

PRINCE HENRY'S HOSPITAL

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MELBOURNE, VICTORIA

FRIDAY 31 MAY 1985

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SOCIAL WORK DEPARTMENT - 50th ANNIVERSARY CELEBRATION

ETHICAL & MORAL ISSUES IN HEALTH CARE

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The Hon. Justice Michael Kirby, CMG*

CONGRATULATIONS TO SOCIAL WORK DEPARTMENT

I want to start by offering my hearty congratulations to the Social Work Department of this great hospital. What changes have been seen in the 50 years of service! The advent of sophisticated drugs and medical technology, place very great pressures on the medical and para medical teams who provide total health care to the patient. Integrated attention to the whole patient, preventive medicine, community medicine and cost benefit analysis in health care are amongst the chief issues that will be before your profession in the next 50 years.

I propose to speak about the last - cost and benefits of health care. It is a subject I have reviewed on an earlier talk at Sydney University and on the A.B.C. It is one which will be before a major international medical congress in Sydney next year. There is remarkably little in the medical literature about

it.

What are the ethical and other criteria by which decisions are made (both at a macro and micro level, as the economists would say) concerning the distribution of scarce resources available for health care in the community? In part, my chosen topic is relevant to the amazing advances of science and technology in our generation. These advances, whether in the realm of in vitro fertilisation, C.T. scans, nuclear magnetic resonance heart and liver transplants or renal dialysis present quandries to the medical community and to the tax payer. They are quandries that have not always been clearly faced though, as I will show, their resolution sometimes involves, literally, life and death decisions. Your predecessors 50 years ago could scarcely have imagined the amazing, but often extremely expensive, developments of science and technology that have occurred. Nor would they have foreseen the remarkable changes in social attitudes that affect the relationship between the patient and the physician. These changes in social attitudes, partly reflected in the decisions of the courts, have tended to replace assured and self-confident decisions of the medical profession with a growing insistence by patients upon their right to know and choose, where vital decisions are made affecting their medical treatment.

My subject, then, is the inter-relationship between the amazing developments of medical science and the scarce resources that are available to spread the fruits of those developments throughout the community to the many patients who might benefit, however fleetingly, from them.

THE CASE OF MR. DEREK SAGE

Early in 1983, Mr. Derek Sage, then aged 42, came under the care of the renal unit of the Churchill Hospital Oxford England. Mr. Sage had a history of psychiatric illness, hypertension and impaired renal function. His right kidney did not function and his left kidney was defective. He lived at Simon House, an Oxford hostel for single homeless men. By March 1984 the functioning of his kidneys had become so poor that he required dialysis. However, immediately after this treatment began, his mental state deteriorated. He spent a period of months in a psychiatric hospital being brought regularly to the Renal Unit for dialysis. His behaviour became 'increasingly disruptive' when he visited the unit. A previously suspected brain tumour was re-explored and it was found that there were extensive areas of cerebral damage. He became demented. His mental age was put at about 3 years. He did not respond to simple questions. At times he was violent, generally uncooperative, dirty, incontinent of urine and faeces, unable to take medication reliably and he could not adhere to a prescribed diet. He exposed himself and masturbated whilst being examined. A great part of his life was spent under sedation, particularly when he was being dialysed. His blood pressure was not properly controlled.¹ The renal unit staff came slowly but surely to the painful conclusion that the treatment by dialysis was a "failure". The dialysis sessions were proving a torment to both the patient and medical staff and the unit's capacity to deal with other patients.²

