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ESSAYS ON ETHICS RELATING TO THE PRACTICE OF PLASTIC SURGERY. **Plastic and reconstructive surgery can, with good justification, be claimed to be the most general surgical speciality. Not only does it serve the neonate to the nonagenarian but even ventures into the correction of foetal deformity. Plastic surgeons treat injuries and diseases of the whole human integument from the sole of the foot to the vertex of the scalp while, in companionship with the relevant specialists, they explore and restore within the intracranial, oropharangeal, thoracic, intra and extra peritoneal cavities as well as various viscera, vessels, musculoskeletal and sensory motor systems. Plastic surgery pathology embraces a wide aetiology and variety from the rare and esoteric to the commonest tumours of infancy, the commonest adult malignancy and the commonest cause for admission to a casualty department.**

By virtue of an era of surgical renaissance in terms of sophisticated and more reliable technology and a clearer understanding of functional anatomy with bearing on more accurate excisional and more predictable reconstructive surgery, there is hardly a part that cannot be removed, shifted or replaced in the treatment of tumours, trauma or congenital malformation. The possibilities within plastic surgery are limited only by the imagination of the plastic surgeon and pass through the spectrum of the spectacular and the inspirational through the ordinary and routine into the outrageous, absurd and frankly embarrassing that stretches the limit of acceptability and credulity.

As in the Italian Renaissance when the people and politicians questioned the purpose and public benefit of so much extravagant art and architecture, so have contemporary patients and healthcare managers at the end of the 20th century begun to query the potential harms and benefits of surgical super-technology. Simply because a pancreatico-duodeno-hepatic transplant in a neonate is now possible, is it in the public interest or in the best interest of that baby and family that it should be attempted? Some answers may become apparent through the audit of surgery which, in the National Health Service hospitals, is now a mandatory clinical responsibility whereby, through the study of outcome of treatment, the surgeon is encouraged to modify his or her practice to become more effective, safe and efficient. But apart from the analysis of facts, figures and statistics there is an important facet of surgery which receives insufficient attention; that is the ethics of surgery.

Ethics relating to the practice of medicine is commonly enough debated but, in comparison, the ethics of surgery is not so frequently discussed and, in a survey of the last fifty editions of the four most widely read surgical and medical journals, there were fifteen articles on ethics in medicine to every one in surgery. Medical ethics has become a standard chapter in medical textbooks yet one looks in vain for such an entry in surgical textbooks. One can attend a 3-day international surgical symposium with five lecture halls in concurrent activity where all the latest in animal and clinical surgical research and innovation is presented but hear nothing of ethics. One is aware of perceived ethical issues raised in the plastic surgical journals but they are usually about advertising and professional territorial disputes which, arguably, have nothing to do with what is at the heart of ethics. The disparity between the expressed ethical conscience of the physician and surgeon is difficult to understand when the act of surgery has greater potential for irreversible harm than the act of physic.

Therefore, in an effort to address what appears to be a neglected area I have, in this and seven subsequent issues of the British Journal of Plastic Surgery, written eight essays on ethics relating to the practice of plastic surgery. The essays are far from comprehensive. They are also written by a plastic surgeon with an interest in medical ethics and may be too elementary or imprecise for the satisfaction of the full-time medical ethicist or medical lawyer. There are also likely to be plastic surgeons who find the essays too pretentious or perhaps totally irrelevant to their work where it is believed that all is required is a reasonable degree of commonsense, logic and honesty. Whatever the reaction, whether it be agreement or disagreement, irritation or enragement, I hope that it will stimulate debate and discussion and, of greater importance, provoke the plastic surgeon to linger a little longer and reflect more profoundly in order to best answer the question: "Am I really making the right decision?" *C. M. Ward*

Defining medical ethics

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An explanation by a moral philosopher of the meaning and origins of ethics is as opaque and longwinded as a plastic surgeon attempting to define plastic surgery. Yet ethics, like plastic surgery, is a term in common public usage with little concept of precise connotation. It is widely believed that plastic surgery is a specialty which only attracts flamboyant surgeons who, through cosmetic surgery alone, exploit the human failings of a vulnerable group of patients entirely for motives of greed and self aggrandisement. Ethics implies a state of goodness verging on saintliness to which we might aspire but are unable to achieve. "Unethical" is an

adjective applied to an act which one knows is not quite right but where it is difficult to explain coherently why it should be so. Therefore, before examining the possible role of medical ethics in surgery and in plastic surgery it becomes necessary to try to define the terms.

