Should the practice of medicine be a deontological or utilitarian enterprise?

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ABSTRACT
There is currently an unrecognised conflict between the utilitarian nature of the overall NHS and the basic deontology of the doctor-patient interaction. This conflict leads to mistrust and misunderstanding between managers and clinicians. This misunderstanding is bad for both doctors and managers, and also leads to waste of time and resources, and poorer services to patients. The utilitarian thinkers (mainly managers and politicians) tend to value finite, short term, evidence based technical interventions, delivered according to specifications and contracts. They appear happy to break care up into smaller pieces, which can then be commissioned from multiple providers. The deontological thinkers (mainly doctors and other clinicians) tend to think about care delivered through a long term continuous relationship, and regard that relationship as therapeutic and salutogenic in itself. To them breaking care up into smaller fragments is a denial of what caring is really about. Very rarely are either or both sides of this debate fully aware of where their powerfully felt and often well argued positions start from. In this paper we offer an appraisal of the strengths and weaknesses of both moral viewpoints as applied in the UK NHS context and we suggest a way in which they can be reconciled, provided neither is pushed too far or too hard against the other. We believe this reconciliation would be good for patients, doctors, managers and improve the service as a whole.

It is said that behind any argument you will hear the bones of an old philosopher rattling about. This is currently an accurate observation in the UK NHS and in the practice of medicine of UK doctors.

We have lived through a period of unnecessarily turbulent change in medical practice and the NHS structures tasked to deliver medical care.1 2 The drivers behind this are political, economic, technological, demographic and social. Although many people who try to answer the question of ‘How best should the NHS be organised and run?’ try to present the debate as a technical issue about resource allocation, there is a far deeper moral question that is begging to be brought back into the view and answered.

The question is this: Should the practice of medicine be a deontological or utilitarian enterprise? Michael Loughlin3 describes well the absurdity of trying to get technical answers to moral questions. A question like this is deeply moral and demands an answer in moral terms, that is, choices about what we value more and what we value less. Many people need to answer it, and to do so fairly they need to understand their own reasoning and perspective and that of others. Sadly, at present in the NHS too many people are setting or rushing after targets, but missing the point about what needs to be done.4–6

WHY DOES THIS QUESTION MATTER?
Medicine, in the UK NHS and worldwide, takes place every day as a series of discrete interactions between individual patients and individual professionals. Historically, medicine has described itself, and been described by others, in terms of the interaction of the doctor, the patient and the disease. The transactions between patient and doctor have been private clinical and commercial transactions, and as such have been guarded by privacy and confidentiality. The ethics of such relationships are intrinsically on a deontological footing—they are about how one person should treat another.

This deontological basis of medical care is strongly buttressed by professional codes such as the General Medical Council’s (GMC) good medical practice5 6 and its starting premise, ‘You must make care of the patient your first concern.’ Note the key point here that it is the individual patient who is the focus of attention, and not the wider needs of the healthcare system or the country’s economy.

These individual doctor—patient interactions are nestled within a larger payment system that provides the financial and other resources within which these interactions can occur. This superstructure is usually either ignored, or taken for granted, during an individual consultation. To a large extent this is how you would want things to be, with the main focus being on the current patient’s needs. However, the needs of the supporting structure do impinge on the space for doctor—patient interaction, and create a silent additional actor in the drama of the medical consultation. In modern complex healthcare systems such as the UK NHS the needs of the system, in terms of its survival as a coherent entity, are rapidly becoming as large as those of the patients in the consulting room. This larger system is unavoidably utilitarian, having to make the best use it can of finite resources.

Its resources are clearly being committed during the many discrete individual interactions between doctors and patients and the decisions and costs about medical treatments that flow from them. It follows that it is not entirely possible for the supporting system to operate in ignorance of, and without some wish to modify, the behaviour and decisions of its individual clinicians.

And so as doctors we are being pushed towards a more utilitarian way of working. The current white paper10 makes this push stronger still. If we do this then making careful use of system resources
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becomes a priority at a similar level to the care of each individual. Then the GMC’s starting premise would have to become something like, ‘You must make care of the patient your first concern, but within the constraints of time and resources made available to you.’

The current GMC guidance is notably weak on the actions doctors can and should take when resource issues prevent them from fully caring for their patients. Newdick comments strongly on the absurdity of having high-sounding professional standards that cannot be delivered by individuals within the system in which they work. He sees it as a recipe for stress in the professionals and disappointment for their patients. If the strain goes too far then doctors could come to view the supporting system as a hindrance rather than as a help to the practice of their profession.