When Mr. Sage arrived at the unit for routine dialysis on 28 December 1984 the nurses on duty told the consultant in

charge that in their view the continuation of his treatment was 'not in the patient's best interest'. The consultant, it seems, expected 'fierce opposition' to any decision to end the treatment. But the decision was made. And it was made without consulting the hostel staff or the general practitioner who had been treating Mr. Sage. These 'friends' of Mr. Sage learned of the decision on 31 December 1984. They were shocked and angry. They asserted that there was 'a reasonable quality of life' that could be enjoyed by Mr. Sage. They begged the consultant to change his mind. He declined to do so. Opportunity for review of the decision were offered to the local medical authority. However, the decision had to be made promptly as, without dialysis, the patient would soon die. It was at this stage that the director of the hostel for homeless men in which Mr. Sage had spent his life approached the President of the British Kidney Patient Association. An appeal was made, not to the courts (as would probably have occurred in the United States of America) but to the High Court of public opinion. Items began to appear in the media. The British Kidney Patient Association took this unlikely, and seemingly unattractive patient as a symbol and as an example of the scarce resources available in Britain for the treatment of patients requiring dialysis. A Labour member of Parliament called for an independent inquiry into the issue of allowing some kidney patients to die because doctors believed that it was 'not worth keeping them alive'.³ The Oxfordshire District Health Authority defended the decision. It asserted that the decision in Mr. Sage's case had been taken 'purely on medical grounds'. It dismissed the claim that his treatment had been cut off after two

years because he was 'dirty and difficult'. It also dismissed the suggestion that the County was practising 'passive euthenasia'. However, a spokesman did concede, in a rather British way,

'He will not take his tablets to keep his blood pressure down. Possibly if he had come from a better background and stable home he would still be treated'.⁴

It was pointed out that far from being unduly parsimonious in the provision of dialysis, Oxford's provision for kidney dialysis was actually higher than the national average in Britain.

Furthermore, the Oxford Authority had a policy of continuing to treat patients who had a high risk of dying.

The British Kidney Patients Association was unconvinced. It offered to pay the 400 pounds a week necessary for dialysis to keep Mr. Sage alive. The President of the Association declared

'You cannot say this man's life is more valuable or worthier than another man's life. Can you imagine what this terrible case must mean to dialysis (sic) patients?'⁵

Springing to the defence of the Government, the Under-Secretary of State for Health, Mr. John Patten told the House of Commons that the National Health Service in England provided places for 33 people in a million to have dialysis compared with only 22 in a million five years earlier. The Government intended, he said, to increase the provision to 40 places in a million by 1987. However, even at this figure the British level was amongst the lower in Europe. In the United States nearly 90 places in a million were provided. Typical figures for other parts of Europe were Belgium 61, Spain 61, West Germany 56, Austria 54, Norway

54, The Netherlands 46, France 44.

THE CASE OF MCNAIR-WILSON

Now, I ask you to contrast the case of Mr. Sage with the case of Michael McNair-Wilson. He is a man aged 54 years who has been the Conservative member of parliament for Newbury, not far from Oxford, since 1974. On 8 November 1984, Mr. McNair-Wilson made a moving speech to the House of Commons. Amongst other things, he said

'Since last January, I have been the victim of a rare kidney disease. Without kidney dialysis, I would be a dead man. The NHS met my need for treatment without requiring me to show that I had funds to pay for it. It operated on supply and need, not supply and demand. That will always remain true of the NHS. That is why it is such a precious asset to us all'.⁶

The contrast between these two cases could not be more stark. But it merely illustrates the position which exists in overall statistics, by reference to two individual cases. I would not want you to think that Mr. Sage was alone in his predicament. The British Kidney Patient Association maintains that between 2,000 and 3,000 people a year die in the United Kingdom from renal failure and the Association asserts that many of these deaths are unnecessary. The facility for dialysis (not to say renal transplantation) varies greatly from one area of the country to another. Of course, the older you are, the more complications you may have and the less, it seems, is the chance of getting treatment by dialysis. In fact, the London Times made an important point, aggregating the experience of Mr. Sage in an

editorial titled, provocatively, 'Prolonging Low Life'.⁷

'It would be a mistake to think of the case of Mr. Derek Sage, the kidney dialysis patient, as unique. He is unusual only because his treatment was stopped after it had been (sic) begun and because someone else has been found to start it up again. Every year in Britain several hundred kidney patients die without ever being offered treatment even though they could perfectly well be saved in the present state of the medical art, and would be saved in almost any other country in Europe or North America. But usually doctors make a long face and explain to the patients that unfortunately their case is not suitable for dialysis or transplant. They seldom add ... that the patient's unsuitability may reside principally in the intractable symptom of having passed his 45th birthday.'⁸

