system of services provided by teams of professionals, usually within institutions and using sophisticated technology. As a result, problems develop, such as the following:

- The new capabilities and demands of health care dispose providers and members of society to consume resources at an increasing rate
- The financial pressures on healthcare delivery have increased, placing the cost of many acute illnesses and chronic care beyond the reach of most individuals. Financing for these services is therefore provided largely through private or public insurance or public assistance
- Limited resources require decisions about who will have access to care and the extent of their coverage
- The complexity and cost of healthcare delivery systems may set up a tension between what is good for the society as a whole and what is best for an individual patient
- Flaws in healthcare delivery systems sometimes translate into bad outcomes or bad experiences for the people served and for the population as a whole. Hence, those working in healthcare delivery may be faced with situations in which it seems that the best course is to manipulate the flawed system for the benefit of a specific patient or segment of the population, rather than to work to improve the delivery

of care for all. Such manipulation produces more flaws, and the downward spiral continues.

In recognition of the ethical tensions exacerbated or created by these changes in healthcare systems throughout the world, we have formulated a draft set of principles intended to serve as a guide to ethical decision making in health care. The purpose of this statement of ethical principles is to heighten awareness of the need for principles to guide all who are involved in the delivery of health care. The principles offered here focus healthcare delivery systems on the service of individuals and the good of society as a whole and can offer a foundation for enhanced cooperation among all involved.

Who can use these principles?

- People who work in healthcare delivery systems—to guide decisions about specific situations or interactions with individual patients
- Healthcare organisations—to fulfil their missions in a manner consistent with their ethical responsibilities, including responsibility to the good of society as a whole
- Insurers, employers, and governments—to ensure that their policies support and are coordinated with effective and efficient healthcare delivery systems
- The public—to understand how a healthcare system should work when there are problems and conflicts within it.

Cooperation throughout a healthcare system can produce better outcomes and much greater value for individuals and for society. Such cooperation requires

Members of the Tavistock Group are listed at the end of this article

agreement across disciplinary, professional, and organisational lines about the fundamental ethical principles that should guide all decisions in a truly integrated system of healthcare delivery.

Ethical principles

Five major principles should govern healthcare systems:

- 1 Health care is a human right
- 2 The care of individuals is at the centre of healthcare delivery but must be viewed and practised within the overall context of continuing work to generate the greatest possible health gains for groups and populations
- 3 The responsibilities of the healthcare delivery system include the prevention of illness and the alleviation of disability
- 4 Cooperation with each other and those served is imperative for those working within the healthcare delivery system
- 5 All individuals and groups involved in health care, whether providing access or services, have the continuing responsibility to help improve its quality.

1 Health care is a human right

- The aim of healthcare delivery is to maintain and improve health, to alleviate disability, and to provide access to appropriate health services to all persons regardless of their ability to pay
- Caring for sick people is a social obligation that extends beyond the commercial realm. While ownership of institutions or other organisations that deliver medical care may be appropriate, care itself cannot be owned and must be viewed as a service that is rendered and remunerated under the stewardship of those in the healthcare system, rather than merely sold to individuals or communities
- Health care is financed in part or in whole by governments, and society heavily subsidises the processes of acquiring medical knowledge, education, and skills. These are important reasons why the care resulting from the application of medical skills cannot belong exclusively to individual providers or organisations
- Stewardship of the specialised knowledge of medicine and health care requires its refinement and extension through research and its distribution through teaching and collaboration with colleagues, regardless of their organisational affiliation
- Stewardship of financial capital and physical resources demands efficiency in their use, appropriate investment for their renewal, and their deployment in a safe, sustainable, and optimally functional state
- Individual clinical data concerning patients belong to them alone and require the highest degree of confidentiality.

2 The care of individuals is at the centre of healthcare delivery but must be viewed and practised within the overall context of continuing work to generate the greatest possible health gains for groups and populations

- The personal experience of illness is generally the principal concern of individual patients, and, therefore, the principal focus of healthcare delivery systems must

be individual patients and their families or support groups

- Those who provide medical care for individual patients are not, in that role, directly responsible for the care of populations. While the duty of individual healthcare workers is primarily to the individual patients whose care they assume, care givers must be aware that the interrelationships inherent in a system make it impossible to separate actions taken on behalf of individual patients from the overall performance of the system and its impact on the health of society
- Doctors and other clinicians should be advocates for their patients or the populations they serve but should refrain from manipulating the system to obtain benefits for them to the substantial disadvantage of others.