One starts with philosophy as the critical evaluation of assumptions and arguments which, when linked with morality becomes moral philosophy (synonymous with ethics) as philosophical enquiry about norms, values, rights and wrongs, good and bad and what ought and ought not to be done.[1] Ethical principles such as these apply in some form or other to everyday family life or in professional activity to guide and govern the behaviour of a society, such as in the practice of law, in economics, in politics or sociology. There are even advisers in ethical investment who attempt to direct clients towards profitable enterprises which do not take undue advantage of the disadvantaged. Thus medical ethics become the obligations of a moral nature which govern the practice of medicine.[2] However, just as the Nobel Prize winning economist or peacemaker is not able to resolve a nation's economic and political problems, or the most humanitarian judge not always capable of implementing justice, so one cannot expect contemporary ills in the delivery of health care to be resolved through medical ethics. Ethics simply provides a route through the process of reasoning whereby a morally respectable and defensible position can be reached.

In the field of medical ethics applied to the practice of surgery there is instant conflict through the polarisation of attitudes where, on the one hand are surgeons working under tremendous pressure, often being compelled to make shortcuts in the decision making process and in surgery itself using a sort of rule of thumb ethics picked up by experience, changing room anecdotes and an encounter with the occasional lawyer. They regard moral philosophers and bioethicists as ivory tower intellectuals who are obsessed with irrelevancies and who have no concept of what life at the hospital coalface is really about. On the other hand sit the academic ethicists who regard surgeons as uncaring oafs inflicting their own values on a susceptible community without any concern or respect for patient rights. There is a little truth in this stage setting and this has been debated,[3] where moral philosophers who ruminated on ethics in isolation were accused of leading a somewhat sterile existence from which they were rescued by applying their minds to matters moral in medicine. The title of Toulmin's essay "How Medicine saved the life of ethics"[3] says it all, but what is required is a closer working relationship between clinicians and the professionals within ethics in attempting to disentangle the huge medico moral dilemmas within surgery, which are escalating at a corresponding rate to the accelerating advances in surgical technology in a world of diminishing resources inhabited by a population demanding increasing standards. There may be a place for a corresponding essay on "How Ethics saved the life of Medicine and Surgery".

It is also unhelpful to think of medical ethics in isolation. For, just as moral philosophy is its source so is medical ethics the foundation of medical law as clearly stated in a 19th Century judgement:

> "It would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral obligation".[4]

The relationship between law and ethics is repeatedly emphasised up to the present day:[5]

> "Law tends to concentrate on rights; ethics, on values. Law tells us what we must do; ethics what we ought to do. The disciplines are nonetheless far from distinct: law needs an ethical base to be useful to human beings and medical law, like medical ethics, demands an understanding of the world of medicine and medical care for its practitioners to be helpful to physicians and their patients. And the major principles underlying both medical law and medical ethics are the same: self determination, beneficence (or at least non maleficence) and justice as fairness."

The triangular territory defined by these three pillars in the Figure bounds the behaviour of the medical community; but the boundary is not clearly defined and moves according to developments in ethics and in statutory and case law relating to the practice of medicine which, in turn, is influenced by the demands and standards of living of a country's citizens and the range and quality of care which is able to be provided directly or indirectly. Thus the three components are interdependent and if one changes stance the others adjust to maintain the triangle. Furthermore, if a doctor deliberately or accidentally steps well outside the boundary there is no penalty unless, at the same time, he or she demonstrably breaches standards and duties of medical care laid down in law or by the General Medical Council, while in law, the penalty is incurred only if the doctor is found out and the patient prepared to take on the daunting and time consuming task of pursuing a successful action. Thus throughout most of a doctor's life the constraining influences are, or should be, his or her own moral obligations derived from education and training and hopefully, learned ethical values. Yet there can be few, if any doctors professing Christianity, who have observed all the ten commandments in their professional lives and, unless they believe in the notion of Hell and damnation, there is no punishment for transgression.