Now, I hope, you will understand why I have begun to display some little interest in the case of Mr. Sage and all his other post-45 year old patients. The inexorable calendar, and the passing of the years, it seems, is the criterion (or at least one of the criteria) for the availability of scarce resources. Is this a correct principle? Is it an acceptable approach to the application to the business of life and death of the fundamental economic problem: the allocation of scarce resources. The students of economics learn of the 'economic problem' in their first lecture. But the community tarries before acknowledging the

application of the economic problem to matters so intangible as justice or so essential and personal as life and death. Yet apply it does. And never more so than in our generation.

OTHER CASES

The cases for the application of what I will now call the "Sage principle" abound in our society. They are rarely acknowledged. They are little discussed. Yet they certainly exist.

* Liver transplants: We heard recently of the decision to establish a liver transplant centre at the Royal Prince Alfred Hospital in Sydney. Everyone will recollect the debate that went on in Australia earlier in the year concerning the cooperation, or lack of it, between Victoria and Queensland. But the debate was in part that of the competition of various medical teams for the privilege and obligation of the National Liver Transplant unit, this country's resources being unable to support, at least initially, more than one.

* CT Scanners, And then there are the CT scanners which I have already mentioned. These were first introduced in about 1979. When initially introduced there was a serious shortage in the facility for CT scanners and there was also a shortage in the places that could be made available for use of the equipment with its remarkable diagnostic abilities. The only answer was to ration the accessibility to the new medical tool. In

theory, the early CT scanners in Australia were provided to the major teaching hospitals only and it was asserted that they would be available there to provide a service to the district around. In practice, the rationing which took place frequently depended upon whether the patient's doctor was attached to the hospital, fortunate enough to have the CT scanner. It is one thing for government health administrators to lay down broad and equitable principles, it is another for the people on the spot, with control of the facility, to ignore their institutional loyalties and time honoured ways of doing things. Yet access to the CT scanner is terribly important and has been so ever since its early availability. According to the British Medical Journal⁹ there is, as yet, relatively little information on the influence of CT on patient management in oncology. However, reported studies indicate that CT directly alters clinical decisions in between 14 and 30 percent of patients. The author, extracting this information from United Kingdom statistics, suggests that further evaluation of the CT scanner in the management of cancer is appropriate because of the high cost of the technology and, by inference, its rationing and, as yet, limited availability to patients.

* Nuclear Magnetic Resonance: There is now another development which should be mentioned. This is the

advent of Nuclear Magnetic Resonance (NMR). This is a new marvel of technology that provides for more sensitive examination even than the CT scanner. It is particularly useful in the diagnosis of benign tumours at the back of the brain. It can help in differential diagnosis taking the technology one step beyond the remarkable advance of the CT. A recent essay in the Medical Journal of Australia under the title 'Magnetic Resonance Imaging' (MRI) - the same thing as NMR - calls attention to the recommendation of the Australian National Health Technology Advisory Panel to the Federal Minister of Health in May 1984 that 3 MRI units should be promptly purchased and installed and evaluated in teaching hospitals in Brisbane, Sydney and Perth. The total cost of these units would be \$9.9 million. However, the Budget Cabinet in Australia decided last year not to fund the purchase and evaluation of MRI for the three sites mentioned. This decision was made despite the support of the Committee, the favour of the Australian Medical Association and the Royal Australasian College of Radiologists and the advocacy of the Federal Minister for Health, Dr. Blewett and his Department.¹⁰ Moreover, a decision was, it seems, made that no fee would be provided in the medical benefits schedule for private MRI. The consequence is that we have no MRI (NMR) units in Australia at all. The comment of the Royal Australasian College of Radiologists was

start:

'These decisions are unconscionable and the College cannot condone the consequence: the Australian public is not obtaining access to the most effective diagnostic services. Patients have already flown to the United States for MRI investigations'.¹¹