In short, there is a tension between the deontology of individual doctor—patient interactions and the utilitarian nature of the NHS as a payment system that exists to enable the delivery of medical services to patients. At root what we see with this question is the old tension between the need to balance overall system resources with the demands of any one individual patient.

The question ‘Should the practice of medicine be a deontological or utilitarian enterprise?’ will evoke different answers from different people. How people answer this question will reveal a lot about their motivations, both as individuals and as members of their own tribe or tribes within the NHS—patient, manager, doctor, relative, etc. For all of us involved in the NHS (which will be almost everyone at some stage in the UK) the basic framework for the NHS is actually an economic one—namely that of pooled risk. Once you are involved with such a third-party payment system, whether funded by insurance or taxation, nothing can remain purely clinical, or confidential, just between doctor and patient. All clinical decisions have financial costs that have to be paid by someone. To try to avoid this fact is an evasion of responsibility. The new NHS white papers bring this fact into sharp focus with their wish to see the emergence of general practitioner (GP) purchasing consortia run by GPs taking direct responsibility for the costs and outcomes achieved by their member’s clinical activities in their localities.

What we have shown is that at present in medicine we have two competing ethical systems, namely deontology and utilitarianism, in operation. What is right under one system may be wrong under the other. We want to examine these two systems of thinking and acknowledge the strengths of both, and see to what extent they can be reconciled with each other.

If they cannot be reconciled then the NHS will not be able to achieve a viable balance between providing a reasonable standard of direct patient care and the responsible use of resources to allow this to happen for the whole population. In short, the NHS would become incoherent and fail as a system.

DEONTOLOGY

Deontology is the ethics of duty, that is, what one person should do in relation to another in a particular situation, regardless of the effect on the common good. The consequences of a deontological action may be right for the individual, but not produce a good outcome for the whole population. Deontological actions are therefore known as non-consequentialist actions.

UTILITARIANISM

This system aims for ‘the greatest good of the greatest number’. It calculates the ‘felicific calculus’ for actions. It is based on the work of John Stuart Mill and Jeremy Bentham. Its focus is on the overall good of society, rather than of individuals within it. It is a ‘consequentialist’ moral approach as it assumes that the results of actions can be predicted, and therefore the ends justify the means, if it is for the greater good. This is a form of act utilitarianism, in that a choice is made to produce the greatest good, but the same consequence can be arrived at indirectly by following a set of rules to produce the greatest good for the greatest number.

Beachamp and Childress proposed four principles against which medical decision-making can be judged from a moral perspective. They are beneficence, non-maleficence (or least harm), autonomy and justice, a framework that is well known to most modern doctors and can help guide ethical decision-making. Sadly, these widely accepted principles do not allow us to answer the unavoidable question addressed in this article, because they always exist in creative tension with each other, and they really describe the tensions within individuals, or in an individual consultation, and not those between individuals and the systems of which they are part.

The difficulty of balancing two separate and conflicting principles is highlighted by Veatch, who maintains that the best approach to resolving this conflict is to adhere to a single principle. We do not believe that this is possible for doctors, or the NHS, due to the conflicting interests of serving patients and paymasters, and to the need to achieve some balance between the needs of individuals and those of the group, namely other patients, paymasters and revenue providing taxpayers.

THE INDIVIDUAL IN SOCIETY: RIGHTS AND RESPONSIBILITIES

The problem of balancing the needs, responsibilities and rights of individuals against those of the group has been recognised since antiquity. The modern NHS poses this old problem in a particularly acute form; that will only become sharper as medicine advances and as the reality of the finite nature of resources is accepted. The questions will be one side, ‘To what extent can any one sick individual command the resources of the NHS be used on them?’ and on the other, ‘How do we use the NHS resources wisely to achieve the most good from them?’

DEONTOLOGY IN MEDICINE

In our consulting rooms we function largely as deontologists. Our concern is mostly for the individual patient in front of us. Almost all of good medical practice is about our relating to our patients in such a way that the patient receives an appropriate balance of:

- Diagnostic skill
- Sensible treatment
- Care
- Useful information
- Concern

The whole is underpinned by rapport made up of good communication and respect between the doctor and the patient. Most medical teaching and our clinical method comes from this deontological tradition. The whole of medical negligence law is based on our duty to our patients as individuals, and their right of legal remedy when the duty is broken.