A rather extreme form of respecting patient rights by revenge was observed in 1750 BC through the authority of the Babylonian King Hammurabi whereby, for example, if in the course of draining an abscess, additional unwarranted damage was caused to the patient, he was entitled to cut off the hand of the

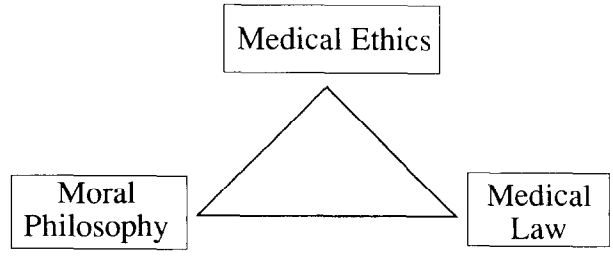

Fig. 1

Figure 1 The triangular relationship.

doctor.[6] Not surprisingly, doctors avoided even riskier pursuits such as cutting for stone and took an urgent interest in the practice of Physic. Yet about 3500 years later there are surgeons such as obstetricians in certain states within the USA who find themselves so threatened by litigious patients demanding unrealistic standards and by correspondingly high malpractice insurance premiums that they are either forced to work uninsured or move to another state or country or abandon their vocation altogether.

Historical perspective

Inevitably one starts with the outcome of years of philosophical debate in the 5th Century BC of a school led by Hippocrates on the Island of Cos leading to the Hippocratic Oath, which was once affirmed at every medical graduation ceremony but is now unlikely to be anything more than a decoration to adorn the walls of a private plastic surgeon's consulting rooms where among all the other certificates declaring surgical worthiness it is intended to impress. However, the Hippocratic Oath was never intended to be an expression of an absolute standard of professional medical conduct. The Greeks had no higher aspirations through a "profession": trades, crafts, professions were all the same to them and merited equal respect. It was probably forsworn by some members of an ascetic philosophical cult of Aesklepios[7] which became popular because early Christians adopted a similarly ascetic lifestyle as described by the Roman physician Scribonius Largus in his Compositions of the 1st Century AD.[8] Here is a blend of the Hippocratic principles and early Christian humanism as the first description of virtue based medical ethical principles which are summed up in the Roman axiom: "Honeste vivere, nemini laedere, suum cuique tribuere; live uprightly, harm no one, give to each his due". The principles were embraced and modified by other civilisations with different cultural and religious backgrounds but without changing the essential Hippocratic lessons, and remain relevant to the practice of medicine and surgery to the present day.

In Britain, it was not until the 18th Century that more specific guidelines for proper medical practice were identified which, given the dominant role of the doctor at the time, tended to be overbearingly paternalistic and relate more to etiquette and protocol; although from this extract from Dr John Gregory's book on the duties and offices of a physician the caring role of the physician in relation to the terminally ill patient is nicely put:[9]

> "Let me exhort you against the custom of some physicians who leave their patients when their life is despaired of and when it is no longer decent to put them to further expense. It is as much the business of a physician to alleviate pain and to smooth the avenues of death, when unavoidable, as to cure diseases. Even in cases when his skill as a physician can be of no further avail, his presence and assistance as a friend may be agreeable and useful, both to his patient and to his nearest relations."[10]