I do not, of course, enter the debate about the decisions of Budget Cabinet. Resources are scarce. Times are hard. The down turn of the Australian dollar will not make the purchase of overseas high technology in medicine any easier. But the case vividly illustrates the economic problem that must be faced when decisions are made concerning new technology. Increasingly government officials and the medical literature are calling attention to the economic implications of the installation of new technology both in a country and in particular hospitals and medical institutions of that country.¹² One of the problems being called to special attention is the lack of a rational plan for the distribution of new and advanced technology, so that equipment that becomes common-place in private offices (even if not supported by Medicare benefits) is often unavailable in the most prestigious medical centres of the country because of limitations in public funding decisions such as are illustrated by the MRI decision in Australia.

I have moved from the micro case of Mr. Sage and Mr. McNair-Wilson to the macro problem of high tech and national budgetary decisions. But ultimately such macro decisions have their ripple effect. Ultimately, they affect the lives of ordinary people. For such people, either the tumour will be discovered early or it will not. Either the dialysis will be made available or it will not. Either the CT scan will be used or it will not. Either the in vitro fertilisation program will be available or it will be declined. Either the heart or liver transplant will be ventured or it will not. Criteria do exist for these decisions. But all too often they are silent criteria hidden behind what the London Times has described as the doctor's 'long face' and the general assertion that the patient 'is not suitable' for the treatment in question or that the facility that might be so beneficial is 'not available' either generally or in his case.

THE LAW

What do lawyers have to contribute to this debate? In the United States there is a much higher level of provision of intensive care than in Britain and, seemingly, Australia.¹³ There is also a much higher level of dialysis. But not everybody welcomes this provision of expensive care. Somewhat self contentedly, the British Medical Journal declared that the difference of 15% acute hospital beds in the United States compared to only 1% in Britain represented evidence of the 'inappropriate use of intensive care' in the United States.¹⁴ Perhaps more relevant to the Sage case, Time Magazine declared

recently

'The only real precedent for Federal intervention is Congress's decision in 1972 to pay 80% of the ruinous cost of kidney transplants and dialysis for anyone whose kidneys fail. Congress expected to pay nearly \$140 million for 5,000 to 7,000 dialysis patients. The first year's bill came to \$241 million for 10,300 patients. In a decade the number of patients has soared 82,000 - including dying cancer victims and nursing octogenarians - at a cost of \$2 billion, which accounts for 10% of all Medicare payments for physicians.¹⁵

In the United States, some at least of the great care that is taken to provide the full panoply of medical facilities, whatever the age and quality of life of the patient, may be attributed to the ever increasing number of medical malpractice suits.¹⁶ Whilst these should not be exaggerated¹⁷ they do represent a haunting concern that stimulates the medical profession into the provision of facilities and treatment that might not be afforded in other countries. As well, there are decisions such as the decision of the Congress. In a sense, the litigation and the Congressional decision reflect American attitudes to the individual human life in the United States. Indeed, it is now being suggested that there may even be constitutional bases for insisting upon the right to treatment.¹⁸ I do not pause to analyse these American developments. We seem further away from a Bill of Rights in this country than ever.' More relevant are decisions and opinions on the law in the United

United Kingdom. The Sage case has directed attention to a previously unknown and unreported decision of the English Court of Appeal in 1980.¹⁹

The case involved four people living in Staffordshire. They had gone to Court urging that the health services were insufficient in their area. They sought a declaration that the Secretary of State had not fulfilled his duties to provide a comprehensive health service. The complainants were two elderly ladies, an elderly man and a girl who had all been on the waiting list for orthopaedic surgery for some years. The complaint was supported by a doctor in the area, including a consultant surgeon. As far back as 1965 the surgeon's duties were to organise a comprehensive orthopaedic and accident service for the area which was an expanding one with a large population. Plans had been made to upgrade a hospital replacing some old huts. But the cost estimates for achieving this had risen every year. The result was that although the project had been approved, it could not be commenced within cost limits. The Minister of the day, Dr. David Owen, explained in 1975 that it was necessary to cut expenditure. His predicament was not dissimilar to that of Dr. Blewett. The result was that the hospital could not 'command sufficient regional priority to start within the next 10 years'. Indeed, by 1978 the proposal for expansion was put off indefinitely.