This deontological ethic is important in giving doctors their motivation to do good by and for each patient they meet. It is an ethic that values the particularity of each individual patient. In this ethic the patient is an end in themselves, and not a means towards anything else.
valuing individuals, their narratives and relationships over time expressed as continuity of care.18

Good is done through each individual patient who is treated well. Harm is done by each individual who is harmed by errors of omission or commission.

THE UTILITARIAN CRITIQUE OF DEONTOLOGISTS

The utilitarian will accept this view up to a point. They will criticise it on several grounds. First, each doctor has more than one patient to deal with, and only a finite capacity in terms of energy, concentration, resources and money with which to deal with them all. Resources are finite, and there must be some way of allocating them between patients. A general practice appointment system is an example of such an allocation system. Nye Bevan’s famous quote about the NHS providing ‘all care necessary from the cradle to the grave’ is great rhetoric, but unachievable in practice. Doctors individually, and the NHS as a system, have to allocate resources as best they can, and hope that they act in such a way as to help individuals, and achieve some collective good for their society. The provision of a health service is an example of a collective good that benefits both society and its individual members.

UTILITARIANISM IN MEDICINE

This is another valid way of looking at the work of doctors and the function of the NHS as a system. Once we leave the confines of our consulting rooms and start discussing our work as whole we unavoidably move into a utilitarian mode of thought.

The NHS system for providing health care must, of necessity, be a utilitarian enterprise. We as clinicians act deontologically, but we do this within a utilitarian NHS, and it is this fact that causes the tensions between us and our paymasters. The NHS has finite resources, a fixed number of patients, and a certain amount of health needs to meet. At this point the only rational response is rationing, even if the process is euphemistically renamed, ‘priority setting’. Once you have reached this realisation then the work of health economists such as Professor Alan Maynard on quality adjusted life years and the creation of a body such as the National Institute for Health and Clinical Excellence becomes inevitable.

Furthermore, as doctors and patients we do not exist as individuals in isolation, but we are both parts of groups and societies, and some problems are best addressed at this level rather than individually. It is difficult to be fully privately healthy, in an unequal and unhealthy society as the study of health inequalities shows.19

The utilitarian viewpoint is very much focused on the overall effects of the medical system. It worries less about who does what than about what gets done. It aims to get the best result it can for each pound of the healthcare budget. Its focus is much more on transactions than relationships. The utilitarian tends to believe in the need for guidelines, and to constrain choices, so that only good choices, defined in terms of clinical or cost effectiveness, are made. Opportunity costs are the hidden harm here, and should be avoided by mandating and implementing good practice across the board.

The utilitarian viewpoint is pragmatic about the incidence of harm in medicine. Some harm is inevitable in any system, and although regrettable, it is justified by the greater good of a larger number of others. For example, it makes sense to talk of accepting some vaccine-damaged children as ‘a price worth paying’ for society’s freedom from epidemics of serious infections. Likewise, the utilitarian sees some iatrogenic harm as inevitable in any system in which a lot of patients have to go past a relatively small number of doctors in a quick time.

The deontologist regrets the lack of time for care. The utilitarian points out that the deontologist is going too slowly and that although one patient is having excellent care, there is a long queue that would benefit from any care at all. There is always a trade-off between speed and quantity of care and thoroughness and quality of care. The NHS has not explicitly acknowledged this trade-off, nor said at what levels it should be played out. Therefore, this tension runs through every doctor’s consulting room, and so why surgeries and outpatient clinics are exhausting work, and can easily run late. The gap between what should be done and what can be done is a major source of strain for health professionals, and of frustration and sometimes poorer outcomes for patients.

THE DEONTOLOGICAL CRITIQUE OF UTILITARIANISM

There are great strengths to the utilitarian view of medicine, but there are great weaknesses too. Utilitarians tend to be generalisers. They value guidelines that state the general pattern of, for example, the treatment of hypertension. The deontologist will be worried about whether the guideline applies well to his particular patient, and will want the get-out clause of ‘exception reporting’ in case it does not. The utilitarian will tend to take umbrage at this, and push for minimal exception reporting, and will see exceptions as a form of barely justified special pleading. The deontologists will be appalled at what they will see as, ‘prescribing by numbers’. The uneasy compromise here at present is tolerance of exception reporting but on insistence that it be justified. To many managers deviation from guidelines raises the spectre of medical malpractice. To any practising doctor such a view is anathema—the guidelines just do not cover the particularity and complexity of their current patient.

THE DOCTOR’S DILEMMA

From the foregoing discussion it is clear that there is potential for conflict between those with a utilitarian mindset and those with a deontological mindset. As it is the doctors and health professionals who are mostly deontological in their work, whereas public health, management and politicians are mostly utilitarian, you can see how the NHS generates its tribal conflicts.