The Edinburgh physician John Gregory was later overshadowed by Dr Thomas Percival whose book on medical ethics is essentially a set of moral guidelines intended for the edification of a group of squabbling physicians in the Manchester Royal Infirmary.[11] His book remained the main influence on Anglo-American medical and surgical practice into the 20th Century and was adopted verbatim by the American Medical Association in the first half of the 19th Century at a time when a vicious battle developed between competing groups claiming greater expertise in the treatment of certain ailments. Both Gregory and Percival held great store in Virtue Ethics whereby the welfare of the patient was dictated by the good and virtuous behaviour of the doctor with little allowance made for the patient to determine his own therapeutic destiny.[12] Here is an example of proper conduct becoming of a doctor according to Percival:

> "Universal temperance both in eating and drinking is particularly incumbent on a physician not merely as being essentially requisite to preserve his faculties in that alert and unclouded state but because it is a virtue which he will very frequently find himself obliged to inculcate on his patients: and will inculcate on them with little effect, if it be not regularly exemplified in his own conduct".

While, in giving bad news he has a slightly different approach to Gregory:

> "A physician should not be forward to make gloomy prognostication; but he should not fail, on proper occasions, to give to the friends of the patient timely notice of danger, when it really occurs, and even to the patient absolutely necessary".

The early part of the 20th Century saw a gradual transition from the paternalistic doctor/patient relationship towards greater patient autonomy and the importance of the rights of the patient, which was catalysed by one of the most horrific episodes in medical history. The parts played by doctors in designing, implementing and recording of the agonising end experiments on fellow humans in the German concentration camps make sickening reading.[13] At the end of the trial before the Nuremberg medical tribunal, 16 defendant doctors were found guilty of war crimes and crimes against humanity—a decision which helped to focus sharply the minds of the medical community on means of never allowing such acts to be repeated and ending with the Nuremberg Code which dramatically underlined certain basic rights of the patient; in particular the right to know, the right to choose and the right not to be harmed. However, the Code and the Nuremberg judgements were ignored in another shameful medical incident reported in the United States national press in 1972 whereby medically handicapped and institutionalised blacks in Tuskegee were used without their knowledge or the knowledge of their families in research for the treatment of syphilis. The hearings by Congress on the Tuskegee syphilis study eventually led to a National Research Act (1974) which established a National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research.

Sadly, there are still reports of the parts played by doctors in horrific acts with humans, and from the Research and Rehabilitation Centre for Torture Victims based in Copenhagen[14] there is evidence that

doctors were involved in 60% of the cases irrespective of the country of origin. If any surgeons believe that patient power is now too overwhelming they should read how medical power can be appallingly misused and how doctors participate in the abuse of human rights.[15] One assumes that no surgeon of one's acquaintance is actually party to torture but one does continue to witness occasionally the gross trespass of rights in the pursuit of "progress" through surgical research and innovation.

The framework of medical ethics

Contemporary medical ethics brings several ethical notions to the doctor/patient relationship which can be very briefly summarised. The first is autonomy, which is the capacity and freedom to think and act independently without obstruction; in other words, self governance without constraint from another person's action. Non maleficence implies the deliberate avoidance of any harm to the patient while beneficence relates not only to the removal of harm but also the provision of benefits of any intended therapy. Justice should speak for itself; in health care the most obvious example is, through distributive justice, the fair and equitable provision of available medical resources.

However, it is probably easier to identify three ethical themes which recur again and again in medico moral issues:[16]