The legal case was based upon the statutory duty of the Secretary of State under the English National Health Service Act 1977 to provide throughout the country 'to such extent as he considers necessary to meet all reasonable requirements' medical

and hospital facilities. It was argued that this duty, imposed by the parliament, had to be fulfilled.

Lord Denning, in his judgment, dismissing the appeal said

'It cannot be supposed that the Secretary of State has to provide all the latest equipment ... it cannot be supposed that the Secretary of State has to provide all the kidney machines which are asked for, or for all the new developments, such as heart transplants, in every case where people would benefit from them.'²⁰

Lord Bridge, during argument, said that, if the patient's contention was right, a startling conclusion emerged, namely that the Ministers of State had been 'in flagrant breach of duty under the statute for ten years and that this had gone (rather surprisingly) unnoticed by parliament. He added

'I feel extremely sorry for the particular applicants in this case, who have had to wait a long time, not being emergency cases, for necessary surgery. They share that misfortune with thousands up and down the country. I only hope that they have not been encouraged to think that these proceedings offered any real prospect that this court could enhance the standards of the NHS, because any such encouragement would be based upon manifest illusion.'²¹

The legal correspondent for The Lancet commented

'It was perhaps unrealistic to hope that the courts

could intervene it what must be seen as a political judgment of priorities. Had they done so, the government could easily have amended the Act, although it would have forced a debate in parliament. But what of it? The position has remained the same under successive governments faced with the Mr. Micawber syndrome, and the misery of patients (and staff) is unchanged.²²

The Economist took the occasion of its analysis of this problem to point out the necessity of rationing and queueing in any medical health service. The consequence can be under treatment of the inarticulate. 'It is by rationing against the inarticulate that Britain's national health service now unfortunately works, and almost every saintly Britain assumes that his NHS is there by the envy of the world. That assumption turns intelligent inquiring foreigners beserk. One party a visiting American Congressman found a young English woman who had waited 8 years after an accident for plastic surgery to remove facial scars that had by then blighted most of her youth. They asked sympathetically for her comments on the NHS. 'Oh, its a wonderful system we have in Britain', she replied, 'You know our medical care is all free'.²³

THE TRIAGE AT WORK

At some time prior to the wars of Napoleon it became a common practice at the battle front to have a Triage Master. His was the duty to stand in front of the first field hospitals. It was he who rejected some casualties as 'insufficiently wounded' to require treatment. Others, he decided needed a poultice. These he

sent to the left. He rejected others with a belly wound as incapable of being saved. By his fiat these were sent to the dying sheds. They were sometimes admitted to a great tent where the surgeons could concentrate their limited resources before anaesthesia. A Canadian judge told the recent World Congress on Law and Medicine in New Delhi

'No matter how it is done, triage is a cruel procedure, perhaps an immoral one, but it is generally recognised as necessary and I suggest inescapable. Whenever the State is involved one of the forces which must influence the politicians is money ... and I tell you that in an undisguised and very direct way our politicians, by their laws, are going to ultimately decide upon all our rights both legal and medical: they do now, will continue and I think must engage in the massive practice of triage, which in our case is not applicable only to the wounded nigh to death on the battle field, but also to those in peril of their life, because they are accused of crime in society which, if it finds them guilty, will demand their death.'²⁴

With perfect equality, this judge pointed to the triage in the law as well in medicine. It operates by delay, queueing or rationing or by classification. It is the operation in the matters of justice and of life and death of the economic problem. A decision to provide one service represents a decision to deny another. The loss of the other services represent the opportunity cost. This decision is rarely faced squarely and candidly. Only

now are we beginning to face openly and to debate the consequences of the failure to provide legal services for people in the courts and the failure to provide high tech diagnostic aids and other facilities to people in the hospital ward.