3 The responsibilities of the healthcare delivery system include the prevention of illness and the alleviation of disability

- Biological, clinical, and social sciences have the potential to prevent illness as well as to cure it or alleviate suffering. The goal of research must therefore be to prevent illness and reduce disability so effectively that health care can increasingly shift its focus from curing or caring for disease to keeping people healthy.

4 Cooperation with each other and those served is imperative for those working within the healthcare delivery system

- Only with cooperation can healthcare delivery systems produce optimal outcomes and value for individuals and society
- Among the essential tasks in the healthcare delivery system that require collaboration are
 - Contributing to sustaining healthy, safe communities in which to live
 - Creating a safe, secure, clean, and disciplined healthcare working environment
 - Assuring that clinical management uses the best available evidence from research and minimises unnecessary and inappropriate variation in practice
 - Managing the various components of a patient's illness or need
 - Minimising errors
 - Remaining oriented towards prevention
- Each professional group involved in healthcare delivery must recognise and acknowledge ethical precepts and principles and promote a culture of ethics within its own membership. All professionals involved in healthcare delivery must collaborate with each other for the benefit of their patients and the public health in a manner that respects the ethical principles of professionalism and health care
- Maintaining ethical principles must not be confused with rigidity or defensiveness over roles and actions. On the contrary, knowing the boundaries and respecting the integrity of principles allows individual healthcare workers to move among groups and operate effectively, according to the requirements of various roles
- All those involved in the healthcare system must be committed to developing and applying the specific skills needed to work creatively in the presence of interpersonal and intergroup tensions

- Patients and families bring their individual experience, capabilities, motivations, and expectations to the healthcare delivery system along with their illnesses, their needs, and their bodies.

5 All individuals and groups involved in health care, whether providing access or services, have the continuing responsibility to help improve its quality

- Healthcare organisations have an obligation to establish processes that identify new procedures or discoveries that have the potential to benefit the care of patients, and to minimise the time required to incorporate these improvements into their system.
- Individual clinicians have an obligation to support and participate in improvements that reduce costs and to suggest how the money and other resources saved could be reinvested to accomplish better care for patients
- Individual clinicians should not impede improvements in patient care because the financial implications of the improvements may affect them adversely

- Individual clinicians have an obligation to change practices that may serve their interests but are costly to the system as a whole
- All who work in the healthcare delivery system have an obligation to share ideas about “best practices” and to learn continually from each other.

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Professional and public attitudes towards unsolicited medical intervention

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Several studies have investigated medical intervention in common aspects of lifestyle, and the subject has been discussed from a legal, ethical, and practical point of view.¹ Fluoridation of water supplies, legal enforcement of safety measures such as compulsory wearing of seat belts or helmets, and restriction of unhealthy habits such as drinking alcohol or smoking are typical examples of paternalistic programmes—actions that aim to prevent harm or promote the good of others, irrespective of the individual's own wishes.²⁻³ What is the position, however, when a doctor's action is neither solicited nor part of his or her contractual duties? In such a situation—which we define as unsolicited medical intervention—the doctor can only speculate about whether his or her action will be welcomed and hence understood as an act of beneficence or whether it will be regarded as an unjustified paternalistic intrusion into privacy.⁴

According to the 1949 international code of medical ethics of the World Medical Association⁵ and to legislation in many different countries, doctors are obliged to offer first aid in an emergency. However, apart from this relatively clear situation, dilemmas in relation to unsolicited medical intervention have rarely been discussed. The European Code of Medical Ethics, issued in Paris in January 1987 by representatives of the medical associations of the European Community, emphasises the principle that “doctors can only use professional knowledge to improve and maintain the health of those who put themselves in their care.”⁶

We aimed to assess the attitudes of doctors and the expectations of the lay public to unsolicited medical

Summary points

Lay people are more likely than doctors to believe that unsolicited medical intervention is appropriate

Attitudes to unsolicited medical intervention are not related to age or sex

Nationality affects attitudes to unsolicited medical intervention

Doctors nowadays may feel a need to resist rather than support increased intrusion of medicine into everyday life

intervention by asking them to consider the ethics of unsolicited medical intervention in three scenarios. We believed that a comparison of the responses of doctors, subgroups of doctors, and lay people would help us to identify gaps between expectations and reality.

Survey of attitudes

A survey was undertaken in four European countries—Austria, Denmark, Slovenia, and Sweden. In each location, an explanatory letter, a questionnaire, and a stamped addressed envelope were mailed or handed out personally to doctors and to lay people. No further

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