George Bernard Shaw20 described the problem of treatment allocation and doctor’s duty beautifully in the play, ‘The doctor’s dilemma’. At that time the decision was a private one for Dr Colenso Ridgeon between his two patients Dr Blenkinsop and the artist. The advent of the NHS now means such allocation decisions have moved into the realm of public and political decision and away from the privacy of individual doctors or individual commercial transactions. The dilemma faced by Dr Ridgeon is the same one now faced by the NHS. Who gets the treatment? What criteria allow us to decide the issue fairly? The play traces Dr Ridgeon’s agonies as he tries to find a fair way of allocating treatment between two patients, both of whom have merits and both of whom have flaws. The truth is, of course, there is no way of deciding the issue fairly.

The National Institute for Health and Clinical Excellence currently faces exactly the same dilemma, but on a larger scale across whole groups of patients and whole classes of disease and treatments. The modern doctor and the modern NHS are in exactly the same bind as Dr Ridgeon.


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IS THERE A WAY OF ACCOMMODATING THESE TWO MORALITIES? A POSSIBLE SOLUTION AND SOME CAUTIONS

Perhaps this brings us to the point we need to reach to answer the question of where we need to be to answer the question of whether the practice of medicine should be a deontological or utilitarian enterprise.

We think that the practice of medicine at the individual doctor–patient level should be mostly deontological. Without the confidence the patient must have that the doctor will fulfil his or her duty, the patient as a taxpayer will start to question the humanity, effectiveness and value of their payments into the NHS. Hence the power to damage the NHS by stories of unmet needs in newspaper and journal articles. Such tales are not hard to come by, as shown by recent stories of GPs being paid a bonus for not referring patients to hospital. Once patients think that doctors will accept incentives not to treat disease properly then the case for an NHS is lost.

In fact, both doctors and patients know that the NHS is a utilitarian institution of finite resources. However, at the level of individual clinician–patient interactions we need to try to maintain the consultation on a deontological basis. That is that the patient can trust that the doctor is doing his or her best to fulfill their duty to them, and we need a clear system in place for when a doctor is unable to deliver what the patient needs, so that an individual doctor is not left carrying the blame for rationing decisions made elsewhere.

At management levels each patient is merely a number or a statistic, or a completed care episode or whatever other unit you want to measure in. This level of analysis should ideally be hidden from public view. It is necessary and essential work, but it should be distinctly ‘back office’. To achieve this will need changes in attitudes on the part of both managers and doctors, and less political interference from government. Or maybe government needs to take some courage, admit that the NHS is a decent, universal, but limited, service, and allow patients to purchase additional care at their own expense.

NECESSARY CHANGES

There is currently a plea going out from NHS management for more ‘clinical engagement’. There is not a parallel appeal going out for management involvement in medicine. Yet understanding of one side by another must go both ways. The failure of politicians and NHS managers to understand the dynamics of medical practice, and in particular the nature and moral duties of the doctor–patient consultation, significantly reduces their ability to get the results they want from the clinicians, and their ability to modify systems to get the service they want for patients.

The current management drivers unleashed on the NHS are distinctly utilitarian, and based on short-term, finite, commercial transactions rather than relationship-based, long-term, open-ended care. To some extent they have to be, but there is a risk that such strategies will destroy the very thing they wish to achieve. As John Seddon points out, ‘When organisations focus on unit costs the costs tend to rise’. One of the great unappreciated successes of the NHS is that it took most doctors out of commerce—if you want to see a return to private provision and unequal provision and standards of care and access, then drive doctors back into the private sector.

CONCLUSION

In this article we have described the conflict between the basically deontological practice of medicine at the basic level of doctor–patient encounters and the overall utilitarianism of the NHS system. The mismatch between these two ways of thinking, and the difficulty of marrying them with the current political drivers, we maintain is at the root of the problems between doctors and management in the NHS.

The resolution will come when theutilitarians appreciate the overall good that emerges from the deontologically based care that medicine has always provided. It may look messy and particular, and it is variable in standard and far from perfect, but it is infinitely preferable to medical care delivered as a series of standardised transactions in a marketplace.

There is a necessary place for both deontological and utilitarian ways of thinking within the NHS. The art is knowing which to use when, and not to try and override one with the other. At present the utilitarian approach is being driven too strongly, and the deontological processes of everyday care are becoming strained as a result.

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