A MODERN PRIVILEGE

One judge, who was both a physician and lawyer (Sir Roger Ormrod) has suggested that the considerations of cost-benefit in individual medical decisions 'cannot be completely ignored'.²⁵

'In reaching the present state of practice [on life support systems] two significant steps were taken implicitly by the medical profession, and it is as well to make them explicit. It recognised that it is concerned with something more than the maintenance of life in the sense of cellular chemistry, and so implicitly accepted the concept of 'quality of life' from which it has, in the past, always fought shy, for obvious reasons. It also has implicitly accepted that considerations of cost-benefit cannot be completely ignored. In the last few years both phrases have begun to appear in print with increasing frequency as the profession gradually comes to terms with them. Ten or fifteen years ago, mere mention of either was enough to precipitate an emotional response from most doctors. Now they are explicit and can be discussed and debated rationally - an important advance from many points of view.'²⁶

According to Sir Roger Ormrod this advance is desirable and it emphasises the great privilege of rational choice which is open to modern man. But the comments on the recent Sage case in

England, at least in the popular journals, is not so sure. The Times editorial pointed out that there was 'no safe dividing line between medical and social criteria'. Indeed, it suggested that a medical practitioner who sought strictly to exclude from consideration the feelings of the children of a patient with a young family, for instance, would only be guilty of another sort of cruelty. The Guardian newspaper, in its editorial, contrasted the treatment of Mr. Sage and Mr. McNair-Wilson

'Did any of the doctors who saved Mr. McNair-Wilson ever stop to think whether they were improving the quality of his life by treating him? Did they reflect on whether it might be officious of them to equip him to return to the government backbenchers? Of course, they didn't and of course, they were right not to do so. They treated Mr. McNair-Wilson because he needed to be treated, and for exactly the same reason that they treated Mr. Sage. It is simply impossible that doctors should choose which of us is more worthy of medical treatment because of the way that we live.'²⁷

The debates continue to rage in the medical and popular literature about these cases. At one level the discussion is addressed to whether the discontinuation of dialysis was justified in the particular case of Mr. Sage.²⁸ At another level consideration has been given to the legal duty of the doctor to provide care for his patient and even the risk that the doctor who tells a patient that his condition is 'untreatable', knowing that it could be treated if only there were more facilities, may

be committing a crime, possibly conspiracy to attempt the manslaughter of the patient.²⁹ I do not enter this debate or the debate about the civil rights of a patient denied full and frank disclosure by his treating physician. It is important, however, to call attention to the latest decision of the House of Lords on 21 February 1985 which suggests that doctors have a legal duty to inform patients of 'substantial risks' involved in medical treatment, though not every risk however small.³⁰ By inference the extent of the patient's right to know available diagnostic and treating facility appears to have been extended by this important new decision. Although English law, which remains most influential in this country, has not gone as far as the doctrines of 'informed consent' in the United States, the decision of the House of Lords appears to have edged it gently in the same direction.

CONCLUSIONS

What conclusions should be drawn from this discussion of budget choices and bedside decisions? A number can, I suggest, be mentioned.

* Duty to patient, First, the guiding principle must always be the medical practitioner's duty to the patient and respect for the patient's autonomy as an individual human being. This is the guiding principle that has activated the House of Lords in its most recent decision. It actuates most of the legal decisions on medical treatment. It is relevant in this area because of possibility that advances in medical technology and

present facilities that would be specially useful in a particular case but which are not available. Endless speculation and the exclusion of every possible diagnosis are not required of the reasonably careful medical practitioner. But if a decision were reasonably made that a particular facility ought to be available to the patient, it does not seem appropriate to judge the provision of that facility or its denial by reference to an evaluation of economic considerations and an assessment of the patient's likely quality of life, without involving the patient or his representatives in that decision.