1. Duty based morality is concerned with the intrinsic merits or otherwise of the act itself rather than the consequences. It stresses the wrongness of contravening moral rules which, in the medical and surgical context, are found within various codes of conduct, examples of which are the Declaration of Helsinki in 1975 relating to human experimentation, the Declaration of Lisbon in 1981 on the rights of the patient, or the International Code of Medical Ethics, most recently modified at the 35th World Medical Assembly in Venice in 1983. The duty based approach essentially places the doctor as the focus, appealing to his or her conscience and sense of what is right thereby enabling duties to be carried out simply because they are required: for example, such doctors would unflinchingly stand by the preservation and sanctity of life at all costs even though, by doing so, they might, in some circumstances, increase suffering: for example, in the care of the terminally ill patient with carcinomatosis and uncontrollable pain or in preventing the abortion of an unwanted foetus conceived by rape. One can see here a clash between the strict observation of duties and the regard for the patient's self determination. One can also see other discomforting moral conflicts through the doctor's duty not to breach the patient's confidence and the serious harm that might come to a third party threatened by the patient in maintaining that confidence (the circumstances are more obviously relevant in the field of psychiatry).
2. Rights based morality is the dominant contemporary theme in medical ethics. Basically it condemns an action if it wrongs someone or violates an important right such as the right of a patient to determine his or her own destiny. It is clearly linked with respect for autonomy and justice with obvious implications in the doctor/patient relationship on consent. Difficulties arise in medicine as to how to combine the negative component of rights based morality in having an unimpeded freedom to choose and not to be harmed with a more positive view of rights which impose duties on doctors to improve the welfare of patients. An example is to be found in a prospective randomised clinical trial where, in a scientific search to find what might be a better form of treatment for patients with a particular disease, a patient might wish to exert freedom to choose by agreeing to defer to the surgeon's preferred therapeutic option.
3. The Utilitarian or the Goal based moralist judges the general aggregative good according to the consequences of an action rather than the act itself. Such a moralist would vigorously support a randomised control trial and morally justify the suffering or possible death of a few patients through the advantages gained by the majority of patients or from the body of patients as a whole who may subsequently benefit from the discoveries. Modern utilitarianism has become a more accommodating framework for moral philosophy by not rejecting outright the importance of following some of the rules of a duty based moralist or of observing certain rights on the grounds that, by doing so, long term benefit can be promoted.

How does all this impinge on the life of a plastic surgeon? Is there, in practice, any need for all this somewhat contradictory ethics stuff in the activities of plastic surgeons who are all honest, decent, God fearing folk who have acquired the right moral values in a caring family environment and at the feet of their surgical mentors? The answer could be found by exploring the alcoves in medical libraries devoted to medical ethics or by reading one of the several student text books[1,17–19] or by examining the three circumstances under which ethics enters the world of a plastic surgeon:

(a) Bedside Ethics: In day-to-day hospital activity ethics influences the surgeon/patient relationships in the discussion and selection of the most appropriate option for treatment, from the glittering available array of plastic surgery procedures.
(b) Armchair or Barstool Ethics: This is where plastic surgeons are at their most relaxed and reflective, in an atmosphere where the problems of the world are easily resolved. It is unlikely that they will trouble themselves with the classical conundrum such as materno/foetal conflict within the abortion debate, although they may now have views on advanced directives, the living will and euthanasia. It is more likely that the influence of limited resources in the pursuit of one's profession is bewailed and, more than likely, that once again the old chestnut of advertising is thrown around. But can the difference between the advantages of the dissemination of honest and relevant information to the public and what is perceived as the unethical

self-promotion of individual surgeons be cogently argued?

(c) Ethics of the technological imperative: Here plastic surgeons are in their element. This is why the specialty was adopted in the first place—to be at the forefront of innovative surgery and to employ one's fertile imagination in order to set oneself out from the crowd, even if it means undertaking high risk or potentially life threatening procedures simply for the sake of appearance. Perhaps we should bear in mind the definition of a technological imperative as an operation which, if it can be done, must be done regardless of expense and of the danger to the patient, regardless of the availability of simpler, safer, more effective and cheaper options and regardless of the fact that as a consequence treatment is delayed or denied to other arguably more deserving patients.

Each of these three scenarios share one common theme which is best expressed in the statement by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research:

> "The primary goal of health care in general is to maximise each patient's wellbeing. However, merely acting in a patient's best interests without recognising the individual as the pivotal decision-maker would fail to respect each person's interest in self determination... When the conflicts that arise between a competent patient's self determination and his or her apparent well-being remain unresolved after adequate deliberation, a competent patient's self determination is and usually should be given greater weight than other people's views on that individual's well-being.
>
> Respect for the self determination of competent patients is of special importance. The patient should have the final authority to decide."[20]

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