* The responsibility of decision, Ultimately, someone must take responsibility for the decisions that are made. Desirably, in our form of political government, the macro decision should be made by elected representatives. Thus, in Australia, the provision (or non-provision) of nuclear magnetic resonance or the expenditure of large sums on expensive programmes such as in vitro fertilisation or heart and liver transplant units, are made by Ministers and governments (and ultimately parliaments) advised by expert committees. It is desirable that the ultimate responsibility should be identified in order that there should be accountability. The increasing propensity to take the exercise of ministerial discretions to the courts, and especially to

the Federal Court of Australia under the Administrative Decisions (Judicial Review) Act 1977 may mean that in the future, in this country, the exercise by Ministers of discretions to provide funds (or not to provide funds) will be scrutinised in the courts, at least to the extent of ensuring that only relevant considerations have been taken into account and that no irrelevant considerations have infected the Ministerial decision.³¹

The privilege of choice. At least now, as Lord Justice Ormrod has said, these issues are out in the open. No longer is the long face (of 'the Thunderer') or a vague generality sufficient. Yet the opening up of the criteria for rationing and queueing expensive medical facilities brings its own problems. In the past, there was a tendency simply to accept the sad decision because of trust in the judgment and decency of the individual practitioner involved. In the future it is unlikely that such unquestioning acceptance will survive. Instead, it is likely that patients and their representative groups such as the Kidney Association, will bring out into the open the uncomfortable fact that an arbitrary birth date may have been chosen or some idiosyncratic judgment of 'quality of life' has been made that excludes the dirty and unpleasant whilst providing facilities to the articulate influential and clean. At least the value of

the Sage case is to confront us squarely with the cruel necessity of rationing and with the obligation to identify more clearly in the future, than in the past, the criteria by which that rationing is to take place in individual cases. To talk in general terms about the need to economise, the economic problem and the modern triage may be intellectually acceptable. But when its impact is upon a loved one, or even (as in Mr. Sage's case) someone not particularly loved but at least defended by a few champions - the decision is harder to make. Someone must make the decision. Criteria must exist. Perhaps we can solve the dialysis problem. But every year will bring more and more expensive technology which simply cannot be provided in Bourke and Wilcanda or even, as in the case of NMR, anywhere in Australia. Governments are elected to make these decisions at the national level. But doctors are not elected. They are not even given special training in these matters. They may no longer resort to the sheet anchor of a commonly accepted religion or generally accepted community ethics. To what, then, will they resort as their criteria for decision making?

If it is to be "quality of life", that expression must be given greater clarity and articulation. For in its generality may lurk the danger of prejudice, bias, even unconscious antipathy and non-identification with a

patient like Mr. Sage.

* Deserving the Privilege. There are many other things that can be said. In part, the economic problem can be addressed by improving our efficiency in the distribution of medical resources. In part, we must always test ourselves (as the British have now begun to do in the matter of dialysis) by comparing our expenditures with countries we would regard as similar in ethical and professional standards and economic capacity. In part, we must engage the attention of the professional colleges and of the medical educators so that such decisions are made in a structured and conceptually acceptable way and not by rude rules of thumb merely asserted, the details of which are hidden from the patient. In secrecy lies obfuscation of decision making. If the apportionments are brought out into the open, political and professional pressure may be applied to have them changed: to increase resources or to re-apportion community expenditure, as on prevention rather than treatment ex post. We may wish to introduce procedures so that decisions are not idiosyncratic but are shared by medical teams and made according to previously stated and clearly available criteria which ensure equality of treatment and diminish the risk of disadvantaging the poor and the inarticulate in the provision of health care. Enough has been said

to show that the great medical issues that will face our country in the decade ahead will include the rational and principled apportionment of the scarce resources available for the medical treatment of precious individuals. On a national level important decisions will be made, as they should be, ultimately by politicians. At the bedside, important decisions will continue to be made by medical practitioners. The appeal of this contribution is for greater openness in the procedures of decision making, greater clarity in the principles of decision making and clearer recognition by all of us of the hard choices, national and individual, that daily must be made. Lord Justice Ormrod has declared that this is a great privilege and an opportunity that is now available to us. But it is only so if we deserve to have it. And we only deserve to have it if we make our decisions by reference to ethical principles that we have bothered to think about, to identify and constantly to rescrutinise and test including against changing community standards.

There is nothing specially new in any of this. In his Doctors Dilemma, George Bernard Shaw you will recollect presented Dr. Sir Colenso Rigeon. Sir Colenso had a new wonder drug - and his dilemma was: which of his patients, so deserving, should get it. But I suspect that if any of the original social workers of 50 years ago had been asked to reflect upon the matters I have

addressed tonight, age would cause them to disdain the arbitrary triage of a youthful birthdate. And moral sense would cause them to reject a triage based on background, wealth, education or social station. New rules must be found for the Triage Master of today. But at least we now recognise that he exists. And that is the beginning of wisdom.

FOOTNOTES

* The views expressed are personal views only. This paper is based on the author's George Judah Cohen Memorial Lecture, delivered at the University of Sydney, 11 March, 1985 to be published in Current Affairs Bulletin.

1. This account is taken from the Times 9 January 1985, 2 and The Lancet, 19 January 1985, 176.
2. The Lancet, 19 January 1985, 176.
3. Mr. L. Carter-Jones, MP cited The Times, 9 January 1985, 2.
4. Mr. Christopher Paine, quoted The Times 9 January 1985, 2.

5. Mrs. Elizabeth Ward quoted *ibid.* See also The Lancet, 18 February 1984, 386. ('End-stage Renal Failure: The Doctor's Duty and the Patient's Right').
6. Cited The Guardian, 9 January 1985, 10.
7. The Times, 10 January 1985, 12.
8. *ibid.*
9. British Medical Journal, 16 February 1985, 527.
10. 'Magnetic Resonance Imaging (MIR) in Australia', statement by the Royal Australasian College of Radiologists, (1985) 142 Medical Journal of Australia, 60
11. *ibid.*
12. AR Margulis, 'Radiologic Imaging: Changing Costs, Greater Benefits' in American Journal of Roentgenology, 181, 136, 657-665; R.G. Evans, 'Economic Implications of a New Technology Installation: a CT Model' in American Journal of Roentgenology 181, 136, 673.
13. 'Inappropriate Use of Intensive Care' in British Medical

Journal, 289: 6460, 1709 (22-29 December 1984).

14. ibid.
15. Time, 10 December 1984.
16. See America Medical Association Third Report by Special Task Force on Professional Liability and Insurance, reported New York times 15 February 1985,
17. MD Kirby, 'Negligence and the Physician' Arthur E. Mills Oration, Royal Australasian College of Physicians, Adelaide, 9 May 1984. Published in Australia and New Zealand Journal of Medicine.
18. CEG P.S. Applebaum, 'Is the Need for Treatment Constitutionally Acceptable as a Basis for Civil Commitment?' In Law, Medicine and Health Care, Vol 12, no. 4, September 1984, 144.
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21. The Lancet, 1224.
22. ibid, 1225.
23. The Economist, 18 January, 1985. See also The Economist, 28 April, 1984 and The Economist, 2 February 1985, 20.
24. CC Locke, 'Law, Medicine and the Ultimate Power of Decision', unpublished paper for the World Congress on Law and Medicine, New Delhi, India, 22 February, 1985.
25. R. Ormrod, 'A Lawyer Looks at Medical Ethics' (1978) 1. 46 The Medico Legal Journal, 18, 28.
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27. The Guardian, 9 January 1985, 10.
28. 'When is Discontinuation of Dialysis Justified?' The Lancet, 19 January 1985, 176. See also CJ Roberts, SC Farrow and MC Charny, 'How Much Can the NHS Afford to Spend to Save a Life or Afford a Severe Disability?', The Lancet, 12 January 1985, 89.
29. The Lancet, 18 February 1984, 386.
30. Sidaway v Falconer; Bethlem Royal Hospital & Maudesley

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31. Cf Beaumont J in Santa Sabina College (by its trustees
Sister Margaret Gannon, Sister Margaret Cameron, Sister
Grace Belcher, Sister Marie Therese Weeks) v Senator the
Hon. Susan Ryan Minister for Education for the
Commonwealth of Australia unreported, Federal Court of
Australia, 17 January 1985.